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APPROVED FOR 10 CPD POINTS
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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.

Don’t forget to visit the College website (www.rcoa.ac.uk/news) for the latest news items. You can also download the current and previous issues of the Bulletin.

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Editor’s choice

Our work as anaesthetists has often been compared to that of airline pilots. Take-off and landings are particularly busy with more mundane tasks in between – or so the analogy goes, albeit an overworked one according to some. But in reality, when it comes to safety, we still have much to learn from aviation and other high risk industries.

In ‘Have you ever make a mistake?’, a remarkable and moving account of the events leading to the death of his wife Elaine, airline pilot Martin Bromiley reminds us how much further we have to go in applying the lessons from human factors research to our own daily practice.

Perhaps such research will feature in the agenda for the new National Institute for Academic Anaesthesia? In ‘from the President’s office’, Judith Hulf announces the birth of this important new research collaboration between the RCoA, AAGBI, BJA and Anaesthesia. Through combining forces, hopefully the new body will become a ‘big player’ in academic medicine and able to attract major funding.

Aviation is a highly regulated activity. Now, like it or not, how we practice medicine is under increasing scrutiny too. In a guest editorial, Chris Dodds explains the nuts and bolts of revalidation with its two components, relicensing and recertification. This will certainly present a challenge for us all as individuals, as well as for the College and for the departments in which we work.

Professor Payne describes a very different world in his account of anaesthetic training in wartime Scotland. How many anaesthetists today would feel confident to anaesthetise a pregnant woman, perform an episiotomy, deliver the baby using forceps and then repair the episiotomy – all single-handedly and in the patient’s own home?

When does an anaesthetic actually start? The answer’s not so simple, as Andrew Norton explains in ‘The (anaesthetic) times they are a-changin’; nevertheless we need to agree on one.

So fasten your seat belts – a turbulent ride ahead.

Keith Apgar
Editor
Although 2008 is not yet a month old as I write, it will be well advanced by the time you receive this and with, I hope, spring almost upon us. Usually, I find that I am inclined to dust my hands of the old year with few regrets and hardly a thought for its passing, and forge ahead with the new. This year I found things rather different.

For one thing, I ‘saw in’ the new year in the operating theatre. I hesitate to relate clinical anecdotes in this very public statement, but this New Year made me resolve to maximise every opportunity in 2008.

As midnight approached, the surgeon and I resolved that we would try for the third (and last) time to separate the patient from bypass, and if unsuccessful, we would stop. I looked at the clock, and the team, and knew that the time of this patient’s passing would be on the stroke of midnight. But he didn’t die; he survived. I think that was the most significant start to a year ever for me. I am hugely grateful to be a part of a profession and a team that just occasionally is permitted to witness such amazing things, and feel that, perhaps, we have all contributed.

Last year was appallingly difficult for many people and I have no doubt that 2008 will have its moments. But there is much to look forward to; certainly there is the will within the College to work for anaesthesia and for medicine, and we will do our utmost.

But enough of philosophy; time for some facts. Some time ago there was an advertisement on television where the voice declared ‘I love it when a plan comes together’. Well, a number of plans that survived the chaos of 2007 have come together.

The National Institute for Academic Anaesthesia
Since the publication of ‘A National Strategy for Academic Anaesthesia’ two years ago, it has been the aim in the College to set up a National Institute for Academic Anaesthesia, as recommended by the authors, to support and promote the academic work of our specialty. I am delighted to say that this ambition, a collaborative initiative for anaesthesia in the UK between the Royal College of Anaesthetists and the Association
of Anaesthetists of Great Britain and Ireland (AAGBI), has been achieved. Most importantly, the new Institute will support the work of the Research Collaboration and its four founding, funding organisations; the British Journal of Anaesthesia (BJA), Anaesthesia, the AAGBI, and the College, in providing funding for research in anaesthesia, critical care and pain management. Council has proposed that the Board of the Institute be chaired by Professor David Rowbotham and I am pleased to tell you that he has agreed.

In announcing the start of the Institute and the Research Collaboration, thanks are due to many people. Professor Tony Wildsmith chaired a group of advisers and initiated the appointment of an Academic Strategy Officer at the College, Dr Jaideep Pandit, who was the author of the report published in December 2005. Over the last year much work has been done to set up the Research Funding Collaboration by members of the Councils of both the College and the Association, and Professor Philip Hopkins and Dr Simon Howell of the BJA. The Research Group starts its work soon, reviewing grant applications and recommending awards. The BJA has already provided funding for a research scoping exercise, aimed at Fellows and Members that will take place during the early part of the year.

Dr David Whitaker and the officers and Council members of the AAGBI have been tremendously supportive. As a result I am quite sure that anaesthesia now has an Institute that will support not just the Research Collaboration but training in academic anaesthesia, revalidation for academic anaesthetists and many other future initiatives. My personal thanks are due to David Rowbotham and Chris Dodds, both of whom have worked tirelessly with the organisations involved to bring this initiative to fruition. I look forward to the formation of the full Board and to their first meeting and that of the Research Collaboration.

**First professor of military anaesthesia**

In October, Lieutenant Colonel Peter Mahoney, RAMC, was appointed to the joint Royal College of Anaesthetists and Ministry of Defence (MoD) Foundation Chair in Military Anaesthesia. This landmark appointment for anaesthesia is the third joint Royal College/MoD chair, and the new professor of anaesthesia joins professors of military medicine and surgery. Colonel Mahoney has taken up his post at the Royal Centre for Defence Medicine in Birmingham that is affiliated to the University of Birmingham. The College offers its congratulations to Professor Mahoney on his appointment and we look forward to working with him and his team in the future. At a time when the British military and its medical services are under severe pressure, we welcome this opportunity to work more closely with them and to learn from their experiences in the field; particularly how their management of the physiological changes in severe trauma can be translated into the civilian critical care and peri-operative medicine environment.

**New Council Members**

Last year we changed the date of election to Council to complete the process before Christmas. We all have difficulty in balancing clinical work with work we do in the wider NHS, and I hope that this earlier process will allow those who permit their names to go forward for election the opportunity to arrange their lives. I am delighted to tell you that Drs Anna Batchelor, Mark du Boulay and Peter Venn, and Professors Chandra Kumar and Robert Sneyd will be joining Council in March as consultant members. Dr Andy Lim was re-elected as staff and associate specialist member and Dr Suneetha Moonesinghe as a trainee representative. Congratulations to them all and we look forward to seeing them at March Council.

**Retiring Council Members**

Welcoming new members of Council means, I fear, that one must bid farewell to others. In March we will say au revoir to Griselda Cooper, John Curran, Chris Heneghan, Rajinder Mirakhur and Stuart Gold. All have contributed so widely to the work of the College and Anaesthesia in its widest sense, that it’s hard to know where to begin. To say that the College will miss them is a great understatement. They have been loyal, always supportive and so hard working and selfless for the aims of our specialty. We all owe them enormous gratitude for their work and their friendship. We shall certainly miss you, but don’t for a...
moment think that you have escaped entirely – there is always e-mail and the telephone!

**World Congress of Anaesthesiologists (WCA)**

By the time this is published, those of us lucky enough to be attending the WCA will be in, or about to arrive in, Cape Town. I would like to offer Professor Mike James and his co-organisers of this great event every good wish from the College for what I am sure will be a most successful week. I am particularly looking forward to the opportunity to meet with representatives of other countries and to have the opportunity to exchange views on all manner of issues relevant to anaesthesia and the conduct of medicine in general. There is a great tendency to think that the ‘grass is greener’ elsewhere, but I bet that most of the perceived problems and difficulties are replicated around the world. The Vice-Presidents and I will be setting aside time for discussion with other Presidents, training organisers, and examiners from colleges around the world so that we can feed ideas back into our own College. We shall also be making contact with those Fellows of the College who work around the globe. If you wish please do contact us. We will leave contact details at the message centre at the conference.

**Physicians’ Assistants (Anaesthesia)**

You will all be familiar with the training programme developed over the last few years to train ‘Anaesthesia Practitioners’. Some time ago, the Councils of the AAGBI and the College agreed that, in order to remain in-line with other specialties and with other UK nations, we would consent to the name change to Physicians’ Assistants (Anaesthesia). In order to be quite clear, henceforth all documentation in print or on our website will use the new title for those who are either training in or qualified from the programme.

**Clinical Excellence awards**

I almost hesitate to raise this topic again so soon after the 2008 national round has closed. I am, however, quite certain that I am not the only person who has had an electronic nightmare with the whole system this year. I’d just like to assure everyone who has dealt with the Advisory Committee for Clinical Excellence Awards (ACCEA) process in the last few weeks that I have made and will continue to make the strongest petition to ACCEA to improve the electronic system for next year. During early January, I telephoned the help-line almost daily, and received some extremely patient and helpful guidance from those who answered, that enabled us to complete the College process with 48 hours to spare. However, the amount of time devoted to a poor IT system nationally doesn’t bear thinking about. I have had absolute sympathy with 2007 MTAS applicants for a very long time, but the fellow feeling I have for them has increased even more recently. David Whitaker and I will make every effort to encourage efforts towards an improvement for the 2009 process.

**Critical care subsection of the Royal Society of Medicine (RSM)**

I’m delighted to say that the new critical care subsection of the RSM hold their inaugural meeting ‘Critical care – the way forward’ in mid-February. I hope that some of you will have had opportunity to attend and I wish the section well for the future.

**60th Anniversary**

2008 is not only the diamond jubilee of the National Health Service, but is also that of our own Faculty of Anaesthetists. Consequently, the Anniversary Dinner this year will celebrate the 60th anniversary of the founding of our Faculty, later College and then Royal College. We are most fortunate that we are able to celebrate this event in St James’ Palace and honoured that it will be in the presence of our Patron, Her Royal Highness the Princess Royal.
Revalidation: where are we now?

The College believes that the entire process will depend on at least three parallel processes that will culminate in successful revalidation:

- the CPD activity and performance of individual doctors
- their departmental approach to maintaining professionalism within their medical staff
- the development of systems within the College to enable it to confirm an individual doctor’s performance to the standards required.

If these are not in place and robust, failure will be more likely. I shall address only the first two in any detail in this review.

Key points

- It is going to happen.
- It is going to directly affect us.
- Reviewing our current activity may identify areas of weakness that have to be addressed this year.
- The vast majority of us are expected to meet the criteria laid down.
- Follow the simple guide at the end to assess where you are and what you need to do.

What is it?

Revalidation is, for most of us, a composite of two processes that lead to two separate end points (see Table 1). It is likely that in reality they will merge into one process.

Relicensing, the maintenance of registration, will be required to be recognised as a doctor with its associated privileges, and will apply for all doctors across the UK once they have completed training. It is a generic process and will be assessed by local ‘affiliates’ of the GMC.

Recertification is the process that allows recognition of the ability to act as a specialist, and will include those who are not on the Specialist Register as well as those who are. This confirms that the doctor has been trained in a particular discipline and has been ‘positively affirmed’ by the appropriate College or Faculty as
continuing to meet their standards of professional practice.

Both of these cycles run together, and the activities of professional practice will be formally assessed and approved every five years. It is vital that these processes are seen as continuous cycles of activity over a lifetime of practice with episodes of formal review every five years.

Both relicensing and revalidation are retrospective! The evidence that will be necessary to achieve both will be that gathered over the previous five years of practice. This means that those of us in the first wave (in 2010) will have to have that evidence from 2005 available.

Responsibilities
The College will have a responsibility to ascertain and affirm that an individual Fellow or Member performs to an acceptable standard of professionalism within anaesthesia, intensive care or pain medicine. This is a new role for all Colleges and one that requires a more structured approach to many elements that were simply ‘approved’ before, for instance, continuing professional development (CPD) activity.

The tasks for individual doctors

Relicensing
We all undergo appraisal within our departments and this will provide the bedrock for relicensing. The documentation should include evidence to confirm that we are performing at a satisfactory level in all domains within the GMC ‘Good Medical Practice’ framework.

One element that will be vital in this process is ‘multi-source feedback’ (MSF). This is going to be specialty based as there are clear difficulties in some specialties in gaining direct patient feedback (pathology comes to mind). It is likely to be an infrequent process for most of us, but does act effectively as a tool to gather independent peer and colleague views. MSF may be managed directly through the College or at a local level, when the results would have to be made available to the College.

How can I record all of this information?
The paper based systems used by most of us for appraisal could still be used for the relicensing process, especially as this is likely to be a local event. However, the College is committed to delivering an e-Portfolio for all anaesthetists that will allow the recording of all information used in completing appraisal, including CPD activity and personal development plans (PDPs). This would be based on individual records, would be completely secure and would be identical in functioning to the version being developed for use by our doctors in training. Whilst it is unlikely to populate the domains of Good Medical Practice directly, it will certainly help identify what activity provides evidence for which domains. The College will have to confirm, for both relicensing and recertification, that CPD has been performed and has been effective. This may involve, for instance, the completion and recording of MCQ activity, reflective diaries of CPD activity or e-Learning logs of course progress.

What should I do now?
Firstly, review the last few years’ appraisal documentation. In particular:

- Check that the evidence claimed – courses attended/CPD points accrued – are in the files.
- Check what aspects of the agreed PDPs have been achieved and what have not. If there are uncompleted ones, identify the reasons and record them.
- Review any changes in job plans or specialist practice and confirm that you have active CPD in those areas.

<table>
<thead>
<tr>
<th>Process</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relicensing</td>
<td>The process for maintaining ‘primary’ registration every 5 years on the General Medical Register</td>
<td>This simply maintains our ability to practise medicine as a doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It is likely to be a local process with some accreditation of continuing medical education by the College</td>
</tr>
<tr>
<td>Recertification</td>
<td>The process for maintaining ‘specialist’ registration, including, but not exclusively, those on the Specialist Register</td>
<td>This is the process that we believe all anaesthetists who are not in training should undergo in the interests of the public and our profession</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It is not dependent on being on the Specialist Register</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This process requires the College to ‘positively affirm’ that an individual meets the standards expected of an anaesthetist</td>
</tr>
</tbody>
</table>

### Table 1 A definition of relicensing and recertification
Review the ‘core topics’ section in the recommended CPD activity and ensure that all clinical skills elements that are relevant to your job plan are clearly covered as part of a rolling programme of revision. These can be confirmed through log books and results from departmental audit and critical incidence reviews.

If you have received any accolades or letters of appreciation, make a list of them – they are all evidence for GMP Domains 2, 4 and 6.

If there are any complaints/issues with patients, make sure that all the relevant documentation is in place.

If you are active in private practice, try to gather the same information as that from your trust. (This may be necessary by the time we start revalidation, by which time it would be too late to start the process.)

Ensure that the ‘responsible officer’ (medical or clinical director) within your trust actually has copies of your appraisals, or that they have acknowledged that they have taken place. This is usually part of the process of applying for clinical excellence awards, but double check.

Then, plan what needs to be in place by 2010 and how you will achieve it. This will probably need a discussion with your clinical director and should take place within the first half of this year to give a reasonable chance of success.

Review the areas from both core clinical skills appropriate to your job plan (including on-call cover) and any specialist practice you provide and see what educational events – RCoA or AAGBI courses, local events or e-learning materials – may be necessary to top these up. These can then be planned and programmed within the demands of the rest of your department (who are all going to be doing the same thing). If it is impossible in practical terms to get all of your department to a core skill training programme such as the difficult airway, consider developing a departmental event and invite an ‘expert’ to deliver the training.

Keep watching the RCoA website for updates on revalidation as they are being posted whenever changes occur.

**Recertification**

This will build on the relicensing platform and will be more specific and individualised. This is because recertification identifies that this doctor is not just fit to practise medicine but is safe to care for patients during anaesthesia, in intensive care or in pain management. Much work has yet to be done here, and we expect to find some difficulty in providing reality based and practical processes.

The elements within recertification will include:

- departmental accreditation
- specialist CDP
- individual professional performance review.

We will externally accredit departments against such criteria, after detailed piloting, to confirm that such a professional ethos exists in the department. It would be difficult to imagine a Trust not supporting such QA.

It is equally predictable that departments that cannot be accredited are unlikely to provide their specialists (consultants and SAS doctors) with the professional support necessary to achieve recertification. In common with most Colleges, we are planning to introduce departmental accreditation in 2009. Details will be posted on the RCoA website as they are finalised and pilots are completed.

**Specialist CPD**

Whereas relicensing will confirm that all core skills are up-to-date, recertification will ensure that specialist CPD will be based on an individual’s job plan. There will not be a specific recertification examination process but we will have
to have a means of identifying that CPD activity has occurred. As with relicensing, this will use a variety of methods that can include MCQ completion as well as completion of a reflective diary after attending courses (as used by the Royal College of Physicians at present).

We will need to alter the way in which we approve CPD to allow the College to confirm that educational objectives are set for all courses and that evaluation of the content and the presenters is acted upon and feedback given. To do this we will be working with the AAGBI and other specialist societies to develop a standard course profile that once submitted will be approved. This will occur over this year and should not involve an individual organisation in too much change if they already use this good practice. There will, however, be a ‘one-off’ re-application process to this profile for all courses (including the RCoA ones).

However, because we need to audit the standard of these courses we will seek from both the organisers and a sample of the delegates information such as attendance registers and copies of evaluation forms and any action they prompted. The completion of an individual’s e-portfolio and their identification of whether the course met its objectives will also be valuable.

It is likely that the College, with the AAGBI, will determine what are ‘core clinical skills’ and will seek advice from specialist societies as to what CPD should be required for the individual areas of practice such as cardiac, obstetric or paediatric anaesthesia.

In common with some other Colleges we are going to create a category of mandatory CPD – ‘professional CPD’ – that will require activity such as direct peer review (see below).

Doctors should actively review their current specialist CPD and then follow the same planning as that for relicensing to eliminate any obvious gaps. This should take place as soon as possible to enable a timely progression at a personal and departmental level.

Professional performance
This is the most difficult, but equally the most important, part of recertification. We need to be able to assess fairly the performance of specialist practice at an individual level in all areas of practice and on all sites. This is likely to require direct observation of practice within the home department and during a ‘routine’ list/clinic/ward round. The practicality of releasing experts is not a minor task but the development of suitable assessment/recording schemes and the training necessary to ensure consistency across the UK is daunting. The judgement on satisfactory professional performance is likely to be straightforward in the majority of cases. However, for the rare case of unsatisfactory performance, the evidence collected and the methods used must be credible and defensible.

It is highly likely that many of us will be taking part in pilots of one form or another, not only for anaesthesia, but for our surgical colleagues and others over the next couple of years.

In summary
We will all undergo relicensing and recertification (or retire) within the next seven years. We have to act now to make this a painless and satisfactory process. As more details emerge we will place them on the College website, but if any individual would like to help with the process of developing assessments of professional performance or if departments would like to help with piloting accreditation, please get in touch with me.

chris.dodds2@btinternet.com
An ‘out of programme experience’ (OOPE), or ‘off rotation training’ in PMETB terminology, has always been a way to broaden your experience in a chosen sub-specialty and to set yourself apart from your peers, with the added bonus of visiting exotic locales under the auspices of training.

For an aspiring paediatric anaesthetist, the options are many: Toronto, Melbourne, Boston, Holborn, South Africa, and Chain of Hope charity missions to name a few. Given the increasing competition for consultant posts, this extra polish is becoming essential. However, those of us less able to travel overseas need not be disadvantaged, as world class experience can be found on our own doorsteps.

Introducing CATS
Nationally, paediatric intensive care is concentrated in a small number of specialist units, and consequently most critically ill children present to a hospital without intensive care and require transfer. Historically, each paediatric intensive care unit (PICU) offered its own retrieval service, often part-time and without devoted staff and equipment. In London there are now two dedicated PICU retrieval services: South Thames Retrieval Service (STRS) based at the Evelina Children’s Hospital, and Children’s Acute Transfer Service (CATS).

CATS is funded jointly through Great Ormond Street, St Mary’s and the Royal Brompton hospitals. Based in Holborn, this service aims to provide a single contact point for triage and advice, consultation and liaison with sub-specialists, referral to an appropriate PICU, and stabilisation and retrieval of critically ill children within North Thames and East Anglia. Additionally, patients referred to Great Ormond Street for extracorporeal membrane oxygenation (ECMO) treatment or for liver transplantation are retrieved nationally to appropriate centres.

Two CATS teams are available 24 hours, seven days a week, each comprising a CATS Fellow, a senior ICU nurse, and an ambulance technician, backed up by the CATS consultant and drawing advice from the full network of intensive care and hospital consultants at the receiving hospitals. Within 20 minutes of a retrieval decision, the team can be en route in one of two dedicated ambulances, specially designed and equipped for the retrieval of children.
Flight retrievals are also used to cope with long distances, but need to show a time advantage. CATS has a close relationship with the RAF search and rescue force, as well as a number of private air ambulance services making Wales accessible in an hour, and the Channel Islands in 90 minutes. Flight retrievals occur about once per week.

A CATS cradle – is this too specialised for me?
Regardless of where you work, five-day-old infants – shocked, blue, acidotic, anuric and in respiratory distress – may not feature regularly on your Wednesday paediatric surgery list. As a CATS Fellow, the skills learnt coping with these situations, and the confidence in your own ability to do so, are invaluable. The assurance gained dealing with these extremes of physiology will make more day to day cases seem routine.

With only larger tertiary centres having the resources to provide a dedicated paediatric on-call service, any district general hospital (DGH) anaesthetist can expect to be faced with managing and transferring an unstable child to specialist care. As an anaesthetist with a specialist interest you become the local resource for clinical management, advice and education within that interest.

For DGH anaesthetists with a sub-specialty interest in paediatrics, current guidance recommends six months dedicated paediatric anaesthesia training. Consultants with a more substantial paediatric commitment will normally have completed 12 months. Subsequently, the onus is on the individual and their departments to ensure continuing education and professional development (CEPD), and this is likely to become more formalised to meet the requirements of relicensing and recertification.

Coupled with the flow-on effects of European Working Time Directives and modular, run-through training, these measures are likely to make Fellowship posts even more popular.

A Fellowship that develops your skills in a key area of paediatrics such as critical care and retrieval will prove invaluable to both you and your department.

A CATS call with a difference
Being the Fellow designated to answer the phone in the CATS office can be a fraught experience. What will it be?: Respiratory failure? Trauma? Sepsis? Von Gierke’s disease? The initial referral call consists of a thorough consultation, including patient demographics, clinical history, and examination findings. As with any in-hospital referral for intensive care support, this can vary from simple, clear cut findings with a clear management plan, to vague inconclusive symptoms and a variety of potential diagnoses.

The key here is communication, and including the CATS consultant in a conference call regularly provides a master class in history taking, defining options and explaining management plans.

Resource management is vital. There is no option to nip down to the emergency department to see the patient – at least not without a two-hour road trip. Transportation of critically ill patients is not without risks and the benefits of reaching a specialist centre must clearly outweigh them. Just as you might manage an ICU referral on the ward, initial advice may involve local management with results assessed via regular follow-up calls. If patients deteriorate or do not respond, a team can then be dispatched. Within the decision making process, transportation and ICU admission logistics are centralised by CATS, leaving the referring team able to focus fully on the patient.

On the scene – CATS amongst the pigeons
Some retrievals may be straightforward, with lines and tubes placed by local staff and patients fully worked up for transfer. Others see local teams operating at the limit of care their hospital can provide, such as coping with a hypoxic, shocked and acidotic newborn following a meconium aspiration. As the CATS Fellow you may have left the office whilst still advising the referring team on respiratory support and inotropes, and planning to organise an ECMO bed en route. Discovering that the nearest ECMO bed is in Leicester means leaving the office to coordinate a flight, whilst you focus on the retrieval.

Contrary to popular myth, once on scene, CATS will not change every line and tube but often
simple measures such as upsizing an endotracheal tube can improve ventilation enough to allow a safe window for transfer. If the normal goal of an uneventful transfer with a stable, well monitored patient is likely to be unachievable, considerable time can be spent on scene resuscitating and stabilising the patient. PEEP of 10 cm H₂O? Adrenaline at 4.0 mcg/kg/min? (Yes that’s 4.0 not 0.4!) Adult doses of bicarbonate? Magnesium? Nitric oxide? Calcium? The weight of syringes alone will exceed that of the patient. All must be tied to the stretcher and hoisted aboard the RAF Sea King helicopter that has landed in the park across the street.

Once on board there is an hour of staring fixedly at the monitor, especially the capnograph, to look forward to, since you can no longer hear the ventilator cycling or any of the alarms! All of your equipment is within arm’s reach, but finding it in this dark noisy environment is daunting. Arriving in Leicester to face a host of surgeons, nurses, perfusionists and intensivists feels a little like presenting at a Grand Round, but this is one of the most critical stages of any transfer, with pumps and monitors being exchanged and any miscommunication having significant consequences. With the receiving team entrusted with the patient there is just a two-hour road journey home to look forward to. Pity your shift is already over.

Curiosity and CATS – training and research
Complex congenital heart disease and rare metabolic disorders are not part of most people’s practice prior to working at CATS, and ample time is provided for induction and training. Each morning starts with a review of the previous day’s cases, with discussion of problems, clinical management and outcomes, frequently pulling up learning points. Affiliated with Great Ormond Street Hospital, the Fellows also have access to the formal ICU teaching sessions as well as the weekly in-house CATS teaching.

Research and audit are encouraged, and, with a computerised database, detailed record keeping and a small captive group of colleagues to fill out your audit forms, many of the usual obstacles to research are removed. There is ample scope to tailor these to your interests, such as induction and intubation practice in my case. Whilst not out on retrieval, housekeeping issues such as equipment checks and patient follow-ups fill part of the time, and there is often opportunity for reading and research.

Conclusion
Both trainees and institutions should consider that there are few stand-alone positions offering high quality training opportunities within the UK. Given the increasing demand for post-FRCA specialisation, these posts will become increasingly desirable.

I could not recommend the CATS service more highly to any paediatric anaesthetist. The clinical experience received in a short space of time is hard to match, and the confidence gained from managing unstable patients in unfamiliar surroundings makes decision making in the anaesthetic room seem calm and stress-free. Furthermore, the lessons learnt in communicating with consultant colleagues in often difficult situations are not to be underestimated. With superb education and support from the CATS team there is nothing I more could have wanted in an OOPE. Not even an exotic locale.
Coincidentally, I write this not far from Heston Aerodrome where the Prime Minister made his famous speech in 1938. Like Neville Chamberlain I may be lambasted as an appeaser who dealt with the devil and got my fingers burned... however, I hope history will not view me so cruelly.

Money (That’s What I Want)
The long and the short of it is that the trainee subscriptions are going up. Not just going up, but doubling! My first reaction was one of incredulity. Was this some kind of joke? But, as Churchill said: ‘A joke is a very serious thing.’ Surely not now? Not after the shenanigans of MTAS, the dearth of consultant jobs and the genesis of PMETB – does the Finance Committee not realise that trainees’ hackles are up? How much wine does the College cellar need?

A small German man with a comical moustache had a good turn of phrase and he said, ‘If you tell a lie big enough and frequently enough it will be believed.’ Well he would know. There is truth in this statement though. I have been haunting the College for nigh on three years now and despite my best efforts find no evidence of profligacy. In fact, you are all welcome to meet me in Churchill House and I will show you where the College cellar isn’t. The reality of it all is that we trainees are not a cheap date and we never have been.

Yesterday
In days gone by, the Department of Health (DoH) would supply the College with a training grant. This ceased with the advent of PMETB. But, unfortunately, PMETB only took over some of the duties from the College. It actually took over the duties of the Specialist Training Authority (STA). The College still keeps, maintains and produces a record of every trainee’s progress. The College uses this to make a
recommendation to PMETB. Now a lot of people out there are sore at the exit fee that PMETB charges for the world’s most expensive certificate. But this would be doubly painful if our College decided to do what others have done – charge a fee for their recommendation to PMETB.

In the past, money was never really made in running the examinations. Nor were the courses for Primary and Final ever a serious cash cow. In fact since the College has been an entity, trainees have been subsidised by the Fellows. This give-away mentality is well illustrated by the fact that the College’s trainees pay the least out of all other College’s trainees and have done for a fair few years. Bear in mind that the Royal College of Surgeons charges £235 per annum! Rightly or wrongly, the College has always tried to be liberal with trainees’ subscriptions. It went to the extraordinary lengths of reducing them in 2001 and only increasing them when necessary. In fact in 2005 and 2006 there were no increases at all.

Fixing a hole
So then why the increase now? There is a hole to be plugged. The loss of the DoH money to PMETB is an issue. We are currently in negotiations to return some of it to the College. Still, there will be a gap. But again the asymmetric funding of the College has to be adjusted. Fellows’ fees are going up according to inflation, as subscriptions generally do, but it is not known how much of the Fellows’ fees will in future be needed for their own needs – who knows what revalidation will cost to implement? The College has to make charges for services it provides or feels it needs to provide in the future. The electronic revolution will change our professional lives but ‘start up’ money for the e-Logbook and e-Portfolio is needed. Add this to some of the cost of the e-LA project (the DoH pays for it but we bear the brunt of the administrative costs) and the numbers start totting up.

... it is not known how much of the Fellows’ fees will in future be needed for their own needs – who knows what revalidation will cost to implement?

In the past, real improvements in service, like the Continuing Education in Anaesthesia, Critical Care and Pain (CEACCP) publication were assumed predominantly by the Fellows. The College will always strive to produce quality courses for trainees when the need is there, but making a profit seems increasingly far off as the near future shows no change in the way trusts view study leave budgets. Examinations will struggle to break even in the next few years due to changes that will have to be made to accommodate advances (like simulation), expansion and reorganisation along PMETB lines. Of course, times like this make one want to dig into one’s reserves – but the reality of Churchill House is that we are asset rich but cash poor.

Clearly, though my article might be seen to be an act of appeasement, in reality I feel no need to act as apologist for the College. There are fights that need to be made for trainees – in medicine, in anaesthetics and in the College – but this is not one. Once the explanations were given to me I realised ‘it is better to jaw-jaw than to war-war’.

Taxman
In short, there is an increase in services to trainees at a time when a lot of funding is being squeezed. The result is that as a trainee the subscriptions are going up. But try and stay positive – the College subscription won’t go up till October. Also it is an allowable expense and can be written off against tax so the real increase is only £36. What is more, when you become a consultant, it screams up to £370! Remember for this you do get the excellent Bulletin. Modesty prevents me from highlighting the value for money the bimonthly Trainees’ Topics column gives. But as ever Churchill gets the last word – I do have a lot to be modest about.
Have you ever made a mistake?

**Martin Bromiley** is the husband of the late Elaine Bromiley.

I’m an airline pilot whose wife died during an attempted operation. In this article I’ll ask you to reflect on the culture within healthcare around ‘error’ and I’ll discuss methods we use in aviation to manage error. Over the last couple of years I’ve had the honour of working (in a voluntary capacity) with some very special clinicians, academics and policy makers. I apologise in advance if my article over-simplifies the complexity of both clinical decision making and human factors. I cannot claim any clinical knowledge, and my understanding of human factors is as a practitioner, not expert. Recently, I’ve helped to bring together a group of people to help grasp the problem of managing error in healthcare; they are the experts, not me. Please see [www.chfg.org](http://www.chfg.org) for more details.

It’s now accepted at some levels that error occurs in medicine and that patients are harmed on occasion. The extent of both that acceptance and of the harm is hard to gauge.

I’m going to start at the end with my conclusion; that the big difference between healthcare and many other ‘high-risk’ industries is this: in healthcare, error is considered poor performance or weakness. If you get rid of the individuals who make error then patients will be safer. The consultant is ‘God’ and is always right. However, in my world of aviation, error is accepted as normal, not poor performance or weakness. The trick is not to eliminate error completely but to maintain a culture which, through system, process and training, increases the probability of small errors being caught before they become errors that harm. The captain is no longer ‘God’ but is someone who, despite great insight, is a normal human and prone to all the errors that normal people make.

In short, if you accept error is normal, you become good at catching it.

**Elaine’s story**

I’d like to offer the story of Elaine, my late wife and ‘mummy’ to our two young children. In this account, all the clinical staff were well trained and technically competent. Arguably, had they taken an exam before my
wife's attempted operation in the emergency they were about to face, then I suspect they would have all scored highly. Indeed, at the inquest, they talked about what they should have done, but none could understand why they hadn’t taken the actions they themselves expected to have taken.

We have a fair understanding of what happened because I was granted an independent review of Elaine’s care. This was conducted by Professor Michael Harmer, MD FRCA, the then President of the Association of Anaesthetists of Great Britain and Ireland. A full anonymous copy of the report and inquest verdict are available at www.chfg.org but the salient points of the attempted operation are as follows.

Elaine was booked in for endoscopic sinus surgery and a septoplasty on 29 March 2005. A very thorough pre-op assessment was carried out and there were no significant concerns. The proposed anaesthetic technique was to avoid tracheal intubation and maintain the airway with a laryngeal mask and there was no pre-oxygenation.

‘Zero minute’: Anaesthesia was induced; it was not possible to insert the flexible laryngeal mask due to increased tone in the jaw muscles. Dr A, the consultant anaesthetist, gave another 50 mg of propofol and had a second attempt. He tried two sizes of laryngeal mask (sizes 3 and 4) but was unable to insert either.

+2 minutes. Elaine looked cyanosed. Her oxygen saturation was 75%.

+4 minutes. The oxygen saturation continued to drop to 40% over the next minute or so. Attempts to ventilate the lungs with 100% oxygen using a facemask and oral airway proved extremely difficult.

6–8 minutes. It was still proving near impossible to ventilate the lungs and the oxygen saturation remained perilously low (40% which we believe was the monitor’s lower limit). Dr A decided to attempt tracheal intubation at this stage to overcome the problems with the airway. He gave 100 mg of suxamethonium (to allow insertion of the tracheal tube).

At about this time, Dr A was joined by Dr B, another consultant anaesthetist who was in the adjoining theatre. Other nursing staff had been summoned to the anaesthetic room to provide any necessary assistance and they also arrived. Mr E, the ENT surgeon waiting to perform the op, also entered the room at about this time. At the inquest additional information came to light and as a result the time at which other staff arrived differs from Prof Harmer’s report. We discovered that one nurse went out to phone the Intensive Care Unit as she was shocked at Elaine’s vital signs and colour. On return she announced: ‘A bed is available in Intensive Care’, but in her own words the consultants looked at her as if to say: ‘What’s wrong? You’re over-reacting’. She went back to the phone and cancelled the bed. Meanwhile, another nurse asked her colleague to fetch the ‘trachy’ kit. On her return she announced to the consultants that ‘The tracheotomy set is available’, but she felt she was ignored. (Later, at the inquest, two of the nurses present stated that they had known exactly what needed to happen. In Professor Harmer’s verbal statement to the coroner, he commented that he felt the nurses ‘didn’t know how to broach the subject’).

+10 minutes. On insertion of the laryngoscope to allow insertion of the tracheal tube, it was impossible to see any of the laryngeal anatomy. Ventilation still proved extremely difficult despite the use of four-handed attempts.

The situation with hindsight was now that termed ‘can’t intubate, can’t ventilate’.

+12–15 minutes. Further attempts at laryngoscopy and intubation were made using different laryngoscopes by both Dr A and Dr B, but to no avail. Dr B attempted visualisation with a fibreoptic flexible scope but this was unsuccessful due to the presence of blood. O₂ saturation remained at 40%.

+16–20 minutes. Mr E attempted intubation with a standard anaesthetic laryngoscope. He was able to see the very end of the epiglottis and attempted to pass a bougie into the larynx over which a tracheal tube could be ‘railroaded’. He was unsuccessful. O₂ saturation remained at 40%.

+20 minutes. Insertion of an intubating laryngeal mask allowed some ventilation, though it still remained difficult to ventilate the lungs. O₂ saturation still at 40%.

If you accept error is normal, you become good at catching it.
+25 minutes. The insertion of the intubating laryngeal mask improved matters and the oxygen saturation rose to 90%.

+28–34 minutes. Attempts were made to insert a tracheal tube through the intubating laryngeal mask. Initially, the attempt was undertaken blindly and then using a fiberoptic flexible scope. The latter attempt by Mr E failed. During these attempts, the oxygen saturation was unstable. At no time did it exceed 90%.

+35 minutes. In view of the problems encountered, it was decided to abandon the procedure and allow Elaine to wake up. At the inquest, the nurses recalled a brief discussion among the consultants about performing an ‘awake intubation’ to which two nurses simultaneously said ‘no’, although the consultants claim not to recall this.

Once Dr A was happy that Elaine was breathing satisfactorily with the oral airway in place, she was transferred to the recovery room.

It is clear now that the recovery staff were far from happy with Elaine’s condition. Even nearly one hour after admission, there was no sign of recovery of consciousness and, whilst Elaine was breathing, the pattern was erratic. Concerns increased and eventually it was decided that Elaine needed to be transferred to the Intensive Care Unit. This took place at about 11.00.

Elaine died 13 days later having never regained consciousness.

Human error

The traditional clinical (and often legal view) is that, whilst people do make mistakes, doctors (and pilots) should be trained not to. Those who prefer blame would argue that if you struck off Dr A or the whole clinical team, then the same mistake could not be repeated. The public is now safe. Is that true?

Aviation has a long history of accident and incident investigation. In the last few years this has been aided by an understanding of ‘human factors’. Human factors can be hard to define; it’s really a ‘pseudo’ discipline covering many areas such as the design of equipment, human behaviour under normal and stressful conditions, and human error. However, in simplistic terms, it’s trying to understand why humans don’t behave as entirely predictable computers, and therefore finding ways to reduce error.

Let’s start looking at Elaine’s case from a human factors (HF) perspective.

None of the staff involved expected 29 March 2005 to be any different from any other. It was a normal day at work. They were normal people. Everything initially looked normal in Elaine’s case. No-one planned to make any errors, everyone involved was well qualified, well respected, just like you.

What mental model did they have at the start of that day? Did any of the team imagine they may face difficulties? Did any of them think through, either privately or with their colleagues, how they might react if certain problems occurred during Elaine’s procedure? Dr A had conducted a thorough and careful pre-op assessment. Arguably there was nothing in Elaine’s condition that would have led him to think now about ‘contingencies’.

Initially, he reacted as many would have expected, in this case by resorting to intubation. However, when intubation was difficult, it appears that the problem became one of difficult intubation. In reality, of course, we know now that the problem perhaps should have been defined as one of ventilation. This is called fixation. When faced with a stressful situation we become focused on it. In simple terms it allows you to cope with a stressful situation by ‘giving your full attention’ to it. Perhaps this is why the three consultants didn’t react to the nurse’s announcement of the ‘trachy’ kit being available?

I understand that in studies of ‘can’t intubate, can’t ventilate’ scenarios abroad, in the majority of cases people continue to attempt intubation despite indications that it’s unsuccessful. This leads us into another typical reaction: denial. This isn’t a conscious choice we make but is a normal reaction to stress; a protection if you like, while we come to terms with the problem. Again, perhaps the ‘under-reaction’ to the nurse who phoned ICU was due to this.

The nurses were clearly aware that things were going wrong, but seemed unable to say anything. We are taught respect for our senior and/or experienced colleagues. It’s often ‘simply not your place’ to speak up. Again this deference to others is very common in incidents and accidents the world over. Were the nurses unassertive, unsure perhaps? Did the consultants create an atmosphere which encouraged junior staff to speak up?

So it would appear that everyone behaved in a predictable way, but the outcome was arguably avoidable. How can we learn from this?
Learning from accidents – how aviation uses ‘human factors’
In essence, aviation applies human factors to three areas. The first is equipment design, although in this case this is probably not relevant. (As an example, if the same switch in two flightdecks operates in an opposite or different sense, is it any surprise that people make the wrong switch selection, especially under stress? So we design aeroplanes with this in mind.)

The second is the use of process development, and the use of ‘drills’, checklists, ‘SOPs’ (standard operation procedures), and pre-flight and approach briefing. All the above mean that we tend to work in fairly predictable ways, especially useful as from one day to the next you may be working with people you don’t actually know. Checklists mean we are less likely to forget to do actions required, especially under stress. Briefings (before and during every flight) are a form of mental rehearsal, but have the added advantage of sharing situational awareness and pulling a team in the same direction. A typical take-off brief will involve the pilot flying that particular flight talking to his colleague about what he expects to happen, and what may happen, including some of the worst-case scenarios such as engine failure or fire. A range of options are discussed so that all flight crew are aware (and made to mentally rehearse) what is expected of them. This discussion of the future also reduces the possibility of denial.

The third area of effort, stemming from HF, is the enormous effort made in training pilots, cabin crew, engineers and air traffic controllers in HF and non-technical skills, such as decision making, situational awareness, team working etc. (Indeed, 50% of my three-yearly assessments are on my non-technical skills.) This helps us to understand our behaviour better and thus anticipate how we may react or behave in crucial moments. For example, we become aware of what may happen under stress and are hopefully more likely to stop and think in an emergency: ‘Hey let’s quickly review what the problem is and see if we’ve missed anything.’ Our training also emphasises the importance of speaking up and provides the tools to let you react appropriately if things are going wrong. This helps prevent either fixation and/or further error occurring. In short, technical skills allow you to do the job; non-technical skills keep you safe.

In summary...
In these brief pages I’ve had the chance to give you a small flavour of a different way of looking at error and how in one industry we manage human factors. I’ve dramatically simplified the whole human factors approach and the vast amount of work in my industry, but hopefully it gives you enough insight to research more. I don’t wish you to be left with the impression that aviation’s got it all correct. We’re still learning, facing up to new challenges and on occasion having to address old ones again. This is part of my challenge as an airline pilot.

Perhaps the biggest benefit of our focus on human factors is the cultural change that has occurred. Over the last 15 years we’ve developed a common language around error and non-technical skills. When I say ‘we’ I don’t mean academics, I mean us, the frontline practitioners.

I’d like to finish by asking you to think about the clinical team involved in Elaine’s care. How do they feel today? How would you feel? They are not bad people, they are not poor clinicians. They were good people doing a good job who had the technical skills to deal with what happened. But by behaving as normal humans do, and not having the benefit of the training and development available to other industries, found themselves following a blind alley.

If I needed an operation tomorrow, I would trust them first. They now understand about error and non-technical skills – not all clinicians do.
Managing chronic pain
Integrating interventional anaesthetic skills with psychological approaches

This year’s winner of the Hospital Doctor Pain Medicine in Anaesthesia award was the pain department at the Dudley Group of Hospitals NHS Trust in the West Midlands. This prestigious award, which took place in London last November, was sponsored by the Royal College of Anaesthetists and the Association of Anaesthetists, and the category was judged by Dr John Lamberty. In this article, lead clinician Jon Raphael describes the approach of the pain department.

Background
The Dudley Group of Hospitals NHS Trust is situated in the Black Country of the West Midlands. Three hospitals function together as the district service for a local population of 350,000. Acute services are provided by the 722 bed Russells Hall Hospital, whilst out-patient and day care services for the north and south of the borough are provided by the Guest and Corbett hospitals.

Dudley has been providing a chronic pain service for over 25 years but, in the last decade or so, it has developed from a uni-modal anaesthetic department service to an interdisciplinary multidimensional team working within a medical infrastructure. This is more appropriate for managing the chronic complex biopsychosocial conditions that are chronic pains.

Ten years ago, a successful business case was made for including psychology, physiotherapy and additional nurse sessions in the development of a cognitive behavioural group pain management programme. The aim of this was not only to broaden the range of pain services available at Dudley, recognising the need for a psychological approach to chronic pain, but also to act as the impetus for the development of the biopsychosocial model of pain assessment and management. This development has enabled the success of advanced interventional therapies by optimising patient selection.

Philosophy
The vision of the integration of high quality behavioural and interventional practices developed from the results of a prospective audit of outcome in over 1,000 patients. Two rather surprising features were noted. Firstly, that the integration of behavioural and interventional therapies improved outcome in back pain. This ran counter to the prevailing view at the time.
that behavioural therapies require cessation of interventional ones.

Secondly, that despite previous failure to manage pain, the subsequent and more advanced interventional treatments were the most successful. This too ran counter to intuition, providing an inverse to the law of diminishing returns, and encouraged an attitude of persistence in interventional pain management.

The results from this audit encouraged an integrated approach to pain management. It led on to referred patients being assessed for behavioural as well interventional approaches, rather than only seeking behavioural avenues when interventions failed. However, the value of interventional practices was also recognised in aiding behavioural rehabilitation, through the use of long-term domiciliary epidural catheters, as discussed below.

Service developments
There have been several innovations in line with this philosophy over the years.

Behavioural approaches
Behavioural pain management programmes are common to many hospitals and the so-called yellow flags of psychosocial distress are well recognised. A greater problem is to achieve significant change by enabling a return to work, addressing the so-called blue flags (or perceived obstacles to return-to-work). To overcome this obstacle, we recruited a vocational advisor to the Pain Management Programme.

Audits of outcome of this programme showed a need to improve patient selection at entry. We supported our nurse specialist for the programme to train in counselling, and she now triages patients for different levels of behavioural therapy, including counselling, one-to-one psychotherapy and referral to more specialised centres. She also acts as a motivational interviewer to bridge the gulf for patients in moving from medical to psychological management of their pain.

Interventional approaches
Typical of most pain departments, our doctors are anaesthetists with technical interest. In the field of chronic pain, where psychosocial factors can predominate, the end points for spinal interventional pain procedures are complex. When limited to a uni-dimensional model of pain relief, such interventional practices can be disappointing, and can lead to ‘throwing out the baby with the bath water’ – their rejection. We developed a method of prolonged (average four months) domiciliary epidural catheter trials to provide a biopsychosocial assessment tool of pain behaviour when pain relief was provided. Firstly, ward nurses were trained to give the epidural top-up injections, and they then trained the patients to do so themselves. This empowered
patients to take greater responsibility for their condition and enabled them to self care at home. This served as a psychological evaluation of their locus of control and has enabled better selection for behavioural or interventional management.

For those patients whose pain, function and quality of life improved with prolonged epidural catheterisation, we introduced a more robust spinal opioid test. This involved the use of single blind trials of spinal opioids at different doses as well as saline. Taking this pharmacological test together with the behavioural response has improved selection for long-term opioid therapy.

Assessment
The assessment of patients on referral is the most important step in pain management. It has taken several years to resource a service in which all new referrals can be seen at the same visit by a psychologist, physiotherapist, nurse specialist and pain anaesthetist, who can then offer a biopsychosocial diagnosis and formulate a management plan.

This design has reduced referrals for interventional practices, increased discharges on first attendance and aided subsequent entry into behavioural programmes. However, the most important aspect of this integrated working has been a cross fertilisation of ideas between those from different healthcare backgrounds and the fostering of a mutual educational process. This has acted against a tendency to polarise pain medicine into behavioural and interventional camps.

Development of skills
To overcome resource limitations, we developed the skills of the staff beyond traditional boundaries. There are many examples of this. A secretary has been trained in database software and psychometric questionnaire analysis to provide computerised data. Two physiotherapists have been trained and mentored in musculoskeletal injections to reduce waiting times to see anaesthetists and to offer patients combined injection with rehabilitation advice. Specialist nurses have learnt how to refill spinal drug pumps, programme spinal cord stimulators, insert subcutaneous field stimulators and undertake musculoskeletal physical examination. One specialist nurse was assisted to undertake MBA modules to support her budgeting role for the department.

For implantation of spinal pumps requiring general anaesthesia, the pain doctors have developed a targeted spinal anaesthetic technique to ease the burden of the anaesthetist by providing them with an awake patient with minimal cardiovascular instability.

Conclusions
Chronic pain management is a challenging problem. The recognition that psychosocial factors are more predictive of outcome than medical factors has altered the traditional relationship of anaesthesia with chronic pain. A need for a wider perspective is evident. In restructuring the delivery of services, our unit has endeavoured to take these matters on board. However, we have continued to rely upon many techniques learnt as anaesthetists and believe that such skills remain valuable. Any enthusiastic anaesthetists seeking a challenging career need look no further – patients in pain need you.

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The author gratefully acknowledges the support of the multidisciplinary team, including those who could not make this event.
MARCH

› 12–13 March 2008 (code: A03) ANNIVERSARY MEETING PAIN MEDICINE: ADVANCES IN BASIC SCIENCE AND CLINICAL PRACTICE A joint meeting with the BJA Regent’s College Conference Centre, London Registration fee: £375 (£260 for registered trainees)


› 19 March 2008 (code: C96) AIRWAY WORKSHOP – CARDIFF Marriott Hotel, Cardiff (limited spaces) Registration fee: £175 (£150 for registered trainees)

APRIL

› 7 April 2008 (code: C19) AIRWAY DAY: RECENT ADVANCES IN AIRWAY MANAGEMENT The Royal College of Anaesthetists, London Registration fee: £210 (£180 for registered trainees) See page 2451 for details

› 8 April 2008 (code: D39) RESEARCH METHODOLOGY WORKSHOP A joint workshop with the BJA The Royal College of Anaesthetists, London Registration fee: £120 (limited spaces) See page 2451 for details

› 9–10 April 2008 (code: B36) TEACHING METHODS WORKSHOP The Royal College of Anaesthetists, London Registration fee: £350 (limited spaces) (£300 for registered trainees)

› 11 April 2008 CLINICAL DIRECTORS MEETING A joint meeting with the AAGBI The Royal College of Anaesthetists, London By invitation only

› 14 OR 15 April 2008 (code: C77) ULTRASOUND – TRAINING THE TRAINERS A joint event with the Intensive Care Society The Royal College of Anaesthetists, London Registration fee: £250 for 1 day See page 2451 for details (limited spaces)

› 15 April 2008 (code: D04) ANAESTHETIC EMERGENCIES – GLASGOW The Teacher Building, Glasgow Registration fee: £220 (£170 for registered trainees) See page 2452 for details

› 17 April 2008 (code: C12) AIRWAY WORKSHOP The Royal College of Anaesthetists, London Registration fee: £175 (limited spaces) (£150 for registered trainees)

› 22 April 2008 (code: A74) AIRWAY MANAGEMENT – TRAINING THE TRAINERS The Royal College of Anaesthetists, London Registration fee: £175 See page 2452 for details

› 23 April 2008 (code: D36) SIMULATION – TRAINING THE TRAINERS The Royal College of Anaesthetists, London Registration fee: £250 (limited spaces) See page 2452 for details

Further information – www.rcoa.ac.uk/events
MAY

- 7 May 2008
  DIPLOMATES CEREMONY
  Kensington Town Hall, London
  By invitation only

- 9 May 2008 (code: D08)
  SAS REVIEW DAY
  A joint meeting with the AAGBI
  The Royal College of Anaesthetists, London
  Registration fee: £120 Members (£240 non-Members)
  See page 2453 for details

- 19 May 2008 (code: D31)
  CORE TOPIC DAY
  The Royal College of Anaesthetists, London
  Registration fee: £175 (limited spaces)
  £150 for registered trainees
  See page 2453 for details

JUNE

- 4–6 June 2008 (code: A32)
  CURRENT TOPICS MEETING - BIRMINGHAM
  Birmingham Novotel
  Registration fee: £415
  See page 2453 for details

- 5 June 2008 (code: C81)
  AIRWAY WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £175 (limited spaces)
  £150 for registered trainees

- 5–6 June (code: C55)
  INTENSIVE CARE SYMPOSIUM
  A joint meeting with the Intensive Care Society
  The Royal College of Anaesthetists, London
  Registration fee: £375
  £260 for registered trainees
  See page 2454 for details

- 9 June 2008 (code: C85)
  RESEARCH METHODOLOGY WORKSHOP
  A joint workshop with the BJA
  The Royal College of Anaesthetists, London
  Registration fee: £120 (limited spaces)
  See page 2451 for details

- 11–12 June 2008
  COLLEGE TUTORS MEETING EDINBURGH
  Edinburgh First Assembly Hall
  By invitation only

- 17 June 2008 (code: C18)
  INTRODUCTION TO TEACHING
  The Royal College of Anaesthetists, London
  Registration fee: £180
  £120 for registered trainees
  See page 2453 for details

SEPTEMBER

- 5 September 2008 (code: D09)
  ULTRASOUND & REGIONAL GUIDED ANAESTHESIA WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website

- 8–19 September 2008 (code: A79)
  FINAL FRCA COURSE
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website
  See page 2455 for details

- 22–23 September (code: A37)
  TEACHING METHODS WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website
  See page 2455 for details

- 24 September (code: D43)
  ADVANCED AIRWAY WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website
  See page 2455 for details

- Date tbc (code: C67)
  PAEDIATRIC ANAESTHESIA MEETING
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website

- 24 September (code: C97)
  CORE TOPICS DAY – BELFAST
  Waterfront Hall, Belfast
  Registration fee: Please refer to website

- 30 September (code: C79)
  CORE TOPIC DAY
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website

OCTOBER

- 2 October 2008 (code: C63)
  CORE TOPIC MEETING – FLUID MANAGEMENT
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website

- 16 October 2008 (code: A71)
  SIMULATION – TRAINING THE TRAINERS
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website

- 16 October 2008 (code: C40)
  AIRWAY WORKSHOP – GLASGOW
  University of Glasgow
  Registration fee: Please refer to website

NOVEMBER

- 6–7 November (code: B05)
  CURRENT CONCEPTS SYMPOSIUM – ADVANCES IN PHARMACOLOGY AND THERAPEUTICS
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website
  See page 2455 for details

- 8 November 2008 (code: A76)
  CME DAY
  A joint meeting with the AGGBI
  The Royal College of Anaesthetists, London
  Registration fee: Please refer to website

Further information – www.rcoa.ac.uk/events
**AIRWAY DAY: RECENT ADVANCES IN AIRWAY MANAGEMENT**

7 April 2008 (code: C19)
The Royal College of Anaesthetists, London

A series of lectures and interactive panel discussions covering what’s new in airway management in the UK such as:

- Complications associated with airway management
  Dr T Cook, Bath
- Moving on from Macintosh laryngoscopy
  Dr R Mihai, Oxford
- Fibreoptic intubation made easier
  Dr S Scott, Oxford
- Extubation matters
  Dr A Diba, East Grinstead
- Training in basic airway skills
  Dr M Stacey, Cardiff
- Responsive Contingency Planning
  Dr S Darshane, Prescot
- The i-gel and other second generation supraglottic airways
  Dr C Seller, Bath

You will also get the opportunity to ask any questions you have relating to airway management and have them debated in a supportive and friendly environment.

Comments from previous airway days:

‘Good clear take home messages’
‘It will change my practice’
‘Relevant to my practice’.

REGISTRATION FEE: £210
(£180 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

**RESEARCH METHODOLOGY WORKSHOP**

8 April 2008 (Code D39); 9 June 2008 (Code C85)
The Royal College of Anaesthetists, London

A joint workshop with the British Journal of Anaesthesia designed to introduce participants to the way in which good research should be conducted and presented. This workshop will be useful for anaesthetists of any grade who are already involved in research or those who are about to embark on a research project.

Teaching sessions will address:
- Developing a research idea
- Study design
- Project management
- Analysis
- Presentation and interpretation of data
- Dissemination of results

Group sessions will allow participants to:
- Provide criticism of a published research paper
- Design a clinical trial
- Detect common pitfalls in analysis and interpretation of data

REGISTRATION FEE: £120
APPROVED FOR 5 CPD POINTS

***NEW FOR 2008***

A JOINT EVENT OF THE ROYAL COLLEGE OF ANAESTHETISTS AND THE INTENSIVE CARE SOCIETY

**ULTRASOUND – TRAINING THE TRAINERS: FOCUSED ULTRASOUND TRAINING IN ANAESTHESIA AND INTENSIVE CARE**

14 April 2008 OR 15 April 2008 (code: C77)
The Royal College of Anaesthetists, London

A one-day comprehensive course designed to empower trainers with the knowledge and practices to manage the delivery of training in vascular access/regional anaesthesia/pleura/lung and focused transthoracic ECHO (TTE).

The course includes small group workshops that enable delegates to use a variety of ultrasound equipment, suitable for consultants and post Fellowship SpRs.

REGISTRATION FEE: £250 FOR 1 DAY
(INCLUDING COURSE CD-ROM)
APPROVED FOR 10 CPD POINTS

**REGISTER**

for programmes, prices and event codes by submitting a registration form. This can be found when clicking on individual event pages on our website.

Further information – www.rcoa.ac.uk/events
AIRWAY MANAGEMENT – TRAINING THE TRAINERS
A ONE-DAY SYMPOSIUM FOR TRAINERS AND COLLEGE TUTORS
22 April 2008 (code: A74)
The Royal College of Anaesthetists, London

This is not an airway workshop. This is a forum to empower trainers with the knowledge and practices to optimise airway training in the face of reduced trainee hours and training opportunities. At a time when airway training is under such pressures, we need to develop radical training methods which optimise every training opportunity to equip our trainees with the appropriate airway management skills. The organisers welcome contribution from all delegates of how they have overcome the challenges or difficulties to airway training in their own hospitals.

The programme for the day will include a series of lectures and workstations which will include:

Airway Training – A Global View
Dr M Popat

Airway Training Programmes
Dr S Benham

Morning Workstations: AIRWAY TRAINING TOOLS – Demonstration of equipment/techniques

Station 1: Optimising laryngoscopy
Dr Atul Kapila

Station 2: Basic fibreoptic skills (Oxford Box)
Dr Mansukh Popat

Station 3: Oral/Nasal Fibreoptic
Dr Hamid Manji

Station 4: Intubating through LMA/ILMA
Dr Nick Woodall

Station 5: Cricothyroidotomy
Dr Shaun Scott

Course Organisers
Dr M T Popat and Dr S W Benham, Consultant Anaesthetists, Oxford Radcliffe Hospitals NHS Trust

REGISTRATION FEE: £175
APPROVED FOR 5 CPD POINTS

ANAESTHETIC EMERGENCIES
15 April 2008 (code: D04)
The Teacher Building, Glasgow

Consent in emergency situations
Dr M Booth, Glasgow Royal Infirmary

Perioperative fluid management for emergency surgery
Dr J Harten, Gartnavel General Hospital

Paediatric emergencies
Speaker TBC

The pregnant adult with congenital heart disease
Dr W Frame, Glasgow Royal Infirmary

Current management of endocrine crises
Speaker TBC

The head injured patient – acute management prior to transfer
Dr P Andrews, Western General Hospital

Management of overdoses
Professor J Kinsella, Glasgow Royal Infirmary

Interventions in disseminated intravascular coagulopathy
Speaker TBC

REGISTRATION FEE: £220 (£170 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

Further information – www.rcoa.ac.uk/events
This year's programme is looking at new anaesthetic techniques and awareness and will include the following topics:

‘TIVA or not (to) TIVA that is the question’
Dr C Rowlands, Bradford

BIS monitoring – or how to avoid awareness in one easy lesson
Professor G Kenny, Glasgow

Desflurane – wonder drug or cash cow?
Dr P Rüther, Salford

Cardiopulmonary resuscitation – what’s new and in fashion?
Dr J Nolan, Bath

GMC – revalidation and recertification – who, what, why, when and how?
Dr R Slack, Bath

PMETB and the SAS doctor – ‘for us or against us?’
Dr K Bullen, Bristol

Q&A Session to include BMA, AAGBI, RCoA, PMETB

REGISTRATION FEE: £120 FOR MEMBERS (£240 NON-MEMBERS)
APPROVED FOR 5 CPD POINTS

CURRENT TOPICS MEETING
4–6 June 2008 (code: A32)
The Novotel Birmingham Centre, Birmingham

Wednesday 4 June
✿ Emerging multi-resistant organisms in hospital
✿ Fluid management during surgery and critical illness
✿ Monitoring and clinical measurement
✿ Future of the AP program? Experiences of a pilot site
✿ Acute pain management
✿ Chronic pain update

Thursday 5 June
✿ TIVA
✿ Managing perioperative arrythmias in thoracic surgery
✿ Blood transfusion and cell salvage
✿ CEMACH update
✿ Obstetric anaesthesia case studies
✿ Establishing research departments in non-university hospitals
✿ Future developments in resuscitation

Friday 6 June
✿ ARF in ICU and application of RIFLE criteria
✿ Surviving Sepsis Campaign update
✿ Delirium in ICU
✿ Emergency preparedness in ICU
✿ Regional anaesthesia update
✿ Cardiopulmonary exercise testing
✿ Anaesthesia for the morbidly obese

Specialist speakers have been invited from the Midlands Region, including Anaesthetists from: Queen Elizabeth Hospital, Good Hope Hospital, Birmingham Heartlands Hospital, City Hospital, Russells Hall Hospital

* Please note this is a draft programme.

REGISTRATION FEE: £415
APPROVED FOR 15 CPD POINTS

NEW EVENT IDEAS
Would you like to organise an event with the RCoA? If so, please visit our website and click on the new event ideas link (bottom left-hand corner) on the Meetings and Events page to complete a proposal form.
INTENSIVE CARE SYMPOSIUM
A JOINT MEETING WITH THE INTENSIVE CARE SOCIETY
5–6 June 2008 (code: C55)
The Royal College of Anaesthetists, London

Session I Technology in the ICU
- What makes an ICU an ICU?
- After PAC-man: what cardiovascular monitoring should we use?
- What's around the corner? Technological advances in the ICU

Session II Research vs critical care
- Clinical Research: what the scientists think
- From idea to evidence: making ICU research work for you
- What the results mean: data & correlations

Session III How safe is intensive care medicine?
- Medical error and patient safety
- A National problem?
- Does outreach improve patient safety?

Session IV Reviewing the current evidence
- What's new in renal replacement?
- Anything new to know about shock?
- What's new in sedation of the critically ill?

Session V Respiratory update
- Pulmonary hypertension
- Airway management after major trauma
- Acute lung injury: options to improve oxygenation
- Management of pleural collections in the critically ill

Session VI Special patients
- The obese patient
- The paediatric patient

Session VII Improving intensive care practice
- Clinical decision making in modern medicine
- Early diagnosis of infection
- Is a post ICU service an affordable luxury or expensive mistake?

Session VIII Law and ethics:
- The Mental Capacity Act
- The patient's perspective
- Withdrawing and withholding lifesaving treatment
- THE MCA in practice: ethical issues and dilemmas

REGISTRATION FEE: £375 (£260 FOR REGISTERED TRAINEES)
APPROVED FOR 10 CPD POINTS

INTRODUCTION TO TEACHING
The Royal College of Anaesthetists, London
17 June 2008 (code: C18)

This one day meeting for all grades is designed to introduce the first stage of the Anaesthetist as Educator Programme. Participants will be introduced to the concepts and skills that are required to facilitate effective teaching and learning in clinical practice. Subjects will include:

- An introduction to educational theory and adult learning.
- How to approach the trainee in difficulty.
- How to create a positive educational environment.
- How to use Workplace based assessments.
- How to teach in theatre (one-to-one).
- How to give a lecture and use PowerPoint effectively.

REGISTRATION FEE: £180 (£120 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

Further information – www.rcoa.ac.uk/events
**FINAL FRCA COURSE**  
8–19 September 2008 (code: A79)  
The Royal College of Anaesthetists, London  
*This course is intended for those studying for the Final FRCA exam.*

The lectures run throughout the day, Monday to Friday and will be delivered by experienced lecturers and examiners.

Participants will be entitled to attend four tutorials during the first week. These will run from in the first week of the course from 4.00 pm to 5.30 pm.

The programme covers various subjects and will include topics such as:
- Applied pharmacology in anaesthesia
- Management of trauma
- Respiratory failure and ventilatory support
- Paediatric Anaesthesia
- Thoracic anaesthesia
- Difficult airway

**REGISTRATION FEE:**  
PLEASE REFER TO THE WEBSITE  
APPROVED FOR 15 CPD POINTS

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**CURRENT CONCEPTS SYMPOSIUM – ADVANCES IN PHARMACOLOGY AND THERAPEUTICS**  
6–7 November 2008 (code: B05)  
The Royal College of Anaesthetists, London

Session 1: Pharmacology in the bioinformatics era
- Pharmacogenomic and non-genomic pharmacological variability
- Bioinformatic drug target modelling

Session 2: Pharmacological approaches to organ protection
- Xenon and cerebral protection
- Myocardial ischaemia/reperfusion injury
- Statins for all – the new premed?

Session 3: Rank Lecture
- Models of Drug Behaviour

Session 4: New methods of drug delivery
- Iontophoresis and transdermal preparations
- New delivery techniques for inhalational anaesthetics
- Developments in drug infusion technology

Session 5: Blood and fluids
- Artificial haemoglobins
- New IV colloids

Session 6: Pharmacology in Intensive Care
- Immunological therapies in critical care
- Pharmacological optimisation of tissue perfusion
- New approaches to sedation in ICU

Session 7: Neuromuscular blockade
- Advances in neuromuscular transmission
- Postoperative residual curarization: does it matter?
- Reversal of neuromuscular block: the new approach

Please note programme is subject to change

**REGISTRATION FEE:**  
PLEASE REFER TO THE WEBSITE  
APPROVED FOR 5 CPD POINTS

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**ADVANCED AIRWAY WORKSHOP**  
24 September 2008 (code: D43)  
The Royal College of Anaesthetists, London

Aimed at Consultants and SpRs years 4 and 5, with a focus on clinical scenario, group discussion and hands-on skill practice. The Advanced Airway Workshop will cover a number of topics in more depth than the standard Airway Workshop, using experienced small group teachers.

Topics to include:
- Video-laryngoscopy – Jet ventilation and MLT
- Anaesthesia and a how-to session – Retrograde techniques (their worth and methods) – Advanced iLMA/Supraglottic device use – Aintree/Frova and other catheter techniques – Case scenarios from moderate to hair-raising!

Please note that there are limited places for this workshop.

**REGISTRATION FEE:**  
PLEASE REFER TO THE WEBSITE  
APPROVED FOR 5 CPD POINTS

Further information – www.rcoa.ac.uk/events
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Date of Birth: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

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Event details

Date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Event Title:

Code:

Registration fee: £ [ ] [ ] [ ]

❖ Our events are open to all grades of anaesthetists, unless specifically stated otherwise.

❖ When an event is full, this will be publicised on the website. To be put on a waiting list, please contact the Events Department on 020 7092 1670. We will then contact you as soon as a place becomes available.

❖ All of our events have CPD approval of five points for a full day and three points for a half day, with the exception of FRCA revision courses, which carry a maximum of 15 points, for non-trainees only.

❖ Lunch is included in the registration fee unless otherwise indicated.

❖ This generic application form is to be used for all events. Further copies of the form are available from the College website.

❖ Bookings will be accepted on a first come first served basis.

❖ Bookings will not be accepted unless the appropriate fee and application form are received together. Please also ensure that the application form shows the event code, title and date.

❖ Please note that places are not reserved until payment is received.

❖ Confirmation of a place will be sent to you within 14 days of payment being received. If you do not receive this, please contact the Events Department.

Cancellation policy

❖ Notice of cancellation must be given in writing to the Events Department or by email to: events@rcoa.ac.uk at least ten working days prior to the event to qualify for a refund.

❖ All refunds are made at the discretion of the College and are subject to the deduction of a £35 administration fee.

❖ Delegates cancelling less than ten days before the event will not be entitled to a refund.

❖ The College will accept name changes for attendees, please inform the Events Department at least seven days prior to the event.

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ADDITIONAL FORMS ARE AVAILABLE TO DOWNLOAD FROM OUR WEBSITE

Further information – www.rcoa.ac.uk/events
Anaesthetic training in war-time Scotland
A personal memory

Professor J P Payne, Emeritus Professor of Anaesthesia, University of London

Starting out in anaesthesia
In 1942, I was a 20-year-old undergraduate studying medicine in the medical school of Edinburgh University. I was in my second year and, like all other war-time students, membership of the Army Training Corps was compulsory. This involved regular field activities and it was during one such exercise that I received an injury to my right eye as a result of a thunderflash striking my face, exploding and damaging my retina. Following this, I took my first steps on the road to a career in anaesthesia.

I had been forbidden to read for some weeks, and it was suggested that, as an alternative, practical experience in the Royal Infirmary was available. However, on investigation there were too many students and not enough patients. Essentially, the students were acting as unpaid porters wheeling patients around the hospital. Such activity did not appeal so I offered my services to my local voluntary hospital in Leith where I was immediately accepted and attached to the Surgical Out-Patient Department (SOPD).

Located in the dock area of the city, it was a particularly busy SOPD with staff who were frequently hard pressed, and I was indoctrinated in the principles of casualty treatment. Anaesthetics in SOPD were expected to be given by the house physician on the Medical Out-patients, amongst his other duties, but he disliked this task intensely so his other duties tended to take priority. As the most junior member present, inevitably I found myself giving the anaesthetics when the house physician was not available which, given his expressed dislike, was almost always. Thus began my career in anaesthesia.

A day in the life of a war-time trainee
The anaesthetic equipment in SOPD consisted of a Schimmelbusch mask, a simple Boyle’s machine with a water-sight flow meter, ether and chloroform bottles and a Magill attachment arranged in series on a suitable metal trolley.

Finally, there was a Guy’s rebreathing circuit, usually used for children. This was first described in 1897
by Dr William Guy, Dean of the Edinburgh Dental School, and two years later he ordained that anaesthetics should only be administered in the Dental Hospital by a qualified doctor. In pursuit of that end, he appointed Dr Thomas Luke who in due course extended his practice to general surgery and was appointed anaesthetist to the Dental Hospital. Eventually, Dr Luke was made University Lecturer in Anaesthesia, possibly the first academic appointment in anaesthesia anywhere in the world.

The Boyle’s machine was the workhorse in daily use. The usual practice was to collect, during the morning, those patients who would need some form of surgical intervention under anaesthesia, for example, pulp infections, paronychias and breast abscesses as well as Colles’ and Potts’ fractures that required reduction and plaster fixation. My instructions were basic: make sure the patient is firmly strapped to the operating table, turn up the nitrous oxide and allow the patient to breathe freely until the colour becomes blue; when that happens add a little oxygen until the colour improves. A maximum of 10% was not to be exceeded. If the patient struggled ether should be introduced at a low concentration and gradually increased as the patient began to tolerate it. Thereafter, the surgery could start and if the patient moved the oxygen was withdrawn until movement ceased. It was essential to keep watch on the eyes; fixed and dilated pupils were to be avoided. It was some years later that I recognised this as a variation of McKesson’s secondary saturation technique. What is surprising is that, as far as I know, none of the patients came to any harm, possibly because the operative procedures were completed rapidly; under these circumstances five minutes was a long time! Nevertheless, vomiting was common. In retrospect, what is equally surprising is that at no time was I ever asked to keep any record of my anaesthetic techniques, nor do I recall ever being asked to describe them.

Research beginnings
As in most industrial areas, the hospital had an active ENT Department which handled many children referred from the school clinics for the removal of tonsils and adenoids. Two operating lists of up to 30 young patients were carried out weekly. On Mondays I gave the anaesthetics for my colleague who guillotined the tonsils and on Thursdays the roles were reversed and I became the surgeon. The anaesthetic technique was simple. The Guy’s apparatus consisted essentially of a face mask and rebreathing bag, connected by a three-way stopcock, the horizontal limb of which was extended sufficiently to allow the connection of a rubber tube about 18 inches long on which was mounted a small boiling tube calibrated in ml up to five. Ethyl chloride was added to the tube at a dose of 1 ml per year of age with a maximum of 5 ml, although for older children this was often exceeded. The child was encouraged to ‘blow up the balloon’ and as the mask was lowered onto the face the boiling tube was immersed in hot water supplied in a tin mug. Evaporation took place rapidly, anaesthesia was established in about 60 seconds and allowed the operator up to three minutes to remove both tonsils and adenoids.

From the anaesthetist’s point of view, this was a very satisfying technique to use in that the whole procedure rarely lasted more than five minutes and the child was fully conscious at the end although not always happy! I personally remember this technique with pleasure because I began my research career at that time. I decided that the method could be improved and the safety of the child enhanced by filling the rebreathing bag with oxygen before the commencement of induction. I have no doubt that others unknown to me made the same adaptation elsewhere and I am claiming nothing more than that I introduced a modification which had not previously been used in my hospital and, as far as I know, continued to be used until the hospital was closed.

At about the same time, I was introduced to chloroform. The hospital had a weekly eye clinic and the visiting ophthalmologist regularly carried out examinations of children below the age of six under general anaesthesia and it was his contention that chloroform, more than any other anaesthetic, provided what he called ‘a quiet eye’. He taught me to use chloroform on an open Schimmelbusch mask so successfully that I continued to use that technique throughout my whole professional career. Indeed, my last list on the day that I retired was a chloroform list, although I hasten to add that I had abandoned the open mask many years before in favour of either a chloroTec or a Goldman vaporiser with oxygen as the carrier gas. Perhaps I should also add that
this was the only formal instruction in the administration of an anaesthetic by any senior member of staff that I received throughout my student period.

The arrival of thiopentone
In the main operating theatre a more modern Boyle’s machine had been installed. Rotameters had replaced the older water-sight flow meters, the ether bottle had a water jacket, and an oxygen by-pass as well as a carbon dioxide supply had been added. Nevertheless, the most common anaesthetic technique in use was that of open ether given through a Schimmelbusch mask after induction with ethyl chloride. Even so, induction was slow, could still last for up to 30 minutes and was often far from smooth. Indeed, the attendant nurse saw to it that the sick bowl was within easy reach.

Elsewhere, thiopentone (Pentothal) had begun to be used, but the elderly senior anaesthetist who had been recalled from retirement to meet the war-time shortage was reluctant to use a new drug, regarded as dangerous even by experienced anaesthetists – a view reinforced by the catastrophe at Pearl Harbor in December 1941. Probably apocryphal, but it has been claimed that intravenous anaesthesia caused more fatal casualties than did the Japanese bombs. The general attitude in the Edinburgh region was that junior anaesthetists should not be permitted to use intravenous anaesthesia until their skill with inhalational anaesthesia had been established, and the arbitrary but unwritten rule was that 1,000 inhalational inductions were required to establish that expertise.

In my own case it was eventually agreed that I should be allowed to use thiopentone, the first time under supervision. The patient’s arm was inspected and a suitable vein was selected and thereafter I scrubbed, gowned and donned gloves while the scrub nurse prepared a sterile trolley with bowls of spirit, iodine and swabs as well as a kidney dish with a 20 ml syringe, a mixing cannula and a selection of needles. A tourniquet was applied to the arm above the antecubital fossa where a suitable vein had been selected. The area was sterilised and towelled appropriately. The syringe was loaded with the appropriate thiopentone solution, a suitable needle attached and, after ensuring that the needle was properly placed in the vein, I began the slow injection of the 5% thiopentone solution until the eyelash reflex as tested by the instructor had disappeared, after which I injected half as much again as the initial dose. The needle was withdrawn, the puncture site suitably dressed and the anaesthetic was continued with an inhalational technique.

In retrospect, the whole procedure probably occupied as much time as a straightforward inhalational induction. Nonetheless, it was safer in one respect. It is not so many years ago since I saw an anaesthetist walk into an anaesthetic room and without washing his hands pick up the loaded thiopentone syringe, at the same time flicking his cigarette into the waste bin which promptly blew up in his face! Swabs soaked in ether had been used to remove the patient’s dressing and to clean up his skin a lesson that anaesthetic explosions can still occur!

Experience, not supervision
Before the outbreak of the Second World War there was little formal training in anaesthetics, most of it was essential to keep watch on the eyes; fixed and dilated pupils were to be avoided. It was some years later that I recognised this as a variation of McKesson’s secondary saturation technique.
absence of any requirement that the administration should have been supervised.

Post-qualification
There was no national standardised education programme for anaesthetists – this only arose after the establishment of the Faculty of Anaesthetists in the Royal College of Surgeons of England in 1948. Before then each university centre differed one from another and different standards prevailed. This account refers only to experience in Edinburgh but there is anecdotal evidence that not dissimilar opportunities existed elsewhere. Nevertheless, if reasonable instruction was obtained it was purely fortuitous, the more so during the war years, partly because of the overall shortage of doctors in civilian practice and partly because of the other commitments of embryo anaesthetists among the medical students. Firewatching duties, Home Guard activities and Army Training Corps responsibilities all eroded the time available for clinical exposure.

Needs must
It may well be asked how it came about that a medical student could manage to carry out so many anaesthetics. It needs to be remembered that it was war-time; doctors were in short supply and many posts remained unfilled. For that reason, medical students could find resident posts during their clinical years and I myself held house appointments almost continuously from early in 1943 until qualification in 1946. I cannot claim that my experience was typical for all medical students of the period but neither was it unique. Suitable provision could be made to attend lectures and although theoretically attendances were recorded, it was fairly easy to arrange that! Moreover, the hospital work was fascinating and there was a sense of satisfaction in carrying out essential duties that needed judgement and technical expertise, even though, on reflection, the arrogance that we sometimes exhibited is a source of embarrassment!

Single handed
The day after graduation I entered a general practice on a short-term contract and within a few weeks I found myself with an anaesthetic problem. I had been called to a domiciliary confinement now rarely encountered in the UK but still common in the 1940s. A forceps delivery was needed but the attending midwife had been delayed and I was left to handle the situation unaided. The patient was very distressed and I agreed, rightly or wrongly, that I would anaesthetise her. The purpose of the Schimmelbusch mask was explained to her and she was asked to hold it just above her face. The chloroform bottle was balanced on an overhanging shelf so that it dripped steadily on to the mask while I prepared to do the forceps delivery. In due course the patient became unconscious and dropped the mask. I pushed the bed so that the chloroform bottle rolled away, carried out an episiotomy, delivered the infant by forceps and handed the newborn to the midwife as she entered the room! The anaesthesia lasted just long enough to allow the repair of the episiotomy.

I question whether I could have done the same with any other anaesthetic and I am certainly convinced that my willingness to improvise was based on the extensive anaesthetic experience that I had accumulated as a medical student. On qualification, I had already given more than 5,000 anaesthetics which enabled me to enter the Royal Air Force as a junior specialist anaesthetist and where, incidentally, I was exposed to my first formal instruction in anaesthesia on a two-week secondment to Princess Mary’s RAF Hospital, Halton, after an initial posting as an anaesthetist.

The National Health Service
One further advantage was to accrue from my service in the RAF. I was able to observe the inauguration and initial development of the new National Health Service (NHS) from the relative security of a guaranteed position as a specialist anaesthetist. On that basis I reached the conclusion that the NHS offered good prospects for a satisfactory career in anaesthesia and accordingly, on completing my RAF service, I returned to Edinburgh.
where I was fortunate to obtain one of the supernumerary appointments reserved for former members of the Armed Forces in the Department of Anaesthetics in the Royal Infirmary under the direction of Dr John Gillies. For the first time, I began an organised training programme which exposed me to disciplines such as neurosurgery and paediatric and plastic surgery in which I had little or no experience.

It may be relevant that on the very few occasions as a medical student when I was reluctant to undertake anaesthetic procedures that I thought were beyond me, the resident surgical officer (RSO) would persuade Dr Gillies to come to the hospital (where incidentally he held no appointment) to supervise my efforts. The RSO would arrange the operations for late evening to accommodate him. It is a measure, first of the scarcity of qualified anaesthetists in war-time but, more important, of the generosity of spirit typical of Dr Gillies, that he would sacrifice some of his precious spare time to support a medical student who at the time was unknown to him, a generosity for which I will never cease to be grateful.


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**AS WE WERE ...**

**The Specialised Anaesthetist**

The specialised anaesthetist is one whose whole day is spent in giving anaesthetics, and in so doing he acquires a degree of skill and experience which makes his problems entirely different from those of the general practitioner. Anyone who has tried giving anaesthetics for long periods on end, will realise that the inhalation of their fumes, and the monotony of maintaining anaesthesia combine to produce a most somnolent effect. It is not surprising, therefore, that there are an increasing number of mechanical devices being marketed, by which the patient can be rendered unconscious without the close juxtaposition of the anaesthetist. On the other hand, however, he does not want to simplify his technique too much, lest it be taken from him and given to a skilled but unqualified assistant. Ask any doctor with a large Indian mission experience how they managed, and you will learn that a totally untrained assistant can be taught to give adequate, if not ideal, anaesthetics in quite a short time; are we not ourselves, many of us, turned out into practice and expected by our patients to be able to tackle anything with only a meagre twenty anaesthetics to our credit? The skilled anaesthetist appears to revel in the complications of technique, and his ideal anaesthetic appears to have the following essentials: it must be ‘safe in his hands’; it must be sufficiently interesting to prevent him falling asleep and sufficiently complicated to make him necessary on the scene.

**The General Practitioner Anaesthetist**

The General Practitioner anaesthetist is a peripatetic. A large number of his anaesthetics are not given in the comparative comfort of hospital or nursing home. Even in a suburban practice the problem of portability assumes large proportions when unmade roads and many-storeyed tenements are part of the itinerary. The country practitioner may have to walk miles over ploughed fields, negotiate stiles, be ferried over rivers, and conducted down mines. Neither the motor car nor electricity are as yet universally available, and no method of administration which demands their services can be considered the practitioner’s ideal.


This book, which contains much common sense and good advice, was written by a general practitioner anaesthetist who resented the spread of the Boyle’s machine, the ‘mechanical device,’ and the displacement of ‘open’ methods, during the early 1930s. But as the National Health Service unravels, and hospitals close, and public services crumble in the hands of inept administration, and global warming and associated problems and prejudices force the doctor back on to his bike, it might be wise to dig out the old Schimmelbusch mask, and try to find someone who can show you how to use it.

Dr David Zuck
The History of Anaesthesia Society
The (anaesthetic) times, they are a-changin’

Dr A Norton, Content Director, International Organization for Terminology in Anesthesia

I am sure this happens to you on a regular basis. You have a complex patient for major surgery on your operating list. You spend 40 minutes establishing invasive monitoring and preparing the patient for the procedure. You then fully pre-oxygenate the patient and cautiously induce anaesthesia with propofol. The theatre staff dutifully record anaesthesia start time in the theatre computer system as the moment you started the propofol injection.

The theatre records therefore indicate that the patient arrived on time for the operating session. From a reporting and theatre efficiency point of view, it seems that the reason for the late surgical start of the case is the ‘delay’ in start of anaesthesia. As regards recognition of anaesthetic activity, you might as well have been reading the newspaper in the theatre coffee room. You are also likely to get the blame when the case overruns.

The scenario outlined above is partially a training and data quality issue. However, with increasing deployment of new operating theatre management systems as part of the National Programme for Information Technology (NPfIT) in England, and similar e-health initiatives in other parts of the UK and in other countries, perhaps the time has come to reconsider how anaesthetic workload is measured and recorded. There is certain to be increased scrutiny of operating theatre activity and efficiency as ever tighter deadlines and targets for treatment are introduced in the NHS.

Definitions of anaesthesia times

The accepted definitions for anaesthesia times in the UK date from 1994 and are approved by the Royal College of Anaesthetists and the Deutsche Gesellschaft für Anästhesiologie und Intensivmedizin (DGAI).

**Anaesthetic start time** is: when the anaesthetist takes charge of the patient in preparation for induction of anaesthesia.

**Anaesthetic finish time** is: when the anaesthetist has finished handing the patient to the care of the recovery staff and is free to commence another case.

Other countries and organisations have published definitions of anaesthesia times. Perhaps one of the most widely known is the Association of Anesthesia Clinical Directors (AACD) procedural times glossary, published in 1995 and approved by the American Society of Anesthesiologists, American College of Surgeons, and Association of Operating Room Nurses (AORN). This proprietary classification currently includes 30 defined times in the operating theatre ‘timeline’, defined calculated times, and utilisation/efficiency indices based on the defined times. Of relevance to this article are:

1.6 **Anesthesia start:** Time when a member of the anesthesia team begins preparing the patient for an anesthetic.

1.12 **Anesthesia induction:** Time when the anesthesiologist begins the administration of agents intended to provide the
level of anesthesia required for the scheduled procedure.

1.13 Anesthesia ready: Time at which the patient has a sufficient level of anesthesia established to begin surgical preparation of the patient, and remaining anesthetic chores do not preclude positioning and prepping the patient.

1.24 Anesthesia finish: Time at which the anesthesiologist turns over care of the patient to a post-anesthesia care team (either PACU or ICU).

At first glance, it appears that the US and UK ‘anaesthesia start’ and ‘anaesthesia finish’ definitions represent similar concepts and meaning, allowing for the differences in models of care and how anaesthesia services are provided. However, these definitions serve to underpin different purposes – utilisation of time and resource in the UK, but to support financial reimbursement in the US. It is therefore not surprising to find further rules and clarification of what is reimbursable for professional services rendered between the anaesthesia start time and finish time. In the US model, much of this relates to the reimbursement rules from the Centers for Medicare and Medicaid Services.3 The Medicare claims processing manuals recognise anaesthesia time as a period of anaesthesia practitioner presence with the patient, from the start of preparation for anaesthesia to the safe placement of the patient into post-operative care. However, there are a number of complex rules, termed ‘billing compliance’, as to what may be included within this time span to prevent ‘unbundling’ of services and excessive claims for reimbursement.

Is it time to think again?
I became interested in this topic as a result of work on the Systematized Nomenclature of Medicine/Clinical Terms (SNOMED CT) for anaesthesia, which will be used in operating theatre and anaesthesia information management systems provided for use in the NHS under NPfIT. The International Organization for Terminology in Anesthesia has held discussions with the Association of Anaesthesia Clinical Directors about modelling of the procedural glossary ‘base class’ terms into SNOMED CT, along with any revisions necessary to the classification. This is still work in progress, but our attention was drawn to new definitions arising from the National Theatres Project4 and the National Clinical Dataset Development Programme (NCDDP) Operating Theatre Phase 1 data standards5 in NHS Scotland.

The National Theatres Project identified ‘Start time of anaesthesia’, which is defined as ‘the time of start of the anaesthetic procedure where this takes place either in the operating theatre or in the anaesthetic room’. This definition applies in NHS Scotland and there is a possibility that the work of the NHS Scotland Information Services Division on clinical datasets may receive wider approval and adoption in other NHS organisations. There is no mention of or definition of anaesthesia finish time. A potential proxy measure of ‘time patient entered recovery’ is defined.

This definition of start time of anaesthesia poses some questions.

- What is the start of the anaesthetic procedure? Is it the concept of preparation for anaesthesia, or does it refer to the induction of anaesthesia?

There is certain to be increased scrutiny of operating theatre activity and efficiency as ever tighter deadlines and targets for treatment are introduced in the NHS.

- By specifying operating theatre or anaesthetic room, this would imply that it cannot take place in any other location (e.g. recovery room, CT or MRI scanner).

It is common practice in the USA and increasing practice in the UK to insert vascular monitoring lines and regional anaesthetic blocks or catheters in a variety of locations termed pre-operative holding areas or block areas. Where this practice is used, there may be a period of discontinuity in professional attendance by the anaesthetist on an individual patient. Indeed, the anaesthetist may be involved in care of multiple patients at the same time point.

In the US model, the reimbursement rules generally exclude pre-operative placement of vascular monitoring or regional blocks from the anaesthesia start and finish times used to determine the number of anaesthesia time units for reimbursement. (These procedures are often separately remunerated, making anaesthesia billing a complex task.)
Is it therefore appropriate to review the concepts of anaesthesia start time and finish time defined by professional attendance as to whether they meet the continuing needs of the specialty? There is certainly a need to ensure that anaesthesia activity and utilisation is properly recorded and recognised in patient and administrative record collections. The NPfIT Cerner Millennium theatre system planned for the South of England uses ‘time anaesthetic started’ and ‘time anaesthetic finished’ but definitions of these times are left to NHS Trusts. There are also optional fields for ‘time anaesthetist(s) into theatre’ and ‘time anaesthetist(s) left actual theatre’, though these are not further defined.

A ‘preparation time for anaesthesia’ defines a period during which appropriate monitoring and nerve blocks are established. In the AACD glossary, ‘anaesthesia preparation time’ is defined as the time between ‘anaesthesia start’ and ‘anaesthesia ready’. ‘Anaesthesia induction’ occurs at a point during this period.

Where surgery is conducted under regional or nerve block, this requires consideration as to what equates to ‘anaesthesia start’ or ‘anaesthesia induction’. Are the added complexities of an ‘anaesthesia ready time’ necessary or desirable even if recording of anaesthesia times becomes more reliable with NPfIT delivered theatre systems (for example real time touch screen capture of timing milestones)? Is the main objective that we try to ensure the reliable capture of anaesthesia start and anaesthesia finish as indicating the start and end of an episode of care?

The Joint Informatics Committee of the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland would welcome views from members of the profession and other members of the peri-operative team as to which timings are necessary and how they should be defined to ensure recognition of anaesthetic workload and utilisation in the future. Please contact bulletin@rcoa.ac.uk.

References
2 http://www.aacdhq.org/members/glossary.asp (password required).

Book review
‘In Stitches’
by Nick Edwards

A doctor’s view:
Dr O Dearlove, Council Member

Oh stop blabbing you cry baby!

Time was when accident and emergency (A&E) was full of juniors, with vomit seeping under the curtains. George, the registrar, was in the habit of asking nurses ‘Can I feel your front?’ and getting a full frontal slap as an answer. Others in A&E also did not learn from their mistakes. Twenty years on, Dr Nick Edwards’ book details the still endless stream of trivial injuries and conditions, along with the old, infirm and incurable who are always with us – not the casualty consultants, I hasten to add.

Dr Edwards’ patients are presented as vignettes. They come into the story and pass out in various ways at which point we lose track of them, as they go to the ward, go out onto the street or die. These pictures are lambent images suffused with humour and pathos but are necessarily temporary; within a few lines, we are on to new patients with fresh problems.

We all remember ‘Dr Finlay’s Casebook’. Moving forward, ‘M*A*S*H’ started life as a book. The replays on television mean nothing to juniors now. When I was that rare beast, a consultant resident on-call – albeit for one night only – I heard the 25-year-olds discussing when MASH took place, and they decided that it was probably during the Vietnam War. In fact, the Americans found that the Viets overran the early MASH’s and massacred the medical staff, so the principle of casualty evacuation was developed. MASH is set in Korea in the ‘50s, and the book rattles along at a hell of a pace. One TV episode is based on about one page of events.

Then we had the ‘House of God’, and later still we had ‘Cardiac Arrest’ – now released on video, readers! – and I sense that Nick Edwards was also working in Birmingham later than Jed Mercurio. One of the events in ‘Cardiac Arrest’ was featured as a case report in the BMJ, that of the frozen drunk. ‘In Stitches’ details a junior doctor’s
There are books for those who prefer life in the 19th century. I liked ‘The surgery at Aberffrwd’ – a Dr Finlay of the Welsh valleys, set in 1908. This is a collection of short stories rather than short paragraphs, and so fulfils the demands of modern literature – the story must have a beginning and an end.

The reader can now see that there is a literature in which this new book sits – 100 years of telling it like it is. Or if it isn’t like that, telling it like it ought to be. The advantage of this book is that one can dip into it, but this is also its disadvantage and it lacks a consistent and coherent narrative thread. The girl in page five who says ‘Doctor...’ doesn’t come back in at page 155 and plunge a knife in a passing porter’s chest with the comment ‘Doctor... I said last month I was ill and no-one listened’. The author may justify his approach in that it reflects the reality of what happens in A&E nowadays – ‘you treat and street ’em and meet them nevermore’ – but it does make for a hard read. Jane Austen this isn’t.

References
1 Cronin AJ. Short Stories from Dr Finlay’s Casebook. Longman, France 1978.

A patient’s view:

Mr R Young, Patient Liaison Group

Nick Edwards writes about the highs and lows of being an A&E doctor with many short anecdotes and observations on his daily life. The book comes across as a sort of ‘Alf Garnett meets ‘Doctor in the House’ – although Alf here is rather more pro Labour and emphatically anti Thatcher. We have a series of rants (his word) about the daft organisation, stifling bureaucracy and the strange underclass of people who turn up at A&E frequently with outrageous expectations of the NHS.

To counterbalance the rants, we are also presented with a view of some ‘salt of the earth’ type patients (usually older) who are absorbed into the NHS via A&E and then engulfed by the establishment in somewhat Kafkaesque fashion. I frequently felt that the interactions described between various hospital staff should have the word ‘comrades’ liberally scattered around.

Essentially, Nick likes the NHS because of its solid socialist principle of free medical care for all. However, he is less than enthusiastic about the way in which the NHS is run – save the district general hospital, too many managers doing made up jobs, stupid targets addressing the wrong objective, lack of staff recognition and the stultifying waste of time, energy and money that often comes from adopting a ‘one size fits all’ policy. Unfortunately, this is a bit naïve since the way it is run actually defines the NHS as it is and not necessarily how the Beveridge Report might have hoped it would develop. To give Nick his due, though, he rightly illustrates the wasted opportunities and how the law of unintended consequences manages to inevitably turn promising patient care scenarios into the medical equivalent of the Mad Hatter’s tea party.

Overall, the biggest impression that the book made on me was not so much in the content but in the style. Because Nick describes his A&E experiences in ‘bite size’ portions, I never felt that I got the whole picture about any of the patients or situations described. It felt a bit like the stereotypical Chinese meal – all the individual bits tasted fine but it left you needing that little bit more. Maybe this reflects what A&E is really like – lots of patient episodes treated in relative isolation.

One final point is that Nick’s continual use of the slang term for what he and his colleagues refer to as ‘faecal matter’, doesn’t enhance the worthwhile points – it just makes them seem a bit vulgar, as my mum used to say.

AAGBI

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2–4 July 2008, Liverpool

ANNUAL CONGRESS

More detailed information can be obtained from Emma Hollington/Nicola Heard, Educational Events Co-ordinators, 21 Portland Place, London W1B 1PY
tel 020 7631 8808/8805 email meetings@aagbi.org
fax 020 7631 4352 website www.aagbi.org
The e-Library

The e-Learning Anaesthesia project (www.e-LA.org.uk) provides access for all UK anaesthetists to approximately 1,000 on-line tutorials or ‘e-sessions’ that support the FRCA curriculum. Its basic structure and function have been described in a previous College Bulletin article (January 2008).

It has always been envisaged that the learning portal would complement rather than replace existing learning resources but the use of an electronic web-based medium confers enormous potential advantages. Browser technology can call upon powerful search facilities and ‘hot text links’ that enable highly relevant background material to be placed at the fingertips of the user. The e-LA curriculum has been organised into seven educational blocks that are designed to accompany clinical units of training from the first three months of supernumerary attachment to the level of competence previously associated with the certificate of completion of SHO training. The content of these blocks represents the core curriculum. To provide more background information, the academic block structure of e-LA has been mirrored with an e-library populated by both internal and external links to peer-reviewed scientific articles.

Agreement has been reached to allow direct toll-free access for e-Library to the full-text html and pdf versions of articles published by:

- BJA
- Continuing Education in Anaesthesia, Critical Care & Pain
- Anaesthesia
- Anaesthesia & Intensive Care Medicine
- World Anaesthesia Society Tutorial of the Week and Update in Anaesthesia

We are currently identifying those articles relevant to a particular session and have placed links to them alongside the session. The entire e-Library may also be browsed for specific subjects and the catalogue searched by keywords. The project is ongoing and we anticipate that other journal publishers will agree to the inclusion of their published material in the catalogue. If so, e-Library has the potential to become the most extensive collection of indexed electronic publications ever to be linked directly to the anaesthetic curriculum.

Q: Is e-Library just for ST 1–2 anaesthetists?
A: The indexed library of journal articles will support the core curriculum. However, it also provides a high quality searchable CPD resource for more senior anaesthetists.

Q: Who can use the e-Library facility?
A: This educational resource is accessible to all UK anaesthetists: trainees; consultants; SAS grades; and acute common stem trainees who have registered with the e-LA project.

Q: Can I gain access to the entire text of a paper?
A: Yes, the full text version will be available to read in html format and to print in pdf format.

Q: How does the e-Library differ from other portals?
A: e-LA provides structured learning material to support the FRCA curriculum. Sessions have been carefully cross-referenced to relevant high quality reviews and journal articles. The Learning Management System (LMS) keeps track of an individual’s progress through the curriculum, and offers access to archives of support and reference material rather than simply acting as a search facility.

e-Learning Anaesthesia and the e-Library went live in January 2008. Please take the time to peruse the material that is now available at www.e-LA.org.uk.

Dr Andrew McIndoe
Dr Ed Hammond
Joint Project Leads
Physicians’ Assistants 
(Anaesthesia)

New guidelines on the supervision of Physicians’ Assistants (Anaesthesia) have recently been drawn up by the RCoA in conjunction with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and will be published on the College website imminently.

Previously known as ‘Anaesthesia Practitioners’ (APs), members of this group have now been given the title of ‘Physicians’ Assistant (Anaesthesia)’, abbreviated to ‘PA(A)’. The re-name was needed to ensure clarity – holders of the title will have completed an appropriate course – and is in line with that currently being used for equivalent grades working with physicians, GPs and surgeons as well as for APs in Scotland. The College hopes that the new standardisation of title will accelerate the route to appropriate registration and regulation for this group of specialty trained healthcare workers, which is now long overdue.

The new guidance for supervision arrangements details individual responsibilities. PA(A)s must be supervised by either a consultant, a suitably competent SAS anaesthetist (who is also recognised as a trainer by the RCoA), or a trainee medical anaesthetist in his or her final year of training (SpR5 or ST7). The supervising anaesthetist must not provide solo anaesthetic cover for a different specific surgical list, must be present at the induction and emergence of anaesthesia and must remain present in the theatre suite and available within two minutes. There must also be a dedicated trained assistant (ODP or equivalent) in every theatre where anaesthesia care is being delivered.

Safer delivery of drugs

When nursing staff administer drugs, they ‘double check’ their actions with another, yet anaesthetists regularly give injectable drugs on a sole basis. Many anaesthetists doubt the feasibility of cross checking drugs in an environment where rapid action is often required and when other team members may be pre-occupied. This area of practice is now being considered by the National Patient Safety Agency (NPSA), together with the Royal College of Anaesthetists.

The intention is to design a pilot study to look at drug administration across the whole anaesthetic process and across a range of different hospitals. This should provide valuable information on both the practicality and the effectiveness of double checking. There is no intention to look at individual accountability or to challenge drug and dose selection.

A further project will trial the use of bar coding technology at the anaesthetic workstation. One existing system speaks the drug name aloud when the anaesthetist scans a bar code on a pre-filled syringe, and will also keep a record of the date and time of administration. Hopefully, this new study will provide evidence of the cost effectiveness of this well established technology, an innovation that could provide a valuable safeguard for our patients.

History of anaesthesia award

Since 1996, the Wood Library-Museum of Anesthesiology, an affiliate of the American Society of Anesthesiologists, has awarded an international honorary post, the Wood Library-Museum Laureate of the History of Anaesthesia, on a four-yearly basis. For 2008, this most prestigious award has gone to Dr David J Wilkinson for his work as an outstanding scholar and his seminal contributions to the history of anaesthesia through numerous publications in this field.

The start date of 1996 for the first of these awards also commemorated the sesquicentennial (150 year anniversary) of the introduction of diethyl ether into clinical practice. The production of painless surgery by inhalation of this agent must rank as one of mankind’s most humane discoveries, and the choice of this date to introduce the award is unlikely to have been a coincidence.

The UK has featured previously in this award; in 2000, the Laureate was awarded jointly to Dr Tom Boulton along with Dr Donald Caton of the USA.
Council report

At a meeting of Council on Wednesday, 12 December 2007, the following appointments/re-appointments were approved (re-appointments are marked with an asterisk):

**Regional Advisers**
There were no appointments or re-appointments this month.

**Deputy Regional Adviser**
Dr E J Fazackerley, Warrington District Hospital (in succession to Dr A G Head-Rapson)

**College Tutors**

**Mersey**
Dr D Banks, Macclesfield District General Hospital (in succession to Dr J Hunter)

**West Midlands (Birmingham)**
Dr H Whibley, Worcester Royal Hospital (in succession to Dr J M Budd)

**Northern**
Dr A K Sharma, North Tees Hospital (in succession to Dr S G Mohan)

**North Thames (West)**
*Dr S I Jaggar, Royal Brompton Hospital

*Dr M B Hacking, Royal Marsden Hospital

Dr J R Poncia, Charing Cross Hospital (in succession to Dr L A V Anagnostopoulou-Ladas)

At a meeting of Council on Wednesday, 16 January 2008, the following appointments/re-appointments were approved (re-appointments are marked with an asterisk):

**Regional Advisers**
Dr Oliver Dyar, Nuffield Department of Anaesthetics, John Radcliffe Hospital (in succession to Dr M T Popat)

**Deputy Regional Advisers**
There were no appointments or re-appointments this month.

**College Tutors**

**Northern**
Dr T Meek, The James Cook University Hospital (in succession to Dr S F Williamson)

**North Thames Central**
Dr M V Chapman, The Middlesex Hospital (in succession to Dr V S Mitchell)

Dr R Sharma, Royal National Orthopaedic Hospital, Stanmore (in succession to Dr J P Barcroft)

**North Thames East**
*Dr A H Presland, Moorfields Eye Hospital

Dr L Davies, Homerton Hospital (in succession to Dr D Halfpenny)

**North West**
Dr S M Richmond, Royal Lancaster Infirmary (in succession to Dr T A Oldham)

Dr N A Mahmoud, Royal Albert Edward Infirmary, Wigan (in succession to Dr B S Hundle)

Leicester and South Trent
*Dr C P Leng, Northampton General Hospital

**West Midlands North**
Dr T J Parker, Stafford District General Hospital (in succession to Dr A A M Taylor)

The following recommendations were made to PMETB for approval, that Certificates of Completion of Training 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 joint CCT in Anaesthesia and Intensive Care Medicine.

**Anglia**
Dr Louise Claire Jeynes
Dr Rhona Siegmeth
Dr Anoop Surendran
Dr Michael Bruce Sidery
Dr Thomas David Auger Standley

**Imperial School**
Dr Seosoon Seah

**Royal Free/UCL School**
Dr Caroline Anne Pritchard
Dr Prashanth Belavadi

**Barts/Royal London School**
Dr Daniel Stephen Jacobs
Dr Guruswamy Karthikeyan
Dr Sonia Jane Hudson*

Dr Andrew Fraser McNaught
Dr Dhuleep Sanjiv Wijayatilake
Dr Chakravathy George Kaleekan
Dr Mohamed Samer Saad Zaghloul Abdalla
North Central
Dr Rebecca Louise Simons
St George's School
Dr Mark Edward George Edsell
Dr Christina Clare Wood
Dr Aled Iwan Hapgood
Dr Helen Victoria Hopwood
Leicester
Dr Philippa Claire Graff-Baker
Mersey
Dr Purva Kristina Khanduja
Dr Hemalatha Sridhar
Dr Janina Holt
North West
Dr Ehsan Hossenbaccus
Dr Veerabadran Velayutham
Dr Adriana Ioana Simionescu
Dr Rini Poddar
Dr Kevin John Walker
Dr Pavan Kumar Kochhar
Dr Christopher Howard Coldwell
Dr Huw William James Twamley*
Dr Terence Kelburn Allen
Dr Matthew Red Kay
Dr Sian Sujata Jones
Dr Vikas Sharma
Dr Ehshan Mahmad Ollite
Dr Aamar Karmarkar
Dr Adel Abdel Raouf Badr
Dr Umakanth Panchagnula
Dr Ravisf Jeeji
Dr Nlulu Vasant Bhadra
Dr Swati Ghosh Karmarkar
Dr Saravanavel Sagadai
Dr Balavarthiraj Chandrasekar
Dr Luis Barbera-Martin
Dr Sridhar Surapaneni
Northern School
Dr Seema Bhargava
Dr Ahamed Thameem Malik Shahul Hameed
Dr John Christian Thorpe
Oxford School
Dr Ahmed Chekairi
Dr Martin Paul Raymond
Dr Sarah Louise Muddle
Peninsular School
Dr Richard Duncan Walker*
Sheffield School
Dr Dean Andrew Hartog
Wessex School
Dr Rupert Charles Broomby
Dr Fraser Renfree Stephens
West Midlands
Dr Carol Kanti Ray
Dr Andrea Jane Gait
Dr Maheshwar Kisan Chaudhahi
Dr Chhavi Srivistava
Dr Nusrath Qadir
Dr Garudanadurga Suresh Chandan
Yorkshire
Dr Nirmala Soundararajan
Dr Stephen Jack Wilson
Dr Brian John White
Dr Heinz Edmund Schulenburg
Dr Yasin Said Al-Makadma
Dr Juliet Alexandra Wolfe-Barry
Dr Oluremilekun Akerele
Tri-Services
Dr Shane Edward Thomas McCabe
Dr Curtis Lee Whittle
Wales
Dr Jonathan Daniel Mark Breamley
Dr Elizabeth Anne Mathieson
Dr Stephen Roy Froom
Dr Margaret Eleanor Lewis
Dr Jason Lewis Butcher
Dr Sheshagiri Bengeri
Dr David Mansell Watkins
Dr Claire Alison Farley
Dr Chitra Janakiraman
South East Scotland
Dr Colum Alasdair Slorach
Dr Imogen Andrea Hayward
Dr Alison Virginia Carlyle
East Scotland
Dr Christina Lesley Beecroft
Dr John Franco Luck
West of Scotland
Dr Radha Sundaram*
Dr Gizzy Mathew
Northern Ireland
Dr Nidhi Gupta

THE MAURICE P HUDSON PRIZE

The late Dr Maurice Hudson’s daughter generously donated money to the College in memory of her father and asked that the interest on the capital sum be used for an annual prize for the best paper on his favourite subject – resuscitation.

Dr Hudson was a consultant anaesthetist in London, took the DA in 1936, was awarded the FFARCS in 1948 and had a particular interest in dental anaesthesia. The Hudson Harness was one of his innovations.

Council decided that this prize would be awarded to the anaesthetic trainee who is the principal author of the best paper relating to resuscitation published, or accepted for publication, in a peer reviewed Journal. If you are such a trainee, would like to apply for the prize, and have published such an article since 1 August 2007, please forward a copy of your paper to the Royal College of Anaesthetists by 31 July 2008.

Applications should be sent to:
Ruth Farmer
Administrative Officer
National Institute for Academic Anaesthesia
The Royal College of Anaesthetists
Churchill House
35 Red Lion Square
LONDON WC1R 4SG
Letters to the Editor

Please make your views known to us via email including your full name, grade and address. All contributions will receive an acknowledgement and the Editor reserves the right to edit letters for reasons of space or clarity.

bulletin@rcoa.ac.uk

Logbook keeping among anaesthetists

Bulletin 46; November 2007;2334–2337

We noted with interest the comments of Drs Kelkar and Chelliah on logbook keeping by anaesthetists. They highlight the Pan-Surgical Electronic Logbook which is available to surgical trainees. The Royal College of Physicians (RCP) has also developed an online diary for specialist registrars and consultants to record CPD activities.1

In order to keep up with the medics and the surgeons, AY recently developed an online anaesthesia portfolio.2 Data can be imported from the RCoA electronic logbook and the system also allows graphical and tabular summaries to be produced for use at annual review. This service is available completely free of charge.

To echo Professor Dodds’ comments in his response (page 2337), it is not possible to guarantee that this service is absolutely safe, secure and foolproof. However, in our opinion it is as close to these ideals as possible given the currently available technology. There are currently over 500 anaesthetic trainees, across the UK and abroad, registered to use the service. It can be used to record details of sessions in theatre, ITU and pain management as well as courses and meetings. We invite any interested anaesthetists to trial the service at www.frca-primary.com.

Dr R Rajendram, ST2 Anaesthesia, Chase Farm Hospital
Dr A Yogasakaran, FTSTA1 Anaesthesia, Ipswich Hospital,

References

1 http://masterclasses.bmj.com/Resources/RCP

Competing interests: AY developed the online anaesthesia portfolio and is the administrator of the website.

I read with interest Drs Kelkar and Chelliah’s article ‘Logbook keeping among anaesthetists’. However, the authors’ assertion that ‘anyone who maintains an electronic logbook is a “data controller” and is required by law to register with the Data Protection Officer’ is not a very accurate interpretation of the Data Protection Act 1998.1

Section 1 of the Act defines a data controller as ‘a person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed’. Section 1 subsequently defines personal data as ‘data which relate to a living individual who can be identified – (a) from those data, or (b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller’.

Data which is not related to any living individual and through which they can’t be identified, is regarded as anonymised data.2 Therefore, if electronic logbook keeping involves the collection of anonymised data; then currently there is no statutory requirement to register with the Information Commissioner’s office for entry into the data protection public register.

Moreover, the data protection public register is available online. This means that an anaesthetist’s registered personal information, including his home address, can be accessed freely by anyone! As a test case, I accessed personal information of one of the authors who lives at 14 **** court. My sincere apologies to the author but it certainly raises alarms about how safe it can be to put our personal information on the web.

Dr I Ahmed, SpR, Pilgrim Hospital, Boston

References:

2 http://www.gmc-uk.org/guidance/current/library/confidentiality.asp#Glossary
Undergraduate and Foundation training – a missed opportunity

Bulletin 45; September 2007:2277–2279

Our specialty, as Dr Jones states, needs to influence how medical students and Foundation trainees are trained.

Medical students value their placement in our anaesthetic department as they are very aware of their lack of training about acutely ill patients. Foundation training sets out to rectify this, and indeed in our F2 pilot, 74% of trainees felt they knew how to manage acutely ill patients.1

Since nearly half of our F2 trainees have worked in critical care, clinicians have noticed a marked improvement in the management of sick patients by them in subsequent posts. The other major benefit was that F2s could help in staffing our expanding ITU, releasing anaesthetic trainees to spend more time in theatre. Some F2 trainees also ‘saw the light’ and came into our specialty.

Recent improvements maybe undone by changes which may follow the Tooke Report. We need to highlight the importance of the management of the acutely ill patient when some want to change the focus to the chronically ill. Whichever training structure is used, critical care and anaesthetic posts should be available in the early years of training.

Risk managers, the National Patient Safety Agency and the NHSLA all highlight how sick patients need to be managed better. Hospital trusts want graduating doctors fit for purpose on acute wards. The College needs not only to engage with these institutions regarding guidelines and curriculum but also to ensure training is properly resourced.

Dr A Strachan, Consultant Anaesthetist, Doncaster

Reference

Simulation and assessment

Bulletin 46; November 2007:2360–2363

I read with interest the article by Dr Whymark and Ms Hannah about the use of simulators for the initial assessment of competency in anaesthesia, and must commend them on their work. The authors illustrate that simulators can lend themselves to the assessment of technical skills. The trainee shows how to perform a real task, assessment is made by direct observation and this is criterion referenced. However, my question is what are we actually assessing? Is it the execution of a technical skill or performance? During the scenario the trainee will use technical skills, interpersonal attributes, and clinical judgement as well as decision-making skills. By assessing a number of competencies the observer ends up forming an opinion on their overall performance. This leads to the question: what is performance? And how do we assess it? With no clear cut guidelines or established criteria on performance assessment, you could question the reliability of the test. The authors correctly allude to this point in the text. Until we define what constitutes performance, the role of a simulator in summative assessment will still be limited.

Dr A Krishnamurthy, Consultant Anaesthetist, Harlow

Conscious sedation for dentistry

Bulletin 47; January 2008:2405-2407

Tony Wildsmith and David Craig give a timely update on the topic of conscious sedation for dentistry. However, the authors in their ‘background’ fail to record the courageous decision taken within the dental profession to restrict the use of general anaesthesia in dental practice. This restriction was aimed to provide greater protection to the public, particularly as there had been an escalating number of tragic deaths of patients receiving dental treatment under GA.

New ethical guidance was adopted unanimously at a meeting of the General Dental Council (GDC) on the 10th November 1998, and was implemented immediately. This meant that only specified anaesthetists were permitted to administer GAs, as well as ensuring that the correct procedures were in place for monitoring and resuscitating patients. Throughout formulating and activating this new guidance, the close collaboration with the RCoA, and in particular the support and advice from its President Professor Leo Strunin and Professor Tony Wildsmith, should not be forgotten.

In 1998 the GDC Review group on Resuscitation, Sedation and
GA in Dentistry also made it clear that urgent steps were needed to safeguard the teaching and practices of sedation and pain control within the profession. The present authors are to be congratulated on returning to this theme. It would indeed be a sad day for patients if sedation was not permitted to be delivered within the confines of a dental practice.

Dr Douglas Pike, GDC Review Group
Dame Margaret Seward, President, GDC 1998

The PLG Debates
Bulletin 44;July 2007:2233–2235
Bulletin 46;November 2007:2338–2339

Healthcare systems are totalitarian at heart. Ethical and behavioural indoctrination produces professional conformity and social conservatism; it is, in the end, what makes us feel like doctors. Whilst necessary and inevitable, this leaves us vulnerable.

Continued meddling with how doctors behave and think shows how well politicians exploit our skill in being indoctrinated. Now we ask for help in being further indoctrinated. Even doctors’ rights to self-govern are partly a poisoned chalice, feeding a professional totalitarianism which slaps our individual professional identities into line, and channelling influence to those who most enthusiastically embrace the puritanical psychological moulding expected of us.

The Patient Liaison Group (PLG) represents patients’ views – at our request. Their opinions are, however, frankly sometimes naïve and downright impractical. I was glad to read the objections in Bulletin 46 (page 2367–2369) to Mrs Wang’s article on informed consent. Another article by a different member of the PLG appeared in the same issue. This seemed to want to give us all cheer; perhaps advice, but its author’s right to comment seemed vaguely of the politically correct variety. A squeamish lay-person’s observations of one anaesthetist during a single, truncated list are no basis for informing anyone of anything.

Patients’ views are important, but so are those of doctors who struggle to meet unreasonable demands. The PLG should make far more serious attempts to understand anaesthetists and their working environments. Taking two years to make a very casual effort is disappointing.

Perhaps there are further burdens we should be prepared to bear, but surely we have the right to be convinced by properly informed argument, rather than through continual attack on our constitutional vulnerabilities.

Dr M Hooper, Consultant, Townsville, Australia

Reply from the PLG
I completely agree with Dr Hooper’s comment that ‘Patients’ views are important, but so are those of doctors who struggle to meet unreasonable demands’. The prime purpose of the Patient Liaison Group is to consider matters relating to anaesthesia, critical care and pain management from the patient’s perspective and advise Council accordingly. There is therefore a limit to how much knowledge and understanding we should have of the professional point of view since otherwise that would compromise our lay status. However, that is not to say that we do not make a serious attempt to understand anaesthetists and their working environments; all new appointees have a period of induction and, speaking personally, it took me well over a year of listening to and participating in informed debate within the College to get a proper insight into the different facets of the specialty, the standards that are expected of a consultant, and the detail of what constitutes good practice. Once one has a grasp of what the benchmark is, it is then useful to see how an individual practitioner works.

If Dr Hooper has risked apoplexy by reading my article in the January issue of the Bulletin (submitted well before he wrote to the Editor) he will either be reassured that the PLG is not a tool of the totalitarian system intent on producing Stepford Anaesthetists, or else be convinced that we are a lightweight, naïve and uninformed group of meddlers. Either way, he is entitled to his opinion – the lay members of the PLG expect their criticisms to be carefully considered, and should be prepared to do the same when the tables are turned.

Anne Murray, Chairman, Patient Liaison Group

The inquisition
Bulletin 47;January 2008:2385–2387

Dr Lappin’s experience of giving evidence in the coroner’s court accurately describes the ordeal. I was involved as a professional witness in a high profile murder case and experienced similar emotions. However, it is worth reinforcing that giving evidence and coping with a gruelling cross-examination is made much easier when you have detailed
and accurate medical notes: it is said ‘if it is not written down, it did not happen’. This is especially true when the case has taken time to be heard in court and one’s memories are fading.

In court, personal areas of weakness evident in my own notes included recording the time (Does a time represent the time of the note entry or the time of the described event?), documenting other staff involved, a poor prescription of resuscitation drugs (writing ‘6x adrenaline, 1x atropine’ is not good enough), and not writing blood gas results into the notes (the printouts fade and can get lost). Thorough and complete notes provide less of an opportunity for the lawyers to sink their teeth into them. Although writing such detailed notes takes time, it is well worth it should the worst ever happen.

Dr Adrian Jennings, StR, Selly Oak Hospital, Birmingham

Advertising and opinion

I submitted an advertisement for inclusion in the January issue of the Bulletin which was, in part, essentially a message of best wishes to all ‘alumni and friends’ of the Mersey courses. Included was the following:

‘Finally, on a personal note, a special mention of appreciation of the many trainees from overseas who have been through our courses and who now find themselves deprived of the future for which they have spent so much time, effort and money. I was embarrassed to be in any way associated with such a draconian remedy as that applied with so little notice and hope that those who instituted it and those affected by it will eventually get what they respectively deserve. DG.’

I was bemused on being advised that the Editor considered this inclusion ‘too political’ to be featured in the advertisement, and this was compounded on learning subsequently that the same advertisement had been accepted by Anaesthesia News, inclusion included.

I am probably out of my depth and/or an innocent abroad, but I cannot see anything seriously ‘political’ in my remarks. Further, my initialling of the inclusion makes it very plain that the sentiments expressed were very much mine and could not be construed as reflecting either on the Bulletin or on the College. On the contrary, at first glance and perhaps still naïve, I am tending to reflect that the exclusion of the inclusion was far more ‘political’ than the inclusion itself.

Dr David Gray, Director, Mersey School of Anaesthesia

Reply from the Editor

Disregarding any personal sympathies with the views expressed, the Editorial Board was unanimous in omitting this paragraph. In short, an advertisement is simply the wrong place to express personal views on current affairs.

There is a line between what constitutes an advertisement and what constitutes an avenue for the free expression of personal opinion. As with all publications, advertisement copy is subject to the same editorial processes as any other content. Just because space is paid for, this does not relieve the Editor of his duties, and indeed the College is liable under law for all of its content.

The Bulletin strives to present a spread of views, and does not seek to make its own judgement on individual topics. We present a balance of views to enable readers to make up their own minds. On the issue of MMC and MTAS, I believe we have already done this; perhaps it is now time to move on and work together in a constructive fashion towards excellence in postgraduate training rather than revisiting old ground?

Dr Keith Myerson, Editor

No laughing matter

College statement on nitrous oxide, News Update, Bulletin 46; November 2007:2365

From: Sir Humphrey [sic] Davy President
The Royal Society, London
10 November 1823

My Dear Esteemed Myerson

Rue the day that I dined with my noble friends and learned of your sordid deeds. While at the Athenæum, my perfectly honest acquaintances, Samuel Coleridge and Robert Southey, gave me notice of your foul skulduggery.

It has been made evident to me that you, Sir, are no longer satisfied with our product. We regularly partake of its fine vapours, believing it to be bestowed of all the benefits of alcohol but devoid of its encumbrances.

May I question how a mere apothecary should dare to question men of science?
We have travelled far and wide, meeting the most noble minds of Europe, and we dare not be put off the path of true discovery by a ruffian from a bathing resort.

Sir, you compound your malevolence by quoting some nonsense from the penal colony where the author even shows base ignorance of the correct usage of the æ ligature. You would be wise to consort with higher orders.

Upon your conscience, Sir, stand aside for we cognoscenti who would administer this fine effluvium to alleviate the ills of mankind.

Davy, President, Royal Society

Reply from the Editor:

My dear most honourable Davy, Esteemed Sir

As a cat may look at a King, and as a mere apothecary, it gives me great honour to converse with the President of our Royal Society.

Sir, I do hope that our affront to your ingenuity will be appeased by our printing your account in our spring journal. Whilst this will bear your good signature, may I use the Editor’s prerogative of removing the adornment of an extra ‘e’ (sans ligature) to your Christian name?

Your most humble servant

The Editor

Erratum

Letter from Dr Heneghan in response to ‘The party planners’, Bulletin 47:January 2008:2420

In Dr Heneghan’s letter, a misprint altered his point that our ‘profession’ is medicine, with anaesthesia as our ‘specialty’ – a point that we should not forget. We apologise for this error.
Royal College of Anaesthetists Advisory Board for Wales

Dr Hywel M Jones, Chairman

The Council of the Royal College of Anaesthetists (RCoA) announces the creation of the Advisory Board for Wales in response to devolved responsibility for healthcare to the Welsh Assembly Government.

Devolved healthcare results in management differences sufficient to generate the need to create a consultative mechanism to deal with issues specific to Wales. The Advisory Board will be the conduit between the Council of the RCoA and the Welsh Assembly Government and its Officers on matters relating to educating, training, and setting standards in Anaesthesia, Critical Care and Pain Medicine.

The constitution requires the election of two consultant and one staff and associate specialist (SAS) representatives in current practice in Wales and in good standing with the College, together with co-opted, trainee and lay representation.

The lay representative shall be appointed by the Advisory Board with assistance from the Chairman of the Patient Liaison Group (PLG) of the RCoA. In order to be familiar with Welsh health issues the lay representative must be resident in Wales. The successful applicant will be a member of the PLG of the RCoA. Applicants will be sought by the usual RCoA processes. The Advisory Board will have its own Web pages on the RCoA Web site www.rcoa.ac.uk, in order to disseminate current news, minutes and membership.

Nominations are invited for two consultant members and one SAS member. A first term of office is for three years with an opportunity to stand for election for a further period of three years. Details of the elections will be posted on the website. Nominations for a Trainee representative will be sought from the Welsh School of Anaesthesia and an appointment made by the Board in Wales. The trainee member will be a member of the RCoA Trainee Advisory Group.

Co-opted members will include Regional Advisors in Anaesthesia, Pain and Intensive Care Medicine as well as a nominee representing the AAGBI.

This long awaited development for Wales will enhance the presence of the specialty within the principality at a time when many changes in medical education have brought uncertainty for Trainees, Trainers and the Health Service. The main beneficiaries to these changes should as always be our patients and the standards of healthcare delivered by our specialty.

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, EPS or high-quality PDF.

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:

<table>
<thead>
<tr>
<th>Advert</th>
<th>Size</th>
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<tr>
<td>Quarter page</td>
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<tr>
<td>Full page</td>
<td>181 mm by 240 mm</td>
<td>£675.00</td>
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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.
NOTICE FROM MERSEY

It has been brought to our attention that we have created confusion throughout the constituency by changing the name of

THE MERSEY SELECTIVE COURSE

to

THE BASIC SCIENCES REVISION COURSE.

In view of the advice of many MSA alumni, the enquiries from potential candidates and the reported comments of a number of College Tutors, we are reversing the change and henceforth this highly respected course will be signalled once again as

The Mersey Selective Course

As has been the case since its inception some seven years ago, this course is designed to cover those aspects of the FRCA Basic Sciences syllabus which are not well explained in the available texts. As such and as always, the course is suitable for both Primary and Final FRCA candidates.

The Next
Mersey Selective Course
14.00 Sunday 13th – 16.00 Friday 18th April

PROVISIONAL PROGRAMME:

Physics Revisited        Electricity Revisited        Measurement Revisited
Pharmacodynamics        Pharmacokinetics
Oxygen & Carbon Dioxide Fundamentals        Acid Base Conundrums
Cardiovascular Physiology        Respiratory Physiology
Muscle Physiology        Metabolism Physiology        Renal Physiology
Statistics for the FRCA        Physiology of Altitude
Physiology of Depth        Physiology of Exercise

Plus
MCQ Revision Exercises

LIMITED TO 30 PLACES*

Aintree Hospitals, Liverpool
Registration fee: £400

Breakfast – Lunch – Refreshments

Details, Assessments & Application – www.msoa.org.uk – Classes & Courses

*Candidates will be sent a Revision & Preparatory Homework Booklet
ADVERTISEMENT

Notice from Mersey

It has been brought to our attention that we have created confusion throughout the constituency by changing the name of The Mersey Selective Course to The Basic Sciences Revision Course.

In view of the advice of many MSA alumni, the enquiries from potential candidates and the reported comments of a number of College Tutors, we are reversing the change and henceforth this highly respected course will be signalled once again as The Mersey Selective Course.

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Provisional Programme:

Physics Revisited          Electricity Revisited          Measurement Revisited
Pharmacodynamics          Pharmacokinetics
Oxygen & Carbon Dioxide Fundamentals          Acid Base Conundrums
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Muscle Physiology          Metabolism Physiology          Renal Physiology
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Limited to 30 places*

Aintree Hospitals, Liverpool
Registration fee: £400
Breakfast – Lunch – Refreshments
Details, Assessments & Application – www.msoa.org.uk – Classes & Courses

Final FRCA SAQ Weekend
(March)
Friday 14 – Sunday 16
No Limit

Final FRCA Viva Weekend
(March)
Friday 28 – Sunday 30
Limited

Final FRCA (Booker) Crammer
(April)
Saturday 6 – Friday 11
Limited & Closed

Final MCQ Week
(March)
Saturday 29 – Thursday 3 April
No Limit

Primary FRCA Viva Weekend
(April)
Friday 18 – Sunday 20
Limited

Primary FRCA MCQ Week
(May)
Sunday 18 – Friday 23
No Limit

Primary FRCA OSCE/Orals Week
(May)
Friday 2 – Friday 9
Limited

Primary & Final FRCA Selective Week
(April)
Basic Sciences Revision
Sunday 13 – Friday 18
Limited

Details, Assessments & Application
– www.msoa.org.uk – Classes & Courses
Deaths
It is with regret that the College records the deaths of the Fellows listed below.
Dr Claire Rebecca Ackroyd, Devon
Dr Peter R W Baynham, Merthyr Tydfil
Dr Christina M Brookes, Surrey
Dr Arthur I Parry Brown, Cambridge
Dr Andrew Kinley Dewar, Gloucester
Professor Thomas Cecil Gray, Liverpool
Dr Ian James MacBean, Kings Lynn
Dr Christine Mary Ramsay, St Martin de Villereal, France
The College is able to receive brief obituaries (of no more than 500 words), with a photo if desired, of Fellows, Members or Trainees.
The obituaries will be published on the College website for a period of three months, after which they will be moved to a permanent archive. Please email your text and any photo to website@rcoa.ac.uk.

Appointment of Fellows to consultant and similar posts
The College congratulates the following Fellows on their consultant appointments:
Dr Joanna Allam, Chelsea & Westminster Hospital
Dr Egidio Joseph Da Silva, Royal Orthopaedic Hospital, Birmingham
Dr Michael Richard Duffy, Derriford Hospital, Plymouth
Dr Zoe Sarah Eke, Royal Victoria Infirmary, Newcastle
Dr Stephen R Froom, University Hospital of Wales
Dr Simon Alistair Hellewell, Royal Devon and Exeter Hospital
Dr Imogen Hayward, Borders General Hospital, Melrose
Dr Paul Michael Rolfe, Addenbrooke’s Hospital, Cambridge
Dr Hugh W Rorrison, Hawke’s Bay Hospital, New Zealand
Dr Shaun Scott, Nuffield Department of Anaesthetics, John Radcliffe Hospital
Dr Nirmala Soundararajan, Hull Royal Infirmary
Dr Alan Christopher Sweenie, Newcastle General Infirmary
Dr Chris Terblanche, Morriston Hospital, Swansea