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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
I am beginning to appreciate the difficulty of producing an article for a journal on a bi-monthly basis. The editorial staff are ever patient but each time I try to ‘put it to bed’ something else crops up that I feel the need to squeeze in. By the time you read this it will be the last Bulletin of 2006 and winter will be upon us. As I write, summer has definitely returned and it is hard to convince oneself that dark mornings and evenings and bare trees will be with us soon.

‘Good doctors, safer patients’

August is traditionally a ‘quiet time’ in the College as there are no committees; not so for the many members of Council who have devoted considerable time to preparing the first draft of the College’s response to Sir Liam Donaldson’s report ‘Good doctors, safer patients’ (GDSP – see: www.dh.gov.uk/CMO). This long awaited report, dealing with the issue of revalidation, dropped into view in mid-July. This is not the first time that a hugely significant document has appeared just as everyone is about to take a well-earned holiday. In fact so regular is this occurrence that maybe we should open the betting on what it will be in 2007.

Many of you will have read the CMO’s report, or at least the summary, and have formulated your own views on the document and its recommendations. Indeed there will be those of you who intend to respond to the consultation on your own behalf. Thus far John Curran has spent his summer collating the responses from a working group and others in the College, and a mighty task it has been. As a document, ‘Good doctors, safer patients’ is not short, with 202 pages, 10 chapters and 44 recommendations. Although a panel advised Sir Liam, he writes, ‘the report represents my own synthesis and analysis of the underlying issues and my own proposals for change’.

Whatever the debate over this report, and it will be extensive, the revalidation issue cannot, in my view, wait much longer. We do need action to maintain public credibility; whether that action is as set out in the CMO’s document remains to be seen.

The draft response from the College will have been discussed by Council in September and October and I have no doubt that it will be revised before the close of consultation in November. Once Council has agreed our response, we will make it available in full to all. However, such is the importance of this document for our future as doctors that I propose to summarise some of our preliminary views. I am grateful to John Curran, author of the summary of the draft version, for his permission (after a bit of moaning about hostages to fortune) to quote here.

The document describes some increase in the State control of medicine, reflected in the view that the duty of Government is to protect its citizens. With good reason many doctors will complain of being weary, distrust the current climate of regulation and find the increased number of stakeholders bewildering. Despite ‘Shipman’ most doctors still enjoy the confidence of the patients they serve. This brings with it the need to appreciate that despite the view that professionals have duties and not privileges, application to duty results in our being privileged. Our obligation now is to demonstrate that we do our duty and do it against clear standards. This is a change from others (such as the GMC) being asked to prove the opposite.

There is some inevitability about the proposals (short of their being headed off by an outright rebellion which it would not be our business to either initiate or condone). That so much time has elapsed since the GMC first proposed re-validation in 1998 is an argument for correct and urgent, rather than hasty, action. We must say what we think; acceptance of the possibly inevitable is likely to turn it into the inevitable, whereas well-argued challenge may improve matters. The document does need improvement. If political determination proceeds despite reasoned argument it can be recognised as ill advised.

We welcome the Secretary of State’s clear acknowledgement in the press release that accompanied GDSP (see: www.medicalnewstoday.com/medicalnews.php?newsid=473980) that professional regulation is a complex matter. Some feel that the changes are oppressive; others think that because of previous poor handling of problem doctors by the profession, the GMC and at local level, changes are needed and that the Colleges should confine their comments to matters that directly affect them.

We must insist that whatever systems are put into place they must be better than those they replace. Evidence that the proposed new systems will be better is scantier than is criticism
of the past. This is particularly important when one of the components, the local employer, will be given a big role in re-licensure. For this reason we do not think it is simply a matter of looking at limited sections of GDSP, but of seeing it in its entirety and deciding which parts to support, those (if any) to actively oppose and those which need to be improved.

No matter how much is better left to other organisations, doctors still look to the Colleges to give effective leadership on professional matters. GDSP is a professional matter, and its overall premise that patients need to be protected from doctors, rather than doctors protect and serve patients, is sadly dominant. Though this will raise hackles in other organisations, it should not stop the Academy of Medical Royal Colleges and individual Colleges from giving dispassionate views, because in its recommendations, there are many things to support.

Whatever of its failings in dealing with complex problems, planned replacement of any of the GMC’s functions must have some prospect of improvement, rather than handing them to another body simply because it is more directly answerable to Government. We doubt that PMETB is ready to assume the GMC’s Education functions.

We support

- retention of the GMC’s power to limit or work to remedy a doctor’s practice with his agreement
- retention of the GMC’s power to make interim orders
- with reservations, the concept of local GMC affiliates
- the transfer of adjudication functions to an independent body
- registration of students
- two-tier listing on the register
- the development of generic standards, which should rely on the GMC’s expertise (cf ‘Good Medical Practice’).

We do not support

- transferring the GMC’s role in undergraduate medicine to PMETB at this stage. The complexity of the work of the GMC probably hides from those proposing change to PMETB just how difficult this will be for this new organisation to take it on. In the longer term, were this to take place, the existing expertise and corporate knowledge of the GMC’s education committee should be retained in any new structure
- all members of the GMC being appointed. While elections might not have so far produced the correct balance, they avoid the allegation of political patronage and cronyism. Some members should be elected; perhaps the fewer the number the better they might be.

Simulation, teaching and assessment

There is little mention of anaesthesia in the Donaldson report but it is mentioned in relation to high-fidelity simulation. There is reference to Ronnie Glavin’s excellent article in this Bulletin (Bulletin 35, January 2006:1746–1748).

Although Donaldson is correct that simulation has yet to be formally incorporated into the anaesthesia curriculum, it is now in the OSCE part of the Primary FRCA examination. In a number of our Schools of Anaesthesia, annual visits to the simulator, appropriate to the year of training, are already a mandatory part of study leave and the RITA process. As Ronnie points out, these expensive technical tools have become less expensive and more widely available.

It is true to say that ‘trainees have embraced simulation-based training and are asking for more’ and that they could eventually become a national quality assurance tool. However, with Sir Liam Donaldson’s suggestion that revalidation be divided into re-licensure and re-certification it is in the latter area that simulation may become a vital assessment tool. That is all very well for those anaesthetists under forty years of age who have been brought up with simulators, but what about those of us at the other end of the age scale? I am under no illusion that I, and I think some of you, would find that we might likely fail such an assessment. I am aware that this is a gap in my education and one I would have to fill, were simulators to become part of Quality Assurance for re-certification.

Whether simulation is used for teaching or assessment, I applaud an increase in its usage. Nothing will ever substitute for hands on experience, but should we not be looking to a combination of technologies to train and maintain skills? To this end the College is currently pursuing an e-learning system with the DoH. As we all know, trainees are present in hospitals for many less hours than they used to be, and it is essential that we embrace new technologies including simulation and e-learning, so that we can maximise the number of hours trainees do spend in direct patient contact, with people who are trying to teach the practical aspects of our specialty.

Welcome to Churchill House

At the end of August and beginning of September the College of Emergency Medicine and the Intensive Care Society, two of our partners in Churchill House, moved into their premises on the third floor; the British Pain Society will move in at the beginning of November. It’s already obvious what an advantage their presence in the building is for Anaesthesia. One only has to nip downstairs to find the person with the information sought, and it’s so much easier with a face to the name. As we develop the curriculum for the Acute Care Common Stem (ACCS) programme,
proximity can only make the task of the training departments easier. We welcome all three organisations and wish them well in their new venture.

Contact with Fellows and Members

In January Peter Simpson asked the question: ‘How does the College provide a more meaningful link to all its Fellows and Members?’ I appear to write here on each occasion that I am most anxious to pursue this and by the time this is published I shall, I hope, have visited two departments for a ‘new style’ College visit – at last! These visits are really intended as an opportunity for you to meet with representatives of your College and exchange views, be they harmonious or not. I have also accepted as many invitations as I am able, to speak to local specialist societies and trainee groups for the same reason.

With the advent and development of PMETB our conventional Hospital Visiting has all but disappeared. We have had considerable concerns about this, as not only has it decreased our links with you but it has also made it difficult for the College to assist with any problems you raised. We have made very forceful representation to the Postgraduate Deans and to PMETB about these concerns and I hope that we are making some progress in a spirit of co-operation.

Perhaps an error in the past was not to see training as completely integral to medical care. The changes in Postgraduate Medical training have forced Colleges to look very carefully at what they hope to achieve by visiting. This enforced look at our approach will, I hope, eventually result in a more effective and ‘user friendly’ visiting system, but it is mighty hard work for a lot of people in the interim. Whatever the eventual outcome of visiting, in its widest sense, it will certainly be a co-operative venture with the Postgraduate Deans and I am grateful to Elisabeth Paice, chairman of the Committee of Postgraduate Medical Deans (COPMED), and her colleagues for their advice over the summer.

Modernising Medical Careers (MMC)

It has surely dawned on the entire medical profession now that, whatever the specialty in which they work and at whatever level, MMC and run-through training will impinge on their lives in less than a year. In July we held a meeting in Churchill House in conjunction with the Association of Anaesthetists where the attendees were mostly Clinical Directors. Although there were profound concerns expressed about the maintenance of service levels during this time of change, it was a useful day for all involved.

This week I sat down with my own Clinical Director to discuss these very concerns. He has to prepare a submission for our Medical Director on the expected practical implications for Anaesthesia in our trust on 1st August 2007 of MMC. I’m sure that many of you are facing a similar challenge. One even has certain sympathy with management, which may take the view that the simplest solution is to use money from posts not in run-through training for Trust Doctor Posts at all levels. In my view, that would be catastrophic for the quality assured maintenance of the standard of patient care. However, information must be provided rapidly now if we are to prevent them looking to such a solution in large numbers. Service must be maintained at, or above, the standard we currently have.

One piece of very good news on this subject arrived recently from Steve Field, the Lead Dean for anaesthesia. Thanks to persistent petitioning by many people, but particularly Steve on behalf of anaesthesia, the MMC Board for England have agreed that although the appointment procedure for run-through training will be annual, starting times for posts may be staggered. This is a very significant advantage for anaesthesia, where trusts and trainers are grappling with the implications of a year’s worth of novice SHO’s all starting on the same day. It is to be hoped that the MMC Boards for the rest of the UK will follow suit.

Some battles you do win.
Introduction

Many children can be very appropriately cared for by the general anaesthetist, despite an increasing trend towards sub-specialisation. In addition to keeping up to date with the clinical skills required, all anaesthetists need to have some basic knowledge of child protection (CP) procedures, now often referred to as ‘safeguarding children’.

Even anaesthetists working entirely in adult hospitals should gain some acquaintance with this thorny subject, as it can be argued that they are treating adults who frequently meet with children in a family setting.

Situations where abuse is suspected are both emotive and relatively uncommon. As a consequence, and because of a lack of specific training, we may feel ill equipped to deal with them. Whilst it is true that these issues can be genuinely difficult and time consuming to resolve, hopefully they will not provoke a response along the lines of ‘I’m not a paediatric anaesthetist – it’s not my business’. In fact the advice is fairly straightforward and easy to follow, and can be summarised as ‘seek help if at all unsure’. Anaesthetists as a group are usually masters of the measured approach, and are not afraid to involve other groups to assist in diagnosis.

Safeguarding children

Safeguarding children is topical because of several disturbing recent high profile cases of actual or suspected abuse. These have been perceived to be poorly managed by the established agencies, and this in turn has put pressure on all groups to improve their efforts to ‘get it right’. Much of what is now recommended is broadly outlined in the recently published National Service Framework for Children. In the area of CP, this framework is the Government’s response to the Victoria Climbé case, which was detailed in Lord Laming’s report. This revealed mistakes and poor communication at all levels in healthcare, social services and education, which contributed to the death of a child. The advice that followed from the Department of Health said that all healthcare professionals had an implicit duty to report suspected child abuse.

Anaesthetists may encounter possible or actual abuse of children in a number of situations.

- Resuscitation of a critically ill child who has sustained an injury under circumstances that cannot wholly be explained by natural circumstances or is clearly ‘non-accidental’.
- They may be called upon to anaesthetise a child for a formal forensic examination, possibly involving colposcopy, sigmoidoscopy and the collection of specimens in addition to visual examination and photography.
- During the course of a routine pre-op examination or surgical procedure, the anaesthetist or surgeon may notice unusual or unexplained signs which may be indicative of physical or sexual abuse.
- Rarely, the anaesthetist may be the recipient of a disclosure of information about abuse from a child, or adult carer.

In all these scenarios, it is essential that healthcare professionals act in the best interests of the child. Probably the most difficult situation, and one for which there has been no specific guidance, is when abuse is suspected after a child is anaesthetised in theatre. A working group involving representation from the RCoA, the Association of Paediatric Anaesthetists (APA), and the Royal College of Paediatrics and Child Health (RCPCH) has recently produced some detailed advice for anaesthetists confronted with this problem, and a modified flow chart taken from this group is reproduced in figure 1. Full recommendations will soon be available on the RCoA website.

Types of abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to the child. This also includes fabrication of symptoms.

Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and adverse effects on the child’s development.
Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening.

Significant harm is the threshold, established by the Courts, which justifies compulsory intervention in family life.

Clinical features
Suspicious signs which may be indicative of physical and/or sexual abuse, include:

- cigarette burns, particularly in young children
- bite marks, finger tip bruising
- slap marks
- unusual injuries in inaccessible places, e.g. neck or ear
- intra-oral bruises or abrasions
- damage to intra-oral frenula, where no clear history of direct trauma is offered, in a non-ambulant child
- genital trauma (where no clear history of direct trauma is offered or part of the clinical presentation).

Consent and confidentiality
There may be concern and confusion in this area with respect to the rights of children, and in particular carers. No one wishes to be accused of making alarmist or unfounded accusations. However, the child’s welfare is paramount, and this should influence decision making and override the needs of parents or carers. Generally, both the child and carers are entitled to know what is going on, and to be helped to understand the steps being taken. If it is believed that it is genuinely not in the child’s best interests for a parent or carer to be informed, justification for such a decision should be made and documented. This is rare.

With regard to disclosing information to others, again the doctor should do so if they feel that it is in the child’s best interests. The General Medical Council (GMC) publication ‘Confidentiality: Protecting and providing information’ states: ‘If you believe a patient to be the victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you must give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient’s best interests.’ However, a competent child’s need for protection does not diminish the need to gain their agreement before information is shared, and generally time should be allowed for this unless the risk is great.

Although, in England and Wales, anaesthesia and surgery may proceed with a Gillick competent child’s consent, it is still generally felt to be good practice that this is also sought from a person with parental responsibility if the child is under 16. In Scotland, competent children and young people consent in their own right. Whilst under anaesthesia, asking a second medical practitioner for advice does not require additional consent, and may be helpful in a case of suspected abuse. This might include asking them to attend theatre to visually inspect a skin marking, provided this can be arranged in a timely fashion. However, intimate examination, or taking specimens or photographs under anaesthetic, should not occur without separate consent.

Managing concerns (see Figure 1)
If the anaesthetist becomes concerned about the possibility of abuse during a procedure for an unrelated condition when abuse has not been previously suspected, then contact
with the child’s paediatrician or the on-call consultant for acute paediatrics is advised. If there is genuine uncertainty about whether signs are consistent with those caused by intentional harm, this should be discussed at an early stage with a senior paediatric or anaesthetic colleague who may attend and give advice. It should be emphasised that any member of the multi-professional team should be able to initiate the process. If there is disagreement about the need to ask for further help with diagnosis (e.g. between anaesthetist and surgeon), the default position should be to seek advice.

Nevertheless, further management should ideally be agreed between the paediatrician, surgeon and anaesthetist. Consideration needs to be given to:

- informing the parents
- further assessment (including forensic samples and photographic record)
- informing Social Services and/or police.

The paediatrician should lead this process, but may well wish to discuss management with the on-call child protection team. It is advisable that the parties present in any discussion with the parent(s) and child should be the consultant paediatrician (the local paediatrician on-call, or the named child protection consultant) and the consultant anaesthetist. In cases where the surgeon has noted the abnormal finding, the anaesthetist might be replaced in these discussions by him/her. However, it would be both unwise and unnecessary to confront parent and child with a committee of three senior clinicians. At this discussion, a reasonable explanation of injuries etc may be put forward. Nevertheless, if there are continued concerns (on the part of any of the consultants involved), a formal referral to the named or designated personnel should be made by phone and followed up in writing.

Referring on

All trusts have access to child protection experts. These are the named doctors and nurses, who usually work within the trust, and designated doctors, who often work within the local area. It is essential to involve personnel with special expertise in CP when child abuse is suspected. Anaesthetic departments need to know who these people are and how to contact them, and it is suggested that this information is readily accessible in theatres. If there are very serious concerns, Social Services need to be informed early, but this will generally be decided upon by the named or designated doctor or nurse.

Both the parents, and (where appropriate) the child, should generally be informed as to why a second opinion has been sought, how the situation will be managed, and how quickly and where any interview and/or examination is likely to occur. The form of words used is extremely important, and the explanation should be couched in terms of a need for a further opinion.

Why should the anaesthetist need to be involved at all, if the paediatrician agrees there is cause for concern? The situation might be compared to that in which the child has an allergic reaction to an anaesthetic agent whilst in theatre. Would we expect a third party to meet and explain what had happened to the family alone? It would generally be easier to have the person who first witnessed the problem available to answer any questions that arise, and guard against future misunderstanding. Since the anaesthetist will have generally met the parent and child, this will help.

If signs of abuse are substantial, this is usually followed by a report by the designated or named doctor to Social Services or the police. It is normal practice that they would then set in motion the initial investigation and assessment of the child’s disclosure. A medical examination pertaining to alleged abuse will be carried out after such interview, and may require general anaesthesia.

Implications for governance/training

It is the responsibility of any hospital providing services for children to ensure that appropriate procedures for child protection are in place and that these are disseminated to all staff involved in the care of children, including the names of the named and designated doctor and nurse for CP. Local training should also be readily available and it is expected that CP awareness training form part of the regular clinical governance programme for all those working with children. It will be shortly added to the competencies expected within anaesthetic training. All of this constitutes level 1 CP training, with which most of our nursing colleagues will be entirely familiar.

Further information

For those who want more information, or those who lead in paediatric anaesthesia within their trust, the RCPCH, together with the National Society for the Prevention of Cruelty to Children (NSPCC), has recently developed a comprehensive training package in child protection, currently available for doctors training in paediatrics and emergency medicine. It is hoped that this will become available for other professional groups. Meanwhile anaesthetists should take advantage of local level 2 training, which is usually readily offered within a trust. The RCPCH has also produced the ‘Child Protection Companion’ which is presently available only in hard copy. This should soon be available from the RCPCH website.
Summary

It is everyone’s responsibility to safeguard children and to take seriously signs of possible abuse. Anaesthetists need to:

- act in the best interests of the child
- be aware of the child’s rights to be protected
- respect the rights of the child to confidentiality
- contact a senior paediatrician with experience of child protection for advice when unsure.

References

4 Department of Health. What to do if you’re worried a child is being abused. DH, London 2003.
6 Royal College of Paediatrics and Child Health. Responsibilities of doctors in child protection cases with regard to confidentiality. RCPCH, London 2004 (see: www.rcpch.ac.uk).
7 Gillick v West Norfolk and Wisbech AHA (1985) A11 ER 402.
10 Age of Legal Capacity (Scotland) Act, 1991.

AS WE WERE...

In the search for a safer anesthetic it has very long been overlooked that mortality, immediate and remote, from the old agents, was really due more to the manner in which they were administered, than to the anesthetic itself.

That such an important specialized branch of medicine should now, after upwards of 50 years since the introduction of anesthetics, be still in its infancy, is, I believe, due to the surgeon. ‘Anyone can give an anesthetic’ is the cry, as old as anesthetics themselves.

I consider it unjustifiable for nurses to administer anesthetics...

This is an abuse which exists in this country to a considerable extent even to this day. In striking contrast to the importance that many surgeons and the occasional administrators attach to the anesthesia is the manner in which the patients themselves view it. It is well known that in the vast majority of cases where operations are necessary, the fears of the patient are centered almost entirely on the narcosis.

The surgeon should divest himself of the idea that he is doing the anesthetist a favor by having him administer the anesthetic... The fact that some surgeons receive fees of from hundreds up to, in some instances, thousands of dollars, and expect the anesthetist’s account to them to be from $10 to $25 seems incredible; it is nevertheless in my experience true.

The way to correct an abuse is to expose it — the abuses of anesthesia in the past are slowly being corrected by the realization of the superior results obtained by the skilled administrators of the present.

It has been questioned as to whether I would have the courage of my convictions. This paper answers that question.

Ref: Excerpted from Goldan, S.O. Anesthetization as a Specialty: its Present and Future. American Medicine 1901, 101–104, a paper as relevant today as it was a century ago.

Goldan recognised the importance of proper training for the anaesthetist. He was also a pioneer of spinal anaesthesia. He stressed the importance of keeping records, and he published what was probably the first purpose-designed anaesthetics chart. More should be known about this thoughtful and interesting man.

Dr David Zuck
The History of Anaesthesia Society
**Part-time doctor, full-time mum**

Full-time or part-time? If part-time: 50%, 60% or 70%? When to take the exam? How to organise childcare? Blimey – I thought choosing Pampers or Huggies was a hard decision.

I didn’t consider flexible training after the birth of my first child because my childcare arrangements were solid. I did not want to lengthen my time of training as a senior house officer, nor did I feel confident enough in my skills as an anaesthetist to be able to work less hours. I do remember toying with the idea. However, I knew of one senior registrar who was a flexible trainee and she appeared to like it. Come the birth of my second daughter, I had passed my Primary FRCA and completed the 24 months’ training required, and flexible training was a very attractive proposition. It would enable me to balance my increasingly chaotic work and home life.

**The admin bit**

Anaesthesia has been at the vanguard of ‘less than full-time training’ for over 30 years. The discrete nature of our care affords us an ability for sessional work. As such, our specialty has more flexible trainees than any other. Of our trainees, 9% work flexibly to some degree with a huge amount of regional variation. In contrast, some of the surgical trainees who requested to train flexibly were treated with disdain by their peers and superiors. The most common surgical specialty to have flexible trainees was Obstetrics, presumably due to the short episodes of care contact on the labour ward and the high number of female doctors in the specialty.

The process started with a request to the Flexible Training Dean. There was the interview to confirm my choices and assess my reasons for training flexibly. As there was a demand for flexible training, the assessment depended upon set criteria – women who had children and childcare considerations were given high priority (thankfully), followed by doctors (men and women) who had illnesses affecting their ability to work, and then those with elderly dependents. Essentially, there had to be a very good reason for becoming a flexible trainee, which was not a God given right. Apparently there was also a waiting list dependent on the availability of posts, which for anaesthetics, thankfully, was short. Traditionally, anaesthesia has been a very proactive specialty in embracing the advancement of working practices for women with children. Some of the current female consultants had completed their training flexibly.

Every specialty has lead consultants for flexible training, who are responsible for advising and organising the flexible trainees within their regions. I was incredibly fortunate to be posted to a hospital where the Regional Flexible Training Clinical Lead Consultant for Anaesthesia was also working. She told me how many days I needed to work (depending on the percentage of full-time I wanted to do), and also how many on-calls I would need to cover to receive training recognition from the RCoA. The leads spend their life under a mountain of paper dealing with the College and Deanery!

My very first post was working 70% in a full-time post. For the days when I was not in, my work was covered by my colleagues, and a locum was booked for the extra on-call days. The department was very supportive. One could work 50, 60, 70 or 80% of full-time and this increased the length of training proportionately. For example a trainee working 80% during their entire training would have 80% of each year recognised and would increase their time by approximately one year. At 70% one would have to do approximately two years extra and at 50% five years extra on top of the standard five years. When applying to become a flexible trainee I had also to consider that it was harder to change from a lower percentage to a higher percentage than vice versa, due to funding issues. With the current rules it is very easy to change up or down and so this is less of a consideration.

I’ve got my number and the baby’s walking – now what?

Once I had been appointed as an SpR on the North Central Thames rotation, I started to job share with other flexibly training registrars. In this, two trainees occupy a full-time slot
on the rotation as opposed to being supernumerary to the department. Both of us were opting to work more than 50% each. This meant that extra on-calls were taken from our colleagues. Unsurprisingly, we were very popular. However, job sharing did not mean that we would have to cover all five of the days of the week: sometimes neither of us were in the department on the same day. This occasionally led to colleagues joking that we were the inflexible trainees! During the week, however, I was allowed to do fixed days. I opted to work on Tuesdays, Wednesdays and Fridays. This coincided quite nicely with nursery days. On one occasion, I had been asked to work on one of my days off, in return for another day and I had forgotten to come in to work! I was phoned at home and rushed in after organising emergency childcare, feeling very sheepish. I was very apologetic and the incident was put down to post-maternity brain shrinkage! Despite this hiccup, my time as a flexible registrar was a very enjoyable one. In general, attitudes to flexible training were very positive. The trainees enjoyed doing less on-call and the consultants did not treat them any differently from the full-time trainees.

The flexible training allowed me to achieve a good work-life balance. During the days I was not at work, I had the opportunity to spend time with my little ones or revise for my FRCA exam. Whilst at work I was able to have some professional time, without the constant interruptions of mischievous toddlers every two minutes. In fact, in the first few months after returning to work, on-calls were a breeze compared to feeding a small baby several times a night for 12 weeks or more! Once in a while I was able to get some hours of continuous sleep! Sometimes though it was hard to tell the difference between dealing with a two-year-old’s tantrum about not being allowed another biscuit and a 52-year-old orthopaedic surgeon who can’t send for his last patient!

Every year, I had a RITA to assess my progress. This was done per calendar year rather than equivalent full-time year. If I had not done enough cases this would have been picked up at that time.

I continued to train flexibly until 2005. At this time, with the commencement of shift work, the hours for full-timers were reduced. Most posts on my rotation became a 2B. At this time, it was my general impression that the number of cases I was doing per month was dropping. This was not helped by the fact that the surgical trainees were also slower than their predecessors, thus compounding the situation. I made a decision to go back to full-time.

What about the money?

At the start of my flexible training, I was paid pro rata for additional duty hours (ADHs). In this system, with a greater percentage of training, i.e. 80% and above, more ADHs were counted. Job sharing was rare and flexible trainees were often supernumerary within the departments. In departments with 1 in 5 or 1 in 4 on-call commitments they were welcomed because they reduced the on call commitment of the full-timers. All colleges insist on trainees doing their proportion of out-of-hours commitments before the job is recognised for training.

When the new deal was implemented with the banding structure of pay, the situation became a little more complicated. If the trainee was working below 40 hours then they received flexible banding. The pay scales were band FA or FB carrying 1.25 or 1.05 multiples (depending on amount of out-of-hours work). However, if the flexible trainee worked more than 40 hours then they were reassessed on the full time pay scale often receiving 1B or higher pay scales depending on the number of hours worked.

This meant that flexible trainees were regarded as expensive and many departments refused to take flexible trainees working more than 60–70%. This created difficulty for a little while for placement of trainees within the rotations. No sooner had this been sorted out when the Deanery started to reduce the funding for flexible trainees. Initially, the Trust received all the basic salary from the Deanery, with the hospitals picking up the ADH supplements or banding supplements, as they do with all full-time trainees. Subsequently, the proportion of basic salary given by the Deanery reduced, at the time when EWTD implementation also required the Trust to take on extra full-time staff. Some hospitals started to refuse to have flexible trainees.

In June 2005, the rules changed to a relative pro rata banding supplement. This enabled flexible trainees to be paid for the work they did. Of course with the changing nature of working in the NHS, we can be certain that nothing will stay the same. One thing is for sure – you will have to get proficient at paperwork to make certain you get paid correctly. At the moment with on-call commitments it is easier to be flexible. I personally think it’s harder to work into rotas and people don’t like having their nights taken away. In anaesthetics most of the trainees now work a rota containing one or two nights per week. If the flexible trainee did one of the nights, the full-time trainee would have to come in both days pre- and post-night. Occasionally some full-time trainees objected to this – especially Thursday nights!
TRAINEES’ TOPICS IN ANAESTHESIA

Also in 2005, following agreement between the Junior Doctors Committee (JDC) of the BMA, the Departments of Health and the Committee of Postgraduate Medical Deans (COPMeD), ‘new arrangements’ for flexible training were launched.Outlined were commitments to ensure less than full-time (LTFT) became mainstream, and:

- to double the number of LTFT trainees within three to five years
- to ensure that all doctors who have a well founded reason are able to access LTFT training and are dealt with positively
- to ensure that pay scales are pro rata to full-time colleagues for all aspects of work undertaken
- to collect UK data on the demand for and access to LTFT training.

As you will guess there are a few specialties which are not as enlightened as ourselves and which have a long way to go to reach these aims. We are good but have a little more work to do.

In summary

I have thoroughly enjoyed training part-time, and would recommend it to anyone!

Occasionally, you may feel a little regret half way through the rotation when your friends finish training and become consultants before you. However, this is momentary and fades quickly when you realise that you have managed to be available as a mother to your children when they needed you most, in addition to working to achieve a career in medicine.

I used to tell my non-medical friends that I was working flexibly and this meant about 50–64 hours a week; they laughed, as most flexible workers in other jobs work less than 40 hours a week. One has to bear in mind that you will be on the rotation for a little longer than your full-time counterparts, often gaining more practical experience due to the extra time spent. Most of my colleagues who have trained flexibly are thus more confident of their own skills as clinicians. In the light of the EWTD requirements to reduce the training hours, this may not hold true for very long.

I would like to thank my Flexible Lead Consultant, Dr Lila Dinner, who worked tirelessly to ensure that all the flexible trainees were able to have a very good rotation with balanced training opportunities equal to those of full-time trainees during the difficult times of funding withdrawal.

Flexible training in anaesthesia
Dr Melanie Jones, Bernard Johnson Advisor – Flexible Training, Royal College of Anaesthetists

Introduction

Over the past decade the numbers of doctors in flexible, or less than full-time (LTFT) training in the UK have increased. This way of training is supported by the Royal Colleges and the Deaneries and reflects a general acceptance that not all doctors wish, or are able, to work on a full-time basis. The current medical school intake is often 70% female and surveys of training grade doctors regularly show that 80% envisage working part-time at some point in their training.

Anaesthesia has a higher proportion of part-time SpRs than most hospital specialties. There are fewer part-time SHOs, reflecting the fact that many trainees perceive the need to consolidate basic skills before moving to part-time training.

Factors affecting availability of posts

Regional variations in numbers result from variations in local demand, the availability of funding and the ability to include part-time trainees within the programme.

Understandably, the demand for flexible training rises in those Deaneries where access is not delayed due to a lack of availability of placements or funding for posts. Where there are larger numbers of flexible trainees within a programme, it is perceived as a normal way of training and again demand increases.

Role models may also affect how part-time training is perceived. Where consultants have trained flexibly, or have chosen to work part-time to meet family demands, the trainees may feel more able to express their wish to train flexibly.

Support for flexible training

RCoA Bernard Johnson Advisor

One of the Bernard Johnson Advisors, based within the Training Department, at the RCoA has specific responsibility for flexible training, and:

- provides advice to individual trainees
- provides advice to the RCoA on flexible training
- calculates CCT dates of flexible trainees
Table 1 Regional distribution of flexible trainees in anaesthesia for Great Britain and Northern Ireland at 31 March 2006

<table>
<thead>
<tr>
<th>Region</th>
<th>SpRs</th>
<th>Female</th>
<th>Male</th>
<th>(All female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglia</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>East Scotland</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
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<tr>
<td>London</td>
<td>33</td>
<td>31</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Leicester</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mersey</td>
<td>5</td>
<td>5</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>6</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nottingham</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>6</td>
<td>6</td>
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<td>3</td>
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<tr>
<td>North West</td>
<td>5</td>
<td>4</td>
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<td>1</td>
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<tr>
<td>Oxford</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peninsular</td>
<td>6</td>
<td>6</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>South East Scotland</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severn</td>
<td>16</td>
<td>15</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sheffield</td>
<td>11</td>
<td>9</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Wales</td>
<td>17</td>
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<tr>
<td>Wessex</td>
<td>12</td>
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<td>1</td>
<td></td>
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<td>West Midlands</td>
<td>12</td>
<td>11</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>West of Scotland</td>
<td>3</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Yorkshire</td>
<td>9</td>
<td>9</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>164</td>
<td>154</td>
<td>10</td>
<td>23</td>
</tr>
</tbody>
</table>

- provides advice to the Flexible Training Advisors, Regional Advisors and College Tutors on matters relating to flexible training
- is a member of the RCoA Training Committee advising on issues relating to flexible training
- attends meetings of the UK Flexible Training Group of the Committee of Postgraduate Medical Deans (COPMeD)
- attends the Inter-Collegiate Improving Working Lives Group.

The Regional Flexible Training Advisor

Each Region has a Flexible Training Advisor who:
- provides advice to individual trainees on flexible training
- provides advice to the local Specialty Training Committee (STC) on flexible training
- works with the Programme Director to implement flexible training
- assists the Regional Advisor in approving flexible training posts
- links with the local Postgraduate Deanery on flexible training in anaesthesia in the region
- links with Bernard Johnson Advisor to raise issues relating to LTFT training.

**Types of flexible training programmes**

There are four ways of training part-time, all arranged through the Regional Postgraduate Deans.

1. **Slot sharing** – where more than one individual working LTFT is placed within a training ‘slot’ in a department. This is not the same as a ‘job share’, where the individuals jointly apply for a whole-time post. This has become the recommended approach for part-time training. Indeed, some Deaneries have adopted a rigorous approach and now expect that all part-time trainees are placed in slot shares.

   Slot sharing trainees are often at the same stage of training. They can share the out-of-hours work associated with a post, although do not need to share the day time work and so may be in work on the same day. Two individuals working 60% of whole-time can occupy one training slot, i.e. delivering 120% whole-time equivalent (WTE). This can benefit a department by providing some additional manpower to support annual leave/sickness gaps in the rota.

   Slot sharing has been most successful where a high proportion of part-time trainees live within a small radius. It can be difficult to arrange in schemes with few flexible trainees or in those which cover a larger geographical area. Sharing partnerships are fluid, and are influenced by training needs, changes of responsibility due to exam passes, periods of absence (maternity and sick leave) and changes of location.

   A further advantage of slot sharing is that it allows the funding attached to a full-time post to be allocated to flexible trainees, rather than delaying access to training whilst waiting for supernumerary funding.

2. **Supernumerary posts** – an individual post is created for a named person who is placed as an additional trainee within a department.
Application should usually be made well in advance of a proposed start date. Many trainee anaesthetists plan their flexible training programme before taking maternity leave. Certain situations involve a sudden move to part-time training, e.g. personal health issues and family crises. The Deaneries and Programme Directors are used to dealing with these difficult situations and will make every effort to assist.

Recognition/approval of flexible training posts

A flexible training post must be at least 50% of full-time, as required by EU legislation. On-call should be organised pro rata, and posts will not be recognised for training by the RCoA unless they include the full range of duties and shifts on a pro rata basis. An individual trainee should be neither advantaged nor disadvantaged by training flexibly.

Individuals, who are unable to undertake a full range of duties and shifts for ill-health or disability reasons and for whom a reasonable adjustment to training may be required, should discuss this with the Deanery and the Regional Advisor. The Training Department at the College should be informed and the Bernard Johnson Advisor may need to refer the case to the Training Committee.

A job plan and timetable will be discussed with the department the trainee is joining. If a slot share is arranged, written confirmation that the post is RCoA approved will be given by the Regional Advisor. The Deanery must also approve the programme which should include protected teaching time.

Since September 2005, the Postgraduate Medical Education and Training Board (PMETB) has the statutory responsibility to approve all new posts and programmes. If the LTFT post is supernumerary and over the previously approved number of posts, then specific PMETB approval must be obtained. The Deanery will advise on how to complete the application form.

Calculation of CCT date

Ten months working at 60% is needed to gain six months’ WTE towards your CCT. Should full-timers reduce their hours, the % WTE and CCT date can be recalculated. Alternatively, hours may be reduced to remain at the same % WTE and CCT date.

Up to three months’ WTE absence (due to maternity or sick leave) may be counted towards the CCT date, provided a written request is made to the RCoA Training Department following a return to work and the College Tutor or Programme Director confirms that any training deficit, which might have occurred, has been addressed.
The Training Department at the RCoA must be given the exact dates of any leave taken which may affect your CCT. The calculation of a CCT for a trainee who has worked both full- and part-time in various locations with periods of absence due to maternity or sick leave can be very complex and may take some time.

Other training regulations
The six-month period of grace after CCT is the same for flexible trainees as for full-time trainees.
SpRs training flexibly are required to have an annual RITA. Regulations and advice regarding out of programme experience (OOPE) are the same for flexible trainees as for full-time trainees.

Outcomes
Most flexible trainees obtain a CCT and then become consultants, working either full-time or part-time. They are more likely to remain in the region where they undertook their training. Part-time consultants have been able to move into full-time posts later in their careers. Consultants seeking flexible retirement can be accommodated in job shares with younger colleagues wishing to work part-time.

In summary, demand for less than full-time training will continue to grow in the coming decade. Adaptation of training programmes and service delivery will be required if anaesthesia is to attract and retain high quality trainees.

Useful contacts and sources of information
- Visit the Royal College of Anaesthetists website www.rcoa.ac.uk.
- Regional Flexible Training Advisors – ask the College Tutor for the name of the individual who undertakes this role for your region.
- Deanery Flexible Training contacts – name from Deanery office or Deanery website www.copmed.ac.uk. This links to all Deanery websites where more information is available.
- Training and Examinations Department, RCoA – tel: 020 7092 1552 or email: training@rcoa.ac.uk
- www.bma.org.uk and follow the links to junior doctors and then flexible training.
Chronic pain services receive a great deal of attention from a variety of interested groups and organisations. At a parliamentary launch on 14 June 2006 the Chronic Pain Policy Coalition was formally launched at Portcullis House. This newly established forum, for patients, professionals and parliamentarians, is to operate at a policy level. Like many other like-minded groups, the Coalition’s aims are noble: ‘improve the lives of people living with chronic pain by developing and sharing ideas for improved prevention, treatment and management of chronic pain in the UK’. At the launch, many fine words and sentiments were echoed around the issues that need to be addressed.

It is clear why there is support for such a coalition from groups such as ‘Back Care’, the ‘British Pain Society’ and ‘Action on Pain’. Most agree that one in seven of the UK population are affected by chronic pain, although this may be an underestimate of the true figure. Given the economic impact of chronic pain, both to individuals, their families and employers, and to the UK economy as a whole, the move to encompass so many interested parties at a national level should be applauded. Hopefully it will result in greater political and media pressure to change the status quo, for despite its obvious beneficial impact to patients and society at so many different levels, treatment for chronic pain remains badly resourced in the UK. But how will the momentum of the launch be maintained?

The Coalition is publicly well supported but the challenges remain firmly fixed. Why? Because despite the number of interested groups and high profile names prepared to speak out about the effects of chronic pain on their lives and the appalling state of chronic pain services in the UK, little changes in the planning and prioritisation of services within the NHS. Authoritative national reports and guidance documents sit upon the shelves of commissioners and providers of services gathering dust, while well meaning and compassionate health professionals from different disciplines struggle to care for patients referred to them, often dedicating their own time and resources in the process.

A painful old age

This information should not surprise the reader; we all know about someone who has taken time off work because of a pain related injury. The older we become (don’t we all want to live to a ripe old age?) the greater the chances that pain and arthritis will set in. The most vulnerable people in society are the elderly who suffer, often unnecessarily, because they are unable to access services or treatment when they need it. This is an area calling out for research. This should focus not only on clinical drug trials but on other methods of pain management that are offered by multi-professional teams, often anaesthesia led. But, as the Coalition has indicated, this too needs to be championed at a national level. Research funding is nowadays very difficult to come by, particularly for Cinderella services such as chronic pain management. A recent edition of the British Medical Journal drew attention to the fact that, of all the studies related to pain, only one % addressed the topic of pain and ageing.

A painful death

I have heard arguments for assisted dying and voluntary euthanasia based entirely on the experiences of chronic pain sufferers who cannot get access to services; they fear for the future, not only for themselves but for those loved ones that care for them. I have been told by a trust director that, given the ‘economic state of the NHS’, such services do not come high on the list of priorities. I have to wonder whether they are on a list at all! I have learnt that chronic pain affects one in three households, and that arthritis is the most common cause. I personally know of many who fall into this category. According to the British Pain Society, 49 % of people who live with chronic pain have taken considerable time off work, and many more have become less physically active. Sufferers are more likely lose their jobs and be diagnosed with depression.

What outputs will result from this new venture; a nationally comprehensive and prioritised approach to funding, or perhaps a nationally prioritised research programme into the treatment of chronic pain? Perhaps the greatest pity is that health service commissioners and managers do not work into old age. Maybe then the need for chronic pain services will move up the NHS business agenda. Is our best hope with age discrimination legislation?

Reference:
1 Minerva. BMJ 29 April 2006;332:1042. ‘An editorial in Pain Medicine (2006;7:57–9) calls out “to those with the power of inquiry, the skills to teach, and the desire to heal”’. 
Staff and Associate Specialists Committee

Time to learn (and teach)

Dr A B H Lim, Dr R Laishley, RCoA SAS Committee

Well, unleash the dogs of war, the British Medical Association’s SAS committee have done the decent thing and stood firm on several issues, one of which is the amount of time that we get for supporting professional activities (SPAs). This is something that we have very strong feelings about, especially now that the Chief Medical Officer’s report has resurrected the spectre of revalidation and re-accreditation. This will require us to keep ‘educated’ and up to date in our specialties, along with audit and maintaining our portfolios. To do this with ‘a minimum of one SPA per week’ is not going to be feasible. We have the same requirements as the consultant body with regard to revalidation and re-accreditation, so we should not be getting any less time than they do. Continuing Medical Education is not just about us going to courses and meetings to learn things: it is about those of us with expertise in our relevant areas of practice being allowed to go and teach these skills too. To date, we have 135 SAS anaesthetists who have registered with the College as being ‘approved to teach’.

By this time next year, the ‘seamless training posts’ will be fully operational and there will be the spectre of trainees who are not able to get onto the ladder because of the sheer pressure of numbers. This means a not inconsiderable number will be ‘pushed to the right’ of the Modernising Medical Careers (MMC) flow-chart into Fixed Term Training Posts or even further right into service posts. These doctors will, for the most part, wish to re-enter training at some point, and we as a group are going to be in the invidious position of both teaching these doctors and (for those that wish to return to training) being in competition with them for whatever spaces appear, in whatever form MMC decrees, on the seamless training ladder.

We have no magic wand to wave, I’m afraid. Future trainees will be entering a health service that is vastly different from the one that most of us entered all those years ago.

*Declare the past, diagnose the present, foretell the future*

– Hippocrates

Hippocrates in his covenant urged physicians to teach the secret of medicine to the next generation. Continuing education and personal development are integral parts of a professional life. In 2003 our consultants acquired a new contract, comprising 10 programmed activities, generally 7.5 for direct clinical care and 2.5 for SPAs, for full-time consultants.

As SAS doctors, we have every need to maintain our skills, and accordingly we should have the same opportunities as our consultant colleagues. Yes, our job plans are heavily service based, but we still need to maintain our key knowledge and skills framework – a process that requires adequate time. The ability to undertake research and audit should be available to all. Through audit we are able to learn and improve the service we provide.

We believe that the path followed by the MMC programme will result in a service grade cohort which in the medium term is likely to be very different from today’s SAS doctors. They will need continuing education with the opportunity to learn new skills and perhaps even to acquire ‘credentials’ (should such a system develop). They will also need to have the opportunity to re-enter training. As well as learning ourselves it will be increasingly necessary for us to teach the future body of SAS doctors.

The Choice and Opportunity document, published in 2003, amongst its 14 recommendations, pushed for better opportunity for teaching, training and personal development. It is essential that our new contract addresses this educational need and that sufficient opportunity and resources are provided. We must build on the ideals expressed in this 2003 consultation exercise and ensure that our educational opportunities are increased.

References:
Examining is one of the most rewarding tasks in anaesthesia and, although extremely hard work, is also an area where long-term friendships are forged. Working alongside some of the most dynamic Fellows is also one of the best ‘CPD by osmosis’ processes yet devised. There are still some myths and misinformation about how examiners are selected and trained, and it is time to correct some of these. In this article, I will describe the process of appointment and cover the attributes we are seeking as well as some pertinent details of the structure of the examinations.

Background

There are two Boards of Examiners (Primary and Final) each with a team of examiners. They both have about 70 examiners and, at present, function independently although this is under close review. There is an Examinations Committee of Council which has overall responsibility for all aspects of the examinations process. This Committee appoints the Chairman of each Board, and recommends to Council all new examiners. It also annually reviews all examiners for renewal of their appointment. The normal term of examinership (including the probationary year) is ten years but this can be extended by Council if it is thought necessary.

The composition of the Boards of Examiners reflects the changes in medical manpower over the last 20 years or so. For instance, the current gender ratio of Primary examiners closely reflects that of consultants in the NHS who would fulfil the regulations for appointment (and matches those published in the BMA equal opportunities report – May 2006) at 25% female. There are 10% non-UK graduates. The age range also is that of appointable consultants (between 40–50 years on appointment). Equally, the number of examiners from smaller hospitals matches those from larger, more specialised ones.

The Examinations Directorate, under its Director, David Bowman, manages the process of examinations and all administrative aspects relating to it, including our equivalence with other overseas anaesthesia examinations. There is no ‘down-time’ in this Directorate because of the number of examinations and their associated written papers, organisation of the formal oral examinations, and requests for information and arranging guidance interviews, amongst numerous other responsibilities. Most oral examinations require between 40 and 55 examiners, all resident in London for the week, as well as the examinations staff, the College facilities management and ‘imported’ staff to help time-keep, act as shepherds for the candidates and assist in a myriad of other ways.

Training for examiners takes place both as a formal event prior to starting and as ‘workplace-based training’ within the examinations themselves. All examiners start in the Primary and most will move to the Final within three years of starting. The reasons for this are largely historical but predominantly because the Primary has a more clearly defined process and established cohort of senior examiners.

The annual commitment to the examinations varies between two weeks per year for new examiners, to about four weeks for senior examiners responsible for key sections of the examinations process. However, being selected as an examiner is accepted as one of the highest accolades possible, and is recognised as such by trusts, colleagues and, especially, trainees.

The selection process

Examiners for the Fellowship of the Royal College of Anaesthetists are appointed from those eligible consultant Fellows who apply to the Examinations Committee. Selection is an open process that strictly follows best practice in all aspects of anti-discrimination procedures and takes place once the closing date has passed. The competition for these examinerships is high, and few are appointed on their first application.

The process is a continuous one that begins in the spring, when the Examinations Committee decides how many new examiners are needed for the next-but-one academic year. This number is also influenced by the experience profile of the current examiners, the expected numbers of candidates and predicted retirements.

During the summer, application forms for examinerships are posted on the College website (www.rcoa.ac.uk) and adverts are placed in key anaesthetic journals. The closing date varies slightly from year to year, but is towards the end...
of October. The key attributes of examiners and the criteria for selection are published in the College Examinations Regulations booklet and on the website (see below).

The application form, in common with many others, has a number of information fields that are considered by the Examinations Committee, as well as confidential ones to monitor anti-discrimination activity within the College. One of the important aspects of completing this form is to express clearly how the activities you describe meet the specifications laid out in the ‘regulations’. We also need confirmation from one of your clinical managers that they are in support of your application. This is more to maintain your local support than for any College view, but it may be very important if there are already other examiners within your department. Fixed clinical or other commitments during the week cannot be honoured during the examination weeks, and this has to be carefully considered before applying.

After the closing date, all the applications are reviewed to confirm that the applicant is in good standing, both with the College and the GMC. The list is then circulated to the entire Examinations Committee (including the Patient Liaison Group representative) for consideration and ranking. The Examination Committee meets in November to establish a ‘long list’. This reduces the field from about 70–80 applicants to about 30–35. This process is exhaustive and meets all ‘anti-discrimination’ good practice principles.

The priority is for applicants who demonstrate an ‘above average’ and consistent commitment to training and assessment, and who are recognised by their peers for this activity. This does not mean that they have to have been a College Tutor for example, but if they have been or are one that would be a point in favour. Other essential skills include team playing, flexibility and conscientiousness. We also look for high level personal and attitudinal skills, and evidence of initiative and drive.

Evidence that they are prepared to help with education in their region or nationally is another marker we would seek. Clear evidence of active CPD and an area of expertise are also considered. The latter is more important when we identify that retirements will dilute expertise in a clinical or basic science component of either examination. There is then a review of the geographical distribution of the applicants against the current cohort of examiners to ensure a representative distribution of examiners across the UK.

We do not use any positive discrimination of any form. The examiners have to meet the expected standard – no more, no less!

Once the 'long list' is decided, the individual applicants are allocated to committee members to seek more information. This is a formal process where as many informed sources of information as possible are contacted to comment on the applicants. This may, for instance, include their Regional Advisor, any local examiners, Council members etc, and requests confirmation/opinions on the applicant’s contribution locally and nationally. Where there are several applicants from the area, ranking is sought and, if there are already examiners in that department, an opinion on whether the department could cope with another examiner.

If there are areas where there appears to be a conflict of opinion, the responsible committee member will ring up sources to try to clarify the situation.

This information is collected and collated over the Christmas period and reviewed at the February Examinations Committee. All applicants are then reviewed and a final ‘short list’ is prepared. This list is then circulated to Council and considered at its February Council meeting. It is the full Council that reviews the short list and has the responsibility to approve each applicant.

The President then writes to all applicants to inform them of the results. No applications are held over to the next year.

Once appointed, the examiners have a probationary year after which they are approved as full examiners. The probationary year starts with a training day to provide detailed insights into the examination process and its place in national assessment for PMETB. Practice sessions in both oral and OSCE examination also take place. No-one can examine without completing this day of training. The probationary examiner then examines for two of the three weeks over that academic year and is observed, videoed and supervised by senior examiners. In the second week they have an appraisal and assessment by the Chairman/deputies of that examination board.

The successful examiners are then confirmed as examiners by the Examinations Committee in September, and the process begins again.

Criteria for selection as an examiner for the academic year 2007/08

Essential
1. Shall normally be a Fellow by Examination, but a Fellow ad eundem, or a Fellow by election of the Royal College of Anaesthetists will also be considered.
2. Shall be in good standing with the College.
3. On 1 September 2007 shall have been a consultant anaesthetist, or have held a comparable appointment, for a minimum of seven years.
4. Shall currently be active in clinical practice.
5. On 1 September 2007 shall have the expectation of
completing ten years as an examiner whilst filling a consultant appointment in the NHS, or a comparable post.

6 Within the past five years shall have visited a Primary or Final FRCA examination.

7 Can demonstrate active involvement in the education and assessment of trainees.

8 Good written and verbal communication skills.

9 Ability to work as part of a team.

10 Evidence that they have attended Equal Opportunities training.

11 Long-term commitment to the role including the ability to devote a minimum of 11 days per academic year to examiner duties.

Desirable

1 Shall demonstrate a special interest(s) directly relevant to the balance of expertise required in the Board of Examiners.

Bulletin Advertising

The Royal College of Anaesthetists’ Bulletin is published bi-monthly and distributed to over 13,500 anaesthetists worldwide, the vast majority being in the UK. Being so widely distributed, it is obviously seen by many other professionals who work alongside anaesthetists.

Advertisements for courses and meetings from anaesthetic societies, or those organisations that are of interest to anaesthetists, are accepted with prior approval of the Editor or Editorial Board. Each advert is generally placed to the rear of the Bulletin amongst the other notices.

Text and any image, logo or crest should be submitted to Mrs Mandie Kelly or Mrs Edwina Jones by email (bulletin@rcoa.ac.uk). Please ensure that images are at least 300dpi in resolution and are sent as a separate file (rather than embedded within a Word document) which will ensure higher quality. Preferable formats are TIFF, JPEG or EPS.

The size of the advert is to some extent dictated by content and the layout of all adverts will be in keeping with the Bulletin style and design. Please note that we do not use loose inserts in any issue and cannot supply the names and addresses of our members for marketing or commercial purposes.

Prices below are per issue and are subject to VAT at the current rate. They are effective from 1 July 2006:

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A 20% discount is available if advertisements are placed in six consecutive issues and are paid for in advance. Please supply a contact name, email and full address for the invoice.
Exam week

I t’s exam week, the culmination of five months’ preparation for both candidates and examiners alike. I arrived yesterday, shoo-ed onto the train by my husband who is looking forward to a week of freedom. Consigned to a gloomy tower block hotel, room 820 is my home for a week. The interior designer has failed to capture even the essence of comfort and luxury, it’s 7.00 am and I haven’t slept. Do I know enough to examine? Can I cope with the intense demands of the week? Irrational anxiety and self-doubt replace my dreams and I drag myself out of bed.

Breakfast, best clothes and I set off on the ten-minute walk to the College. In the lane where I live snowdrops, primroses, blackberries and holly delight me on my way to work and guide me through my life, but here I enter Queen’s Square, close and oppressive year round, with tall buildings that exclude the light, grey dust-laden grass struggling to exist, and I feel intense, primitive unease. The garden is surrounded by black, spiked iron railings, symbols of brutality, and, in the road are gleaming vicious motorbikes, fixed to the ground with thick heavy chains. I reflect on man’s bestiality, barely hidden, and I ponder the task ahead. On to Holborn and our fine new College. Past the waiting candidates, each enveloped and isolated by fear, and up the stairs to my allotted desk. A pile of papers has to be sorted; audit forms need numbers and dates so that our performance can be compared with our past performance, our colleagues’, and the norm. All the candidates’ details must be checked and, however early I arrive, it feels as if there are only moments to sort out the morning’s questions.

When appointed as examiners we accept that the examination will be our first priority. We examine in pairs and where possible keep the same co-examiner for a week. A lot of thought is given to the examiners’ pairings. Personalities, the way we mark and several other factors, including an audit of examiners’ individual performances, are all considered with the aim of giving the candidates the best chance. The supportive relationships I have during the week keep me going as I become increasingly drained, especially when examining with an inexperienced Final examiner. Tradition and common sense dictate that new examiners have first choice in the areas of questioning that have been scheduled, and their co-examiners take the rest. We are expected to have enough knowledge to cover the whole syllabus, whatever our sub-specialty, and most of us continue to study in a manner similar to the candidates.

The morning viva

Ten minutes to go and we anxiously divide up the work. I’ll do the long case and you do the three short questions. I read the information given to the candidate and try to collate the investigations. I scan the lung function tests, the chest x-ray and the ECG if provided. I summarise my conclusions, glance at the examiners’ guidance and memorise the areas of questioning suggested. Each candidate will cover several of the same areas but we are not given specific questions. Most time is spent in assessing the candidate’s ability to come to some common sense decisions relating to a clinical scenario. Would I be happy being on-call with this candidate tonight? Would he be able to deal with this situation? The clock ticks away. We have to keep to time and not dwell too long on areas where the candidate struggles. Often the candidate has no idea of the level of ability we are expecting. Perhaps he is doing well. Is he a prize candidate? To find out we increase the level of difficulty to the point where he cannot answer. Or alternatively, as he fails to answer the simplest of questions we do our best not to humiliate him. Should we award a 1 which will ensure that the candidate fails? He may be unaware of the level of his ignorance or, just occasionally, so consumed by nerves that he cannot answer. Or alternatively, as he fails to answer the simplest of questions we do our best not to humiliate him. Should we award a 1 which will ensure that the candidate fails? He may be unaware of the level of his ignorance or, just occasionally, so consumed by nerves that he cannot answer. I, too, know how it feels to have questions hurled at me and all one can hear is words, no sentence, no sense and certainly not the question. Yes, I have sometimes felt, in a state of confusion as hope slips away, it is easier to say ‘I don’t know’ rather than try and think. But I can’t let you get away with that. You have done at least three years’ anaesthetics and before I wreck your life I have to be certain.

My co-examiner asks his three short questions and I attempt to make a written record of his interaction with the candidate. The bell goes and I make my judgement. I am unaware of the candidate’s previous marks, or, as the day goes on, any other marks awarded. There are no quotas, and my co-examiner cannot see my mark as he awards his. Borderline candidates are of course the most difficult, and we have less than five minutes to mark and prepare for the next candidate. We show each other our marks and hope we agree, which we do, mostly. If not, a discussion ensues and the examiners must compromise. It is so difficult to be objective. Some examiners say they find it easier than I do. We examine with an expected level in mind. The performance of the previous candidate and all the usual influencing factors must not come into it.
The College officers keep us going and the next candidate appears. Then, after another five minutes break, we present a new selection of questions. It’s exhausting. Coffee, back again for new questions and two more candidates and then lunch. If only there were time to enjoy the delicious food. We sit amiably, exchange anecdotes and plan our night out, never able to relax because we have to sign 80 certificates and get back in three quarters of an hour. I found my own certificate recently. Wow. What famous names let me through. As I struggled to bring up my kids, keep my career and my life together, never, never for one moment did it occur to me that I too would write my name in full (to show I am a woman) in such a prestigious place. I write with overwhelming pride. Me. How amazing. I owe a lot to two consultants who steadfastly refused to let me pack in my training.

The afternoon viva

Helter-skelter, back to the afternoon viva. Clinical science to tax the candidates and examiners. I plan my questions – seven minutes on Cytochrome P450. No wonder I lost sleep through self-doubt. It’s good practice to introduce the question through a clinical route. With outline answers provided I dredge my brain for information on drug metabolism and not even sludge comes up. I hope for a good candidate, the bell goes and my thoughts transfer to the young person opposite me. We have an observer. The candidate doesn’t know it’s my own performance that is being assessed but, like the candidate, I am concentrating to the exclusion of everything extraneous.

The examiners responsible for organising the clinical science viva have provided 12 questions for the afternoon and the last candidates deserve the same standard of examining as the first. I am relieved my own area of responsibility finished weeks ago. I write Short Answer Questions. It takes all my spare time for about two weeks per question. They are checked and rechecked several times but at least they are well out of the way before the vivas. All examiners are expected to contribute to the examination process as well as attending all the planning meetings and the vivas. It’s a massive commitment, inevitably supported by departmental colleagues. There are hardly any women and sometimes I am the only one. With the best of motives, because to them I am no different, some of my co-examiners cannot see this makes me uncomfortable. I think differently, I behave differently and I have different values. Despite recent improvements I feel the examination system is solidly male in its knowledge, skills and attitudes. Having said that, my co-examiners are the nicest, best bunch of people one could ever wish to work with. We get on extremely well and unfailingly work cohesively and constructively. We look forward to seeing one another and enjoy each other’s company. I think this is what keeps us going through all the demands.

Call-over

However, before we can party there is more work. At call-over, every candidate’s marks are reviewed and we dread having to defend a decision to award a 1 to a candidate who otherwise would have passed the exam with a 1+. Our discussions are recorded and there is a signed report of our reasons. Believe me: the assumption is that the candidates should pass at this stage. Our last task is to congratulate those who have been successful. We know what they have been through to reach this standard and the exuberant delight on their faces brings almost as much delight to me. I think of those who aren’t there, especially my own trainees. Crushing, savage disappointment.

It’s after 6.00 pm, at least ten demanding hours on, and what do doctors do on a precious night off, no matter how exhausted they are? Back through Queen’s Square. As I pass the old examination hall I remember my Final. I remember the dress I wore, the questions I was asked and the nightmares I had about it for years afterwards. I am distracted by a million alluring lights, glinting and shimmering provocatively. It’s 7.30 pm in the bar, and we pick somewhere decent to eat, adding substantial amounts to our allowance. I have tried everything available on Charlotte Street, know every restaurant through and through and, since the College move, sleazy Farringdon beckons wantonly. Who misses primroses when the theatre, the opera and the cuisine of the world are on offer?

By Thursday I can sleep, dwindling anxiety, increasingly shattered and, on Friday evening, my husband meets me off the train. He, ready to enjoy our time together; me, wiped out and unable to speak. After a couple of hours, like one of those insects who risks being devoured as it courts its mate, he tentatively mentions he has booked a table. Sweet morsels, sweet talk, I relax and the concerns of the week fade away. By nightfall all thoughts of the exam have gone. A whole month goes by without it so much as flitting through my mind, and now as I write at the beginning of August, the whole intense process has recommenced. Arrangements. Questions. The books and the journals are back out.

We give our best. Sometimes we must get it wrong, both ways. As I stand in front of those proud ecstatic faces I know that one day they will be the examiners standing where I am, proud and ecstatic again. They’ve gone through it once (please). I’m back next time round – twice a year for ten years.

Well, I suppose I must have learnt something in all that time.
NOVEMBER

2–3 November 2006 (code: B05)
CURRENT CONCEPTS SYMPOSIUM
NEUROLOGY AND ANAESTHESIA
The Royal College of Anaesthetists, London
Registration fee: £360
(£250 for registered trainees)

4 November 2006
CME DAY
A joint meeting held with the Association of Anaesthetists of Great Britain and Ireland
The Royal College of Anaesthetists, London
Registration fee: £195

7 November 2006 (code: C43)
RESEARCH METHODOLOGY WORKSHOP
A joint workshop held with the British Journal of Anaesthesia
The Royal College of Anaesthetists, London
Registration fee: £115
(£85 for registered trainees)

15 November 2006 (code: C65)
AIRWAY WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £55
(£100 for registered trainees)

7 November 2006 (code: C65)
AIRWAY WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £55
(£100 for registered trainees)

15 November 2006 (code: C65)
AIRWAY WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £55
(£100 for registered trainees)

22 November 2006 (code: A12)
INTRODUCTION TO TEACHING
The Royal College of Anaesthetists, London
Registration fee: £160
(£100 for registered trainees)

30 November–1 December 2006 (code: C22)
SCOTTISH WINTER MEETING
A joint meeting held with The Scottish Society of Anaesthetists
Hampden Park, Glasgow
Registration fee: £150
See page 2037 for further details

DECEMBER

4 December 2006
IT’S A KNOCKOUT... WAKE UP TO A FUTURE IN ANAESTHESIA!
The Royal College of Anaesthetists, London
Open day for young people who are thinking of a career in medicine or any of its allied areas
See page 2036 for further details

6–7 December 2006 (code: C80)
TEACHING METHODS WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £300
(£200 for registered trainees)
See page 2036 for further details

2007 – JANUARY

8–10 January 2007 (code: B08)
PRIMARY FRCA: BASIC SCIENCES PHASE A
The Royal College of Anaesthetists, London
Registration fee: £150
See page 2038 for further details

11 January 2007
NEW TUTORS MEETING
The Royal College of Anaesthetists, London
By invitation only

22–24 January 2007 (code: C68)
CURRENT TOPICS MEETING
Russell Hotel, London
Registration fee: £390
See page 2039 for further details

29 January 2007 (code: C79)
MEDICAL INNOVATIONS
The Royal College of Anaesthetists, London
So you’ve had a great idea, what next? An introduction to innovation: how to take your idea from concept to commercialisation.
Registration fee: £150 (£100 for registered trainees). See page 2039 for further details

NEW EVENT IDEAS!
Would you like to organise an event with the RCoA? If so, please visit our website at: www.rcoa.ac.uk and click on the light bulb on the Courses and Meetings/Events page to complete a New Event proposal form.
FEBRUARY

- 5 February 2007 (code: B53)
  AIRWAY WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £150
  (£100 for registered trainees)
  See page 2036 for further details

- 5–7 February 2007 (code: B63)
  PRIMARY FRCA: BASIC SCIENCES PHASE B
  The Royal College of Anaesthetists, London
  Registration Fee: £150
  See page 2038 for further details

- 7–8 February 2007 (code: C84)
  TEACHING METHODS WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £150
  (£100 for registered trainees)
  See page 2036 for further details

- 19 February – 2 March 2007 (code: A82)
  FINAL FRCA COURSE
  The Royal College of Anaesthetists, London
  Registration Fee: £500
  See page 2039 for further details

MARCH

- 7 March 2007 (code: C96)
  AIRWAY WORKSHOP – CARDIFF
  Marriott Hotel, Cardiff
  Registration fee: £150
  (£100 for registered trainees)
  See page 2036 for further details

- 9 March 2007 (code: C49)
  CORE TOPIC MEETING ANAESTHETIC EMERGENCIES
  The Teacher Building, Glasgow
  Registration fee: £200
  (£150 for registered trainees)

APRIL

- 19–20 April 2007 (code: D04)
  REGIONAL ANAESTHESIA MEETING
  Manchester Conference Centre
  Registration fee: £360
  (£250 for registered trainees)
  Further details to follow

- 25–26 April 2007 (code: B36)
  TEACHING METHODS WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £300
  (£200 for registered trainees)
  See page 2036 for further details

MAY

- 2 May 2007
  DIPLOMATES CEREMONY
  Kensington Town Hall, London
  By invitation only

- 8 May 2007 (code: C85)
  RESEARCH METHODOLOGY WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £115
  (£85 for registered trainees)
  Further details to follow

JUNE

- 5–7 June 2007 (code: A32)
  CURRENT TOPICS MEETING
  Manchester Conference Centre
  Registration fee: £390
  See page 2039 for further details

- 20–21 June 2007 (code: C55)
  CARDIAC DISEASE AND ANAESTHESIA
  The Institute of Education, London
  Registration fee: £360
  (£250 for registered trainees)
  Further details to follow

- 21 June 2007 (code: C18)
  INTRODUCTION TO TEACHING
  The Royal College of Anaesthetists, London
  Registration fee: £160
  (£100 for registered trainees)
  See page 2036 for further details

OTHER EDUCATIONAL EVENTS

- 17 November 2006 (code: C29)
  PAEDIATRIC ANAESTHESIA LINKMEN CONFERENCE
  The Royal College of Anaesthetists, London
  An Inaugural meeting of the Paediatric Anaesthesia Linkmen by the Association of Paediatric Anaesthetists.
  Registration fee: £50

Further information – www.rcoa.ac.uk
ANNIVERSARY MEETING

ANAESTHESIA, CRITICAL CARE AND PAIN CONTROL IN THE OLDER PATIENT

21–22 March 2007 (code: A03)
The Royal College of Anaesthetists, London

The main focus of the meeting will be the care of the elderly. The meeting will also include the Frederick Hewitt lecture and the Macintosh Professorial lecture.

Anaesthesia and the older patient
- What is different about the ‘fit’ elderly patients?
- Post-operative cognitive dysfunction
- Day surgery and the elderly patient

Outcome of surgery in the elderly
- Predictors of outcome in older patients
- The impact of multimodal care
- Postoperative management in the elderly patient

Critical care
- Should the age of the patient influence clinical decision making in critical care?
- Critical care in the elderly – the patients’ view.
- Strategies for withdrawing treatment in critical care.

Ethics
- When to treat – The ethics of surgery and critical care in the elderly
- Competence and consent for operations with elderly patients
- Do not resuscitate orders

Treatment
- Managing the older obstetric patient
- Acute pain in the elderly patient – what are the problems?
- Regional anaesthesia surgery in the elderly
- Prescribing and the elderly

The older specialist
- Are older specialists more dangerous?
- Why do we get out of date?
- Modifying your job plan as you get older?

DEBATE

Should anaesthesia as a specialty have supported the Assisted Dying Bill?

REGISTRATION FEE: £360
(£250 FOR REGISTERED TRAINEES)

APPROVED FOR 10 CPD POINTS
AIRWAY WORKSHOPS

LONDON
The Royal College of Anaesthetists
15 November 2006 **EVENT FULL**
5 February 2007 (code: B53)
6 June 2007 (code: C81)

WALES – Marriott Hotel, Cardiff
7 March 2007 (code: C96)

The day is aimed at Consultants who wish to ‘catch-up’ with current practice but is also suitable for trainees who wish to receive or top-up their manikin experience of valuable airway skills.

During the day each delegate rotates around all the activities, usually in a group of no more than 8 people.

The workshop features the core practical skills that are required by all anaesthetists and concentrates on difficult/failed intubation or ventilation.

The individual study areas will cover:
- failed ventilation and emergency cricothyrotomy with both needle and large cannula
- failed intubation managed by the intubating laryngeal mask airway and Proseal
- setting up and basic handling skills of an intubating fibroscope, low-skill fiberoptic intubation via an oral airway or laryngeal mask and with the Aintree catheter
- fiberoptic intubation via the nose and mouth
- airway anaesthesia and awake intubation.

There are usually 1–2 interactive case-based discussion sessions.

Workshop organisers are experience small group teachers

REGISTRATION FEE: £150
(£100 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

INTRODUCTION TO TEACHING

22 November 2006 (code: A12)
21 June 2007 (code: C18)
The Royal College of Anaesthetists, London

A one day meeting for all grades of anaesthetists which is designed to introduce doctors to the skills that are required to facilitate effective teaching and training. Subjects will include:
- Introduction, including an introduction to teaching adults
- Teaching for small groups and tutorials
- Teaching and assessing in theatre, including teaching practical skills
- Educational supervisors
- How to give a lecture
- Using PowerPoint effectively

REGISTRATION FEE: £160
(£100 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

TEACHING METHODS WORKSHOPS

6–7 December 2006 (code: C80) **EVENT FULL**
7–8 February 2007 (code: C84)
25–26 April 2007 (code: B36)
The Royal College of Anaesthetists, London

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

DAY ONE
- Introduction: Adults as learners
- The Qualities of Teachers and Learners
- Teaching Practical Skills
- Non Technical Skills

DAY TWO
- Small group teaching
- What is a small group
- Types of small group
- Small breakout group work – convergent/divergent
- Group process/difficult personalities
- Commissioning and organising a Lecture
- PowerPoint – the dos and don’ts

REGISTRATION FEE: £300
(£200 FOR REGISTERED TRAINEES)
APPROVED FOR 10 CPD POINTS

IT’S A KNOCKOUT... WAKE UP TO A FUTURE IN ANAESTHESIA!

4 December 2006
The Royal College of Anaesthetists, London

The Royal College of Anaesthetists will be holding its open day for young people 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.

The lecture is aimed at pupils who will be making their choice of A Level subjects this year, but older pupils are most welcome.

Please contact the Events Department for further details.
SCOTTISH SOCIETY OF ANAESTHETISTS ANNUAL SCIENTIFIC MEETING

DAY 1: 30TH NOVEMBER

Coffee/ Registration/ Trade
Session 1: Chair – Dr Margaret Stockwell
Management of the circulation. Some simple but effective strategies
Colin Runcie, Western Infirmary Glasgow

Hyperdynamic goals: where are the goalposts?
Malcolm Daniel, Glasgow Royal Infirmary

Molecular targets for lipid regulating drugs
Allan Gaw, Director Clinical Trials Unit, Glasgow Royal Infirmary

From ENT to ETT
Gordon Todd, Western Infirmary Glasgow

Lunch/ Trade/ Stadium Tour
Session 2: Chair – Dr Alf Shearer
Special interests. Do they affect day-to-day anaesthetic practice?
Ian Russell, Hull Royal Infirmary

Judgement day
Willie Frame, Glasgow Royal Infirmary

Gillies Memorial Lecture
‘Do you want to get better?’
Alastair Chambers, Aberdeen Royal Infirmary

OPTIONAL EXTRAS:
Dinner at Oran Mór (1900 for 1930) on Thursday 30th November: £55
Tour of Hampden Stadium: £3

REGISTRATION FEE: £150 (£85 FOR ONE DAY)
APPROVED FOR 10 CPD POINTS

RCOA SCOTTISH WINTER MEETING
UNRESOLVED ISSUES IN ANAESTHESIA

DAY 2: 1ST DECEMBER

Cerebral monitoring is the gold standard of anaesthetic depth monitoring
Pro: Gavin Kenny, University of Glasgow
Con: Ian Russell, Hull Royal Infirmary

All patients undergoing major abdominal surgery should have a thoracic epidural
Pro: Nick Scott, Golden Jubilee National Hospital
Con: Malcolm Daniel, Glasgow Royal Infirmary

Tight glycaemic control improves outcome in the intensive care unit
Pro: John Kinsella, University of Glasgow
Con: Nigel Webster, University of Aberdeen

The labour ward is no place for the occasional obstetric anaesthetist
Pro: Liz McGrady, Glasgow Royal Infirmary
Con: Graeme Hilditch, Western Infirmary, Glasgow

All predicted difficult intubations should have an awake fibreoptic intubation
Pro: John Henderson, Western Infirmary, Glasgow
Con: Gordon Todd, Western Infirmary, Glasgow

Use of hypotonic fluids in paediatric practice should be abandoned
Pro: Pam Cupples, Royal Hospital for Sick Children, Glasgow
Con: Phil Bolton, Royal Hospital for Sick Children, Glasgow

Further information – www.rcoa.ac.uk
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.

Phase A: 8–10 January 2007 (code: B08)
Phase B: 5–7 February 2007 (code: B63)
Phase C: 26–28 March 2007 (code: C73)

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

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

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

Lunch will be provided throughout these courses.

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

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

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

Further information – www.rcoa.ac.uk
EDUCATION EVENTS PROGRAMME

CURRENT TOPICS MEETING
22–24 January 2007 (code: C68)
Russell Hotel, London
5–7 June 2007 (code: A32)
Manchester Conference Centre

These three day meetings consist of lectures which are followed by ample time for discussion. It is intended for doctors engaged in clinical anaesthesia (i.e. Consultant, Staff and Associate Specialist Grade or their overseas equivalent) who feel they may benefit from a refresher meeting in the latest techniques.

REGISTRATION FEE: £390
APPROVED FOR 15 CPD POINTS

MEDICAL INNOVATIONS MEETING
29 January 2007 (code: C79)
The Royal College of Anaesthetists, London

So you’ve had a great idea, what next?
An introduction to innovation: how to take your idea from concept to commercialisation

INTRODUCTION AND WELCOME
Dr D Williams – Shakerscope Ltd

DESIGN AND CREATIVITY
Dr D Williams

INTELLECTUAL PROPERTY
Mr John Grant – IP Consultant
Trevor Baylis Brand Plc
Including: confidentiality agreements, the first meeting, patents, registered designs, trademarks and proprietary knowledge, the patenting process, costs and common pitfalls.

REFRESHMENTS

PROTOTYPING AND PROOF OF CONCEPT
Dr Richard Bibb – Head of Medical Applications PDR Ltd
Including: computer aided design, design for manufacture.

SETTING UP A COMPANY
Dr James Murray – Armstrong Medical Ltd
Including: how to do it, role and responsibilities of company director, sole trader versus limited companies, the highs and lows of running a medical device company.

LUNCH

THE PHYSICIAN AS ENTREPRENEUR
Dr Andy Goldberg – Director, Medical Futures Ltd

INTO THE DRAGON’S DEN
Professor Ken Board – Former WDA Chair of Entrepreneurship
Including: the Elevator Pitch, Business Plan – why and how to do them, raising funds and raising profile, publicity.

REFRESHMENTS

TAKING CARE OF BUSINESS
John Davidson – Lecturer Newport Business School
Including: an introduction to book-keeping, corporation tax and vat registration.

LICENSE OR MANUFACTURE?
Dr J Dingley – Art of Xen Ltd, Shakerscope Ltd, CO Therapeutics
Negotiating licence agreements: worked examples.

QUESTION AND ANSWER SESSION

END OF DAY

REGISTRATION FEE: £200
(£150 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

Further information – www.rcoa.ac.uk
Please complete and return this form to:
Courses & Meetings/Events, Institute of Education, The Royal College of Anaesthetists, Churchill House, 35 Red Lion Square, London WC1R 4SG
Switchboard: 020 7092 1500 Fax: 020 7092 1735 email: events@rcoa.ac.uk
ADDITIONAL FORMS ARE AVAILABLE TO DOWNLOAD FROM OUR WEBSITE

Your details

Full name: ____________________________
Please use BLOCK CAPITALS.

College Reference Number (CRN): ____________

GMC Number: ____________

Full mailing address:

Please ensure you complete your full postal address.

Tel: ____________________________
Fax: ____________________________
Email: ____________________________

This address is (tick one only): 
Temporary ☐ Permanent ☐

Date of Birth: ____________ ____________ ____________

Present appointment and hospital:

Payment details

☐ By cheque. A cheque for £ ____________ is enclosed (Sterling cheques should be made payable to ‘The Royal College of Anaesthetists’)

☐ By credit/debit card. Please debit my card (tick whichever is appropriate):

Cardholder’s name: ____________________________ Card Number: ____________________________

Please use BLOCK CAPITALS.

Valid from: ____________ Expiry date: ____________ Issue number (if available): ____________

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☒ Delegates cancelling less then ten days before the event will not be entitled to a refund unless the College considers there to be exceptional circumstances that warrant a refund.
☒ The College will accept name changes for attendees, please inform the events department seven days prior to the event.

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Only one thing is certain – when you write an article like this, you'll be wrong and people will delight in pointing this out to you for years to come! My colleague and mentor Joe Stoddart always used to say, and write, that intensive care medicine (ICM) was a young man's job and it was important to have dual training so you could return to a life in theatre with your feet up doing the *Daily Telegraph* crossword (metaphorically speaking of course). But when it came to making a choice he decided to drop anaesthesia and maintained his sessions in ICM until his retirement.

There are several areas I would like to explore in this article, including what will be the scope and place of critical care in the hospital of the future, how we will staff our units, and what treatment advances I think we might see. Inevitably, the result is a mixture of my hopes, aspirations and nightmares of what intensive care might become.

**Looking back**

When I started training in anaesthesia most ICUs had four to six beds and only really admitted patients who required ventilation, which was delivered by Manley or Cape Wain ventilators, familiar to anaesthetists from their use in theatre. Treatment for renal failure was intermittent haemodialysis, if you were lucky, and in many cases involved transfer to a unit with an associated renal dialysis facility.

Monitoring was by ECG, sometimes with a ‘travelling spot’, CVP with a water manometer, and BP measured non-invasively in all but the sickest patients. Indeed, in the 1980s, some of the units that I worked in had no facilities for intra-arterial monitoring. Pulse oximetry was still a technology of the future. Feeding, if done at all, was usually by total parenteral nutrition, with the gut completely forgotten. Patients were routinely paralysed, with phenoperidine and pancuronium as a common cocktail. Sedation (or the lack of it) seems not to have been a problem because pancuronium always works! There were few if any follow up clinics, so we didn't discover the error of our ways. High dependency units were unheard of, and outreach beyond our ken. So much has changed in the last 20 years, but what might the future hold?

**ICM in the hospital of the future**

Units will be large, encompassing levels 1, 2 and 3 patients in areas providing for their social and personal, as well as medical, needs. No longer will we see ‘aircraft hanger’ units with ten patients in one big room, but units will be built with individual cubicles affording patients a greater degree of privacy and possibly greater protection from hospital acquired infection. ICU will no longer be a small and expensive bit of the hospital, often not considered in the fight to gain resources, but will almost become the hospital. We will have outreach to the ultimate degree as the proportion of monitored critical care beds to total hospital beds approaches 50% and all patients well enough to be cared for in the community are moved out of hospital. Much of peri-operative care as we know it at present will be delivered by general practitioners and nurse practitioners, and most routine surgery will be done as out-patients in treatment centres without critical care support. The only surgical patients left in hospital will be the very sick and those with complications. The elderly will make up an increasing proportion of our throughput. There will be a temporary blip as patients with congenital abnormalities that used to be lethal in childhood survive to develop a whole new set of problems, before prenatal screening and treatment render them uncommon once again. Medical problems will be predominantly those of old age and degenerative conditions; the vision of ICM as returning young previously fit patients to productive life will be replaced by one of trying to get elderly people back to an independent existence.

**Ethics**

The classical tenets of medical ethics of beneficence and non-maleficence will remain, but autonomy will assume much greater importance over distributive justice. The fundamental principle of the NHS of not consuming more resource than is your fair share will disappear. The rights of the individual will rule: patients will have not only choice but also power. The current trend of referring clinicians being reluctant to make judgements about treatment limitation will continue, with intensivists reviewing patients who currently...
would not be referred to them because they are thought unlikely to benefit from intensive care. We will be engaging in many more conversations with patients and families over the merits or not of offering invasive organ support to patients with marginal chances of success. Court cases about critically ill patients will become more frequent, especially concerning the role of doctors in discontinuing 'futile' care and treatment. An increasing faith in our ability to cure all ills, inappropriately fuelled by media optimism, will not be matched by faith in our judgement of when to stop.

**Staffing**

A consultant based, though not delivered, service will continue. Intensivists will share the management and care of these large numbers of patients with acute physicians, acute surgeons and anaesthetists. Various models will exist for shared care of level 1 and 2 patients, but as clinicians with an 'ology' will spend more time doing outreach clinics in the community, their ability to deliver continuity to ill patients will diminish. Consultants with training and sessions in ICM will deliver a 24/7 service for level 3 patients; the days of anaesthetists with no day time sessions in ICM covering an ICU on-call are numbered.

With reduced working hours, training as an anaesthetist will not allow sufficient time to acquire the competencies required of an intensivist, and it will become essential to have completed either a joint Certificate of Completion of Training (CCT) or a single specialty ICM CCT. The role of the anaesthetist as a perioperative clinician will be enhanced as anaesthetic practitioners take on the routine work and medically trained anaesthetists care only for patients undergoing more complex surgery or with multiple co-morbidities.

Who will provide the service commitment in units currently delivered by trainees? This is a tricky question – the financial situation at present would seem to dictate we will not be looking at greatly increased numbers of consultants. Without a large increase, there will not be a need to train huge numbers of intensivists. Trainees will come to ICU, from a wide variety of specialty and Foundation programmes, as very junior doctors to learn the recognition and management of acutely ill patients. The numbers of trainees in later years of training will be limited by the numbers of consultants required.

As the old system of slavery/apprenticeship finally ends with the introduction of Modernising Medical Careers, the service contribution of senior trainees to ICM will greatly diminish. I think this will leave a service gap which will be filled by Advanced Critical Care Practitioners – highly trained people who will have undergone a two-year academic and clinical programme on top of their own basic training. These practitioners will provide long-term input to a unit, and will assist with the delivery of care to protocols that they will be much better at following than doctors. Practitioners will be able to see, assess, investigate and treat patients under an appropriate level of supervision from a consultant in much the same way as our medical trainees do at present.

The changing workforce programme will also lead to more of the bedside nursing care being delivered in teams which include assistant practitioners – people who were healthcare assistants and who will have received extra training and can care for most patients in ICU. The sacred ratio of 1:1 nursing will disappear to be replaced by a system of variable ratios depending on patient need. The change to advanced practitioners will be cost neutral but assistants paid at level 4 of Agenda for Change will be cheaper than qualified nurses on level 5. The need to deliver a cost effective and efficient service will be even more of an issue than it is today.

An alternative vision for ICU service delivery is the 'hospitalist' – a role which is becoming established in the US. These are fully trained doctors who provide resident cover to an entire hospital if necessary as a long-term career, but have no ongoing patient responsibility. In the UK, where might such people come from? With the potential mismatch between training and career posts which seems imminent, there may be a lot of people for whom this would not be a first choice of job but would be better than nothing or histopathology. A lost tribe with a different name?

**Treatment**

Intensive care will be the new cardiology. Large multicentre trials carried out in this and other countries will help us to consolidate the evidence base of ICM and offer treatment based on more than gut feeling and anecdote.

Monitoring will make use of metabolised dyes and transcutaneous sensing to monitor organ function. Electrolytes, glucose and blood gases will be measured and displayed continuously, and biofeedback loops and neural networks will control the patients’ blood concentrations along with the currently measured physiological variables.

Imaging will become more portable and radiologists more interventionist. The fight between pathogenic bacteria and the pharmaceutical industry will continue but will inevitably be won by the bugs. We will develop ways to enhance the patient’s immunity, and work with the patient’s own bacterial flora to counteract the pathogens. As we use less antibiotics we will see a decrease in the number of multi-resistant organisms selected out. At present, less than 20% of hospital acquired infections are from cross infection from
staff and other patients, with the rest arising from bacteria already present in or on the patient, that have become invasive. We will make extensive use of pre- and probiotics, so using naturally helpful bacteria to defend our patients. Our understanding of the immune system, its genetic variations and ways of working with and moderating it, will mean we can either use or limit the patient’s own response to infection and trauma, rather than allowing the current free-for-all of immune mediators. Steroids will once again be out of fashion, though the adage that patients die and steroids live on will remain true.

More use will be made of mechanical and extracorporeal support, with organ rest to allow regeneration of tissue, particularly in the heart and liver. Organ transplantation will largely be replaced by the regrowing of organs from the patient’s own stem cells, thus eliminating the problems of immunosuppression. This advance is necessary given the continued reduction in mortality from trauma and increased longevity of the population.

We must not forget the psychological welfare of our patients. Post-traumatic stress disorder is still a common consequence of ICU admission. Fortunately, muscle relaxants are now rarely used, but we are still a long way from the ideal agents for sedation and analgesia. In the future we will have patient controlled anxiolysis, either via machine controlled biofeedback or by patient demand. Pain relief will be more effective for the uncomfortable things such as drain sites, where current analgesics often don’t help. Psychological support through ICU follow up clinics will be available to all patients after ICU discharge, to enable them to put their episode in ICU behind them and to get on with their lives.

Conclusion

Whilst this may appear a rather negative and depressing vision of the future, I don’t see it as black at all. Intensivists have seen massive changes in the specialty and the treatments they can offer patients over the last 20 years. This is a specialty that embraces change and, indeed, tries to drive it. Just look at the rise of outreach services over the last few years and the alacrity with which intensivists have leapt outside the walls of ICU. We need to maintain that energy and drive.

Our healthcare systems are changing, and intensivists can be at the forefront of that change, creating safer, better hospitals for the critically ill of the future. We must be willing to challenge not only the treatments we offer but also the way we deliver our service. We must consider what will offer the best for our future patients and how we can be out there making it happen. We must educate the population and counter the unrealistic views of intensive care portrayed on the television. Only then will we be able to retain our role as gatekeeper to ICU. Yes, more of our patients will be old but, with better lifelong healthcare, they will be more likely to be able to take advantage of a long and healthy old age. Critical care should not deny them that chance just because they are old. I am proud of where intensive care is at present and I think things (to quote the song) can only get better.
The practice of regional anaesthesia is not uniform within the United Kingdom. Justification for neural blockade includes prolonged pain relief, less opioid-induced nausea and vomiting, and an improvement in post-operative rehabilitation when included within a multimodal approach to patient care.

However, anaesthetic and surgical opponents claim that regional anaesthesia takes too long to perform, cannot guarantee success, is associated with excessive motor block and delays mobility. Typically, when single injection regional blocks wear off, many patients after operations such as total knee replacement and amputation still experience severe pain.

The management of such pain may be guided by Kissin's hypothesis of preventive analgesia or pre-emptive analgesia in the broad sense. The recommendation is that pain relief should 'last until central sensitisation subsides and the intensity of the afferent input is below the level that could potentially reinitiate central hypersensitivity', and thus should be 'complete and of sufficient duration'. A recent large retrospective study investigating patients receiving thoracic epidural analgesia after abdominal surgery has corroborated these findings, showing that analgesic benefits start to accrue when pain relief lasts at least 12 hours after surgery.2

Long lasting pain relief with regional anaesthesia may be achieved in two ways. The first involves administration of a high volume, high concentration solution of local anaesthetic. However, it must be remembered that toxic reactions occur with all local anaesthetics and, if the new long acting local anaesthetic agents are inadvertently injected into the vascular system in excessive and inappropriate doses, then serious central nervous system and cardiovascular sequelae will occur.

Advances in techniques

The second means of extending pain relief uses a catheter technique not dissimilar to that used for epidural anaesthesia. A peripheral nerve is located with a nerve stimulator, a hydrospace is created with injection of local anaesthetic and a catheter is threaded within the fascia enveloping the nerve. Perineural infusions were introduced into routine clinical practice in Ninewells Hospital three years ago and are now routinely used for primary knee arthroplasty, secondary hip and knee arthroplasties and lower limb amputation.

An initial audit of over 800 patients undergoing lower limb arthroplasty by Dr Matthew Checketts (Consultant/Part-Time Senior Lecturer) and Dr John Luck (SpR) showed that perineural combined femoral and sciatic infusion of ropivacaine 0.2% at 5 ml h⁻¹ was associated with better pain relief between 24 and 48 hours after surgery compared to single injection regional blocks. Unfortunately, good pain relief was complicated by motor block in a number of patients. This is not surprising considering that the concentration of ropivacaine used in randomised controlled studies of perineural infusions is the commercial concentration of ropivacaine derived from epidural studies of human volunteers!

A switch from high concentration, low volume solutions to low concentration, high volume solutions ensued in order to increase the spread of local anaesthetics and reduce motor block. Infusion of ultra low concentrations of levobupivacaine (0.025% to 0.05%) at 10 ml h⁻¹ provided consistently good pain relief over 36 hours without bolus rescue, considerably reduced motor block, and enabled knee flexion, measured 24 hours after surgery, from 30° to 90°. At 24 hours some patients, particularly younger men, were able to fully straight leg raise, but a number of patients were unable to lift their heel off the bed despite hip flexion to 60° and knee flexion up to 90°.

Despite considerable success in improving pain relief and reducing motor block, acceleration of post-operative rehabilitation was not possible for some patients for two reasons. First, a local orthopaedic and physiotherapy rule states that if the patient cannot lift their heel off the bed, then the patient cannot be mobilised (even prevented from sitting in a chair) and, secondly, physiotherapy is not provided at weekends.

Advances in techniques, technology and training in regional anaesthesia

A report on the Payne-Stafford-Tan Award

Dr G A McLeod, Consultant and Part-Time Senior Lecturer in Anaesthesia, Ninewells Hospital and Medical School, Dundee
Nevertheless, the greatest benefits were seen in patients after secondary knee arthroplasty. Femoral perineural infusions for 60 hours and sciatic infusions for 36–48 hours provided complete pain relief and movement when using a continuous passive motion machine. Both time to 90° knee bend and time to readiness for hospital discharge were significantly reduced.

Having achieved successful pain relief, but limited success with peri-operative rehabilitation, I decided to visit two well recognised centres of regional anaesthesia in North America. This was only made possible by the generosity of the Royal College of Anaesthetists in awarding me the Payne-Stafford-Tan Award 2005.

**Advances in technology**

Toronto Western Hospital is one of the teaching hospitals of the University of Toronto. Regional blocks are performed in a ‘block room’ – a two bed converted operating theatre situated within a 13 theatre complex and fully equipped with medical gases and monitoring. Staffing consisted of two nurses, a trainee anaesthetist on rotation, research fellows and a supervising specialist. Approximately 1,200 peripheral nerve blocks are performed per year, mostly under ultrasound guidance.

Recent advances in ultrasound technology now allow visualisation of peripheral nerves. Two ultrasound machines were used for nerve blocks and perineural catheter insertion – a high resolution floor standing Philips ATL HDI 5000 and a portable SonoSite Micromaxx. Direct observation of needle injection, prevention of intraneural injection, spread of local anaesthetic and exact placement of perineural catheters have changed regional anaesthesia from an ‘art’ form to a scientific discipline and complete nerve block for operation is now virtually guaranteed.

The use of a ‘block room’ increased theatre efficiency considerably. Time between cases was limited only by the time required to clean the operating theatre (15 minutes). Sedated patients were supervised in theatre by respiratory therapists and not anaesthetists. Applied to Ninewells Hospital, the time saved by a change in anaesthetists’ work patterns would allow an extra arthroplasty on the operating list. A simple calculation shows that 250 extra arthroplasties could be performed per operating theatre per year. Of course, in the UK we already have ‘block rooms’. They are otherwise called anaesthetic rooms, but optimal use of the combined operating theatre and anaesthetic room is prevented by a shortage of staff, and a resistance to flexible working. Clearly, a need exists to perform a health economic analysis of present UK working practice compared to an appropriately staffed orthopaedic anaesthetic service with ultrasonic equipment and a ‘block room’ based on the Toronto model.

In New York I was escorted by Dr Hadzic of the New York Society of Regional Anesthesia (NYSORA) fame, initially to visit Dr Sandhu in the Bellevue Hospital, New York University, then across Manhattan to the Roosevelt Hospital. The hospital is famed as the site at which Halsted experimented in 1884 with cocaine for regional anaesthesia. In both hospitals, regional anaesthesia was administered within the operating rooms, and seemed to be fully supported by the surgeons. It was encouraging to see that the practice of regional anaesthesia in all centres was similar to that in Ninewells Hospital.

**Advances in training**

However, unlike similar regional anaesthesia centres in North America, opportunities for training in regional anaesthesia in the UK are limited. Advanced regional techniques invariably take longer, considerable pressure exists for ‘throughput’ in operating suites, and surgeons have an ever increasing expectation of excellent pain relief linked with full mobility. Thus, the practice of regional anaesthesia tends to be limited to consultant specialists. We have been fortunate in Ninewells Hospital in having AstraZeneca Regional Fellows, and this experience has demonstrated that it is important that teaching should take place within an area where teacher and trainee do not feel pressurised by time or surgeons. The introduction of ultrasound into UK regional anaesthesia practice will require even more theatre training time, and consideration should be given to how this is provided. What is clear is that the present system of organising and managing theatre lists is inadequate for the teaching needs of regional anaesthesia.

The initial approach taken to improving and formalising training in Dundee by the consultant anaesthetists specialising in regional anaesthesia (Drs Checketts, Coventry and myself) has been to link with the new Anatomical Skills Unit which resides within the established Surgical Skills Unit. This facility offers all the components necessary for regional anaesthesia training at basic and advanced levels. There is a lecture theatre where Prof. I Parkin, Professor of Applied Clinical Anatomy, provides in-house anatomy teaching. Other staff include anatomy technicians and administrators who oversee the use of cadaver specimens, animal phantom models, surface anatomy, ultrasound teaching on volunteers, and direct video links to operating theatres. The first regional anaesthesia course will take place in December, and our intention is to undertake educational assessment of trainees before and after the training course.
Conclusion
The introduction of perineural catheters into anaesthetic practice has extended pain relief for patients after limb arthroplasty and amputation. Ultrasound guided nerve blocks now allow the accurate injection of local anaesthetic, and the avoidance of intraneural and intravascular injection. Time is needed to perform and teach regional anaesthesia, particularly with the introduction of ultrasound guided blocks, but may not exist within the present structure and management of operating theatres in the UK. In view of the considerable benefits of regional anaesthesia, there is a clear need to rationalise service delivery in order that the operating theatre is used more efficiently, and concentrate the expertise of the consultant anaesthetist on ensuring the quality and teaching of regional anaesthesia.

Acknowledgements
I wish to acknowledge Professors Chan and Katz, Dr McCartney of the Toronto Western Hospital, and Dr Hadzic of the Roosevelt Hospital, New York, along with their staff for their hospitality.

The comparison of anaesthetic practice between Ninewells Hospital and hospitals in Canada and New York was made possible by the generosity of the Royal College of Anaesthetists in awarding me the Payne-Stafford-Tan Award 2005.

References

RCoA awarded for new ‘Risk’ series
The Royal College of Anaesthetists is delighted to announce that the new series of patient information articles, Risks associated with your anaesthetic, has been ‘Highly Commended’ in the BMA Patient Information Awards (Printed Materials), part of the BMA’s annual Medical Book Competition. This award follows on from the previous success of two of the original RCoA patient information leaflets, Your child’s general anaesthetic and Anaesthetic choices for hip and knee replacement, which also received awards in this category.

The Awards programme described the series as follows: This set of leaflets about risks and complications of anaesthesia are well produced, written, and meet a clear patient need. Since there are 14 leaflets written by different authors, there are some differences in approach; however, the editorial style and language are excellent so that the end result is a harmonised resource. Patient experiences of anaesthesia and occasions on which there are side effects are used and made clear in all leaflets. Altogether, this is an excellent resource.

The 14 articles in this series have been developed using methodology adopted during the first RCoA patient information project, most significantly the close involvement and consultation of patients at every stage. This resource will be useful for health professionals as well as patients – including ward and pre-operative clinic nurses, surgeons, and anaesthetists who would like to be updated on numerical data for risks. Research suggests that even when patients don’t ask their anaesthetist about their fears, the fears still exist and are frequently misplaced and never addressed. We are very pleased that this important project has been recognised by the receipt of this award, and consider it a great achievement.

The College wishes to express sincere thanks to the project lead Dr Lucy White, Consultant Anaesthetist at Southampton General Hospital, for her tremendous efforts in co-ordinating the production of the series. We would also like to thank the many anaesthetists and lay representatives who contributed to the project, either as authors, editors, or advisors.

A hard copy of the Risk series has been sent to all NHS anaesthetic departments, and all of the articles are also available to download from the College website: www.rcoa.ac.uk.
I recently had a patient with suspected bony TB. The patient was being nursed in an expensive side room, and possibly would stay there for six weeks whilst waiting for the culture to grow. I was on the phone to the management trying to get a sample to Peru, where an infectious diseases consultant from the Hammersmith Hospital, called David Moore, was on secondment. He was developing, in Lima, a new diagnostic test for TB, which relies on the growth pattern of Mycobacterium TB in a special liquid media, viewed with an inverted microscope. Using his technique the bacteria can be identified in just days and, through the addition of drugs to a 24 well plate, it can even tell you what antibiotics they are sensitive to. His work was so new that even the chest physician at our Trust was unaware of the availability of this test. Meanwhile, I was informed that delivery to Peru was not possible, despite my argument that we could save the cost of an NHS bed for maybe six weeks. It was the old, ‘someone else’s budget’ argument.

Ideas and innovations are the oxygen which fuel organisations’ ability to adapt and evolve. However, to many, an ‘innovative NHS’ is an oxymoron. There are thousands of NHS ideas, which could drastically improve the quality and efficiency of the healthcare we provide.

Now in many cases, as illustrated above, this relates to failings of the NHS to accept and disseminate innovation. Nonetheless, the problem is actually far deeper rooted than this. Less than 1 in 100 ideas ever come to fruition and, when a clinician is involved, there is often a lag of ten to 15 years before the idea even leaves their head and makes it to the drawing board.

For example, Fleming published his findings with penicillin in 1929, but it was an Australian, Florey, and a German, Chain, who took it to the US to commercialise it, 15 years later. Similarly, medical student, Thomas Fogarty, invented the balloon catheter in 1950, yet it was 1969 before the patent was granted and it was subsequently commercialised.

Now, assuming that every anaesthetist has at least one good idea (and I would be worried if the reality wasn’t a lot more), then why is it that so few come to fruition?

The answer seems to be threefold: aptitude, desire and culture.

**Aptitude:** we tend to be entrepreneurial virgins. Most of us lack any training or knowledge of how to convert a great idea into reality. The world of patenting, business planning and venture capitalists is alien and best left to someone else.

**Desire:** faced with this ‘knowledge gap’ and a busy work schedule, it’s so much easier to do nothing, than to embark on an unknown journey without a guide or a map.

**Culture:** the fabric of the NHS culture is woven from a patchwork of sub-cultures, power centres and over-inflated egos, where leadership is lacking, blame is an ideal and risk is a swear word.

The irony is that, as clinicians, we have all the ideas. Meanwhile, there are plenty of people out there with the money and skills to develop those ideas. The problem is that they don’t know how to find us nor do we know how to find them. Even worse, when potential investor and clinician occasionally do meet, they invariably speak a different language.

So are anaesthetists creative? Well, there certainly are some good examples out there. Cathy Price from Southampton demonstrated real creativity and leadership in reforming the chronic pain service she delivers. David Humphrey designed the ADE anaesthetic system and, more recently, Drs Dingley and Williams developed the ShakerScope. Some innovations have worldwide visibility, such as Archie Brain and his laryngeal mask.

Nonetheless, during an after dinner discussion, rarely do I hear anaesthetists mentioned first when it comes to medical breakthroughs. Orthopods maybe, cardiologists definitely, but anaesthetists? To test the question, we are launching the Anaesthesia and Critical Care Innovation Awards, which are searching for new technologies, services and treatments to improve patient care. Everyone is encouraged to enter and so we have made the entry form short and simple via an Awards website. Short listed entrants will have to pitch their idea to a Dragon’s Den style panel of anaesthetic, clinical and commercial experts to
prove they have what it takes. Winners not only gain unparalleled validation and endorsement of their idea, but stand the chance to meet investors and industry and enter into dialogue on a whole new level.

However, what if your idea is still on the back of that beer mat? Well, you still have time to attend the anaesthesia stream of the i2 Event, a one-day ideas and innovation conference taking place in January 2007, which can help you learn the steps necessary to develop your ideas.

So, no matter whether you are an ideas person or an entrepreneur, you will be able to meet patent agents, designers and investors and a whole host of other people who can add value to your idea. Armed with this knowledge, even if you are not ready to enter the Anaesthesia Awards this year, at least it won’t be 10 or 15 years before you are.

Andy Goldberg is an orthopaedic trainee from London, who helped set up the Anaesthetics and Critical Care Awards with the AAGBI and the RCoA. The Clinical Lead for Anaesthesia and Chair of the i2 Faculty is Dr David Williams, an anaesthetist from Swansea (davidjwilliams@doctors.org.uk).

Entries will be accepted between November 2006 and January 2007. For details on the i2, awards entry and for a full list of the Anaesthetic Judges visit the website: www.medicalfutures.co.uk.

A doctor pitches to the awards judges in a daunting ‘Dragon’s Den’ style arena.
Anaesthesia & Critical Care innovation awards

Call for Entries

We all have great ideas, but we usually do nothing about them, because we don’t know how. Medical Futures in conjunction with The Royal College of Anaesthetists & The Association of Anaesthetists are looking for your novel ideas for services, technologies or devices that can bring improvements to patient care.

Entry to the Awards is free to all anaesthetists and pain specialists via the website www.medicalfutures.co.uk

Winning an Award could help raise your profile, build credibility with investors and most importantly help your idea to change people’s lives.

Entrants will also have the opportunity to attend the Anaesthetic stream of the i2 Event (Ideas & Innovation Conference) where they can learn the steps to protecting and developing their ideas or maybe even find an industry partner.

To find out more or to enter visit

www.medicalfutures.co.uk

Your ideas could change peoples’ lives

Entries close January 2007
Standardisation of drug infusion concentration in the United Kingdom

Intravenous Drug Infusion Safety Working Group

Alexander Pope once said: ‘To err is human, to forgive, divine.’ The phrase is firmly embedded in English parlance, and there can be few in the English speaking world that do not grasp its deeper meaning. Type the phrase ‘to err is human’ into the Google internet search engine though, and the top result has nothing to do with the works of Pope, but is an open source book with the same title, published by the National Academies Press in the US. The book is a blueprint for a safer healthcare system and makes many recommendations for safeguarding patients from errors, with a key theme being standardisation.

The results of a pilot study looking at the concentrations of commonly infused drugs in critical care in some 60 UK critical care units have identified the existence of a large variation in practice. A multi-professional working group consisting of critical care doctors, nurses and pharmacists has been set up to further examine this area and draw up some recommendations. The group enjoys support from the Intensive Care Society (ICS), the National Patient Safety Agency, the Royal College of Nursing Intravenous Therapy Forum and the United Kingdom Clinical Pharmacy Association.

There is not going to be a large randomised study to examine the effect of standardisation of drug infusion concentrations on error rates and outcomes in critical care units. There is already evidence from the paediatric literature that non-standardisation does result in errors and most would admit that, at least intuitively, a set of standard concentrations makes sense. Written protocols for preparation and administration of IV drugs reduces errors as does the presence of full-time specialist staff. Standardisation would lead to reduction of some aspects of staff re-training on moving job. It would allow the pharmaceutical industry to bring to market ready to use solutions, made affordable by volume efficiencies in manufacturing because of widespread uptake. Ready to use solutions bring further benefits through reduced preparation time for nurses, and reduction of error from preparation, administration, physiochemical incompatibility, and administration rate. Standardisation fits into the NHS’ electronic prescribing aspirations and makes the job of calculating doses and programming infusion pumps easier.

The ICS has kindly allowed the group access to the Linkman system to circulate a questionnaire. Recipients are asked to complete the questionnaire and return it to the project group, even if their unit has already sent a response in the pilot phase. The data generated will be analysed, and a list of candidate standard infusions will be drawn up. These will largely be based on the most widespread concentrations used, although some consideration will also be made regarding the feasibility of mass manufacture of the identified infusions. The project group intend to report back their findings, with a proposed list of standard infusion concentrations by spring 2007.

Alexander Pope also wrote: ‘Act well your part, there all the honour lies.’ The project group needs as much information as possible in order to come up with informed, and therefore satisfactory, conclusions.

References


Mark Borthwick, Susan Keeling, Peter Keeling, Justin Woods, Katie Scales, Carl Waldmann
Intravenous Drug Infusion Safety Working Group

The questionnaire is available on the College website at: www.rcoa.ac.uk/index.asp?PageID=64&NewsID=173. Forms should be returned to Mark Borthwick, Pharmacy Department, John Radcliffe Hospital, Oxford OX3 9DU, or return electronic copies to: mark.borthwick@orh.nhs.uk.
Council report

At a meeting of Council held on Wednesday, 19 July 2006, the following were admitted/re-admitted as Deputy Regional Advisers (re-appointments are marked with an asterisk):

Mersey
*Dr A G Head-Rapson, Southport District General Hospital

North Thames Central
*Dr R M Milaszkiewicz, Barnet General Hospital
(One year term)
*Dr C I Beard, Royal Free Hospital
(One year term)

The following were admitted/re-admitted as College Tutors:

Northern Ireland
*Dr A S Phillips, Royal Victoria Hospital

North Thames (Central)
Dr A K Krishnamurthy, Princess Alexandra Hospital (in succession to Dr G J Raine)

North West
*Dr R J K Perkins, Royal Manchester Children's Hospital
(Third term requested)

Severn
Dr S Shinde, Frenchay Hospital
(Post of second College Tutor)

South Thames (East)
Dr C H Taylor, Kent and Sussex Hospital
(Returned from maternity leave)

West Midlands North
*Dr E O Hughes, Robert Jones and Agnes Hunt Orthopaedic and District Hospital

The following recommendations were made to PMETB for approval, that Certificates of Completion of Training (CCT) be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia. The doctors whose names are marked with an asterisk have been recommended for a dual CCT in Anaesthetics and Intensive Care Medicine.

Anglia School
Dr Christopher Elwyn Thomas
Dr Darryl Rachel Johnston
Dr Jeremy Gordon Cheleby Lermitte
Dr Hemantha Dinuka Bandara

Imperial School
Dr Munita Grover

Royal Free/UCL School
Dr Martinus Jakobus Terblanche*
Dr Kevin Hamilton
Dr Michael Jan Shaw
Dr Manisha Surain singh Sodhi
Dr Paramaswamy Krishnan
Dr Bahu layan Nair Sujith
Dr Paul Edward Robert Flynn

Barts/Royal London School
Dr Charlotte Marie Dempsey
Dr Srdjan Nikolic
Dr Amruta Mahesh Patwardhan
Dr Ashok Kumar Das
Dr Matthew James Allen
Dr Alistair Robert Brown

Mersey School
Dr Rakesh Ghanshyam Parikh
Dr Sonia Princy De Silva

Leicester School
Dr Felix Nyuga Fombon

Nottingham School
Dr Munib Malik

Northern School
Dr Kaye Louise Cantlay*

Oxford School
Dr Omer Hashmat Lodi
Dr Rachel Jane Hignett

Peninsula School
Dr Stephen John Harris*

North West School
Dr Amanda Louise Baldam
Dr Catherine Smith
Dr James Peter Corcoran
Dr Helen Claire Bird
Dr Karen Anne Leonard
Dr Jonathan David Greenbaum*
Dr Dale Gary Watson
Dr Mathias Tautz
Dr Rajkumar Vishin Nichani*
Dr Jayalal Nadukkarottu Narayanan
Dr Suresh Zachariah Abraham
Dr Sheik Sayeed Ahmed
Dr Edward Kee Yuen Kam
Dr Michael Arthur Entwistle

Sheffield School
Dr Srinivasan Illalavajady
Dr Brian James Donnelly

Severn School
Dr Peter Neville Richard Ford
Dr Kay Joanna Spooner
Dr Michelle Claire White
Dr Paramita Ray
Dr Palanikumar Saravanan
Dr Stephen Paul Nyners

Wessex School
Dr Michele Carraretto
Dr Clare Maria Skinner
Dr Wilson Trevor Fungayi Chimbira

West Midlands
Dr Bernard John Mcclement
Dr Jayesh Ramachandra Menon
Dr Ehab Mohamed Ragaie Foda
Dr Sherly Bhaskaran
Yorkshire
Dr Ganesh Baranidharan
Dr Simon Turner
Dr Katherine Annabelle Wood
Dr Marcus Ronald Beadle
Dr Geraldine McEnroe

Tri-Services
Dr Sanjay Gupta*

Wales
Dr Rajapapp-Nair Arun Kumar
Dr Venkatraya Shenoy
Dr Simon Alexander Reid
Dr Ivan Brauner
Dr Naomi Goodwin
Dr Anette Scholz
Dr Richard Hugh Jones

Scotland – East
Dr Martin Fraser Clark*

Scotland – South East
Dr Mark Peter Rockett

Scotland – West
Dr Corinne Jayne Rimmer
Dr Catriona Macneil*
Dr Robyn Lee Smith
Dr Mark Charles Higney

Northern Ireland
Dr Orla Mary Hayes

At a meeting of Council held on **Wednesday, 20 September 2006**, the following was admitted as **Regional Adviser**:

**South Thames (West)**
Dr P J Williams, East Surrey Hospital
(in succession to Dr J-P van-Besouw)

The following were re-admitted as **Regional Advisers in Pain Management** *(The following are re-appointments for 12 months only)*:

**Oxford**
*Dr A D Lawson, Royal Berkshire Hospital*

**Yorkshire**
*Dr K H Simpson, St James’s University Hospital, Leeds*

**Northern Ireland**
*Dr W I Campbell, The Ulster Hospital, Belfast*

**North Thames (West)**
*Dr A C Rice, Chelsea and Westminster Hospital*

**North West**
*Dr K M Grady, Wythenshawe Hospital, Manchester*

**North of Scotland**
*Dr K A W Cranfield, Aberdeen Royal Infirmary*

**East of Scotland**
*Dr D H F Hartmann, Ninewells Hospital, Dundee*

**South East Scotland**
*Professor I Power, New Royal Edinburgh Infirmary*

**West of Scotland**
*Dr P A Mackenzie, Southern General Hospital, Glasgow*

**South West**
*Dr M B Taylor, Derriford Hospital, Plymouth*

**South Thames**
*Dr A J Nicolaou, St George’s Hospital, London*

**Sheffield and North Trent**
*Dr D Graham, Doncaster Royal Infirmary*

**Wales**
*Dr S Underhill, Wrexham Maelor Hospital*

The following were admitted/re-admitted as **Deputy Regional Advisers** *(re-appointments are marked with an asterisk)*:

**Yorkshire**
*Dr R H Cruickshank, St James’s University Hospital, Leeds (re-appointed for two years)*

**Scotland – South East**
*Dr M B Taylor, Derriford Hospital, Plymouth*

**South Thames**
*Dr A J Nicolaou, St George’s Hospital, London*

**Sheffield and North Trent**
*Dr D Graham, Doncaster Royal Infirmary*

**Wales**
*Dr S Underhill, Wrexham Maelor Hospital*

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

**Anglia**
Dr S Abdy, The Queen Elizabeth Hospital, Kings Lynn (in succession to Dr H E Hobbiger)

**Oxford**
*Dr A M Forbes, Stoke Mandeville Hospital, Aylesbury*

**Yorkshire**
*Dr A J Vipond, York District Hospital*

**North Thames (Central)**
Dr D G Williams, Great Ormond Street Children’s Hospital (in succession to Dr P M D Cunnington)

**North West**
Dr M E Eltoft, Trafford General Hospital (in succession to Dr A Shaw)
The following recommendations were made to PMETB for approval, that 
Certificates of Completion of Training (CCT) be awarded to those 
set out below, who have satisfactorily 
completed the full period of higher 
specialist training in anaesthesia. The doctors whose names are marked 
with an asterisk have been 
recommended for a dual CCT in Anaesthetics and Intensive Care Medicine.

Anglia School
Dr Amgad Fakhry Ragheb
Dr Duncan Alexander Baines
Dr Suhail Musa Zaidi
Dr Parameswaran Pillai
Dr Sherril Kumar Thiyagarajan
Dr Peter Graham Bradley

Imperial School
Dr Nivedita Chandrashekhar Kelgeri
Dr Surbhi Malhotra
Dr Joseph Sebastian
Dr Alan James Bourke

Royal Free/UCL School
Dr David Ernest Whitelock
Dr Alice Fung Wah Man
Dr Ehelepola Ranjika Kumari Seneviratne
Dr Marc Davison
Dr Christopher Mark Woollard
Dr Holly Bethan Jones

Barts/Royal London School
Dr Lorna Miriam Greta Gallagher

St George’s School
Dr Pushpa Shankaranahalli Bheemappa
Dr Edward Julien Lams
Dr Rupert William Harris
Dr Somi Ramachary Desikan

West Midlands North
Dr K Hassan, Queen Elizabeth Hospital, Birmingham (in succession to Dr J L Issac)
A badge too far

Sir,

As a post-Primary SHO looking to gain a specialist registrar training number, I was most interested to read Dr Griffiths’ views on life support and resuscitation courses (Bulletin 38, July 2006:1942–1944) and the discussion that followed – especially as I have not yet attended an Advanced Trauma Life Support (ATLS) course.

It is clear that ATLS has an important role in training trauma teams. However, Dr Griffiths advocates in-house local teaching in the place of ATLS on the grounds of cost. I feel that this is missing the point. We have a course that works1,2 with international standardisation. Surely this must be better at the 3.00 am trauma call than a group of individuals all trained differently on local courses.

The real issue is simply cost. Over the past two years, study leave budgets have been gradually eroded: £900, to £750, shortly to become £500 pa in our Trust. This is due to primary care trust cutbacks (with GPs’ pay at record levels). The British Medical Association’s advice is that all approved study leave should be funded without annual limits; if this is not done they recommend taking your employer to the small claims court3 – hardly a practical suggestion.

I feel that it is time we stand up to this threat to our training – this will require the support of our consultant colleagues. At the very least we should ensure that these vital resuscitation courses are funded centrally as an integral part of the new Foundation programmes.

However, for now, at the sharp end of an increasingly competitive application process, I will be getting out my cheque book and ticking the ATLS box – but also very much looking forward to it.

Dr L Hulatt, SHO, Cheltenham

References

Editors note:

Many thanks to all those who have submitted letters on this subject, however please note this correspondence is now closed.
The Lost Trainee

Sir,

In response to Dr S K Vijayan's letter (Bulletin 39, September 2006:1998), I agree with many of his points but feel that his views are too extreme. Many new changes are being implemented – due to the European Working Time Directive, Modernising Medical Careers, New Ways of Working in Anaesthesia and the Hospital at Night project – which make me feel uneasy. However, on reflection I do not feel that we need fear losing good trainees and training forever.

Practical experience at work is sometimes difficult to obtain and with the reduction in working hours (that we as juniors negotiated for ourselves), it seems inevitable that the situation will worsen. However, as professionals, I strongly believe that we have a responsibility to use our initiative to maximise our learning potential during the hours we are at work. One could argue that the changes being made to doctors' training are simply exposing weaknesses that had previously gone unnoticed because of the higher volume of cases and hands-on experience which trainees encountered in the past. The easiest option would be to sit back and complain about the new system. We should recognise existing limitations in training and develop new methods to optimise our learning. As for trainers, I believe that they may remain entrenched in the previous system, and so may also require a change in their attitude towards training. Finally, we can expect more adjustments as we go along the new-found path.

Dr M A Ali, SHO, Swansea

Acute Care Common Stem training

Sir,

As an anaesthetic trainee, I always feel that we should be capable of contributing something to patient diagnosis. Acute Care Common Stem training (ACCS) which ‘blends’ acute specialties, will hopefully accomplish this desire.

Often we find something missed by our surgical colleagues in our preoperative assessments (Bulletin 39, September 2006: pp 1972–1973). An ACCS training programme is a brilliant way of making anaesthetists better peri-operative physicians. I believe trainees should be more judgemental and decisive by the end of their rotations. Such programmes are scheduled to provide lot of flexibility to the trainees and have been framed considering the value of broad medical experience before specialist training.

I would like to suggest that rotating the anaesthetic and emergency medicine trainees through their respective specialties at the outset could provide them confidence and better insight when they take on call rotas as ST2 trainees.

Dr R Sundararajan, SHO, Nuneaton

Author’s response

Sir,

I thank Professor Norman for spotting our short months in Bath! I wish I could claim...
that we had found a way to deliver training more efficiently, but unfortunately I can only confess to my poor proof reading. The two acute specialties rotations in Bath last for 18 months and 30 months.

Dr J Nolan, Consultant, Bath

Paediatric emergencies – trainees can help too

Sir,

I was pleased to read our new president’s editorial (Bulletin 39, September 2006:1961–1963), particularly the section on managing paediatric emergencies in the district general hospital (DGH). Having recently completed a six-month SHO job in paediatric intensive care in Bristol, I would like to point out that many anaesthetic trainees have valuable paediatric experience to bring to their departments.

Many SHOs and SpRs rotate through paediatric anaesthetic and intensive care jobs during training, and we are a useful cohort of anaesthetists, particularly in the DGH setting, when consultant paediatric anaesthetic cover is not always at hand. As an SpR in a DGH, my skills in the management of the sick child have already been put to good use, in conjunction with my consultant colleagues. In the last 12 months our department has also benefited from the presence of a paediatric intensive care trainee adding general anaesthetics to their training, and an anaesthetic SpR who has completed a year at Great Ormond Street.

Despite the trend for modernising our medical careers, I feel this additional experience prior to specialist training has been invaluable, particularly as it is often the on-call anaesthetic registrar who first meets such emergencies in the DGH setting.

Dr A C Mayell, SpR, Torbay

Day surgery – back to the future

Sir,

The article by Dr Kamming is very informative and helps us understand the importance of day case surgery (Bulletin 39, September 2006:1969–1970). The information about the rise of day case surgery in America, the various roles played in the UK by the Health Care Commission, trusts and clinicians, and the advice for trainees are quite useful.

All would agree with the author’s opinion that patient selection is the most critical part of day case surgery. With all the advantages of patient preference, cost savings and increased throughput, day case surgery is here to stay.

Being exposed to day case surgery as a trainee, I find it interesting, and I feel that training under different consultants and learning different approaches and methods (TIVA, regional blocks etc) can be helpful for trainees in evolving their own methods for the future.

Dr C Srinath, SHO, Stirling

The acutely or critically injured child in the DGH: a team response

Sir,

Dr Heneghan’s discussion of this DoH publication was most informative (Bulletin 38, July 2006: 1940–1941). We agree that an anaesthetist’s concerns should be for the patient and not about litigation. It is comforting to know that the guidelines state that the employing trust’s duty is to support the anaesthetists in these difficult situations.

However we do not entirely agree with the author’s statements regarding deskilling in this area. There is a perception that this may take place, but it not borne out by current data. A study in 2003 found that the advent of a retrieval service does not decrease skills within the referring hospital1.

In our region (Wessex), a review of retrieval data showed an even higher number of procedures (intubations and vascular access) being performed by teams at referring hospitals. This may be in part to Continuing Educational and Professional Development and Advanced Paediatric Life Support, but also because anaesthetists are already practicing in line with the DoH guidelines and simply getting on with the job.

Dr S Neill, Dr SA Hellewell and Dr P Wilson

2056 Bulletin 40 The Royal College of Anaesthetists November 2006
Reference

1 Ramnarayan et al. Does the use of a specialised paediatric retrieval service result in the loss of vital stabilisation skills among referring hospital staff? *Archives of Disease in Childhood* 1988;10:851

Authors response

Sir,

I am encouraged that there is evidence that a paediatric retrieval service does not deskill resuscitators in referring hospitals: this is as it should be.

But I actually wrote that removal of paediatric anaesthesia from DGHs is the cause of deskilling, not presence of a retrieval service, and I continue to believe that.

Dr C Heneghan, RCoA Council Member

RAISING THE STANDARD:
A compendium of audit recipes for continuous quality improvement in anaesthesia
(Second edition 2006)

The Royal College of Anaesthetists has recently published the second edition of the popular ‘Audit Recipe Book’, which includes over 150 revised and new audits, a CD-ROM, example data collection questionnaires and a new audit template.

Copies have been sent to all NHS hospitals, and a limited number of additional copies are available from the College.

The complete Audit Compendium is also available to download from the College website: www.rcoa.ac.uk

To obtain a copy email us at: auditrecipes@rcoa.ac.uk

Acute Pain Management: Scientific Evidence
(Second edition 2005)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS AND FACULTY OF PAIN MEDICINE

COPIES NOW AVAILABLE

The Royal College of Anaesthetists has a limited number of copies of ‘Acute Pain Management’ available for purchase for £20 (including postage and packaging).

To order your copy please contact the Finance Department at the College on tel 020 7092 1584.

Needle Nightmare!
Is this how kids view anaesthesia?

The Royal College of Anaesthetists and the Association of Paediatric Anaesthetists of Great Britain and Ireland have formed an Anaesthesia Information for Children Project Team to follow on from the success of the Patient Information Project. The team needs your help.

We aim to produce a national resource of information about anaesthesia aimed specifically at children rather than their parents. We are aware that many hospitals already use information packs for children in preparation for surgery and we wish to see as many examples of these as possible.

If you have a leaflet, video, puzzle book, DVD, story book or website in use in your hospital which provides information for children (rather than their parents) about their forthcoming anaesthetic, we would be most grateful if you could send us a copy. The samples we collect will be invaluable in helping to design further information resources after consultation with children having surgery.

Please send your information, with as many details as you can provide about the process by which it was produced, to:

Dr Judith A Short, Department of Anaesthesia, Sheffield Children’s Hospital, Western Bank, Sheffield, S10 2TH

With many thanks,

Anaesthesia Information for Children Project Team
The Royal College of Anaesthetists

EDUCATION PROGRAMME ADVISOR

The Royal College of Anaesthetists wants to develop its Education Programme and make the best use of the new Institute of Education. The position is a newly created fixed-term post of one year to support this development.

The post holder will work closely with the Courses and Meetings Committee and the Director of Education, to review the existing programme of courses, meetings and workshops, to seek new ideas and implement changes. The post holder will provide advice and support to individual course leaders and the Education directorate of the College. We are looking for a consultant anaesthetist who has knowledge of current concepts, education and training requirements of anaesthetists and is not only aware of revalidation requirements, but is also able to develop courses and meetings to cater for these.

The successful applicant will be a highly organised individual who has a proven commitment to the College and experience of successfully running and organising anaesthesia related conferences/courses/events. The role requires the post holder to work at the College; hours and days of working are flexible and should reflect the needs of the post. The commitment will be two sessions per week. A number of options are available for remuneration, details of these, the job description, the person specification and an application form are available from the website (www.rcoa.ac.uk/index.asp?PageID=32) or upon request from Mrs Willmott, Director of Education.

Applications should be submitted by 30 November 2006 to:

Tara Willmott
Director of Education
The Royal College of Anaesthetists
35 Red Lion Square
LONDON WC1R 4SG
twillmott@rcoa.ac.uk

Interviews will be held on 12 December 2006.

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BRISTOL MEDICAL SIMULATION CENTRE

FORTHCOMING COURSES 2006–07

Doctors

- 7–8 December 2006
  Transport of the Critically Ill Patient: for Anaesthetic SHOs, and year 1 SpRs (£275)

- 15 December 2006
  OSCE: for the Primary FRCA (£125)

- 8 February 2007
  Train the Trainers Day: for all simulator users/teachers (£200)

- 7–8 March 2007
  Team training for Critical Incidents: for all grades of anaesthetists (£275)

  Transport of the Critically Ill Patient: for Anaesthetic SHOs and year 1 SpRs (£300)

- 27 April 2007
  OSCE: for the Primary FRCA (£125)

Healthcare Professionals

- 8 November 2006
  Paediatric Recovery Study Day: for Nurses (£86)

All course fees are subject to VAT except where stated.
Specific Departmental Courses can be arranged upon request (fee negotiable).
Includes coffee, tea, biscuits and lunch or afternoon tea.
CPD points approved; 5 points (for one-day courses) and 8–10 points (for two-day courses).

For bookings please contact:
Gerri Whitrow, Centre Administrator,
The Bristol Medical Simulation Centre, Bristol BS2 8AE
0117 3420108
gerri.whitrow@ubht.nhs.uk
or visit:
http://simulationuk.com
for course details online.
The Association of Anaesthetists of Great Britain and Ireland

10–12 January 2007
AAGBI Winter Scientific Meeting
Queen Elizabeth II Conference Centre, London

27–29 June 2007
AAGBI GAT Meeting,
The Corn Exchange, Brighton

More detailed information can be obtained from
Ms Joanne Barnes, Education and Membership Services (supported by GE Healthcare), Association of Anaesthetists of Great Britain and Ireland,
21 Portland Place, London WC1B 1PY
tel 020 7631 8802 fax 020 7631 4352
e-mail meetings@aagbi.org website www.aagbi.org

State of the Art 2006
The Intensive Care Society
State of the Art 2006 Meeting

Mark your diary and book your study leave now!

11 CPD Points
An essential meeting for Consultants and Trainee Intensivists and anyone involved with caring for the critically ill, including doctors, nurses and others working in anaesthesia, outreach, emergency or acute medicine.

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THE UNIVERSITY OF EDINBURGH

FIBREOPTIC INTUBATION COURSE
7–8 MARCH 2007

For further information please contact:
Mrs Cindy Middleton
University Department of Anaesthesia, Critical Care and Pain Medicine
Royal Infirmary of Edinburgh
Little France
EDINBURGH EH16 4SA
Tel 0131 242 3292 Fax 0131 242 3138
e-mail cindy.middelton@ed.ac.uk
web: www.anaes.med.ed.ac.uk/univ/fibreoptic.html

Norwich Anesthetic Study Day
Friday 15 December 2006
The John Innes Centre, Norwich
Time to take the masks off
An Update in Anaesthetic Practice
What’s New What’s Controversial and What’s Next in...

Registration Fee only £30 (including 1 CPD point)
Large Trade Exhibition
Big Prize Competitions
Registration Fee only £30 including lunch and all refreshments
Places Strictly Limited
Please make cheques payable to: "Norfolk and Norwich Institute Ltd"
FINAL FRCA VIVA WEEKEND
2.00pm Friday, 1 December to 4.00 pm Sunday, 3 December 2006
Intense Viva Practice
This course has proved to be the most popular and potential candidates are encouraged to view the many plaudits at www.msoa.org.uk (Classes and Courses).

PRIMARY FRCA VIVA WEEKEND
2.00 pm Thursday, 28 December to 4.00 pm Saturday, 30 December 2006
Intense Viva Practice
The aim of the Weekend is to suffuse the 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.

PRIMARY OSCE WEEKEND
2.00 pm Friday, 5 January to 4.00 pm Sunday, 7 January 2007

Weekend Course Registration fee: £250
Includes Breakfast, Lunch, On-going Refreshments, Water and Sweets.
Venue: University Hospital, Aintree

Please see our website at: www.msoa.org.uk for details, comments and application forms.
THE FINAL FRCA EXAMINATION

THE SAQ PAPER
Prospective Examination Candidates are invited to join

The SAQ Writer’s Club

Membership of the Club will expose you to the intricacies of the Short Answer Paper

As a number and not a name

You will be expected to address under examination conditions one twelve-question paper per fortnight

You will be expected to set questions and to mark answers

Through such intimate involvement with the Short Answer Challenge, you will become that much more fit for Victory and able to Triumph

CLUB ONE
Opens on November 1st
Registrations will close November 30th

Club introductory meetings
Registered members are invited to attend one of the two meetings

‘Introduction to the Mersey Method’
11.00 am – 4.00 pm Saturday, 9 December and Saturday, 16 December 2006
Aintree Hospitals

One fee for Membership of £400 will entitle the Member to remain in the Club and to attend the Introduction Meeting and the Mersey SAQ Weekend Courses Free of Charge until successful in the SAQ Paper Examination

For registration and club rules please see msoa.org.uk

IN THE DISCIPLINE LIES THE REWARD
**Appointment of Members, Associate Members and Associate Fellows**

The College congratulates the following who have now been admitted accordingly:

**Members**

**July 2006**
Dr Raghu Kumar Kota

**August 2006**
Dr Chander Bhanu Sharma
Dr Sunil Kumar
Dr Shahzad Nisar Khan
Dr Seema Dnyanesh Nadkarni

**September 2006**
Dr Arti Shripad Inamdar
Dr Guenter Ignaz Weissenhorn

**Associate Member**

**July 2006**
Dr Anthony Ernest Alderman

**Affiliate**

**September 2006**
Dr Ian Anthony Self

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**Deaths**

The College regretfully records the deaths of the following Fellows:

Dr William Wren, Dublin
Dr Daniel James David Chillistone, Leicester
Dr Peter Houlton, West Sussex
Dr James Inglis, Sutton Coldfield
Dr Benedict John Barry, Australia

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**Appointment of Fellows to consultant and similar posts**

The College congratulates the following Fellows on their consultant appointments:

Dr Katherine Wood, Diana, Princess of Wales Hospital, Grimsby
Dr Felix Fombon, University Hospitals of Leicester NHS Trust
Dr Lucy Smith, St George’s Hospital, London
Dr Steven Sale, Frenchay Hospital, Bristol
Dr Jerry Thomas, Scunthorpe General Hospital
Dr Jonathan Cousins, Hammersmith Hospital
Dr Martin Akioyame, St Helier Hospital, Carshalton
Dr Rajkumar Vishin Nichani, Victoria Hospital, Blackpool

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**DR JOHN S M ZORAB**

The Royal College of Anaesthetists was very sorry to hear of the death of Dr John S M Zorab, a past Member of Council and well-respected Fellow of the College. We would like to extend our deepest sympathies to Dr Zorab’s family at this time.

A full obituary for Dr Zorab has been published on the College website at [www.rcoa.ac.uk/index.asp?PageID=758](http://www.rcoa.ac.uk/index.asp?PageID=758)

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**College staff**

**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

**Advisory Appointment Committees**
Ms Anita Mattis: 020 7092 1571
Miss Dipa Begum: 020 7092 1572

**Courses and Meetings/Events**
Mr Amit Kotecha: 020 7092 1673
Miss Chantelle Edward: 020 7092 1672
fax 020 7092 1735
email events@rcoa.ac.uk

**Educational approval for Schools of Anaesthesia and hospitals**
020 7092 1660

**Examinations Manager**
Mr John McCormick: 020 7092 1521

**Individual Trainees**
Mrs Gaynor Wybrow: 020 7092 1552

**Membership Services**
Miss Karen Slater: 020 7092 1700

**Regional Adviser/College Tutor appointments**
Mrs Karen Morris: 020 7092 1573

**Website/Bulletin**
Mrs Edwina Jones: 020 7092 1692
Mrs Mandie Kelly: 020 7092 1693
Challenge your expectations

Equal efficacy\(^1,2\) to, and lower potential for CV and CNS toxicity\(^3,4\) than, bupivacaine

chirocaine\(^\text{v}\)
levobupivacaine HCl
Perform with confidence

Clinical V (Levobupivacaine Hydrochloride)
Refer to Summary of Product Characteristics for full information

Presentation: Ampoules. Three strengths are available: 2.5mg/ml, 5mg/ml and 7.5mg/ml as levobupivacaine hydrochloride. Two strengths are available in 10ml prefilled syringes: 2.5mg/ml and 5mg/ml as levobupivacaine hydrochloride. Each strength is available in 1ml prefilled syringes in packs of 10. Bag: Two strengths are available: 0.5mg/ml and 1.25mg/ml as levobupivacaine hydrochloride. Both strengths are available in 10 ml prefilled syringes. All are supplied with an aluminum foil overcapal at 250°C in a 250ml prefilled plastic bag with an aluminum overcapal.

Indications: Ampoules: For infiltration, nerve block and epidural administration. Bag: For the management of postoperative pain and in labor analgesia. Reg: Adults: Surgical anesthesia - Apreo, e.g. epidural for cesarean section, intrathecal and peripheral nerve block, e.g. peripheral nerve block, intrathecal block, posterior cord block, epidural block, intravenous digital block, intraneural block.

Dosage and Administration: Ampoules: Apreo solution for injection is for adult use only. It must not be used for intravenous administration. Careful observation before injection is recommended to prevent intravascular injection. If a symptom occurs, the injection should be stopped immediately. The maximum dose should be determined by evaluating the size and weight of the patient. The maximum recommended dose during a 24 hour period is 400mg. For postoperative pain management, the dose should not exceed 10% of the maximum recommended dose during a 24 hour period. For labor analgesia or epidural injection, the dose should not exceed 12.5mg/kg. Bag: The precision pack will depend upon the procedure and individual patient concern. Careful observation before and during injection is recommended to prevent intravascular injection. Adverse events are thus expected to be minimal. The maximum recommended dose during a 24 hour period is 400mg. For postoperative pain management, the dose should not exceed 10% of the maximum recommended dose during a 24 hour period. For labor analgesia or epidural injection, the dose should not exceed 12.5mg/kg. Bag: The precision pack will depend upon the procedure and individual patient concern. Careful observation before and during injection is recommended to prevent intravascular injection. Adverse events are thus expected to be minimal.

Contraindications: General contraindications related to regional anesthesia or analgesia, regardless of the local anesthetic used should be taken into account. Intravenous regional anesthesia (Bier's block), patients with severe hypothyroidism such as congenital or hypothyroidic adult, use of paracetamol in children (see pregnancy and lactation) and known hypersensitivity to local anesthetics should be taken into account. Intravenous regional anesthesia (Bier's block), patients with severe hypothyroidism such as congenital or hypothyroidic adult, use of paracetamol in children (see pregnancy and lactation) and known hypersensitivity to local anesthetics should be taken into account. Intravenous regional anesthesia (Bier's block), patients with severe hypothyroidism such as congenital or hypothyroidic adult, use of paracetamol in children (see pregnancy and lactation) and known hypersensitivity to local anesthetics should be taken into account.

Precautions and Warnings: All local and regional anesthesia should be performed in well-equipped facilities and attended by skilled trained and experienced in the required anesthetic technique and able to diagnose and treat any unanticipated adverse effects that may occur. Aderent administration of local anesthetics in patients with previous CV disease may potentially exacerbate some of those disease states. Spinal anesthesia with any local anesthetic may cause hypotension and bradycardia. All patients must have intravenous access established. The probability of appropriate fluid, electrolyte and/or blood product replacement and supportive measures must be ensured. Levobupivacaine should be used with caution for epidural anesthesia. Intravenous patients with liver disease or with reduced liver blood flow e.g. a statistical presence of non hepatocellular insufficiency or in elderly, patients. During epidural administration of levobupivacaine, concentration solution (10-50mg/ml) should be administered in incremental dose of 3 to 5ml with sufficient time between doses to allow the dose to be absorbed systemically. Intravenous injection of 50mg/ml with a concentration solution is recommended. An intravenous injection of 50mg/ml should be administered before the full dose is given. The lowest dosage of local anesthetics that results in effective anesthesia should be used to avoid high plasma levels and respiratory effects. Small doses of local anesthetics injected into the head and neck area, including subcutaneous, dental and intercostal block may produce adverse reactions similar to systemic toxicity seen with unintentional intracranial injection of large doses. Reactions may be due to intravascular injection of the local anesthetic with sympathomimetic effects in the central circulation. They may also be due to the presence of the drugs of the optic nerve. Although there is a risk of local anesthetic toxicity, the risk of serious disability associated with the local anesthetic toxicity. However, local anesthetic to a level below the limit of detection may occur. The local anesthetic should be used with caution in patients with liver disease or with reduced liver blood flow e.g. a statistical presence of non hepatocellular insufficiency or in elderly patients. During epidural administration of levobupivacaine, concentration solution (10-50mg/ml) should be administered in incremental dose of 3 to 5ml with sufficient time between doses to allow the dose to be absorbed systemically. Intravenous injection of 50mg/ml with a concentration solution is recommended. An intravenous injection of 50mg/ml should be administered before the full dose is given. The lowest dosage of local anesthetics that results in effective anesthesia should be used to avoid high plasma levels and respiratory effects. 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The confidence that comes from a first choice anaesthetic

Sevoflurane
From induction to maintenance

Prescribing Information: Sevoflurane 250ml
Refer to Summary of Product Characteristics for full information.

Presentation: Amber bottle containing 250ml Sevoflurane, water (as a Lewis Acid Inhibitor). Indications: For induction and maintenance of general anaesthesia in adult and paediatric patients for inpatient and outpatient surgery. Dose: NAC values decrease with age and the addition of nitrous oxide (see Summary of Product Characteristics). Induction: In adults up to 5% Sevoflurane usually produces surgical anaesthesia in less than 2 minutes; in children up to 7% Sevoflurane usually produces surgical anaesthesia in less than 2 minutes. Up to 8% Sevoflurane can be used for induction in unpremedicated patients. Maintenance concentrations range from 0.5-3%. Elderly: Lesser concentrations normally required. Administration: Deliver via a vaporizer specifically calibrated for use with Sevoflurane. Induction can be achieved and maintenance sustained in oxygen or oxygen-nitrous oxide mixture. Contra-Indications: Sevoflurane. Known or suspected genetic susceptibility to malignant hyperthermia. Precautions: For use only by trained anaesthetists. Hypotension and respiratory depression increase as anaesthesia is deepened. Malignant hyperthermia. Experience with repeat exposure is very limited. Until further data are obtained, Sevoflurane should be used with caution in patients with renal insufficiency. Levels of Compound A produced by direct contact with CO2 absorbents increase with: increase in body temperature; increased in anesthetic concentration; decrease in gas flow rate; and increase more with the use of Bari-forin rather than soda lime. The exothermic reaction that occurs with inhalational agents, including Sevoflurane and CO2 absorbents, is increased when the CO2 absorbent becomes desiccated (dried out). If the CO2 absorbent is suspected to be desiccated, it should be replaced.

Interactions: Potentiation of non-depolarising muscle relaxants. Similar to isoflurane in the sensitisation of the myocardium to the arrhythmogenic effect of adrenaline. Lesser concentrations may be required following use of an IV anaesthetic. Sevoflurane metabolism may be induced by CYP2E1 inducers, but not by barbiturates. Side-Effects: Very Common side-effects: Dose-dependent cardiopulmonary depression, nausea, vomiting, cough, hypertension, bradycardia and agitation, particularly in children. Common side-effects: Somnolence, chills, dizziness, increased salivation, respiratory distress, hypotension, tachycardia, laryngospasm, fever, headache, hypothermia, increased SGO2. Uncommon side-effects: Arrhythmias, increased LOH, increased IOP, hypokalaemia, pruritus, bronchospasm, anaphylactic or anaphylactoid reactions. Also post-operative hepatitis, but with an uncertain relationship to sevoflurane. Very rare side-effects: Malignant hyperthermia, acute kidney failure, pulmonary oedema and convulsions, particularly in children. As with other anaesthetics, twitching and jerking movements, with spontaneous resolution have been reported in children during induction. Patients should not be allowed to drive for a suitable period after Sevoflurane anaesthesia. Prescribers should consult the summary of product characteristics for further information on side effects. Use in Pregnancy and Lactation: Use during pregnancy only if clearly needed. It is not known whether Sevoflurane is excreted in human milk - caution in nursing women.

Overdose: Stop Sevoflurane administration, establish a clear airway and initiate assisted or controlled ventilation with pure oxygen and maintain adequate cardiovascular function.


Code No. AXSEV20061047

Information about mechanisms for adverse event reporting can be found at www.yellowcard.gov.uk
Alternatively, adverse events can be reported to Abbott Laboratories.

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