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Awareness: only 1:80000?

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BULLETIN 31

THE ROYAL COLLEGE OF ANAESTHETISTS

May 2005

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CORRESPONDENCE

Jones JG, Absalom A, Norman J, Gibson J,
Brandstater B, Macdonald R, Haisma HJ



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Chirocaine ampoules: **Surgical anaesthesia** – Major, e.g. epidural (including for Caesarean section), intrathecal, peripheral nerve block – Minor, e.g. local infiltration, peripheral block in ophthalmic surgery. **Pain management** – Continuous epidural infusion, single or multiple bolus epidural administration for the management of pain especially post-operative pain or labour analgesia. **Children:** analgesia (iioinguid/ibthypogastic blocks). **Dose and Administration:** Chirocaine bags: Chirocaine solution for infusion is for epidural use only. It must not be used for intravenous administration. Careful aspiration before and during injection is recommended to prevent intravascular injection. If toxic symptoms occur, the injection should be stopped immediately. The maximum dosage must be determined by evaluating the size and physical status of the patient. The maximum recommended dose during a 24 hour period is 400mg. For post-operative pain management, the dose should not exceed 18.75mg/hour. For labour analgesia by epidural infusion, the dose should not exceed 12.5mg/hour. Chirocaine ampoules: The precise posology will depend upon the procedure and individual patient concerned. Careful aspiration before and during injection is recommended to prevent intravascular injection. When a large dose is to be injected, e.g. in epidural block, a test dose of 3-5 ml lidocaine (lignocaine) with adrenaline is recommended. An inadvertent intravascular injection may then be recognised by a temporary increase in heart rate and accidental intrathecal injection by signs of a spinal block. Aspiration should be repeated before and during administration of a bolus dose, which should be injected slowly and in incremental doses, at a rate of 7.5 – 30 mg/min, while closely observing the patient's vital functions and maintaining verbal contact. The recommended maximum single dose is 150mg. The maximum recommended dose during a 24 hour period is 400mg. For post-operative pain management, the dose should not exceed 18.75mg/hour. For caesarean section, higher concentrations than the 5.0 mg/ml solution should not be used. For labour analgesia by epidural infusion, the dose should not exceed 12.5mg/hour. In children, the maximum recommended dose for analgesia (iioinguid/ibthypogastic blocks) is 1.25mg/kg/side. **Contra-indications:** Chirocaine bags and ampoules: General contra-indications related to regional anaesthesia/analgesia, regardless of the local anaesthetic used should be taken into account. Intravenous regional anaesthesia (Bier's block); patients with severe hypertension such as cardiogenic or hypovolaemic shock; use in paracervical block in obstetrics; and known hypersensitivity to amide local anaesthetic agents are also contra-indicated. Chirocaine ampoules: The 7.5mg/ml solution is contra-indicated for obstetric use due to an enhanced risk for cardiotoxic events based on experience with bupivacaine. There is no experience of levobupivacaine 7.5mg/ml in obstetric surgery. **Precautions:** Chirocaine bags: General warnings related to regional anaesthesia, regardless of the local anaesthetic used, should be taken into account. Epidural anaesthesia with any local anaesthetic may cause hypotension and bradycardia. All patients must have intravenous access established. The availability of appropriate fluids, vasopressors, resuscitation equipment and expertise must be ensured. Levobupivacaine should be used with caution for epidural anaesthesia/analgesia in patients with impaired cardiovascular function e.g. serious cardiac arrhythmias; in patients with liver disease or with reduced liver blood flow e.g. alcoholics or cirrhotics; in patients receiving anti-arrhythmic agents with local anaesthetic activity, e.g. mexiletine, or class III anti-arrhythmic agents since their toxic effects may be additive. Chirocaine ampoules: The availability of anaesthetics with anticonvulsant properties, myorelaxants, atropine, resuscitation equipment and expertise must be ensured. Levobupivacaine should be used with caution for regional anaesthesia in patients with impaired cardiovascular function e.g. serious cardiac arrhythmias and in patients with liver disease or with reduced liver blood flow e.g. alcoholics or cirrhotics. **Interactions:** Chirocaine bags and ampoules: Metabolism of levobupivacaine may be affected by CYP3A4 inhibitors e.g.: ketoconazole, and CYP1A2 inhibitors e.g.: methylxanthines. Levobupivacaine should be used with caution in patients receiving anti-arrhythmic agents with local anaesthetic activity, e.g., mexiletine, or class III anti-arrhythmic agents since their toxic effects may be additive. No clinical studies have been completed to assess levobupivacaine in combination with adrenaline. **Side-Effects:** Chirocaine bags and ampoules: Adverse reactions with local anaesthetics of the amide type are rare, but they may occur as a result of overdose or unintentional intravascular injection and may be serious. Accidental intrathecal injection of local anaesthetics can lead to very high spinal anaesthesia possibly with apnoea, severe hypotension and loss of consciousness. The most frequent adverse events reported in clinical trials irrespective of causality include hypotension (22%), nausea (13%), anaemia (11%), post-operative pain (8%), vomiting (8%), back pain (7%), fever (6%), dizziness (6%), foetal distress (6%) and headache (5%). Other side effects include: CNS effects: numbness of the tongue, light headedness, dizziness, blurred vision and muscle twitch followed by drowsiness, convulsions, unconsciousness and possible respiratory arrest. CVS effects: decreased cardiac output, hypotension and ECG changes indicative of either heart block, bradycardia or ventricular tachyarrhythmias that may lead to cardiac arrest. Neurological damage is a rare but well recognised consequence of regional and particularly epidural and spinal anaesthesia. This may result in localised areas of paraesthesia or anaesthesia, motor weakness, loss of sphincter control and paraplegia. Rarely, these may be permanent. **Use in Pregnancy and Lactation:** Chirocaine bags and ampoules: Levobupivacaine should not be used during early pregnancy unless clearly necessary. The clinical experience of local anaesthetics of the amide type including bupivacaine for obstetric surgery is extensive. The safety profile of such use is considered adequately known. There are no data available on excretion of levobupivacaine into human breast milk. However, levobupivacaine is likely to be transmitted in the mother's milk, but the risk of affecting the child if therapeutic doses is minimal. **Overdose:** Chirocaine bags and ampoules: Accidental intravascular injection of local anaesthetics may cause immediate toxic reactions. In the event of overdose, peak plasma concentrations may not be reached until 2 hours after administration depending upon the injection site and, therefore, signs of toxicity may be delayed. Systemic adverse reactions following overdose or accidental intravascular injection reported with long acting local anaesthetic agents involve both serious CNS and CVS effects. **Special Storage Conditions:** Chirocaine bags and ampoules: No special storage precautions. Once opened, use immediately. **Legal Category:** POM. **Marketing Authorisation Numbers:** PL 0037/0404 – Chirocaine Solution for Infusion 0.625mg/ml. PL 0037/0405 – Chirocaine Solution for Infusion 1.25mg/ml. PL 0037/0300 – Chirocaine Solution for Injection/Concentrate for Solution for Infusion 2.5mg/ml. PL 0037/0301 – Chirocaine Solution for Injection/Concentrate for Solution for Infusion 5.0mg/ml. PL 0037/0302 – Chirocaine Solution for Injection/Concentrate for Solution for Infusion 7.5mg/ml. **Basic NHS Price:** Chirocaine ampoules: 2.5mg/ml pack: £16.60, 5.0mg/ml pack: £19.00, 7.5mg/ml pack: £28.50. Chirocaine bags: 1.25mg/ml 200ml 12 pack: £146.40, 1.25mg/ml 100ml 24 pack: £204.96, 0.625mg/ml 200ml 12 pack: £124.80, 0.625mg/ml 100ml 24 pack: £187.20. **Further information** is available on request from Abbott Laboratories Ltd., Abbott House, Norton Road, Maidenhead, Berkshire, SL6 4XE. Tel: 93/12/001. **Date of Preparation:** March 2004. **Reference:** 1. Burke D & Bannister J. Current Anaesthesia and Critical Care 1999; 10: 262-269.



ABBOTT ANAESTHETICS
operating with care

HXCH20040007



ALL AGES ALL STAGES

Sevoflurane

FROM INDUCTION TO MAINTENANCE

SEVOFLURANE PRESCRIBING INFORMATION

Presentation: Amber vial containing 250ml sevoflurane.

Indications: For induction and maintenance of general anaesthesia in adult and paediatric patients for inpatient and outpatient surgery.

Dose: MAC values decrease with age and the addition of nitrous oxide (see Summary of Product Characteristics). Induction: In adults up to 5% sevoflurane usually produces surgical anaesthesia in less than 2 minutes; in children up to 7% sevoflurane usually produces surgical anaesthesia in less than 2 minutes. Up to 8% sevoflurane can be used for induction in unpremedicated patients. Maintenance concentrations range from 0.5-3%. Elderly; lesser concentrations normally required.

Administration: Deliver via a vapouriser specifically calibrated for use with sevoflurane. Induction can be achieved and maintenance sustained in oxygen or oxygen-nitrous oxide mixtures.

Contra-indications: Sensitivity to sevoflurane. Known or suspected genetic susceptibility to malignant hyperthermia.

Precautions: For use only by trained anaesthetists. Hypotension and respiratory depression increase as anaesthesia is deepened. Malignant hyperthermia. Experience with repeat exposure is very limited. Until further

data are obtained, sevoflurane should be used with caution in patients with renal insufficiency. Levels of Compound A (produced by direct contact with CO₂ absorbents) increase with: increase in canister temperature; increase in anaesthetic concentration; decrease in gas flow rate and increase more with the use of Baralyme rather than soda lime.

The exothermic reaction that occurs with inhalational agents, including Sevoflurane and CO₂ absorbents, is increased when the CO₂ absorbent becomes desiccated (dried out).

If the CO₂ absorbent is suspected to be desiccated, it should be replaced.

Interactions: Potentiation of non-depolarising muscle relaxants. Similar to isoflurane in the sensitisation of the myocardium to the arrhythmogenic effect of adrenaline. Lesser concentrations may be required following use of an IV anaesthetic. Sevoflurane metabolism may be induced by CYP2E1 inducers, but not by barbiturates.

Side-Effects: Dose-dependent cardio-respiratory depression. The type, severity and frequency of adverse events are comparable to those seen with other inhalation anaesthetics. Most adverse events are mild to moderate and transient: nausea, vomiting, increased cough, hypotension, agitation and bradycardia. Hepatitis has been reported rarely. Convulsions may occur extremely rarely, particularly in children. Rare reports of allergic reactions,

such as rash, urticaria, pruritus, bronchospasm, anaphylactic or anaphylactoid reactions have been reported. There have been very rare reports of pulmonary oedema. As with other anaesthetics, twitching and jerking movements, with spontaneous resolution have been reported in children during induction. Patients should not be allowed to drive for a suitable period after sevoflurane anaesthesia.

Use in Pregnancy and Lactation: Use during pregnancy only if clearly needed. It is not known whether sevoflurane is excreted in human milk - caution in nursing women.

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

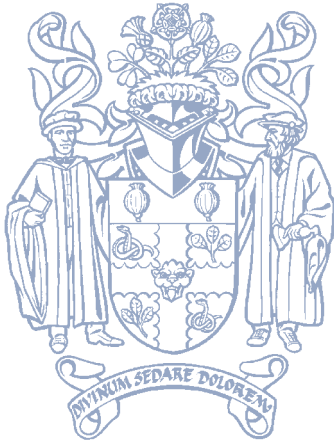
Special Storage Conditions: Do not store above 25°C. Do not refrigerate. Keep cap tightly closed.

Legal Category: POM.

Marketing Authorisation Number: PL 0037/0258

Basic NHS Price: 250ml bottle £123.00

Further information is available on request from Abbott Laboratories Ltd., Abbott House, Norden Road, Maidenhead, Berkshire SL6 4XE. Ref: PL/12/009. Date of Preparation: March 2005. Item Code: HXSEV20050067



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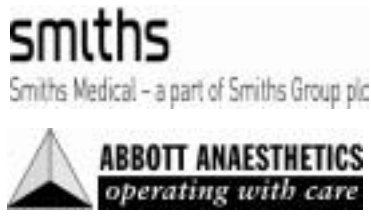
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All contributions will receive an acknowledgement. The Editor reserves the right to edit articles for reasons of space or clarity.

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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



FROM THE PRESIDENT'S OFFICE

Facing reality

Peter Simpson, President

The past two years have seen enormous changes in the way in which training takes place and, importantly, the amount of time in which trainees are available to be trained. Both the implementation of the European Working Time Directive (EWTd) and the development of Modernising Medical Careers (MMC) began with a firm emphasis on the need to continue to deliver high quality training, but inevitably, as reality bites, service issues come to the fore. Complying with EWTd hours, and in particular those imposed by the SiMAP and Jaeger judgements, means that trainees' work load has become even more concentrated out of hours, sustaining service rotas. Although many of us emphasised that the solution could not simply be a redistribution of trainees across on-call rotas to comply with EWTd regulations, but rather a more wholesale look at the way in which a department delivered out-of-hours service, the former has in fact become reality in many hospitals. This was brought home to me recently, when my youngest son took up a medical SHO post and on the first day began a rota of eight consecutive nights on-call, as his induction to the training programme! While this is undoubtedly the way that many trainees have learned in the past, the situation seems to be getting worse rather than better following EWTd implementation, with full shift work being the norm in many specialties. While we acknowledge that service work is undoubtedly an integral part of training in an apprenticeship style programme, this must not be its prime aim. I was reminded of Peter Hutton's amusing anecdote of a discussion on 'the experiential process of skills acquisition' and when he questioned this, stating that it seemed to be another expression for learning on the job, was told that the two things were completely different. He and I still subscribe to it being jargon for training coming secondary to service commitment!

The emphasis on service delivery is now also percolating through to the MMC programme. The idea of taking many existing six-month SHO posts and converting them into four-month rotation posts in foundation programmes will inevitably mean a significant loss of service delivery, particularly in the final months when, as trainees become more experienced, they required less supervision. While the generic foundation programmes are undoubtedly ideal for training new doctors in the skills of being a good doctor and looking after acutely ill patients, a four-month ICM rotation

will depend largely on the senior members of staff delivering the service while the trainees are present to learn and undertake a limited number of key procedures and competencies to complete their log book.

We are now experiencing considerable problems in certain anaesthetic departments, with trainees being virtually unavailable for training during daytime hours. With a major amount of their time being spent covering on-call rotas in general anaesthesia and particularly in intensive care and obstetrics, training is undoubtedly suffering as a result. In all cases it would appear that the key issue is the trust having to comply with EWTd regulations without either an increase in trainee numbers or alterations in the ways in which the overall anaesthetic service is delivered. Unlike many other specialties, anaesthetic SHOs and SpRs also make a major contribution to daytime service delivery and many departments depend on this to ensure that routine operating takes place. Hospitals are required to meet daytime targets for elective surgery and, as such, these take priority over other areas of work and, more importantly, of training. When this is combined with maintaining out-of-hours on-call rotas, training sometimes comes a distant third.

We have had a recent spate of College visits all of which have shown that training, following EWTd implementation, is becoming inadequate. As a result, we are having to plan revisits or even action plans to try and sort out the problems. With the changes to visiting programmes proposed by PMETB, we must ensure that such issues around the quality of training do not go unrecognised if local inspections develop into a more hands-off approach.

Elections to Council

There is always excitement at the beginning of March, waiting for the results of the elections to College Council. We had five vacancies this year, two for double term appointments, two for single term and one SAS member. Retiring from Council are Mark Garfield and Stephanie Glover, both of whom have made invaluable contributions during the years they have been with us, emphasising how important it is to have the views of trainees and recently appointed consultants represented on Council. Chris Rowlands has shouldered an enormous load as an SAS Council member, while continuing to undertake an equally

onerous workload in his Trust. Chris has helped us through many difficult issues and, in particular, the way in which they impact on SAS doctors. Doug Justins' contributions both as a Council member and Vice-President have been immense, has also completed his term. There is little with which Doug has not been involved, particularly in the key role he has played in our competency-based training programme, and it is fitting that he will play a continuing role as we develop our new Faculty of Pain Management.

However, all is not lost and we are delighted to welcome Paul Cartwright, re-elected to his second term, and Andy Tomlinson to the other double term vacancy, Roger Laishley to the SAS vacancy and Stuart Gold and Alan McGlennan to the two single term, trainee vacancies. Many congratulations to them all.

A Faculty of Pain Management

Over recent years Pain Medicine has become a major interest of many anaesthetists. The commitment of the College to this group of Fellows and trainees is demonstrated by the College 'strap-line' which includes anaesthesia, critical care and pain management. There is already an Intercollegiate Board that supervises specialist training in Intensive Care Medicine and Council recognised that aspects of the training of pain management also fall outside the normal jurisdiction of College Tutors and Regional Advisers in anaesthesia. For example, advanced trainees in pain management will be learning about cognitive-behavioural pain programmes, spinal cord stimulation and palliative care.

As a result, two years ago, Council approved the appointment of Regional Advisers in Pain Management. This year Council has approved the establishment of a Faculty of Pain Management within the Royal College of Anaesthetists. A Founding Board will be appointed to advise Council on the Terms of Reference of the Faculty and work is underway already on achieving this. We have ensured that other Colleges with a potential interest in pain are aware of our plans and I am delighted to report that there has been nothing but encouragement from other specialties. This is a really exciting development for our specialty. It will emphasise that anaesthetists make massive contributions to healthcare outside the operating theatre and it will ensure that trainee anaesthetists can obtain excellent training in all aspects of pain management.

Understanding anaesthetic equipment

A significant part of my role as College President is to address a wide variety of audiences on topics concerned with College activity. While some lectures are relatively easy to write, because they involve work which we are currently

undertaking and, therefore, with which I am very familiar, others are far more challenging and difficult to write. One such was to speak to Barema (the trade association for anaesthetic and respiratory equipment manufacturers) on 'The Role of the Industry in Training'. While an intriguing title, this stopped me somewhat in my tracks before it developed into a very interesting exercise. The expanded title was 'How can industry become more integrated, through its product training programmes with (a) the education of anaesthetists in training and (b) maintaining the highest professional standards of consultant anaesthetists in today's changing environment for healthcare delivery?'

There is, of course, a wide variety of staff who need training, both career grade and trainee anaesthetists, together with many of our non-medical colleagues including anaesthetic and theatre nurses, ODPs and anaesthesia practitioners of the future. The key to all such training is that it must be competency based and there is surely a need to include an understanding of the equipment we use, both disposable and non-disposable in these competencies. In truth, our trainees have little or no opportunity to see anaesthetic equipment taken apart or manufactured and as a result there is relatively little awareness of possible manufacturing faults and errors. While the curriculum for both medical and non-medical anaesthetic training includes significant areas of physics and measurement linked to equipment, the opportunities to have this explained in anything other than textbooks are relatively few. We all understand how to check an anaesthetic machine and in the past have had to span and calibrate transducers or to measure blood gases by tonometry, but modern equipment is so sophisticated we hardly dare change the default settings, let alone understand what is going on inside 'the box'!

So how can industry become more integrated through its product training programmes with the education and training of anaesthetists and those who work closely with them? What could industry teach that we can't? Undoubtedly when new equipment and techniques are introduced, industry could play a key role, both in the teaching of principles as well as in the use of specialised pieces of equipment. The need is to make anaesthetists both safe and adaptable, allowing them to use a wide range of equipment and to see disassembled anaesthetic machines, ventilators and monitoring equipment. It is also important for anaesthetists to understand the legal side of manufacturing and what safety and manufacturing law requires together with the issues around sterility, packaging, labelling and so forth. Some of the things which we would like to see as practising clinicians are, frankly, not possible under the legislation controlling today's commercial environment. It

is also important for us to understand the manufacturing costs related to development, clinical trials, promotion and demonstration, patenting, tooling up and stocking production lines, and loaning equipment without charge on a trial basis. It is only when we understand the threat to a manufacturer, resulting from a production error or the need to replace an item without charge, that we can really appreciate how difficult it is for them to develop products which we may assume are straightforward and easy to produce.

Industry, of course, can act as teachers, encouraging us to spot equipment malfunctioning and demonstrating how this happens. We could certainly contribute to the design of apparatus in terms of safety features, improvements, modifications, weaknesses of design or performance in practice and minimising and designing out errors. As a profession we need to work in partnership with industry to learn together and understand what equipment users would actually like to see or not see and equally what is impossible or impractical to design and produce. The design of displays, alarm systems and the methods of preventing malfunction are all crucial factors to users, particularly when we're in crisis situations. An understanding of how anaesthetists perform under stress could certainly inform the production of equipment in the future.

So how can industry become more integrated in maintaining the highest professional standards of anaesthesia in our changing healthcare environment? Standards to which we all aspire include the safe delivery of anaesthesia, training, communication and record keeping together with the quality, safety, sterility and efficacy of the products we use. We rely heavily on manufacturers for the latter, but their involvement with our critical incident reporting systems, enhancing our awareness of likely causes of problems, using equipment in accordance with the manufacturer's instructions and the issues over single-use items could undoubtedly improve safety even more. The future development of communication and record keeping is a vital part of high quality patient care, and the development of automatic record keeping systems with appropriate download and storage facilities and linkage to logbooks and personal record keeping will be an important area of progress in the future. We would all wish to maintain modern and safe equipment, funding regular servicing, calibration and replacement. Planned programmes within trusts are the only realistic way forward for the replacement of expensive items of equipment to ensure adequate budgeting and expenditure; however, from industry's point of view it is equally important for us to realise that the concept that the best price is the lowest is not always true and will certainly impair innovation and quality.

Sensational television journalism

If the recent Channel 4 'Bodyshock' broadcast 'When Anaesthesia Fails' was designed to shock, then I am sure it has achieved its aim. By concentrating on three extremely unpleasant and unacceptable cases of anaesthetic awareness, the viewer was given the impression that experiencing the pain of surgery was the inevitable result of anaesthetic awareness and that this occurs in approximately one in 1,000 cases. While we should not in any way belittle such experiences, no reassuring explanations were given to emphasise the varying degrees of awareness and that the figures quoted referred to awareness and recall of any part of the anaesthetic process, not necessarily during the actual surgery. Based largely on North American experience, the fact that many patients never receive muscle relaxants was not mentioned, nor was the fact that the vast majority of obstetric anaesthesia in the UK is regional anaesthesia. On a positive note, however, the skill and knowledge of the anaesthetists and their ability to tailor anaesthesia to the needs of individual patients, were emphasised on a number of occasions.

While such programmes may well make sensational television and sell advertising space, the misrepresentation of the facts, and lack of provision of a balanced view or positive statements, do nothing other than create shock and anxiety for the viewers. I am sure that much more material was available to the editors than was shown and, had this been included, it would have provided a much more balanced and less sensational programme. This programme has the potential to do for anaesthesia and surgery what Panorama did for organ donation, and one must ask whether this is really what we should be doing for patients about to undergo surgery, who are often in an exceedingly vulnerable and distressed state.

CORRECT SITE SURGERY

In response to a number of recent phone calls and emails, I feel I must clarify the College's position and involvement over this guidance (*NPSA Patient Safety Alert 06 – Correct Site Surgery*). The College and Association were both represented on the working group and the document had several iterations through Council. While acknowledging the need for such guidance, Council felt unable to endorse it in its present form. The reason is simply that, in all four check boxes, signatures indicating responsibility are required, but none of these has to be the operating surgeon. As a result, it is perfectly possible for an anaesthetist, theatre nurse or ODP to assume this responsibility with a formal signature, with the attendant consequences, and Council found this unacceptable. We hope that our anxieties will be addressed in a future revision of the document, allowing us then to endorse what is otherwise a major improvement in patient safety.



Guest Editorial

Neurosurgical transfers: where are we going wrong?

Dr M Smith, Consultant in Neuroanaesthesia and Neurocritical Care,
The National Hospital for Neurology and Neurosurgery, London

Background

Neurosurgical services in the UK are organised so that the majority of patients with severe head injury are admitted to a local hospital for resuscitation, diagnosis and stabilisation prior to secondary transfer to a neurosurgical unit. These arrangements do not disadvantage patients if triage, resuscitation and transfer are well managed but they do have the capacity to generate anxiety and tension between clinicians and, from time to time, adverse comment in the popular press.

Emergency referrals to seven neurosurgical units in the south east of England were audited in July 2003.^{1,2} In all, 1,071 referrals were recorded and 219 (20%) of these required access to a level 3 neurocritical care bed. Only 55% of these 219 patients were admitted to their local neurosurgical unit and no unit had sufficient capacity to admit every level 3 patient from their area, although those with dedicated neurocritical care beds were able to accept patients most often. Contact with three or more neurosurgical units was necessary to secure a bed for 17% of the patients finally accepted for level 3 care and advice to referring clinicians was inconsistent, both from within the same neurosurgical unit and between different units. Shortcomings were noted during management in referring hospitals, including delay in instituting cardio-respiratory resuscitation, and transfer of unconscious patients (or those with deteriorating conscious level) to the CT scan without airway control or appropriate escort. The audit also identified delays in arranging secondary transfer once the patient had been accepted by the neurosurgical unit. Delayed discharge at the end of the neurosurgical episode accounted for the 'loss' of 413 level 1 and 52 level 3 neurosurgical bed days during the month of the audit. Although arrangements are more robust in some other parts of the country, the deficiencies identified in this audit will be familiar to many.

The Royal College of Surgeons recommends that each A&E department should establish a formal link with a single neurosurgical unit and that all patients with severe head injury should be transferred to that unit regardless of whether they need surgical intervention.³ The NHS Modernisation Agency has also recently suggested that all

patients with potentially life-threatening insults, including those with head injury, should expect immediate admission to a neuroscience centre and that, in line with the Royal College of Anaesthetists guidance on critical care services, an appropriate and staffed bed should be available for greater than 95% of requests.¹ No-one would disagree with these recommendations but the day to day experience of many clinicians is of a process that can be inefficient and is often badly managed.

Acute management and referral

Resuscitation after head injury is a key stage at which outcome can be influenced. Primary brain injury occurs at the moment of trauma and causes variable degrees of irreversible cell damage that cannot be treated by medical intervention. Secondary brain injury, which can be prevented or treated, begins from the moment of primary injury and develops during the subsequent minutes, hours and days. It represents additional insults to 'at risk' neuronal tissue and adversely affects the ultimate neurological outcome. The importance of prompt and effective restoration and maintenance of cardio-respiratory variables cannot therefore be overestimated. Consensus guidelines for the management of severe head injury have been published^{4,5} but, despite this, blood pressure and arterial blood gas targets are not maintained in many patients in the early stages after injury.⁶ Delay in providing definitive neurosurgical treatment is another preventable cause of morbidity and mortality, and evacuation of an expanding intracranial haematoma should occur within four hours of injury.³ Criteria for transfer to a neurosurgical centre were previously based on deteriorating neurological status but the widespread use of CT scanning has led to revision of referral guidelines and recommendation of a more proactive strategy.⁷ However, sub-optimal management and delay remain at all stages of the process.¹ There may be lack of availability of appropriately skilled staff at the referring hospital to deal with patients with severe head injury (particularly out of hours) and indications for referral to the neurosurgical unit may not be clear. Access to the appropriate person in the neurosurgical unit who can give timely and appropriate advice can be difficult and

inconsistent advice is a cause of confusion, particularly if this is dependent on capacity in the neurosurgical unit. The decision to transfer a patient for specialist treatment should be a joint one between senior staff in the neurosurgical unit and referring hospital, but these decisions are often made by relatively junior staff. Review of the CT scan by the neurosurgeon is crucial to this decision but image links are not established at all sites and many are unreliable. This is a major cause of frustration for referring clinician and neurosurgeon alike. Local policies, based on national and international guidelines, should therefore be agreed between neurosurgical unit and local clinicians in order to standardise resuscitation and management of head-injured patients in A&E departments and identify which patients should be referred to the neurosurgical unit. Better telemedicine facilities and greater involvement of consultants at both sites are also likely to improve management and speed the referral process.

Referring clinicians require rapid access to staff in neurosurgical units and some units now provide the resident on-call team with mobile telephones and at least one frees up the on-call consultant neurosurgeon from other duties. The publication of a directory of services to referring hospitals that includes contact details and on-call rotas at the neurosurgical unit would facilitate improved communication. There is some understandable concern amongst neurosurgeons that open access will generate an increased inappropriate workload. Only 20% of the 'emergency' referrals in the 2003 audit^{1,2} related to true emergencies and many referrals were actually requests to review CT scans. Arrangements should therefore be put in place at referring hospitals to facilitate referral of non-emergency cases during 'daylight' hours and for local reporting of CT scans.

A major cause of frustration amongst referring clinicians is the failure of some neurosurgical units to assume responsibility for emergency patients within their own catchment area. Whilst the request to 'accept all patients who need surgery and sort out the bed later' is understandable, this is not always the best option for the patient. Obviously those with a life-threatening expanding intracranial mass lesion should have immediate access to neurosurgery but, for others, transfer to a unit that can provide the whole episode of care might be preferable. It is difficult to legislate for the generality of such situations and it is therefore vital that a decision to 'treat and transfer' is made by a consultant neurosurgeon for each patient individually. Increased neurocritical care capacity will alleviate this situation but is unlikely to resolve it totally. The role of bed bureaux should therefore be clarified with regard to identification of beds for neurosurgical

emergencies. Assistance from a bed bureau does not permit local neurosurgeons to abdicate on-going responsibility until after the patient is accepted into another unit, but it would stop clinicians in A&E departments having to make multiple referrals. The geographical catchment area of each neurosurgical unit should therefore be defined and the clinical responsibility for patients with severe head injury within this area agreed. However, this issue is most unlikely to be resolved unless linked to review of neurosurgical capacity.

When a decision has been made to transfer a patient, further delays can be encountered because of difficulties in identifying staff who can accompany the patient or in obtaining an ambulance. Transfers can take considerable periods of time and often occur out of hours. This removes key staff from the referring hospital with significant knock-on effects to other parts of the service. Emergency surgery is delayed in around 80% of hospitals as a result of anaesthetists' involvement in transfer of head-injured patients.⁸ It has been suggested that neuroscience units should provide a retrieval service but it is unlikely that every neurosurgical unit will ever be able to provide this service, which would in any case be used only infrequently. The development of network-based transport services for all critically ill patients is an alternative option. Co-operation with local ambulance services can result in significant improvements in service provision, such as the emergency head injury transfer protocol that has recently been developed by the London Ambulance Service and assures an immediate response for the secondary transfer of pre-agreed categories of critically ill neurosurgical patients.¹ Referring hospitals should establish policies for identification and immediate release from other duties of appropriate staff to transfer patients and arrangements should be made with local ambulance services to ensure that such transfers are treated as a priority.

Transfer

Although the transfer of head-injured patients may be associated with physiological deterioration, this can be prevented by pre-transfer stabilisation and good management during transfer.⁹ However, transfer remains a potentially hazardous procedure because it is often poorly managed.^{6,9} All staff involved in the transfer of head-injured patients should therefore be familiar with and adhere to previously published guidelines¹⁰ and local induction and training programmes should be used to improve awareness and competencies. A new edition of the Association of Anaesthetists and Neuroanaesthesia Society guidelines for the transfer of head-injured patients will be published later this year and will address these important issues.

Capacity

Neurocritical care capacity remains a problem in many areas. In 1999, the Society of British Neurological Surgeons (SBNS) reported that there were 111 level 3 neurocritical care beds in the UK and recommended that this number should be increased to 281 by 2005.¹¹ The exact number of level 3 beds available to neurosurgical patients is uncertain because many are not 'ring fenced'. However, Department of Health data suggest that in March 2004 there were 193 neurocritical care beds (including level 2 and 3 beds), an increase of only six beds since September 2003¹ and significantly short of the SBNS target for level 3 beds by 2005. All patients with severe head injury should be managed in a specialist unit whether or not they require neurosurgery³ but lack of access prevents this on a regular basis. In 1998, 56.7% of hospitals without neurosurgical units routinely admitted patients with severe head injury, amounting to approximately 2,100 patients *per annum*.¹² This represents an unmet need for neurocritical care that should be factored into commissioners' plans for development of neurosurgical services. Although neurocritical care capacity is clearly inadequate, best use is not being made of existing resources. Delayed discharge from neurocritical care represents an inappropriate use of tertiary beds and prevents timely access by patients who need these specialist services. Discharge and repatriation policies should therefore be agreed between neurosurgical units and referring hospitals with 'buy in' from senior management. Robust data collection is essential to identify unmet need accurately and to inform future planning in order to ensure that new resource is directed toward those areas and services where deficiency is currently present. Although additional level 3 neurocritical care beds are urgently required, the other issues that affect current capacity must also be addressed because provision of more beds alone is unlikely to solve the problem. Furthermore, it is unlikely that sufficient resources can ever be provided in a neurosurgical unit to support local work on every occasion and functional neuroscience networks should be developed to maintain timely access to an appropriate bed during peaks of demand.

Summary

Whilst additional capacity is clearly required, significant improvements in service provision can be made within existing resources if referral pathways and co-ordinated policies are agreed between neurosurgical units and referring hospitals. Recent experience demonstrates that it is possible to improve services for patients with head injury by relatively minor changes in practice and process.¹ Anaesthetists are uniquely involved at all stages of the

resuscitation and transfer of patients with severe head injury, and therefore have a crucial role to play in developing and modernising these services.

References

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- 2 Crawford B et al. Insufficient neurosurgical critical care capacity exists in SE England: more beds may not be the only answer. *Brit J Neurosurg* 2004;**18**:438–439.
- 3 Report of the working party on the management of patients with head injury. *Royal College of Surgeons of England*, London 1999 (http://www.rcseng.ac.uk/services/publications/publications/index_html?pub_id=6).
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- 5 Management and prognosis of severe traumatic brain injury. *Brain Trauma Foundation*, 2000 (<http://www2.braintrauma.org/guidelines/index.php>).
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- 7 Early management of patients with a head injury. *Scottish Intercollegiate Guidelines Network*, Publication No 46, 2000 (<http://www.sign.ac.uk/guidelines/fulltext/46/index.html>).
- 8 Knowles PR et al. Meeting the standards for interhospital transfer of adults with severe head injury in the United Kingdom. *Anaesthesia* 1999;**54**:283–289.
- 9 Andrews PJ et al. Secondary insults during intrahospital transport of head-injury patients. *Lancet* 1990;**335**:327–330.
- 10 Recommendations for the transfer of patients with acute head injuries to neurosurgical units. *The Neuroanaesthesia Society of Great Britain and Ireland and AAGBI*, London 1996 (<http://www.aagbi.org/pdf/26doc.pdf>).
- 11 Safe Neurosurgery 2000. *The Society of British Neurological Surgeons*, London 2000.
- 12 McKeating EG et al. The intensive care of severe head injury: a survey of non-neurosurgical centres in the United Kingdom. *Br J Neurosurg* 1998;**12**:7–14.



SAS Committee

Dr A B H Lim, Chairman, SAS Committee

One of the more interesting problems with deadlines for articles is that they, the articles, often have to be written well in advance of the actual publication date. So here I am, shivering in March, writing an article that will be read by all of you in May! By the time you read this, you will all know that Roger Laishley has won the election for the second SAS Council seat. On your behalf, I'd like to bid him welcome and hope that he has as interesting and rewarding a time on Council as Chris has had.

SAS Review day

Because the College will be moving to its new premises this year, I have asked the Association to host the SAS Review day for 2005. This will be in November and both Ramana Alladi and I are hoping to have an interesting day for all of you.

AAGBI 'glossy'

The Association 'glossy' for NCCG doctors is seven years old and is now the subject of a review, to which I will contribute. The aim is to make this more relevant to the SAS anaesthetist of today and hopefully you will all get to see it early next year.

Named consultants

There has been some disquiet over the call for all anaesthetic charts to have the name of the supervising consultant appended as well as that of the anaesthetist giving the anaesthetic, if the latter is not a consultant. Whichever way you look at it, I do not think that this is an attack on our clinical autonomy. The current regulations for a Staff Grade doctor or Associate Specialist still stipulate that they are to be 'under supervision', though this can be open to interpretation by anaesthetic departments up and down the country. Further, if you have read the relevant article in *Anaesthesia News*,¹ you will have noted that since the inception of the NHS in 1948 every patient must be under the care of a named consultant. I would see this as 'crossing the t's and dotting the i's' by the Department of Health. The degree of autonomy that we all have is, I believe, earned by us as clinicians within our respective departments and trusts. We are an incredibly disparate group, some with

years of experience, others with just the bare minimum required. This leads to a problem in formulating rules that can encompass this wide range and variety of experience. Having a nominated consultant in charge protects both patients and anaesthetists and can help to prevent inappropriate delegation. This puts the onus on the various departments of anaesthesia up and down the country to deal with the issue locally and sensibly. I am sure that this will not be the end of the debate on this subject but, for now, I would commend all of you to engage in healthy and sensible debate with your consultant colleagues in your respective departments in order to achieve a consensus locally on the degree of supervision which should be in place.

Reference

- 1 Chambers A. Message from the Honorary Secretary: The Named Consultant. *Anaesthesia News* Dec 2004;**209**:15–16.*
- 2 Kenny G, Daniel M. Re: Message from the Honorary Secretary: The Named Consultant. Dear Editor... *Anaesthesia News* Mar 2005;**212**:11.

**Please note that since this article appeared in the December 2004 issue of Anaesthesia News there has been a letter to the editor clarifying the origin of the 'Named Consultant'. This letter appears in the March 2005 issue of Anaesthesia News.²*

Dr Stephanie Glover has recently retired from Council and therefore as the Editor of Trainees' Topics. We are very grateful to her for undertaking this role so enthusiastically and encouraging trainees to contribute to the Bulletin. We would like to offer our sincere thanks for all her efforts, and we wish her well.

Please send articles for submission, together with any declaration of interest, to the Editor, via email (preferred option) to: bulletin@rcoa.ac.uk or by post (accompanied by an electronic version on disk) to:

**The Editorial Officer
The Royal College of
Anaesthetists
48-49 Russell Square
London WC1B 4JY**

The Editor reserves the right to edit articles for reasons of space or clarity.

Training in Pain: two perspectives



A trainer's perspective

Dr J Hughes, Consultant Anaesthetist, James Cook University Hospital, Middlesbrough

Introduction

Advanced pain training is aimed at those trainees wishing to undertake a consultant post with a substantive commitment to pain management. The requirements are clearly outlined in the Royal College of Anaesthetists (RCoA) competency training manual.¹ The requirements for centres offering advanced training are also set out and time may need to be spent at more than one unit. This supersedes the previous arrangements where hospitals had to apply to be registered with the College for advanced training status. The curriculum can be supplemented by reference to the International Association for the Study of Pain (IASP) core curriculum which is currently being rewritten.

We have developed a one-year within programme module for advanced training that has fulfilled the pain training objectives and allowed maintenance of anaesthetic skills. This has required a significant amount of forward planning and a trainee with a high level of organisational skills and motivation. The result has been a diverse and fulfilling year with benefits for all.

Organisation of pain module

Early discussions with the regional adviser in anaesthesia, programme director and more recently the regional adviser in pain were required. It is necessary to place the trainee at an appropriate base unit for one year with no daytime commitment to anaesthetic duties. The pain unit has to fulfil the requirements (on its own or in conjunction with other centres) for advanced training. On-call commitments

to anaesthesia continued and this provided maintenance of skills as well as some operational management experience.

An educational supervisor was approached and involved from an early stage along with the trainee. Meetings occurred several months ahead of the attachment to design an outline programme encompassing:

- 1 past experience
- 2 RCoA requirements
- 3 trainee's areas of special interest.

The outline plan for the year included arrangements for spending time in other clinics and centres (e.g. palliative care, rheumatology, spinal injuries). Teaching, audit and research opportunities were planned along with study leave planning and budgeting.

During the year there were monthly meetings with the educational supervisor. These allowed progress to be checked and objectives set whilst maintaining flexibility to utilise opportunities which became available but ensure that core areas were not forgotten.

Twice during the year, at six months and 11 months, a formal assessment was performed using the department's forms for trainee assessment. These were circulated to all members of the pain team including the administrative support staff. This feeds back on attitudes and the team involvement that is integral to pain management. This in turn allows a constructive appraisal to be undertaken with the trainee as well as feeding the RITA process.

Expectations

The Fellow is expected to participate actively in all areas of the pain management unit.

1 Clinical work included:

- out-patient clinics
- ward rounds
- regional block sessions
- time with other members of the team (psychology, nursing, physiotherapy etc)
- a solo clinic was started with access to consultant supervision (available but not physically within the clinic) for new and follow-up patients. The aim was to develop an understanding of running a clinic and not to increase the service provision of the department
- solo ward rounds were done as part of the in-patient pain service
- attachments to other units and departments were arranged to broaden experience, understand referral patterns and gain insights in cross-departmental communication
- palliative care experience is essential and off-site, and included some community-based work.

2 Management experience was gained by participating in departmental business meetings and the annual business planning process. The solo clinic also develops managerial skills.

3 Academically, the expectations have to be tailored to the trainee's experience, abilities and aptitudes. The opportunities available alter with time and some compromise is required to use them fully. The level of involvement in any academic area has to be tailored to the individual but without omissions.

- Teaching exists at undergraduate and postgraduate levels locally and at the regional primary and final anaesthetic courses. Further presentations were given at GP and national meetings held both within the region and outside it.
- Audit work was performed fitting in with departmental requirements with input from the trainee.
- Research was undertaken with involvement at all stages of projects. These can be ongoing or new pieces of work. A realistic expectation of completing projects is essential.

Difficulties

Lack of time is often the principal problem for the trainer but is not insurmountable. Keeping track of the programme and not missing essential elements are important.

Training for the other trainees on attachment to the pain clinic has to be timetabled with greater precision in order to ensure that they get appropriate experience, but this can be turned into a benefit by allowing more time for discussion and teaching (assuming the size of the clinic does not increase). It is imperative that SHO and SpR training (at a basic and higher level) is not diluted by the presence of a specialist trainee.

It was thought that anaesthetic experience would be a problem. In reality, doing on-call allowed sufficient exposure to maintain skills as well as log book numbers. This was in part due to forward thinking and ensuring the main anaesthetic disciplines had been completed prior to taking up the post.

Benefits

Having a fresh questioning and interested trainee has allowed us to look in directions that may have gone unnoticed. There is an opportunity critically to appraise some of the processes and systems with the potential to find new solutions. It has made us think about why we do things. Some projects have been completed where in the past they may not have been, or at least not as quickly.

With a year available, the opportunities for teaching, audit and research can be well utilised with a real expectation of results. This is of clear benefit to all members of the team.

The communication between members of the team is improved with a better understanding of each other directly as a result of the trainee interacting with all of us. It has helped disseminate knowledge and techniques between colleagues more easily than previously in the normal working patterns of the NHS.

Outcomes

The first Fellow has been a great success from the trainer's perspective. I cannot speak for the trainee but hope it has provided elements of training, audit, teaching, research, management skills, solo practice and support. There are definite benefits for the unit and understanding between team members. That said, the amount that you get out depends on the amount that has been put in.

Reference

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



A trainee's perspective

Dr A Gulve, Specialist Registrar, Northern School of Anaesthesia

Introduction

I have recently completed one year of advanced training in pain management in the Northern Schools of Anaesthesia. Consultants with a special interest in pain management require six months to one year specialist training, but most of the Pain Fellowships in the United Kingdom are locally funded and not available to trainees outside the region. There is no established Pain Fellowship in my region.

The options available to get this training were:

- 1 Fellow's post in another region
- 2 Pain Fellowships abroad
- 3 Organise the training locally.

The College guidelines (CCST in Anaesthesia IV) state that: 'during SpR training up to one year can be taken as full time dedicated work in a single sub-specialty.'¹ I decided to accomplish my training in this way.

Aims

- To get experience in all facets of chronic pain management.
- To obtain skills and knowledge to enable me to take up a consultant post with a substantial commitment to chronic pain management in a multidisciplinary pain clinic.
- To have protected time for pain training.
- Anaesthetic on-calls to keep my skills and pay.
- Training to count towards my CCST.
- To consolidate this training by taking one additional year out of programme.

To achieve all this, I had to plan well in advance.

Planning ahead

I met up with the College Tutor and the Regional Adviser in Pain Management one year in advance to explore the feasibility of this training. We formed the structure and content of this training with the help of guidelines from the Royal College of Anaesthetists. Approval was sought from the Programme Director of the Northern Schools of Anaesthesia, the Regional Adviser for Anaesthetic Training, the

Postgraduate Dean's office and the Royal College. I was advised to do general anaesthetic training in my final six months leading to CCST. The selection process was informal by expressing an interest to the College Tutor and Clinical Head of the Pain Unit. We did not have to look for funding of the post because it was an in-training post and the hospital was able to cope with the loss of daytime service commitment.

Given the fact that I would not be doing any routine lists during this period, I had to monitor carefully the numbers in my anaesthetic logbook well before starting the pain training. I made sure that by requesting appropriate placements, I could gather the experience in deficient sub-speciality areas.

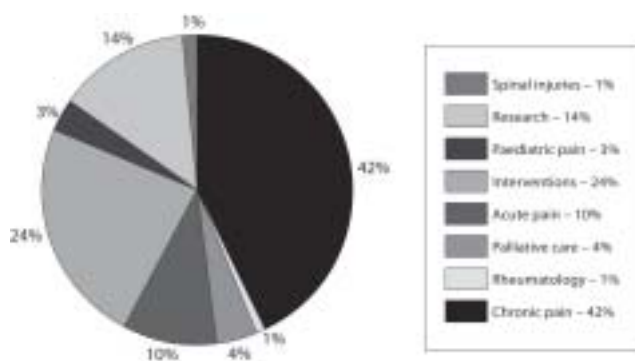
The Pain Management Unit

The Pain Management Unit at the James Cook University Hospital is housed in its own dedicated accommodation. Approximately 1,100 new patients attend the clinic and 700 interventional procedures are performed every year. The acute pain service sees about 3,000 patients per year, most of whom require peri-operative pain management. It consists of four consultants, nine clinical nurse specialists (five chronic pain, two acute pain, and two research). It covers two NHS trusts and four hospitals with a hub and spoke arrangement. In a week 13 clinics, five interventional sessions, and two acute pain rounds are offered. To complement this, additional nurse-led activities include three TENS clinics, community pain clinics, daily acute pain rounds and telephone follow ups. Full-time physiotherapists, an occupational therapist and three clinical psychologists complement this set-up. Wide ranges of diagnostic and therapeutic interventions are offered including radio-frequency lesioning, implanted intrathecal pumps, spinal cord stimulators, spinal endoscopy and pain management programmes. There is also a multidisciplinary paediatric pain clinic.

The training obtained

The time spent during this post was protected training time. This not only offered the best possible experience but also facilitated attending directorate meetings and participating in teaching activities. I had full flexibility to organise my

Figure 1: Break-down of clinical activity during Fellowship



weekly clinics and interventional sessions according to training requirements. Chronic pain has no out-of-hours on-call commitment. I could still continue to do anaesthetic on-calls and maintain my anaesthetic skills. A partial shift rota and an opportunity to keep up with pain sessions till 5.00 pm even on on-call days assured continuity of clinics. I am sure a full shift system will reduce the number of sessions available for training. Apart from a regular weekly session of research time, when consultant clinics or interventional sessions were cancelled, this time was utilised for research. Figure 1 demonstrates the training obtained.

After one month, I was allocated my own solo (level 3 supervision) clinic every week. To allow enough time during the learning phase, the clinic was limited to three new and two review patients. This was on a day when there are no consultant-led clinics but all the pain consultants are available in the hospital. I could not only get their advice for complex patients but also rescue myself from very difficult patients. I also had an opportunity to conduct case discussions later on with my educational supervisor and transfer some difficult patients to his clinic. This not only gave me the opportunity to monitor closely the progress of these patients and increase my confidence but also fulfilled the service commitment. I had to plan my annual and study leave two to three months in advance to prevent last minute clinic cancellations. Timely follow ups meant occasional overbooking of the clinic before or after the leave!

One month in a hospice and one week each in rheumatology and spinal injuries clinics were very useful. I also learned about complex management and financial issues by regularly attending the monthly pain directorate meetings. To gather experience in highly specialised areas like spinal cord stimulation, implantable intrathecal infusion devices, pain management programmes and other complex interventions, I had to stay back on post-on-call days.

A formal meeting with my educational supervisor on a monthly basis helped to reflect on the previous month's achievements, identify training needs and set up goals for the next month.

Additional qualifications

The College of Anaesthetists at the Royal College of Surgeons in Ireland conducts a Pain Diploma examination that has a structure very similar to the Anaesthetic Fellowship examination. The details are available on the College website (www.rcoa.ac.uk).

Opportunities to attend meetings

One of the perks of extended one-year pain training was the opportunity to attend national and international meetings in order to learn from the experience of world experts in various pain sub-specialties.

Apart from the British Pain Society meeting, I was able to attend the Neuromodulation World Congress in Madrid, the International Spinal Injection Society's meeting in Amsterdam, the Neuropathic Pain Congress in Madrid, and the Advanced Hands-on Neuromodulation Cadaver Workshop in Brussels.

Outcome

As far as I am concerned this year has been a great success. I got the training that I had always dreamed of.

Ideal training

An ideal rotation for advanced training in pain management should involve at least one month each in rheumatology and palliative care and two weeks each in a spinal injuries clinic and a psychology unit, in addition to one year in pain management. Further experience in neurology, dental surgery, acupuncture and complementary medicine could be useful depending on your pain sub-specialty interest.

Attributes for being a pain specialist

You have to be very patient, a skilled listener, and a good historian. You should not make false presumptions from the patient's story. This is enough to win their confidence in you. Most patients come with several 'labels' (diagnoses) attached to them. Accepting their pain even if it does not fit their label and making a diagnosis about the type of their pain help tremendously in how you are going to treat it. Having a positive attitude is essential. After all it is their pain affecting their life style. Whatever difference we can make is very much appreciated by most of the patients.

Chronic pain management is not as boring as you think provided you get an opportunity to feel what difference you can make to patients' lives. The ability to follow up the patients at least two to three times is essential for learning. Having diverse, enthusiastic teachers is also essential. Otherwise during basic training you will be put off choosing pain as your sub-specialty.

There is a very long learning curve. There is a lot more to pain management than just vitamins 'A' (amitriptyline), 'G' (gabapentin) and needles!

Reference

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

Developing patient information leaflets: principal requirements

Mrs M Wang, Chair, Patient Liaison Group

Dr J P Curran, Chair, Professional Standards Committee

The College and the Association of Anaesthetists of Great Britain and Ireland sponsored the production of 'Raising the Standard: Information for Patients' (www.rcoa.ac.uk). This award-winning project began by examining the whole concept of providing patients with the information they both want and need and, as its most tangible product, generated a series of easily read information leaflets on selected aspects of anaesthesia.

A major aim was to encourage development of good quality information in hospitals. To spread examples of good practice, we would be pleased to publish, on the Patient Information section of the College website, leaflets generated by teams in hospitals if the teams have used the same methods as outlined in 'Raising the Standard: Information for Patients'; drawing on the accumulated knowledge of the project team, we think it is essential for local teams writing leaflets to be familiar with good practice in writing patient information material.

Preparation, the involvement of service users, support of clinicians and management and funding are central to success. The projects are time consuming but we think they are rewarding given both patience and careful planning. The principal requirements are:

- to study existing sources of information and good evidence
- to assemble a team that includes anaesthetists and other healthcare professionals together with at least an equal number of 'consumers' (patients with experience of what the proposed leaflet intends to describe, patient representatives and, where appropriate, patient group representatives or parents)
- to write in plain English
- to use local experts, not directly involved in the writing, to review the material
- to submit the finished material to expert review (professional and lay) identified by the Association and the College
- to agree that once your leaflet is published on the College website other hospitals may use the information to generate their own information for local use.

Before you begin, contact us through the Professional Standards Directorate of the College (**email:** profstans@rcoa.ac.uk); we or our successors will help you, in the first instance by putting you in touch with either someone involved in the original project or someone who has successfully completed one of our existing leaflets.



Outcomes of delivery of anaesthetic services

Mr R Young, Lay Member, Patient Liaison Group

*The little fishes of the sea,
They sent an answer back to me.
The little fishes' answer was
'We cannot do it, Sir, because...'*
– Lewis Carroll – 'Alice Through The Looking Glass'.

Many medical procedures and interventions require the use of anaesthetics in one form or another. It seems pretty sensible, therefore, to make every effort to gather as much information about what works best for which types of procedure and for which types of patient, both from the clinician's and the patient's viewpoints.

From the standpoint of an individual patient, anaesthesia can naively be regarded as merely a support activity that allows a surgical procedure, as a typical example, to proceed without the attendant discomfort. From a Department of Health standpoint, it seems that a similar view of anaesthesia is being adopted.

However, since we know that the type of anaesthesia used can have a significant effect on the outcome for the patient, we would assume that patients, the public and the Department of Health would recognise that it is essential to collect and analyse anaesthetic data. Nevertheless, it is not intended to gather these data and patients will be disadvantaged and deprived of making choices because of a lack of information.

Data regarding medical procedures carried out in the United Kingdom are currently gathered under methodologies determined by the National Health Service Information Authority (NHSIA). At present, this has limitations and a new scheme for data acquisition is being introduced within the framework of the National Programme for Information Technology.

There are two main aspects

- 1 National data covering medical procedures that will be based upon the major procedure which the patient is undergoing.
- 2 Individual data within the electronic care record that will hold details of which procedures and which medical interventions have occurred as part of an individual patient's history.

Meanwhile, various different bodies have been attempting to reach a consensus view on an internationally recognised coding scheme to record anaesthetic data. These include the Society for Computing and Technology in Anaesthesia (SCATA) and the Academy of Colleges Information Group.

However, as far as NHSIA is concerned, no anaesthetic data will be included in the data to be gathered at a national level. This cannot be through limitations on space since modern hardware and software facilities allow the capture of more data than you can normally wish to shake a stick at – just ask any major retailer or financial institution. It also cannot be that it is particularly difficult to do, since many other countries achieve it. The only conclusion that can therefore be drawn is that NHSIA is not really concerned about anaesthetic data, or worse still that it does not recognise the significance of these data in terms of developing effective overall treatment for patients.

Two outcomes loom large on the horizon

- 1 No overall statistical inference can be drawn on a national basis either from the single perspective of anaesthetic coding or in any form of multivariate analysis. This inevitably means that no conclusions can be derived on the efficacy of different anaesthetic procedures under a range of different circumstances. This lack of contribution to the body of knowledge has only one consequence for patients and that is overall poorer outcomes (and that includes greater risk).
- 2 The fact that NHSIA is either not bothered enough, or is incapable of gathering anaesthetic data despite the evidence that anaesthetic procedures have a material effect on patient outcomes, also leads to the inference that NHSIA is primarily concerned with establishing a methodology to determine how many procedures have been carried out rather than how effective the procedures are. This may be politically astute in that one can then talk in terms of large numbers but it doesn't say a lot for the institutional view of patient care or safety. It's a bit like telling everyone that you've built a million miles of motorway while omitting the fact that it is all made of cobblestones.

Part of the NHSIA's remit is to 'Improve patient care and achieve best value for money by working with NHS professionals, suppliers and academics and others to provide national products, services and standards, which support the sharing and most efficient and effective use of information.'

I don't think they are discharging this function in relation to anaesthetic coding.

The PLG thinks this issue is serious and we intend to pursue it either directly through the DH or any of the bodies involved with the National Information Framework or indirectly via the various patient groups and organisations operating within NHS trusts.

Advice or comments from readers would be most welcome.



Intensive Care National Audit & Research Centre (ICNARC)

An appreciation following its 10th anniversary

Dr P Nightingale, Consultant Anaesthetist, Wythenshawe Hospital, Manchester

There are thousands of experts in the care of the critically ill patient on the Intensive Care Unit, and some of them work there.

– Adapted from Sodde’s *Laws of Anaesthetics*

Background

Until very recently, the development of intensive care medicine over the last 50 years or so had not been accompanied by adequate evaluation.

To audit outcomes, and compare performance nationally, it is necessary to have an agreed dataset. Clinicians recognised this many years before Government; the Intensive Care Society (ICS) was setting standards and protocols 30 years ago.

In the mid 1980s there was a dearth of nationally available information about intensive care practice in the UK. At the time, a consensus meeting to be organised by the King’s Fund Centre for Health Services Development had to be cancelled because of lack of data and a plea was made for a ‘substantial programme of research’.

Following earlier work by members of the Society, and with the support of others in this field, funding was eventually identified to allow the appointment of Kathy Rowan in 1987 as Research Officer, University of Oxford, with the task of validating the second Acute Physiology and Chronic Health Evaluation (APACHE II) severity of illness scoring system in the UK. This she achieved by 1993, with two seminal papers in the same edition of the *British Medical Journal*,^{1,2} followed by a new UK specific APACHE II system published in *Critical Care Medicine* in 1994.³

After further years of lobbying, the Department of Health and the Welsh Health Common Services Authority finally agreed to fund the initial start up costs for two years in order to establish ICNARC – a charitable company limited by guarantee to provide an independent evaluation of intensive care in the UK. The independence of ICNARC from control by the profession or Government was a controversial decision at the time but was undoubtedly the correct one.

On 4 January 1994, Alasdair Short (then Honorary Secretary of the ICS) and Kathy Rowan took possession of the vacant office space at BMA House which still houses

Key personnel intimately involved in ICNARC’s early development



Alasdair Short
Honorary Secretary and
Treasurer ICS 1990–1995



Mick Nielsen
President ICS 1990–1992



Ed Major
President ICS 1992–1995



Kathy Rowan
Director of ICNARC
1994–present

ICNARC to this day. This was also a unique opportunity for the ICS, which benefited by establishing its first independent office along with ICNARC. The history of ICNARC’s development is summarised in Figure 1.

ICNARC celebrated its 10th birthday last year with a highly successful reception of the great and good in the field, and a session of appreciation by the ICS at its last Winter Scientific Meeting.

ICNARC’s mission has been to foster improvements in the organisation and practice of critical care in the UK based on an initial programme of audit (the Case Mix Programme [CMP]) and then research on the evaluation of all aspects of provision and current practice of intensive care in the UK.

The Case Mix Programme

The CMP is a national, comparative audit of patient outcome from critical care. Over 70% of ICUs in England, Wales and Northern Ireland now contribute and the list continues to grow. The CMP has the largest, and best, database of critical care admissions in the world; over 332,000 and counting.

There are a number of benefits to being enrolled in the CMP including:

- data collection using standard rules and definitions
- trained data collectors
- external validation of data
- ability to view and download *ad hoc* analyses.

Figure 1: History of the development of ICNARC

1987	ICS UK APACHE II study starts
1988	King's Fund panel meeting
1989	Department of Health introduces Clinical Audit
1990	Steering Committee formed to set up ICNARC (January)
1992	Proposal to Government (summer)
1992	Dr K Rowan D Phil Oxford
1993	Two papers with APACHE II results published in <i>BMJ</i>
1993	Pump-priming funds obtained for two years (Easter)
1994	ICNARC established (January)
1994	UK APACHE II model published in <i>Critical Care Medicine</i>
1994	ICNARC registered as a charity (July)
1995	Establishing the Case Mix Programme
1996	Rolling out the Case Mix Programme
1997	Launch of version 2 of the the Case Mix Programme Dataset Specification (July)
2000	Building up the research programme
2005	Launch of Version 3 of the Case Mix Programme Dataset Specification (April)

Also, the database can be queried on-line by participating clinicians.

'...to indicate how we compare to other units...'

'...investigating outcomes for specific groups...'

'...feedback to unit staff and user groups on issues such as outcomes...'

'...bench-marking by comparison of mortality with other units...'

'...analysis of unexpected survivors/non-survivors...'

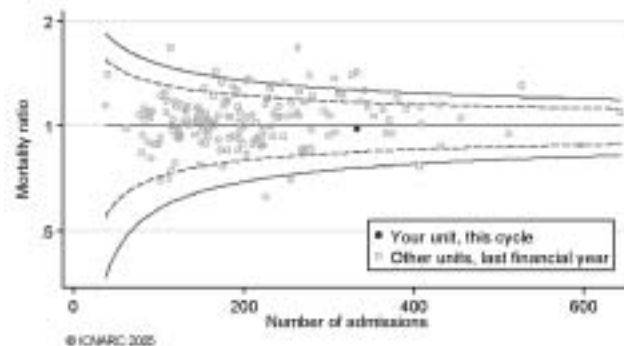
'...outcomes for patients transferred out of base hospital...'

Version 3.0 of ICNARC's Case Mix Programme Dataset Specification was released at the April 2005 Annual General Meeting of Case Mix Programme participants and has a new algorithm for case-mix adjusting the Risk of Death (ROD) in the UK population; this is the most accurate predictor ever.

The Data Analysis Report

The The Data Analysis Report DAR provided by ICNARC to each individual unit provides a wealth of data which describes the way the Unit performs compared to others submitting data. For example, using the ROD calculation, the report highlights the number of observed *versus* expected deaths in your unit (see Figure 2). This information is invaluable for performing in-house audit.

Figure 2: Mortality ratio for an individual unit (black circle) compared to all other units in the Case Mix Programme (open circles)



The DAR has a number of other benefits:

- enhanced clinical audit – learning lessons from the 'unexpected deaths' and 'unexpected survivors'
- more meaningful input into cross-specialty audit
- feedback to data collectors and other unit staff
- more robust data to inform management issues – supporting business cases and guiding operational management decisions
- use in teaching – illustrating 'audit in action' for medical trainees using local data to illustrate teaching messages, using graphs/tables in the report
- identification of possible areas for research.

The DAR often throws up interesting, and sometimes surprising, information for units to ponder – e.g. why is the length of stay on your unit so different from others when the hospital mortality is the same for similar patients? Is this due to inappropriate admissions, inappropriate therapy or inappropriate use or availability of HDU beds?

As its Director since inception, Kathy Rowan has developed a world-class centre attracting researchers from all over the globe. Due to her drive and energy the Centre has been successful in attracting funds from prestigious bodies such as the Medical Research Council, the NHS Research and Development Health Technology Assessment Programme and many others. The ICS has also sometimes been able to contribute monies!

ICNARC is held in high esteem internationally and is the template upon which many other specialties have established their own audit organisations. A large body of national and international collaborators has developed a formidable programme of research, much of which has come to fruition; ICNARC is an organisation that achieves. In recognition of these outstanding achievements, the College recently awarded Dr Kathryn Rowan the Humphry Davy Medal.

Figure 3: The scope of ICNARC's research work

RECENTLY COMPLETED PROJECTS	ONGOING PROJECTS
<p>Adult Risk Adjustment Medical Research Council Final report submitted to MRC. Main papers submitted for publication.</p> <p>UK Paediatric Intensive Care Outcome Study (PICOS) Medical Research Council Collaboration with University of Sheffield. Final report submitted to MRC. Main paper submitted for publication.</p> <p>PAC-Man Study: An evaluation of the clinical and cost effectiveness of pulmonary artery catheters in patient management in intensive care NHS R&D Health Technology Assessment Programme Collaboration with University of Sheffield. Final report submitted to HTA Programme. Main papers reporting results of both the clinical and cost effectiveness evaluations submitted for publication.</p> <p>Teamwork and Safety Survey ICNARC Collaboration between ICNARC and University of Texas. Main paper submitted and under review with Quality & Safety in Health Care.</p> <p>System of Patient Related Activities (SoPRA) Evaluation Study ICNARC Collaboration with London School of Hygiene & Tropical Medicine. Main papers about to be submitted for publication.</p> <p>CAOS: Chronic obstructive pulmonary disease and Asthma Outcome Study Medical Research Council Collaboration with London School of Hygiene & Tropical Medicine. Publications in preparation.</p>	<p>An evaluation of outreach services in critical care NHS R&D Service Delivery & Organisation Programme Collaboration with University of Sheffield. Started July 2004. 30-month project.</p> <p>Audit of the use of drotrecogin alfa (activated) ICNARC Started December 2002. 3-year project</p> <p>Pilot audit of treatments received in the critical care unit ICNARC Started May 2003. 24-month project.</p> <p>Personal Experiences of Health and Illness (DIPEX): critical care module ICNARC Collaboration with DIPEX. Started December 2004. 12-month project. See www.dpex.org</p> <p>Evaluation of the modernisation of adult critical care services Department of Health Collaboration with London School of Hygiene & Tropical Medicine. The feasibility study had four objectives: clarification of the aims of the proposed evaluation; identifications of data requirements and sources; identification of suitable approaches to data analysis; and estimation of the timescale, resources and costs for a full study. Confirmation of funding is pending.</p>
<p>ICNARC RESEARCH PROGRAMME 2005</p>	
<p>Intensive Care National Audit & Research Centre (ICNARC), Tavistock House, Tavistock Square, London WC1H 9HR Tel: 020 7388 2856 www.icnarc.org</p>	

The continuing work of ICNARC

A visit to ICNARC's website (<http://www.icnarc.org>) will show the scope of what has been achieved and what is being planned. Figure 3 depicts some of this body of work.

ICNARC has been fully self-financing for several years. There are six staff, with a dedicated hot-line, who administer the Case Mix Programme and five administrative and technical support staff. Currently, seven researchers work within the Centre although the actual number varies depending on the research programme at any one time. An additional Research Fellow, for the study on Outreach Services, will be added shortly.

Conclusion

At the end of ten exciting years of development ICNARC has been an outstanding success for UK intensive care. All those involved in its conception and development should be justifiably proud of what is a national treasure.

I would like to acknowledge the help of all those who have contributed to the text of this summary which has been compiled from a number of sources.

References

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- 2 Rowan KM et al. Intensive Care Society's APACHE II study in Britain and Ireland-II: Outcome comparisons of intensive care units after adjustment for case mix by the American APACHE II method. *BMJ* 1993;**307**:977-981.
- 3 Rowan KM et al. Intensive Care Society's Acute Physiology and Chronic Health Evaluation (APACHE II) study in Britain and Ireland: A prospective, multicenter, cohort study comparing two methods for predicting outcome for adult intensive care patients. *Critical Care Medicine* 1994;**22**:1392-1401.



A medical graduate 60 years ago

Professor Sir G Robson, Past Dean, Faculty of Anaesthetists,
Royal College of Surgeons of England

Student days

In the university vacations in the two and a half years before my finals I was a student resident in the Obstetrics and Gynaecology Department of the Royal Infirmary of Stirling, my hometown. In the war years with so many doctors in the forces, there was little help for peripheral hospital consulting staff and there were times when my chief was on her own without a house surgeon, and had to rely on nurses or the occasional resident from medicine or surgery to assist, so that I was made welcome, given hands-on experience and encouraged to read widely in obstetrics, gynaecology and anaesthesia.

I qualified in medicine in June 1944 and, as there was no pre-registration year, I was then registered by the General Medical Council and fully qualified to practise. I took the post of resident house surgeon in obstetrics and gynaecology in the Royal Infirmary.

The salary for a resident house officer in 1944 was £10.00 per month with room and board and the teaching hospitals at that time did not pay a salary at all. Time off was one evening and one half day each week although frequently I didn't go out, an obsessive tendency I suppose, but I felt that I could not leave problem patients to one of the other housemen, whose obstetric knowledge was minimal. The evening and the half day off did not include night duty relief.

At that time the simple laboratory work-up for emergency patients had to be done by the residents themselves and in the Stirling Royal Infirmary there was a little central laboratory. In it we did differential white cell counts, red cell counts, haemoglobin estimations, urinalysis etc, and grouped and cross-matched blood from the small bank of group 'O' blood held in the hospital. This was routine in the '40s. Wards in most hospitals then had a clinical side room where such estimations and tests were done. We did not have laboratory technicians at that time in Stirling and I believe that the pharmacist was given responsibility for maintaining supplies for the laboratory and ordering blood from the Glasgow blood bank when the stock had been depleted. Investigative samples were sent to Glasgow Western Infirmary.

I had fulfilled these duties and responsibilities as a student resident. They certainly gave me a sense of really having arrived in medicine, applying newly gained physiological, biochemical and pathological knowledge knowing that patients' lives could depend upon my care and accuracy. In surgical emergency patients, with whom I had to deal when covering for others, having taken the history, examined the patient and carried out any necessary side-room investigations I telephoned the chief with the results, ordered the theatre and stood by either to assist at operation or to give the anaesthetic. Before all this, of course, one had to decide whether or not to accept the patient as an admission from the general practitioner. This was much resented by some GPs but usually only by those who attempted to pass off chronically ill and socially disadvantaged patients as acute emergencies. A few of them were good diagnosticians and I would order the theatre and chief to stand by on the basis of the admission call. The housemen were caught between the displeasure of the general practitioner and the wrath of the chiefs if admission was not most carefully screened.

Anaesthesia was the responsibility of the surgeons in those days and for many years thereafter, and since they were in fact held to be in charge of the whole patient they could and did elect me, as a student, to give the anaesthetic. The surgeons in Stirling Royal Infirmary had the local general practitioners 'do' their lists as they did in their private practices. It seemed to me that none of them had had any special training in the art and science of anaesthesia and they used chloroform on an open mask as their main technique, occasionally using di-ethyl ether after chloroform or ethyl chloride induction of anaesthesia. With diathermy in use, anaesthesia was maintained with chloroform. Although there was a Boyle's machine of the bubble flowmeter variety it was never used. This really was pre-First World War anaesthesia and little more advanced than at its introduction in 1846. All that could be said for it was that the patients were relieved of operative pain if not of out-dated life threatening techniques. One or two of these practitioners had very little expertise even with the latter and in my vacations I saw a number of anaesthetic emergencies

and accidents, including some deaths during the course of surgical lists. Understandably, spinal anaesthesia was administered by the surgeon as a priority when it could safely be used to give them reliable muscular relaxation. However, I saw several deaths with spinal anaesthesia which, as I later learned, could easily have been avoided. I have a vivid memory of a particular surgeon and general practitioner anaesthetist in their operating sessions. George (verbatim): 'She's blue Leslie.' (The patient had stopped breathing, being overdosed with chloroform.) Leslie: 'Give her a pump, George', and George would cover the wound and perform artificial respiration by squeezing the chest until breathing started again. This frequently happened several times to the same patient during an operation. No-one seemed to think that this was abnormal. Of course I was not privy to any enquiry into deaths on the table and any procurator fiscal activity.

When I was a student my leaning towards anaesthesia was aroused by a house physician with an interest in anaesthetics, who frequently gave emergency anaesthetics and who stood in for the general practitioners from time to time on elective lists. He was an older and experienced doctor and he taught me to use chloroform and ethyl chloride and ether techniques. He also introduced me to the challenges of stormy induction of anaesthesia in hard drinking, very large and extremely strong bronchitic miners with perforated peptic ulcers and other acute emergency conditions which do not worry today's anaesthetists but which, before curare was available, presented a major challenge both physically and psychologically. Having been faced with this on one vacation in my fourth year as a student I made contact with Dr H H Pinkerton, Dr Roy Sinclair and Dr Andrew Tindal, full-time teaching hospital consulting anaesthetists in Glasgow. With such time as I could scrape from the formal teaching of the medical course, I learned from them how to use the Boyle's machine, how to maintain a clear airway, the induction of anaesthesia with 'Evipan' and how to intubate patients, both blindly by the nasal route and orally with the Magill laryngoscope. Armed with these advances my patients in Stirling did a great deal better than with the 19th century techniques, and I was soon in demand for anaesthesia in the hospital during my 'holidays'. I administered some hundreds of anaesthetics as a student and this experience and the scientific challenges inherent in the phenomenon of chemically induced controllable narcosis were the major influence on my future career.

In residence

On graduation, when I became the resident obstetric house surgeon, I had responsibility for 30 obstetric beds and the care of the babies. Care of the newborn was rudimentary in comparison with practice today but nursing was excellent. Gynaecological bed numbers varied with demand and in addition I had duties with my chief for the children's tonsil and adenoid surgery, and with Dr Stephen Young, consulting surgeon in Glasgow Royal Infirmary, who visited once a week to deal with adult ENT.

My chief assisted me to operate whenever time permitted and when she considered that it was safe I was left to do it on my own. This covered all the obstetric operating manoeuvres and I became proficient at Caesarean sections, both lower segment and extra-peritoneal lower segment, and all the forceps and abnormal presentation deliveries. In gynaecological surgery I was taught to do the common operations, at first under supervision and then left to do them by myself. In ENT surgery I did many tonsillectomies in children in our ENT sessions since we did anaesthetic and operation turn about. In pre-antibiotic days we had large numbers of children with tonsils meeting in the mid-line and adenoidal respiratory obstruction and although our list was limited to ten cases each week we could have filled it every day. It probably had something to do with war-time diet and housing conditions but such cases are not seen in these numbers today. My chief was a good paediatric surgeon, having trained with the great Gertrude Herzfeld in Edinburgh, and she operated on many interesting referred patients.

The obstetric beds were largely designated for abnormal cases, the great majority of deliveries at that time being in the home, so that there was a high incidence of obstetric operating in the hospital. In these pre-antibiotic days foetal death *in utero* from obstructed labour was most safely treated by instrumental extraction, if necessary by foetal destruction, which I also learned to do. All too often patients were admitted very late in labour with dead babies, due in many cases to a failure of ante-natal care or poor judgement of the course of labour. Maternal mortality was very much greater in the '30s and '40s than in the present day and it was quite clearly mainly due to ignorance and the failure to put aseptic precautions into practice. Interested readers should look up the maternal mortality figures for the 1940s in the Report on Confidential Enquiries into Maternal Deaths in England and Wales (CEMD) well described by the late Professor Sir Alex Turnbull in chapter 19 of the report for 1982–1984, and reflect on 60 years of progress in this specialty.

I also had a great deal of practice in layered perineal repair since the sister midwives did not favour episiotomy and there was often extensive muscle damage to the pelvic floor masked by intact perineal skin. As this was a frequent occurrence in the small hours when babies seem to prefer being born, there were few undisturbed nights. The management of post-partum haemorrhage from the uterus and from cervical tears was more or less routine and this experience has been of considerable benefit to patients throughout my career in both obstetric and anaesthetic practice.

Although concerned about them, I did not think of the patients in the way that I came to do later in life but rather in a generic sense as people with medical problems which needed to be sorted out, and I did not think of what I did as being in the least unusual in relation to my age and experience. I would report about admissions to my chief by telephone and if I thought that I needed help she came in to guide me rather than to take over. In those days the patients did not expect lengthy explanations and there were no informed consent rules and forms. I simply made a note in the case sheet of the diagnosis and decision and the procedure carried out, together with the operative findings.

Looking back on that residency I realise that in student vacations and six months in post I covered most of the practical aspects of obstetrics and gynaecology which seem nowadays to take full senior house officer and registrar-ship periods. Of course there was no-one else competing for experience. Gynaecological procedures were much more limited in the '40s and obstetric and gynaecological endocrinology was in its infancy. There is absolutely no comparison with what the trainees have to learn today. Practical skills, however, came very much faster and the hour long lower-segment Caesarean sections that I have had to endure over my years as an anaesthetist would then have placed the patient's life at serious risk from infection and from the anaesthetic itself. In 1944 an hour of anaesthesia was considered to be the safe maximum duration. Even this produced profound toxicity, probably liver damage if chloroform was used, carrying a risk of 'acute yellow atrophy' of the liver and slow recovery post-operatively. A whole staff of consultants and trainees now covers the present day work of the hospital department and neonatal medicine, supplemented by a large hospital staff of anaesthetists and their trainees.

One of my more unusual duties was to carry out a post-mortem examination on a patient who had died very shortly after admission from an undiagnosed cause. Medical students at that time in Glasgow in the Western

Infirmery had the real blessing of Professor Shaw Dunn as Professor of Pathology. He was a gifted teacher and I had attended a large number of his post mortems over the pathology year, so that I had no doubts about doing it myself. The autopsy disclosed that death was due to a ruptured splenic artery, a well recognised complication of pregnancy. Looking back on this I can see myself all on my own in the mortuary doing the autopsy and clearing up at the end since the mortuary man was unavailable. I wasn't disturbed by it. It was just a job to be done. The stringent precautions and regulated environment of the post-mortem rooms today were not even thought of then.

We had many cases of pre-eclampsia referred to our ante-natal clinic and we admitted fitting eclamptic patients from the district with some regularity. Magnesium sulphate 20% solution intravenously was used to control seizures, our standard procedure in 1944, many years before any blood pressure reducing drugs were available. It certainly was an effective treatment in a fitting patient, when combined with rapid delivery of the baby. I recall that during slow intravenous administration the patients experienced the sensation that we had set them on fire. Not pleasant.

Another of our duties was to go each week to Kirkintilloch to do an ante-natal clinic for Clydebank mothers who had to be selected for delivery in the war-time obstetric unit. This had been set up in Airthrey Castle at Bridge of Allan, following the loss of local facilities during the devastating bombing of Clydebank in 1941.

Airthrey Castle later became part of Stirling University which was built on the estate. It was the former home of the Donaldsons of the shipping line. We tried to ensure that only those who were likely to deliver normally were booked and bussed through a week before they were due, but inevitably from time to time some complication would arise and the patient was rushed to the Infirmery, only a few minutes away along those empty roads of the day. The nursing at Airthrey Castle was excellent and could be relied on to warn in time of complications.

Before the NHS, the organisations and facilities for obstetric emergencies which we now take for granted were not available. My chief was on-call to the district midwives for advice and help. On the occasions when she went off elsewhere she left me her car and emergency bag and expected me to get on with whatever arose. Can you imagine that responsibility today for a newly qualified doctor? One evening lives in my memory. I had a call from a district midwife who was in a miner's house in the village of Cowie, just a few miles and minutes away from the Infirmery. She was attending a primipara whose labour had

ceased to progress and she thought that a forceps delivery was needed. I found the house, to be greeted by worried parents who looked absolutely appalled at the sight of this juvenile carrying a black bag. I have a familial disposition to look quite a few years younger than I am and, at the age of 23 as I was then, suitably dressed I could have passed for a school boy. The girl was in the back room with the midwife and on examination I found a deep transverse arrest of the head and a very distressed baby. As there was an open fire in the room, I anaesthetised her with chloroform on an open mask. We put up the girl's legs in a harness and the midwife climbed into the wall space into which the bed was built to continue the anaesthetic, with which she was familiar. I successfully turned the head and delivered the baby with forceps. Today this complication would be treated by Caesarean section, but that was not an option in the circumstances because the time taken trying to get the girl to hospital and get a theatre ready would have meant the death of the infant and the likely death of the mother from sepsis. The infant was what we then recognised as 'shocked', rather poorly in fact, and I wrapped it, placed it in a Moses basket and took it through to the parents, propping it up head down against the fender in the warmth of the fire and told them just to leave it until it recovered. By the time I had repaired the episiotomy and had overseen emergence from anaesthesia it was crying heartily. On follow up, mother and baby did well. Just imagine the furore in 2005 if a 23-year-old first house job doctor was given this responsibility.

The RAMC and afterwards

When I joined the RAMC immediately following this post I became a 'graded' anaesthetist in the army in Nairobi but I also practised obstetrics for three years there in the Pumwani Maternity Hospital in my free time and I was able to manage all the work required. Needless to say I loved every minute of it, enjoying the challenges, exploring the literature and fulfilling my sense of vocation which has persisted all my professional life. When I was demobbed in 1948 I decided that a career in anaesthetics held a greater intellectual challenge than in O&G, the decision encouraged by the late Major John West (pre-war consulting anaesthetist in St Bartholomew's Hospital) who taught me as a trainee anaesthetist in the RAMC in Nairobi, and by Dr Pinkerton.

In general practice pre-war, it was fairly commonplace for the doctor, or invited specialists when fees could be found, to remove tonsils and do other surgery on the 'kitchen table'. Many years later I gave a lecture to the

Manchester Medical Society and over dinner I was talking to a GP there about the past. He said that in his area before the NHS, if a patient was not a member of a works or other health scheme which could pay for treatment then there was no possibility of hospital admission and the patient might well die unless the GP did the operation himself or arranged for someone else with more experience to do it in the home. Considering my own experience as a house surgeon it probably was the case for many general practitioners that one or two surgical and medical house jobs would have been sufficient to impart the necessary skills, giving them practical experience which could never be matched today.

I wonder how all the new plans for undergraduate and postgraduate education will produce better doctors, and with the implementation of all the new regulations how young doctors are going to acquire adequate experience in the time available. One cannot turn the clock back but on looking back on my own progress after qualification there would appear to be no quicker or better way of learning than that which I have described. It certainly gave me confidence and ability based on 'hands-on' experience.



THE ROYAL COLLEGE OF ANAESTHETISTS EDUCATION PROGRAMME

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

DIPLOMATES' DAY

4 May 2005

Kensington Town Hall, London

By invitation only.

AIRWAY DAY: RECENT ADVANCES

19 May 2005 (code: C19)

The Royal College of Anaesthetists, London

For further details see page 1556.

Registration fee: £185.

CORE TOPIC DAY

ANAESTHETIC EMERGENCIES

20 May 2005 (code: C49)

Institution of Electrical Engineers, Glasgow

For further details see page 1557. Registration

fee £185.

HOW TO TEACH

AN INTRODUCTION

24 May 2005 (code: C18)

*School of African and Oriental Studies
(SOAS), London*

A meeting designed to introduce specialist registrars, SAS grades and consultants to the skills that are required to facilitate effective teaching and training.

For further details see page 1557. Registration fee: £185 or £115 for trainees registered with the College.

SLEEP DISORDERS AND ANAESTHESIA

25 May 2005 (code: C77)

The Royal College of Anaesthetists, London

For further details please see page 1557.

Registration fee: £185.

CURRENT TOPICS IN ANAESTHESIA

6–8 June 2005 (code: A32)

Holiday Inn, Leicester

A three day refresher course for career grade anaesthetists. For further details see page 1558.

Registration fee: £390.

AIRWAY WORKSHOP – LONDON

8 June 2005 (code: C84)

St Bartholomew's Hospital, London

With a focus on clinical scenario, group discussion and hands-on skill practice. The Airway Workshop will cover a number of topics

using experienced small group Teachers.

Please note that there are limited places on this workshop. For further details see page 1558. Registration fee: £285.

SAS AS TEACHERS

9 June 2005 (code: D10)

Holiday Inn, Leicester

For further details see page 1558.

Registration fee: £185.

DEVELOPING PARAMEDIC PRACTICE

13 June 2005 (code: A74)

The Royal College of Anaesthetists, London

For further details see page 1559.

Registration fee £165.

CORE TOPIC DAY

PAEDIATRIC ANAESTHESIA

22 June 2005 (code: D08)

The Royal College of Anaesthetists, London

A joint meeting with Great Ormond Street

Hospital. For further details please see page

1559. Registration fee: £185 or £115 for

trainees registered with the College.

COLLEGE TUTORS MEETING

7–8 July 2005

University of Wales Institute, Cardiff

By invitation only.

PRIMARY FRCA: BASIC SCIENCES PHASE A

11–13 July 2005 (code: A78)

The Royal College of Anaesthetists, London

For further details and a registration fee, please see page 1560.

FINAL FRCA COURSE

5–16 September 2005 (code: A79)

Clore Management Centre, London

For further details see page 1560. Registration fee: £600.

PRIMARY FRCA: BASIC SCIENCES PHASE B

26–28 September 2005 (code: A71)

The Royal College of Anaesthetists, London

For further details and a registration fee, please see page 1560.

CORE TOPIC DAY, BELFAST

5 October (code: C97)

Waterfront Hall, Belfast

A joint meeting with the College of

Anaesthetists RCSI. For further details please see page 1560. Registration fee £130

AIRWAY WORKSHOP – GLASGOW

12 October 2005 (code: C40)

University of Glasgow

With a focus on clinical scenario, group discussion and hands-on skill practice. The Airway Workshop will cover a number of topics using experienced small group Teachers.

Please note that there are limited places on this workshop. Registration fee £300.

CURRENT CONCEPTS

AT THE EXTREMES OF PHYSIOLOGY AND PRACTICE

3–4 November 2005 (code: B05)

Institution of Electrical Engineers, London

For further details please see page 1561.

Registration fee £360 or £275 for trainees registered with the College.

CONTINUING MEDICAL EDUCATION DAY

5 November 2005

A joint meeting with the AAGBI. Further details to follow.

RESEARCH METHODOLOGY MEETING

8 November 2005 (Code: C43)

A joint meeting held with the British

Journal of Anaesthesia to introduce participants to the way in which good research should be conducted and presented. It 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. Post FRCA Specialist Registrars and Lecturers will find this meeting to be particularly appropriate to their needs since knowledge of research methodology is one of the non-clinical topics which form an important part of Post FRCA training. Even if actual research is not undertaken it is considered essential for trainees to acquire an understanding of research methodology so that they are able to critically appraise research reports in the literature.

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 £115.

CURRENT TOPICS IN ANAESTHESIA

9–11 November 2005 (code: C11)

Venue in Manchester to be confirmed

This course consists of three days of lectures, each of which is followed by ample time for discussion. It is intended for doctors engaged in clinical anaesthesia (i.e. Consultant, Specialist grade or their overseas equivalent) who feel that they may benefit from a refresher course in the latest techniques. Places will not be allocated to anaesthetists in training. Registration fee £410.

SAS JOINT REVIEW DAY

17 November 2005

Association of Anaesthetist of Great Britain and Ireland

A joint meeting of the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland.

Further details to follow.

PRIMARY FRCA: BASIC SCIENCES PHASE C

21–23 November 2005 (code: A89)

The Royal College of Anaesthetists, London

For further details see page 1560.

ANNIVERSARY MEETING

15–16 March 2006 (code: A03)

Institution of Electrical Engineers, London.

Further details to follow. Registration fee £360 or £275 for trainees registered with the College.

DIPLOMATES' DAY

3 May 2006

Kensington Town Hall, London

By invitation only.

INTENSIVE CARE MEETING

22–23 June 2006 (code: C55)

Institution of Electrical Engineers, London

A joint meeting with The Intensive Care Society. Further details to follow. Registration fee £360 or £275 for trainees registered with the College.

All meetings have CEPD approval on the basis of five points for a full day and three points for half a day.

Members of the Senior Fellows Club are entitled to attend meetings at half price.

Please complete the generic application form or contact the Courses and Meetings Department at the College for further information.

The Courses and Meetings Department
Training and Examinations Directorate
The Royal College of Anaesthetists
48/49 Russell Square
London WC1B 4JY

switchboard 020 7813 1900

ansaphone 020 7813 1888

fax 020 7636 8280

email educ@rcoa.ac.uk

Please note that new meetings and updated programmes are available on the College website (www.rcoa.ac.uk)

AIRWAY DAY

RECENT ADVANCES

19 May 2005 (code: C19)

The Royal College of Anaesthetists, London

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

10.00 Introduction and welcome

An overview of recent advances
Dr Adrian Pearce (London)

10.15 Physiological perspectives on oxygenation and apnoea

Dr Jonathan Hardman (Nottingham)

10.45 Recent advances in management of the lost airway

Dr Chris Frerk (Northampton)

11.15 The rise and rise of supraglottic airways

Dr Tim Cook (Bath)

11.45 Discussion on previous 3 talks

11.55 Are national airway guidelines beneficial? – a debate with the audience

Dr John Henderson (Glasgow)

12.25 Three interactive case histories – to be discussed after lunch

Dr Tony Turley (Llandough)

12.30 Lunch

13.30 Panel discussion

13.50 The educational value of the previously presented case histories

Dr Tony Turley (Llandough)

14.25 Extubation strategies

Dr Vicki Mitchell (London)

15.05 Single use airway equipment

Dr Mark Blunt (Kings Lynn)

15.35 Good practice and medicolegal considerations

Dr Ian Calder (London)

16.00 Close of meeting

Registration fee: £185

Approved for CPD purposes

Please note that there are limited places on this meeting.

CORE TOPIC DAY

ANAESTHETIC EMERGENCIES

20 May 2005 (code: C49)

The Institution of Electrical Engineers, Teacher Building, 14 Enoch Square, Glasgow

- 10.00 Registration and Coffee
- 10.25 Introduction
Professor Gavin Kenny, Glasgow Royal Infirmary
- 10.30 Monitoring and management of major haemorrhage
Dr Tim Walsh, Edinburgh Royal Infirmary
- 11.15 Anaesthesia and poorly controlled hypertension
Dr Malcolm Daniel, Glasgow Royal Infirmary
- 12.00 Monitoring depth of anaesthesia
Dr Nick Sutcliffe, Golden Jubilee Hospital, Glasgow
- 12.45 Lunch
- 13.45 Paediatric resuscitation and stabilisation
Dr John Sinclair, Royal Hospital for Sick Children, Glasgow
- 14.30 Pain control in children
Dr Jane Peutrell, Royal Hospital for Sick Children, Glasgow
- 15.15 Recent advances in obstetrics
Dr Elizabeth McGrady, Glasgow Royal Infirmary
- 16.00 TOE and the anaesthetists
Dr Stephen Hickey, Glasgow Royal Infirmary
- 16.45 End and tea

Approved for CPD purposes

Registration fee: £185

SLEEP DISORDERS AND ANAESTHESIA

25 May 2005 (Code: C77)

The Royal College of Anaesthetists, London

Subjects to include:

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

Registration Fee £185

Approved for CPD purposes

HOW TO TEACH

AN INTRODUCTION

24 May 2005 (code: C18)

School of African and Oriental Studies, London

- 09:00 Registration and coffee
- 09:30 Introduction – why bother with teaching?
David Greaves
- 09:45 An introduction to teaching adults
David Greaves
- 10:15 Discussion
- 10:45 How to give a lecture
Alex Goodwin
- 11:15 Discussion
- 11:30 Teaching in theatre
Kirsty Forrest
- 12:00 Discussion

- 12:15 Lunch
- 13:15 Preparing candidates for the exams
John Curran
- 13:45 Discussion
- 14:00 Teaching practical skills
Nikki Maran
- 14:30 Discussion
- 15:00 Teaching for small groups and tutorials
Mike Clapham
- 15:30 Discussion
- 15:45 Using PowerPoint effectively
Gavin Kenny
- 16:15 Discussion and Close

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

Approved for CPD purposes

CURRENT TOPICS IN ANAESTHESIA

6–8 June 2005 (code: A32)

Holiday Inn, St Nicholas Circle, Leicester

This course consists of three days of lectures, each of which is followed by ample time for discussion. It is intended for doctors engaged in clinical anaesthesia (i.e. Consultant, Specialist grade or their overseas equivalent) who feel that they may benefit from a refresher course in the latest techniques. Places will not be allocated to anaesthetists in training. The programme will cover topics under the following headings:

- Scientific foundations of anaesthesia and their clinical implications.
- Advances in anaesthesia, intensive care and pain.
- Local and regional anaesthetic techniques.
- Anaesthetic equipment and monitoring.
- Postoperative care.

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

Registration fee: £390

Approved for CPD purposes

AIRWAY WORKSHOP

8 June 2005 (Code: C84)

St Bartholomew's Hospital, London

10.00 Welcome and aims of the Workshop

10.15 Split into 4 groups – each group (30 min, 8 delegates) rotates through each station

Station 1: Failed ventilation including cricothyrotomy

Station 2: Failed intubation and use of ILMA and Proseal

11.45 Station 3: Failed intubation and low skill FOI via airway and LM

Station 4: FOI setting up, handling skills, decontamination

13.00 Lunch

14.00 Four groups – rotating (30 min) through each small group teaching

Group 1: Awake intubation

Group 2: Retrograde techniques blind and fiberoptic assisted

15.30 Group 3: Difficult airway trolley and new airway equipment

Group 4: Extubation and follow-up

16.30 Finish

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

Registration fee: £285

Approved for CPD purposes

SAS AS TEACHERS

9 June 2005 (code: D10)

Holiday Inn, St Nicholas Circle, Leicester

10.00 SASGs as teachers

Andy Lim, Royal United Hospital, Bath

10.35 Current experiences of teaching

The participants will discuss their current teaching role in their departments and discuss how this can be increased

10.55 Teaching Small Groups

Mike Clapham, Queen Elizabeth Hospital, Birmingham

11.20 Small group discussion

12.00 Teaching practical procedures

David Greaves, Royal Victoria Infirmary, Newcastle

12.30 Lunch

13.30 Helping to prepare candidates for examinations

Chris Dodds, The James Cook University Hospital, Middlesbrough

13.55 Whole group discussion

14.10 Teaching in Theatre

David Greaves

14.35 Small Group Discussion

14.55 Using PowerPoint

Chris Dodds

15.35 Developing your teaching portfolio

David Greaves

16.00 Small Groups

16.30 Whole Group

17.00 Meeting Ends

Registration fee: £185

Approved for CPD purposes

DEVELOPING PARAMEDIC PRACTICE 2005

13 June 2005 (code: A74)

The Royal College of Anaesthetists, London

This is an annual one day seminar, hosted by the Royal College of Anaesthetists, that provides an opportunity for both discussion and education in topics of current clinical interest to ambulance staff and medics involved with patient care, to include:

- Anaphylaxis revisited
- Life-threatening asthma
- ECP... and beyond!
- Implantable Cardiac Defibrillators
- Paramedics and lawyers
- Continuous Professional Development and the ambulance service
- Dealing with the inevitable – the expected death.

There will be ample opportunity for discussion and a small trade display.

Registration fee: £165.00

Approved for CPD purposes

CORE TOPIC DAY

PAEDIATRIC ANAESTHESIA FOR NON-SPECIALIST ANAESTHETISTS

22 June 2005 (Code: D08)

Royal College of Anaesthetists, London

09.25 Introduction

Isabeau Walker, Great Ormond Street Children's Hospital (GOSH), London

09.30 The National Service Framework for Children

Speaker to be confirmed.

10.00 What is a paediatric anaesthetist?

Mike Sury, GOSH, London

10.30 Update in paediatric resuscitation: why are children different?

Bob Bingham, GOSH, London

11.10 Coffee

11.30 Workshops

The paediatric airway

Mark Thomas, GOSH, London

Fluid management in children

Isabeau Walker, GOSH, London

Regional anaesthesia in children

Liam Brennan, Addenbrooke's Hospital, Cambridge

13.00 Lunch

14.00 Debate: 'Anaesthetists dealing with the occasional sick child should receive regular simulation training'

David De Beer, GOSH, London

Dan Lutman, GOSGH London

15.00 Tea

15.00 Resuscitation scenarios in the A&E department

ICU emergencies in the under 1s

Mark Peters, GOSH, London

Dan Lutman, Great Ormond Street Children's Hospital, London

Registration Fee £185

Approved for CPD purposes

PRIMARY FRCA: BASIC SCIENCE COURSES

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

Phase A 11–13 July 2005 (code: A78)

Phase B 26–28 September 2005 (code: A71)

Phase C 21–23 November 2005 (code: A89)

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

PHASE A

Cardiovascular

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

Physiology of special systems

- Renal physiology
- Nutrition and metabolism
- Metabolic response to injury
- Acid base balance
- Liver

PHASE B

Physics

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

Pharmacology

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

PHASE C

Physiology of special systems (I)

- Endocrinology and anaesthesia
- Neurophysiology of pain
- Autonomic nervous system
- Cerebral physiology
- Paediatrics
- Neurophysiology
- Pregnancy, placenta and foetus

Pharmacology

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

Physiology of special systems (II)

- Anatomy
- Gastric physiology and pharmacology

FINAL FRCA COURSE

5–16 September 2005 (code: A79)

Clore Management Centre, 25–27 Torrington Square, London

This course is intended for those studying for the Final FRCA Exam and consists of lectures on anaesthesia, intensive care and pain relief. The lectures run throughout the day – Monday to Friday. Each participant will be entitled to attend four tutorials during the course.

Those wishing to apply for admission to the course are strongly advised to do so as soon as possible as places are strictly limited.

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

Registration fee: £600 (excludes lunch)



The Royal College of Anaesthetists



The College of Anaesthetists, RCSI

CORE TOPIC DAY, BELFAST

5 October 2005 (Code: C97)

Waterfront Hall, Belfast

Subjects will include:

- Anaesthesia for vascular surgery
- Ventilation in Respiratory Failure
- Perioperative fluid therapy
- Management of obstetric haemorrhage
- Airway management

The meeting also includes the Autumn Faculty Lecture of the College of Anaesthetists in Dublin.

Registration fee: £130

Approved for CPD purposes

CURRENT CONCEPTS MEETING

FORMERLY COLLEGE SYMPOSIUM

'At the extremes of physiology and practice'

3–4 November 2005 (code: B05)

Sessions and topics will include:

- Fit or Fat** – The pathophysiology of sportsmen
Moribund patient
Anaesthesia and obesity
Anorexia and starvation
- Young and old** – Anaesthesia and the elderly
Anaesthesia and babies
- Rich and Poor** – High technology in anaesthesia – new toys
Anaesthesia in Developing Countries
- High and Low** – Physiology and pathophysiology of altitude
Physiology and pathophysiology of diving
Anaesthesia at high and low atmospheric pressures
- Hot and Cold** – Deliberate and accidental hypothermia
Near drowning
- and in the End...** Radiation threats
Chemical threats
Biological threats

Registration Fee: £360 or £275 for trainees registered with the College

Approved for CPD purposes

COURSES AND MEETINGS BOOKING PROCEDURES

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

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

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

To ensure that bookings are processed correctly, it is essential that the booking form shows the code number, title and date of the event being booked, e.g. C97 – Core Topic Day, Belfast, 5 October 2005.

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

Fees and cancellations

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

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

Accommodation

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

Application forms

Completed generic application forms should be returned to the Courses and Meetings Department, Training and Examinations Directorate, The Royal College of Anaesthetists, 48/49 Russell Square, London WC1B 4JY

switchboard 020 7813 1900 **ansaphone** 020 7813 1888

fax 020 7636 8280 **email** educ@rcoa.ac.uk



Education support services at the Yorkshire Deanery

Dr J McMillan, Education Adviser, The Yorkshire Deanery

Introduction and background

The Yorkshire Deanery recognises the importance of providing support to doctors and dentists in training who are experiencing difficulties, whether those be personal, professional or career-related. Support in various forms has been available for many years, but more recently we felt that there was a greater need for the services to be increased, co-ordinated and better publicised. At present the Yorkshire Deanery provides a structure of support as outlined in the diagram (see Figure 1 below).

The need

Doctors and dentists using these services are mostly specialist registrars at critical points in their training who, for various reasons, may require individual advice, information, guidance, counselling, coaching and training.

Many of the doctors we see follow a typical pattern: they are very busy professional people working long hours with increasing responsibilities. They are at crucial stages in their professional exams, starting families, trying to synchronise their work with their partner's work, rotating jobs around the region, moving house etc, etc – enormous change and transition, that in themselves bring their own pressures and stress.

Education Adviser role

As Education Adviser at the Yorkshire Deanery I lead the Education Section, of which the Education Support Unit is a part. The Education Section is also responsible for providing 260 days of Professional Education and Management training for SpRs and consultants in the Yorkshire region.

My role in the Support Unit is to be the initial referral point to identify how we can help to meet the trainees' needs.

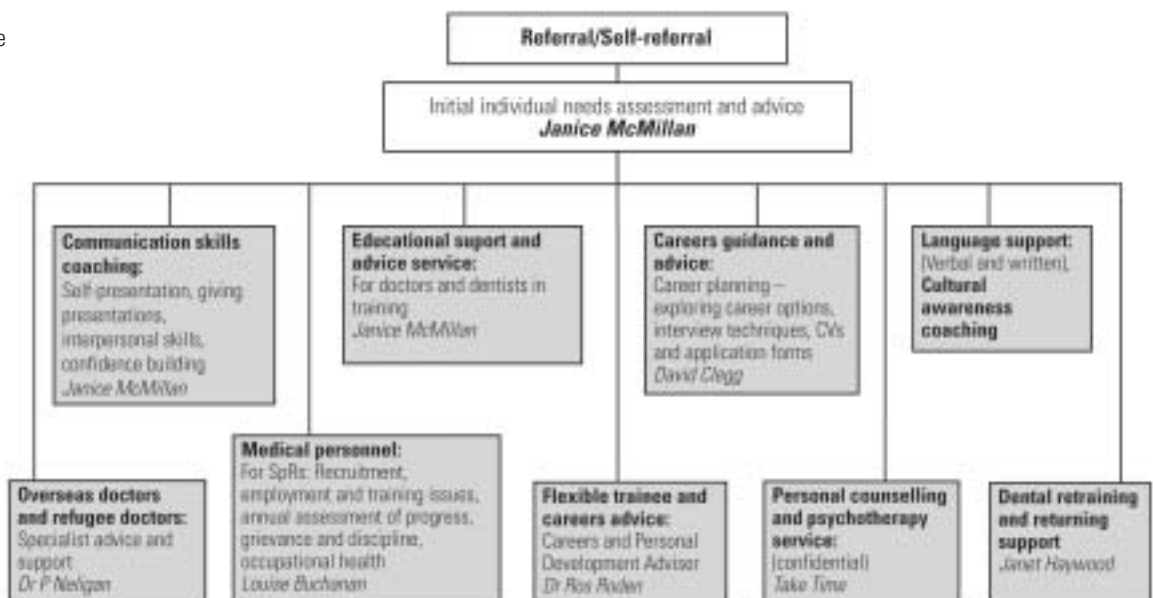
Facts and figures

Over the period of September 2003 to September 2004, 49 doctors used the service through either the referral or self-referral system – 35 SpRs, ten SHOs, two PRHOs and two LATs. Several doctors self-referred for career development advice and coaching – such as reviewing their CVs, preparing for job interviews and presentation skills. The majority are referred through the RITA (Record of In-Training Assessment) process or through their consultant trainers.

Types of difficulties identified in the RITA process

Clearly, there are some trainees who are having problems because they are not reaching the required standards in their clinical skills. They may need targeted training with closer supervision or they may need to repeat their training period in a particular placement.

Figure 1: Support structure for doctors and dentists at the Yorkshire Deanery



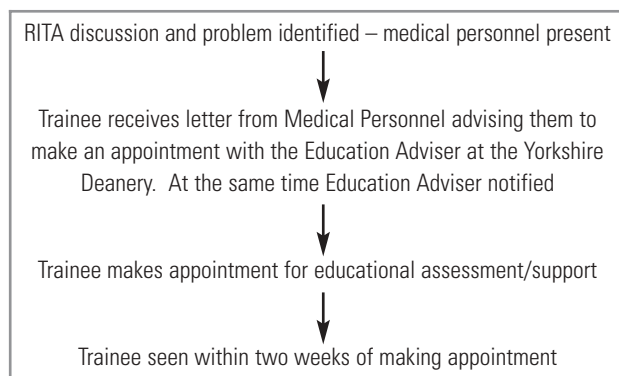
The trainees with whom I am largely concerned present with a whole variety of issues, but most fall into the following categories.

- **Behavioural** – such as poor communication skills, poor team working, arrogance, temper outbursts/aggression, and lack of assertiveness and confidence.
- **Exam failures** – written exams – very often associated with poor presentation, organisation and study skills rather than lack of knowledge. Viva/oral exams – again more to do with self-presentation, handling difficult questions, confidence and handling nerves in stressful situations, than a poor knowledge base.
- **Language and cultural issues** – less to do with fluency in English language (most of the doctors have excellent spoken and written skills) and rather more to do with accents which can become more pronounced under pressure or stress. Also, some overseas doctors welcome discussion and help with cultural differences which can affect their confidence, self-esteem, relationships with colleagues and team working.

The RITA referral structure and system

So, how do we get the trainee into the system? The diagram (Figure 2, below) shows how trainees are referred.

Figure 2: The referral process



The trainee is seen for an initial meeting lasting about one hour to identify and assess need, discuss the issue and plan a way forward. Most trainees are seen for another session of up to two hours. A few have a third or fourth session.

Network of services

After the initial discussion, we agree on our plan of action. If appropriate, I refer the trainee to a specialist for expert help. This may be our specialist language and cultural development tutor who sees individuals or small groups for coaching support. Alternatively, I may refer on to one of our associate deans for specialised help – for example, in career and personal development – or to our research skills tutor for help in getting their research articles published.

Strategies for helping

How can we help the trainee and offer the required support? The network of linked and co-ordinated services is undoubtedly a strong feature of the support structure. Once we ascertain the problem and identify the development targets and an action plan, we can tailor the support to the individual trainee. The ways in which we can help include the following.

- **Individual one-to-one coaching** (very often using simulators and video playback):
 - to develop communication skills such as dealing with difficult behaviours in patients or colleagues or breaking bad news
 - to offer practice for viva/oral exams
 - to provide language/cultural development with specialist tutors.

- **Self-assessment questionnaires and multi-source feedback**

A variety of instruments are used to give the trainee more self-understanding and insight which can help them see themselves as others see them. For example, questionnaires on learning styles, emotional intelligence, team working, leadership and personal values can all contribute to this process. These tools provide a useful focus for discussion and can illuminate aspects of personality or blind spots, confirm strengths and identify areas to work on for further development.

- **Mentorship**

This is an immensely helpful strategy that can give the trainee essential on-going workplace support. It is vital of course that the trainee can identify a respected colleague in their professional sphere with whom they can work in a climate of trust, confidence, support and challenge.

- **Work shadowing/work placements**

Occasionally, it may be that a trainee wishes to explore another type of work within the medical profession. We have organised short placements or shadowing periods in, for example, a GP practice or an accident and emergency department to clarify career plans and help the decision-making process.

- **Courses at the Yorkshire Deanery**

The Yorkshire Deanery provides a range of Professional Education and Management courses for specialist registrars and consultants. There is a recommended pathway through the courses starting in the first year of training to the Certificate of Completion of Specialist

Training (CCST). This can be an excellent way for a trainee to gain broader general knowledge and the skills to complement their clinical skills. They join colleagues from all other specialties and, through discussions and small group activities, have the opportunity to reflect on their own practice.

- **Recommended reading/literature**

There is always scope for general professional further reading and I have found trainees very receptive to recommended sources of educational and self-development material.

Is it all worth it?

We do need to ask the questions:

- Do the trainees benefit?
- What are the outcomes?
- Do patients in the end receive a better service?
- How can we evaluate the process?
- Is it worth the time and resources?

These are all good challenging questions. We do know that some of the trainees who have used this service go on to pass their exams after coaching – because they tell us. Is that partly due to the coaching intervention or would they have passed their exams in any event?

We do know that some trainees after sessions on language/culture coaching continue to progress successfully on to their next stage of training. We know that some trainees who receive career development advice and guidance obtain their chosen consultant post – but would they have been successful irrespective of our help? We know that some trainees change their inappropriate behaviours and progress well at work – but would this have happened anyway?

It is all very difficult to evaluate. However, what we can say, albeit unscientifically, is that we have had considerable feedback from trainees and their trainers that this is a positive process and a service that we should continue to provide in the region.

Final reflections

From my own point of view, I believe that the Education Support Unit provides trainees with the opportunity and time for structured self-reflection that they would not otherwise be given. The benefits are that they have an objective listening ear from a non-medical person. The Service is both supportive and challenging. Whilst they are

treated with respect and empathy, they are also asked to face their weaknesses and this can be both personally and professionally uncomfortable. They have an opportunity to discover their blind spots and seek new perspectives, something many of us never have in a lifetime. They are given support during the RITA D or E period when they may feel acute distress at what they perceive as failure. For many, this is the first time they have not progressed and achieved their goal. For strong achievers, this can be a blow to their self-esteem. They may feel hurt and humiliated among their peer group.

An aspect we need to develop further in the Education Support Unit is to involve the consultant trainers more in the process and try to close, even further, the feedback loop. We need to keep trainers more fully informed about the trainee's development plans and progress. We need to explore the most appropriate mechanisms and documentation to do this.

In conclusion, I do feel immensely privileged in this role and I too learn a great deal through the process. I am pleased to be able to pass on what I have learned to others.

- There are usually two sides to the story. Both trainees and trainers have their separate and unique perceptions of situations. An education support service can help to resolve some of these difficulties and provide a positive way forward.
- Good communication, openness, regular reviews and continuous constructive feedback from both trainers and trainees are vital for a healthy teaching and learning climate.
- What is a strength is often also a weakness. For example, trainees who are very high achievers, competitive and with high standards of performance, can appear to their colleagues as arrogant, over-critical and impatient. These negative traits are often tolerated, as though intractable. Addressing some of these 'difficult to assess' behaviours, through early and timely feedback, is an important part of medical education.
- Generally, trainees welcome constructive feedback when it is genuinely given to help them progress personally and professionally. What they dislike intensely is not being told openly about their weaknesses by their trainers and then getting a shock when they attend their RITA interview to be told they are not up to standard.



My exam experience

Dr U Buehner, Specialist Registrar, Bradford Royal Infirmary

This is no time for ease and comfort – it is time to dare and endure.

– Winston S Churchill

Success at last after many failed attempts!

My perfectionism was the biggest stumbling block for passing the exam. I wanted to have the perfect knowledge base, wanted to give the perfect answer. I tried so hard to think about every detail about a subject, to be articulate, that in the end I lost all impetus to answer the questions succinctly.

The exam day that led to my success I shall never forget. I enjoyed the day because I felt truly positive about myself and confident that I had gained enough experience and knowledge to pass the exam. My mind was focused no more on the things I didn't know but on what I knew; not on the outcome of the exam but on a strategy to tackle difficult or unexpected questions. I don't think my knowledge was all that different from previous exam attempts as much as my attitude towards it had changed.

What made the difference?

- Very helpful was a consultation with Janice McMillan, the Education Adviser to the Postgraduate Dean in Leeds. In our conversation I realised that a good knowledge base alone was not all that I needed for a successful exam. A lack of self-confidence compounded by previous failed exam attempts undermined my performance at the exam.
- A video assessment of myself in a simulated exam viva by two consultants was a real eye opener. This demonstrated clearly to me what a different impression I gave on answering questions to which I could give a structure:
 - I spoke clearly and fluently
 - I looked animated
 - I was leaning forward
 - I used hand gestures
 - I smiled at the examiners

- I maintained good eye-contact
- I was starting to enjoy it.

Then came the question I hadn't thought about and all came to an abrupt halt:

- I leaned backward
- My shoulders dropped
- My head lowered
- My fingers started to fidget with embarrassment.

Watching the video replay, I was stunned by my silence because in my mind I had not been silent at all. I had run through all possible ways of answering the posed question without ever daring to verbalise it because there was a chance it would be incomplete and possibly some of it wrong.

For the rest of the viva I had lost all confidence to answer the next set of questions although I knew much more about those topics. I had given up and failed myself.

Only this video experience made me aware of the impact my fearful mental attitude towards unprepared or difficult questions had on the rest of my performance and consequently the examiners. How could they help me to get back on track when I was afraid to keep talking?

- Two exam crammer courses also boosted my confidence, providing me with more opportunities to apply in mock exams the tips the Education Adviser gave me. They confirmed to me that my knowledge was sufficient to pass but the presentation of it was all-important.

Tips I can pass on

- Take heart. Don't give up. It is worth the battle.
- Boost your self-confidence with factual knowledge as well as positive thinking.
- Keep practising SAQs focusing on a structured, clearly laid out answer within the allocated time frame.
- Ask early on for mock vivas in order to practise formulating answers whether your knowledge is extensive or scanty on a subject.
- Don't judge yourself on your exam performance. Don't let the performance in one part of the exam influence the subsequent ones.

- Make the first exam attempt your final one, as this will be the one you will be most positive about, not having the baggage of previous failures with you and the anxiety of further failings.
- Crammer courses provide excellent guidance for revision by putting your exam strategy to the test.

Checklist of tips for the viva

- Make a mental list of the main points you want to get across – don't get lost in too much detail.
- Have a clear structure – order your answers.
- Don't be afraid to keep your answers simple and to the point.
- The questions may not be as complex as you imagine them to be.
- Have a 'game plan' for each question.
- Keep focused on the question; be specific, concise and snappy.
- Give regular summaries – this will help you and the examiners.
- Even if your knowledge of a subject is scanty, try to mention a few, simple facts.
- Don't let this put you off – most examiners will move on to the next question fairly quickly.

Some tips on body language and self-presentation

- Project your voice, practise speaking louder, especially if you are softly spoken.
- Sit back tall in the chair, shoulders upright.
- Use your hands, make appropriate hand gestures – you will look enthusiastic and energetic.
- Try to smile more often – this will make you feel more assertive and confident.

Last but not least I want to thank Dr C Evans, our Regional Adviser, Mrs J McMillan, the Educational Adviser and all my colleagues in Leeds and especially in Bradford for encouraging me to go on pursuing my exam battle to the sweet end of final success. Joy unimagined! Were it not for all their help and time I might have given in and regretted it forever.

Electroconvulsive Therapy Accreditation Scheme (ECTAS)

VOLUNTEERS REQUIRED

The College supports the Royal College of Psychiatrists in this voluntary scheme for the accreditation of centres undertaking ECT. Non-trainee Fellows and Members in good standing who undertake ECT sessions and who would be willing to serve as anaesthetic assessors are invited to contact:

Dr John Curran, Chairman of the Professional Standards Committee, either at the College (48–49 Russell Square, London WC1B 4JY) or by **email** at JPCSedate@aol.com.



The origin of the Ambu Bag

Dr P Baskett, retired Consultant Anaesthetist, Wiltshire

If you could have invented anything that could get you out of trouble during your anaesthetic career, I'll bet it would have been the self-inflating bag valve device. How did this precious piece of ubiquitous equipment come about?

A happy coincidence

A strike by lorry drivers in Denmark in 1954, that caused supplies of oxygen in Danish hospitals to run dangerously low, provoked that most ingenious anaesthetist and inventor, Henning Ruben, to conceive the idea of the self-inflating bag designed to provide manual artificial ventilation without compressed gases.¹ He asked a bicycle mechanic to weld together the ends of four bicycle spokes. He then fed these into a rubber anaesthetic reservoir bag and, with the aid of a piece of string (as you do), pulled them into an oval shape. He found that if he compressed the bag, it would regain its shape, drawing in air when it was released. The device worked in conjunction with an inlet valve with an oxygen port and the Ruben unidirectional valve, designed for use in anaesthesia some years earlier.^{2,3}

The prototype was refined, using foam rubber instead of the bicycle spokes, and was produced by the Danish Company, Testa Laboratorium, headed by Dr Holger Hesse, being marketed under the name of the Ambu Resuscitator.

The rest is history and the 'Ambu Bag' has undoubtedly been one of the greatest life saving devices ever created. It is a compliment to Ruben and the company that, although the device has been copied by many, the 'Ambu Bag' has become

a generic term, in much the same way that a 'Hoover' has become synonymous with a vacuum cleaner. The American Medical Association in 1964 declared that Ruben's Ambu Resuscitator was 'one of the most significant advances of the last 25 years'. How right they were.

But that is not all.

Ruben the man

Henning Ruben, the dental student who had been an Olympic fencer, had been forced to flee Denmark in a fishing boat to Sweden at very short notice at the dead of night during the Second World War, for being rather a pain in the neck to the occupying Nazi forces. He had a few talents up his sleeve and was able to earn a living while at university in Sweden, continuing to study dentistry by playing to full houses as a magician. He was a member of the prestigious and exclusive Danish 'Magisk Circle'. He was also a very talented ballroom dancer (in the 'Strictly Come Dancing' mode) and earned a bit on the side teaching and doing that as well. After his return to Denmark at the end of the war, he qualified as a doctor in the University of Copenhagen and decided upon the noble art of anaesthesia as a career, ending up at the Gentofte Hospital and the Finsen Institute. Like many at that time, he travelled during his training to the United States, for post-war Europe was devastated and bereft of any hope of research opportunities. Working with James Elam in Buffalo, New York, he discovered the open airway position and verified it with X-rays (succinctly described in a one page article in *The Lancet*).⁴ He was interested in resuscitation and the mouth to mouth method which had been confirmed as physiologically effective in 1958 by remarkable studies by Peter Safar in Baltimore.

Ruben the inventor

Aside from his Ruben valve (later developed to become the Ambu E valve and a real bonus to anaesthetic circuitry), his Ambu portable suction pump⁵ (the first of its kind, and invented to fulfil a need during the sporting anaesthesia used for domiciliary ENT surgery popular at the time) and the first syringe pump,⁶ he designed manikins to accommodate mouth to mouth ventilation and the technique of external chest compressions that was



The Ambu Bag

introduced by William Kouwenhoven, Guy Knickerbocker and James Jude in Baltimore in 1961.

Henning Ruben was honoured by many august bodies worldwide, including our own Royal College (when it was a Faculty) when he was made a Fellow by Election. At the dinner that evening this brilliant inventor, prolific publisher, sought after speaker, jocular bon viveur and raconteur produced objects (including a mouse it seemed) out of his fellow guests' pockets, handbags, ears and other orifices, that they did not know were there. They probably were not there, but it seemed they were at the time.

However, the Ambu Bag did not come out of a hat.

Henning Ruben died on 4 December 2004, aged 90, and his obituary appears in the March issue of *Resuscitation*.⁷

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Further reading

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AS WE WERE ...

In 1908 George Washington Crile wrote:

About this time I had a revealing but embarrassing experience. I believed that nitrous oxide-oxygen anesthesia put the patient completely to sleep. While making rounds with my staff and some visiting doctors I asked an extremely intelligent woman who had had an abdominal operation under complete nitrous oxide-oxygen anesthesia what her memory of the event was.

She asked, 'Shall I report everything?'

Thereupon she began, 'This is a white female, aged fifty-eight,' and continued to give an exact repetition of the notes read by the intern while she was supposedly under full anesthesia. (George Crile – an Autobiography [Ed Grace Crile]. Lippincott, Philadelphia 1947, 197.)

Contrary to the assertion made in the recent television programme on awareness under general anaesthesia, about which the less said the better, this phenomenon was first reported many years before the introduction of the neuromuscular blocking agents.

David Zuck

History of Anaesthesia Society

Tutorial of the week

Dr I Wilson, Chairman, WFSA Publications Committee

Many anaesthetic colleagues who work in remote hospitals overseas have no access to books and journals. The World Federation of Societies of Anaesthesiologists (WFSA) Publications Committee organises a number of ventures to assist these anaesthetists, and the International Relations Committee of the AAGBI and the *British Journal of Anaesthesia* have been very supportive with various initiatives. The increasing availability of computers and email, even in remote areas, is offering new opportunities to deliver education.

The Publications Committee of the WFSA wishes to pilot a new project, 'Tutorial of the Week'. This is an ambitious project to provide a weekly, web-based, anaesthesia tutorial to anyone with web access. The tutorial will also be emailed to anaesthetists who can receive email messages but cannot browse the Internet.

In time, the tutorials will cover a wide variety of anaesthesia and critical care topics, and will build up to an on-line library of information providing CME for many people. Tutorials may be presented in a variety of formats, but those which encourage the anaesthetist to reflect on the material, or their own practice, will be ideal. We would like tutorials that are:

- Well written, accurate and evidence based.
- In straightforward language (English is not always the first language).
- Up to 1,200 words on a wide range of topics.
- Contain questions for the reader to consider.
- Use clinical examples to stimulate interest.
- Recommend solutions that are not necessarily reliant on the most modern and sophisticated anaesthesia.

- Written in Microsoft Word or pdf and submitted by email. Photos and figures can be included, but large files will be difficult to download and will not be suitable for slow modems in remote hospitals.
- Contain the email address of the author (optional) so that readers can make contact for further clarification.
- Include a maximum of two or three references that can be obtained on-line by overseas readers.

The tutorials will appear on the World Anaesthesia Society website (www.world-anaesthesia.org). This site also contains substantial educational material in the form of *Update in Anaesthesia*, which may be used as reference material.

We wish to start this project in April 2005. Initial take-up will be slow but the demand is likely to be very large within 12 months. If you would be willing to help with this project we would be delighted to hear from you. There will be opportunities to help organise the project, write and contribute material, and review tutorials. We would welcome the involvement of senior trainees and SAS doctors as well as consultants.

After receiving a tutorial, we shall obtain an independent reviewer's opinion as to whether the material is suitable for web publication. If the tutorial is suitable, the author will be given a publication date. If the tutorial is not suitable, an email will be sent to explain this. Normally the editors and reviewers will not modify suitable material.

If you are interested in helping with this rather ambitious scheme, please **email** me on: iain.wilson5@virgin.net.

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ELECTION TO COUNCIL 2005



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The Election of two Fellows to consultant vacancies on Council took place on Wednesday, 2 March 2005. The votes were counted by Electoral Reform Services (ERS).

Consultant vacancies

Two consultant vacancies occurred in 2005. These are caused by the retirement of Dr D M Justins at the completion of ten years as a Consultant Member, and the completion of one term of service on Council by Dr D P Cartwright. Dr Cartwright was eligible to stand for election for a second term of four years.

The results of the consultant elections are as follows.

Elected (in order of seniority)	
CARTWRIGHT David Paul	755
TOMLINSON Andrew Alan	679*

Not elected (in order of seniority)	
GREEN David William	332
COHEN Andrew Timothy	464
McKEOWN Dermot William	439
BOWLES Brenda	483
THORNBERRY Elizabeth Anne	672*
BROMLEY Lesley Muriel	489
MAGEE Patrick Terence	468

*Confirmed by full manual recount

- The total number eligible to vote was 8,896.
- The number actually to vote was 2,666.
- In addition to this figure, there were 15 invalid votes.

Trainee vacancies

Two trainee vacancies occurred in 2005. These are caused by the retirement of Dr M Garfield after completing his full term of service of four years, and the resignation of Dr S Glover. **Dr Stuart James Gold** (Fellow 2002); (Date of birth: August 1974) and **Dr Alan Patrick McGlennan** (Fellow 2002); (Date of birth: November 1971) gave notice that they intended to stand as candidates for these vacancies. As no other nominations had been received, no ballot was required. Dr Gold and Dr McGlennan were therefore elected, effective Wednesday, 2 March 2005.

SAS vacancies

One SAS vacancy occurred in 2005. This is caused by the resignation of Dr C J Rowlands.

The results of the SAS elections are as follows.

Elected	
LAISHLEY Roger	918

Not elected (in order of seniority)	
ALDERSON Peter John	795
NATARAJAN Michael Ravi	231

- The total number eligible to vote was 9,459.
- The number actually to vote was 1,973.
- In addition to this figure, there were 29 invalid votes.

Report of meetings of Council

At a meeting held on **Wednesday, 19 January 2005**, Dr Frank Walters (Bristol) and Dr Roger Eltringham (Gloucester) were presented with the Humphry Davy Medal, Dr James Cottrell (New York) and Dr Debra Schwinn (North Carolina) were admitted to the Fellowship by Election, and Dr Afrenda Vassiliki Lena Anagnostopoulou-Ladas (London) was admitted to the Fellowship *ad eundum*.

The following were admitted as **Deputy Regional Advisers**:

Oxford

Dr O J Dyar, John Radcliffe Hospital, Oxford
(in succession to Dr M T Popat)

South Thames (East)

Dr A C Pearce, Guy's and St Thomas' Hospital NHS Trust (in succession to Dr P J H Venn)

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

Northern

*Dr H Mohan, North Tees and Hartlepool University Hospitals

Northern Ireland

Dr C W Renfrew, The Ulster Hospital
(in succession to Dr C M Wilson)

North Thames (Central)

Dr J Evans, Barnet Hospital
(Acting College Tutor for 12 months to provide maternity cover with effect from March 2005)

North Thames (East)

Dr A H Presland, Moorfields Eye Hospital
(in succession to Dr S M Bailey)

North Western

Dr S D Tomlinson, Hope Hospital, Salford
(in succession to Dr P Eadsforth)

South Western

Dr S G O Rees, Cheltenham General Hospital
(in succession to Dr J D Francis)
*Dr C J Ralph, Royal Cornwall Hospital, Truro
*Dr D J Snow, Torbay Hospital, Torquay
(re-appointment for one year only)

Wales

*Dr J D Bryant, Withybush General Hospital, Haverfordwest

The Humphry Davy Medal

Dr F Walters



Dr Frank Walters graduated in 1970 and after training posts at the Westminster, Southampton, and the Hospital for Sick Children in Toronto, he was appointed consultant anaesthetist to Frenchay Hospital, Bristol. He played a key role in the development of anaesthesia, not only for neurosurgery, and cerebrovascular surgery in particular, but also for plastic and burns surgery. He has been President of the Neuroanaesthesia Society of Great Britain and Ireland, the Plastic Surgical and Burns Anaesthetists and the Section of Anaesthesia of the RSM.

Frank has also devoted an enormous amount of his energy and enthusiasm to teaching and examining overseas. This started when he was a College examiner and went to examine externally in Egypt and Kuwait. He was also a European Diploma examiner in Moscow and developed a particular affinity for Russia, sufficient to make him learn the language. He has travelled and taught widely with WFSA and the PTC Programme in Zimbabwe, Malawi, Paraguay, Latvia, St Petersburg, Minsk and Moscow.

He is an example of someone who doesn't just talk about it but goes out and actually delivers what the specialty of anaesthesia worldwide so desperately needs. It is in recognition of his magnificent service to anaesthesia that I am pleased to recommend him to Council for the award of the College's Humphry Davy Medal.

Dr Peter Simpson

The Humphry Davy Medal

Dr R Eltringham



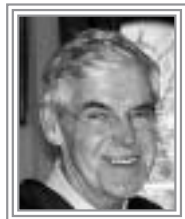
Dr Roger Eltringham is a worthy recipient of the Humphry Davy Medal, in recognition of his many years of work in World Anaesthesia, and his contributions to the development and advancement of anaesthesia in developing countries.

He has been active in the World Federation of Societies of Anaesthesiology since 1988, holding numerous posts, culminating in his appointment as Vice President last year. He was co-ordinator of the inaugural WFSA refresher course, and he has co-ordinated or spoken at 60 subsequent refresher courses in 41 countries. As Chairman of the Publications Committee, he was responsible for the distribution of the WFSA journal *Update in Anaesthesia*, and its translation into French, Spanish, Russian and Mandarin. Perhaps his most notable contribution is in his research, directed to the practice and teaching of basal flow anaesthesia, and to the development of the Glostavent Anaesthetic Machine. This is the only complete anaesthetic machine in the world, which will continue to function even if supplies of oxygen or electricity fail and is currently being used in Mozambique, Zambia, Ghana, Malawi, Ukraine and Vietnam.

Dr Paul Cartwright

Fellowship by Election

Professor J Cottrell



Professor Cottrell was born and educated in West Virginia, obtaining his MD in 1968. His anaesthetic training was undertaken in Pittsburgh; since 1979 he has worked in the Anaesthesiology Department at the University Hospital of Brooklyn, the teaching hospital of the State University of New York Downstate Medical Center where he is Professor and Chairman. He has also served as Chief of Anaesthesiology at Kings County Hospital Center in Brooklyn since 1979 and as Regional Chairman of Anaesthesiology at Long Island College Hospital since 1983.

Professor Cottrell is Editor in Chief of the *Journal of Neurosurgical Anaesthesiology*. He has led a world renowned research team with a prodigious output. He has co-edited major textbooks such as *Anesthesia and Neurosurgery* and the *Handbook of Neuroanesthesia*. He has held 23 offices within the American Society of Anesthesiologists culminating in his Presidency in 2004.

Professor Cottrell has many other widely recognised facets. He has been actively involved for many years in various charitable foundations, including the AIDS Action Foundation and God's Love We Deliver, an organisation that delivers meals to home-bound AIDS patients. When not pursuing professional and community goals, he is an enthusiastic collector of modern art, a skier, a cyclist and a scuba diver.

Dr David Saunders

Fellowship by Election

Dr D A Schwinn



Educated at Malabar High School, Ohio, Dr Schwinn read chemistry at the College of Wooster, Ohio, before studying medicine at Stanford University, California. An internship in internal medicine at the Pennsylvania Hospital, Philadelphia, was followed by residency training in anaesthesiology in the same city and a clinical fellowship in cardiac anaesthesiology at Duke University Medical Center, Durham, North Carolina. She has been there ever since, progressing to her current primary position as James B Duke Professor of Anaesthesiology. Dr Schwinn's curriculum vitae is littered with prizes and awards, membership of academic societies, fellowships and visiting professorships, to say nothing of a significant portfolio of major research grants and the publications which inevitably follow. This might be more than enough for most people, but along the way she has found time to have two daughters and pursue a range of varied hobbies: the violin, string quartets, mystery and 19th century Russian novels. She has visited Britain on a number of occasions since undertaking an international student exchange in 1979, has spoken at a number of College meetings and undertook a Rank lecture tour for us in 1991.

Professor Tony Wildsmith

At a meeting held on **Wednesday 16 February 2005**, the following were admitted/re-admitted as **College Tutors** (*re-appointments are marked with an asterisk*):

Yorkshire

Dr P T Hutchings, Calderdale Royal Hospital, Halifax (in succession to Dr G Reah)

North Thames (West)

*Dr L Anagnostopoulou-Ladas, Charing Cross Hospital

North Thames (Central)

*Dr J P Barcroft, Royal National Orthopaedic Hospital, Stanmore

North Thames (East)

*Dr N A Watt, Newham University Hospital NHS Trust

Mersey

*Dr M R Blayney, Noble's Isle of Man Hospital, Douglas

Wessex

Dr C R Cox, Salisbury District Hospital (in succession to Dr D P Murray)

South Western

Dr A P Whaley, Bristol Royal Infirmary (in succession to Dr M J L Scrutton)
Dr R L Aspinall, Bristol Royal Infirmary (in succession to Dr A K McIndoe)

Nottingham and Mid Trent

Dr J C Haycock, University Hospital Nottingham (second College Tutorship established)

West Midlands (South)

Dr B V R N Murthy, University Hospitals Coventry and Warwickshire NHS Trust (in succession to Dr A J Thacker)

The following were recommended to the Specialist Training Authority for the award of a **Certificate of Completion of Specialist Training** having satisfactorily completed the full period of higher specialist training in anaesthesia (*a dual CCST in Anaesthesia and Intensive Care Medicine has been recommended for the doctors marked with an asterisk*):

Anglia

Dr Patricia Mary Mills
Dr Anand Madhusudan Sardesai
Dr Jonathan Guy Hudsmith
Dr Elizabeth Anne Bright
Dr Nicola Andrea Barber
Dr Brendan Michael Paul Pearmain

Imperial School

Dr Nigel Laurence West
Dr Jonathan Mohan Handy
Dr Christopher Terence Hopkins
Dr Ruth Van Hoogstraten
Dr Scott Peter Kemp
Dr Christopher Arthur Jenner
Dr Jason Whitworth Brooks
Dr Parindkumar Bipinchandra Patel*

Royal Free/UCL

Dr Sinead Anne O'Malley
Dr Andrew Cohen
Dr Mark Timothy David Downing
Dr Harriet Anne Nicholls
Dr Jane Marie Tilley
Dr Michael William Broadhead
Dr Madhusudan Puchakayala Sivaloganathan Rao
Dr Suzanne Jane Pearson
Dr Sanjay Gulati
Dr Nisa Patel
Dr James Anderson Smart
Dr Nicola Janet Beale
Dr Susan Kamal Kaur Basi
Dr Mehrdad Ali Mofeez

Barts & Royal London

Dr Lisa Kritzinger
Dr Christopher Paul Parker
Dr Heike Kerstin Bojahr
Dr Gordon Leon Morton
Dr Sajith Philip
Dr Victor Adalbert John William Mendis
Dr Ngozi Maria Okoisor
Dr Sabeena Qureshi

St George's

Dr Justin James Dickens
Dr Kashi Vishwanatha
Dr Benjamin Charles Alan Fitzwilliams

South East

Dr Roger Piers Lightfoot
Dr Sleem Rahim
Dr Michael Charles McCabe
Dr Andrew Frederick Taylor
Dr Oliver John Tweedie
Dr Michael Alexander Munoz Gillies
Dr Debkumar Pandit
Dr Sean Anthony Kerr

Leicester

Dr Neil Andrew Hall
Dr Sunita Manmalji Sanghavi

Mersey

Dr Andrew Patrick Breen
Dr Shiv Kumar Singh

Nottingham

Dr Caroline Margaret Burgess
Dr Andrew Michael Taylor

Northern

Dr Krishnan Asokan
Dr Gail Margaret Fitzsimmons
Dr Anil Kumar Sharma
Dr Ashok Kumar Bandela
Dr Morag Renton
Dr Angus Vincent
Dr Joseph Anto
Dr Claire Lisa Woods
Dr Paul Charles Edgar
Dr Mritunjay Kumar Varma

North West

Dr Kim Hong Lim
Dr Richard Andrew Cross
Dr Rajashekhar Madadi Reddy
Dr Oliver Jonathan Hill
Dr Helen Vlachtsis
Dr Adam Conrad Pichel
Dr Gareth Lewis Thomas
Dr Gavin Gerard Teague

Oxford

Dr Julian William Giles
Dr Deborah Jane Painter
Dr Anthony Graham Lloyd Allan

Sheffield

Dr Paula Clare Fisher
Dr David Keith Turnbull

South Western

Dr Rachael Mary Craven
Dr Mathew Varghese Patteril
Dr Caleb Eccles McKinstry*
Dr Julius Harry Cranshaw
Dr Ciara Anne Ambrose
Dr Steven James Twigg
Dr Duncan John Sim

Wessex

Dr David John Sparkes
Dr Helen Jayne Wise
Dr Matthew Williams
Dr Tamsin Elisabeth Layland Dodd
Dr Robert Neill McCormick

West Midlands

Dr Gareth Paul Sellors*
Dr Cornelia Blunt
Dr Rajive Dabas
Dr Julia Christine Josephine Ely
Dr Anthony Michael Sutherland
Dr Anwar Abdool Karim
Dr John La Rosa

Wales

Dr Victor Ajitkumar Francis
Dr Jochen Hans-Peter Brombacher
Dr Andrew David Bagwell
Dr Kate Elizabeth Rose Harvey

Yorkshire

Dr Wendy Lum Hee
Dr Joanna Claire Stockwell
Dr Richard James Harding
Dr Simon Jonathan Galloway
Dr John Shaw
Dr Gordon Staple
Dr Nalini Malarkkan
Dr Ananthasayanam Ananthakrishnan
Dr Indranil Kolay
Dr Kandasamy Krishnan
Dr Heidi Grogan
Dr Alison Louise Lansbury
Dr Andrew Michael Lindley

Northern Ireland

Dr Robert Alastair Walker

Scotland – South East

Dr Mohammed Arif-Ur Rahman
Dr Catherine Barbara Hunter
Dr Alasdair Waite
Dr Colin Scott Moore

Scotland – North

Dr Thomas Engelhardt
Dr Jamie MacDonald

Scotland – West

Dr Andreas Kopka
Dr Roland George Black*
Dr Gail Gillespie
Dr John Mark Steven
Dr Kenneth Hunter McKinlay

Scotland – East

Dr Cameron John Weir

Tri-Services

Dr Andrew David Griffiths

Correspondence

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

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Awareness; only 1 in 80,000?

Madam, – The article on awareness during general anaesthesia (*Bulletin* 29, January 2005, pg 1463–1467) emphasises the puzzling fact that complaints of awareness are rare. Sherlock Holmes would conclude that the explanation is obvious; even small doses (0.5 MAC) of anaesthetics have powerful amnesic effects and most patients immediately forget such experiences. But do our patients really need to be unconscious throughout the operative procedure? If profound analgesia and amnesia will do then the indications for plumbing the depths to ensure unconsciousness may owe more to commercial zeal than clinical need.

Over 150 years ago Snow¹ noticed the powerful amnesic and analgesic effects of ether in conscious patients. This was ignored for a century until Artusio² used ether sedation for cardiac surgery; his patients had profound analgesia and no memory for contemporary events but responded to commands throughout. He claimed this was ideal for surgery and that larger doses of anaesthetics causing unconsciousness would become a thing of the past; 40 years passed before this was endorsed.³ The contemporary use of potent short acting opioids combined with modern anaesthetics easily achieves Artusio's state of profound analgesia and amnesia; time flashes by for the recipient and unconsciousness can be regarded as an interesting side effect.

It is not surprising that in a recent study⁴ when 11,785 patients were interviewed post-operatively only 18 admitted memories of intra-operative events and most were unperturbed by this. Of the 7 in whom awareness was 'definite' 5 were due to obvious anaesthetic mistakes. The remainder had inhalation anaesthesia with vapour monitoring but it was not known if this signal was used in anaesthetic management or simply ignored.

During a 40-year period the incidence of awareness has ranged from 110 per 1,000 general anaesthetics⁵ to 0.1 per 1,000.⁶ In 1999, working at the same centre as Siegmeth *et al*, I expected on the basis of 0.1 per 1,000, to have heard of 3 cases per year at that hospital. Anaesthetic staff could remember none and the ironically named 'Patient Satisfaction Unit' told me that only 2 complaints of awareness had been made in the previous 6 years. This gave an awareness claims incidence of 1 per 90,000 general anaesthetics. Between 1996 and 1999 in 11 surrounding hospitals there were 7 cases of awareness in 558,000 anaesthetics giving a frequency of 1 per 80,000.⁶ This is a 40-fold difference between self-reported awareness and awareness discovered by post-op interview. Despite the wide publicity on anaesthetic awareness in the last 10 years are patients still reluctant to complain because they fear that they will not be believed? Or does this reflect a spectrum with debilitating awareness on one end, 'dreams' on the other with vague

recollections in the middle? If complaints of debilitating awareness are rare (1:80,000) do we need to monitor every patient? Several large-scale studies using BIS monitoring have concluded that such monitoring is desirable for all anaesthetics. Unlike pulse oximetry the running costs are not trivial. Assuming that the cost of a disposable electrode set for BIS was £10 it would mean that almost £1,000,000 would be spent to detect/prevent one case of debilitating awareness.

It is worth remembering that John Snow's fame rests mainly on his pioneering anaesthetic research but also on the removal of the Broad Street pump handle (and the reduction of cases of water borne cholera); unfortunately he removed the handle seven days after the peak of the cholera cases. It would be ironic if we started large-scale depth of anaesthesia monitoring after we realised that the incidence of really debilitating awareness was already vanishingly small.

JG Jones, Formerly Professor of Anaesthesia, University of Cambridge

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Authors' response: Thank you for the opportunity of responding to the interesting comments made by our esteemed former colleague Professor Jones. Although his comments are largely beyond the remit of our article (which was to examine the evidence that anaesthetic depth monitoring has an influence on the incidence of awareness), we feel that a reply is warranted.

Firstly, when assessing the incidence of any medical complication, it is important to be cautious about making assumptions based on anecdotal evidence or self-reporting by patients. This is particularly true of awareness, even if we only consider conscious awareness with recall. Few anaesthetists routinely ask their patients about awareness during the post-operative visit (unpublished data), and most only visit their patients during the immediate post-operative period, whereas Sandin *et al* have clearly shown that recall of intra-operative events may only be evident a few days or weeks after the event.¹ The only scientifically robust method of establishing the incidence of an adverse event is a formal prospective study with serial follow up interviews.

Secondly, we would like to respond to the suggestion that unconsciousness can be regarded as an interesting, but non-essential side effect of general anaesthesia. At present there is no evidence that awareness without recall does not affect clinical outcome. This

should lead to caution regarding major changes in the way we define and describe anaesthesia.

This last consideration brings up the issue of the professional contract that we have with the patients whom we treat. While it may be true that analgesia and profound amnesia without loss of consciousness may provide stable operating conditions for some types of operation without leading to patient distress (and indeed may be common during opiate and benzodiazepine-based techniques)^{2,3} we believe that at present most anaesthetists and most members of the lay public understand the term 'general anaesthesia' to imply a state during which there is hypnosis or lack of awareness.

The paradigm of anaesthesia that Professor Jones describes may be an option that we should consider and validate over time. Indeed, it may be a (or even the) new frontier that we should explore as a profession. However, until such exploration provides a rigorous assessment of this proposed new construct of anaesthesia, we would urge caution and suggest that anaesthetists should continue to aim for hypnosis in addition to amnesia and analgesia in all their patients undergoing general anaesthesia.

A Absalom, R Siegmeth, I Bergmann, Cambridge

References

- 1 Sandin RH et al. Awareness during anaesthesia: a prospective case study. *Lancet* 2000;**355**:707–711.
- 2 Russell IF. Midazolam-alfentanil: an anaesthetic? An investigation using the isolated forearm technique. *Br J Anaesth* 1993;**70**:42–46.
- 3 Vuylsteke A et al. Amnesic awareness during cardiac surgery: comparison of three different regimens. *Br J Anaesth* 1996;**76**:A81.

Anaesthesia in Africa

Madam, – In recent years there has been an increase in the number of papers which address the following issue: why does it seem that despite the enormous prosperity in the western world, people still complain so much? Why are people not satisfied and continue to moan about shortness of time and money, about the educational system their children have to cope with, the railway system which is unsafe and unpunctual, the insecurity with which they have to live etc etc? To deepen this paradox, why is there more laughter in Blantyre than in Bristol, as Professor Broadhead from the Medical College in Malawi would say? To try to explain this paradox is beyond the scope of my letter. It is up to philosophy and economic analysis to give us the correct answers. I will only try to simplify the issue by looking at the origin of the needs of people and by dividing those into basic and dynamic needs.

Basic needs

Basic needs are those without which people cannot survive, meaning food and water. (One could argue that the fundamental rights of humans, as described by the United Nations or the Geneva Convention, should also be included in these basic needs.)

In most African countries, people are satisfied when their basic needs are fulfilled, because they can never be sure if disasters like severe drought, flooding or too much rain, a plague of insects or war will destroy their harvest and create famine and death.

Dynamic needs

In parts of the world where basic needs are always fulfilled, people will develop dynamic needs, which change with time, are always expanding and are never satisfied, despite all the

efforts people make. This expansion of needs is, nowadays, the panacea for economic trouble for many economists.

Consumers are encouraged to spend more money and so ensure economic growth. Needless to say, they look at the Gross National Product and not at the well-being of the people. It is like a drowning man who is simply encouraged to lift himself out of the water. It is a never-ending story and it looks as if we are chasing a *fata Morgana*. Even in paradise people will not be satisfied and will be found eating an apple.

Anaesthesia in Africa

Can we use these thoughts when we want to address anaesthesia in Africa? What are the basic needs in anaesthesia? I think the answer should be: safe anaesthesia. This implies that people trained in anaesthesia, who know how to take care of airway management, resuscitation and primary trauma care and can provide simple anaesthetic techniques in a difficult environment, are needed. It should be the overall goal of organisations in anaesthesia and individual anaesthetists to make sure that everybody in the world has access to basic anaesthesia.

The Royal College of Anaesthetists has supported this goal by recently awarding medals to Paul Fenton, Roger Eltringham, Frank Walters and Cyril Goddia. All these people have contributed to improving and expanding this basic anaesthetic care.

Cyril Goddia is a non-physician senior anaesthetic clinical officer and director of the Malawi School of Anaesthesia. By awarding him a medal the Council had the courage to take the responsibility for creating a link between the College and basic non-physician anaesthesia in Africa.

Why is it so important to focus on the basic needs in anaesthesia? First of all, because in no way is there complete coverage of basic anaesthesia in Africa. It is still concentrated in central hospitals and does not reach the majority of the people who live in the rural areas and are dependent on health clinics. Secondly, health in Africa is not the biggest issue for international organisations like the UN and the EU. The fight against poverty and corruption is the main target. When this is the case, how can we even consider expanding our 'basic' anaesthesia to a 'dynamic' one? We will only increase the demands which will never be satisfied; we will increase the costs and be chasing, again, a *fata Morgana*.

Physician anaesthetists will demand a lot more for their patients to provide safe anaesthesia, with regard to drugs, monitoring and other equipment. They will also need more incentives for themselves, not strictly in this order, and will want a higher salary, good housing and education for their kids, a car etc. This is only logical, and there is nothing wrong in it, but when a country cannot feed its own people and when their Government and administration are so corrupt that the available money will not be used to strengthen the economy for the whole country, then changing from 'basic' to 'dynamic' anaesthesia will not be sustainable but counterproductive, and should be stopped. A careful build up of anaesthetic service that generates sustained improvements would be vastly better than a dramatic expansion that ends up in chaos and disappointment.

**H J Haisma, anaesthetist/Intensivist
(with eight years' working experience as
physician [anaesthetist] in Africa),
The Netherlands**

Revalidation

Madam, – Mrs Wang's article on revalidation caught my attention (*Bulletin 30, March 2005, pg 1500*). May I correct her assertion that nurses have no obligations regarding revalidation? In fact nurses must re-register with the Nurses and Midwifery Council (NMC) once every three years. To renew their registration a nurse needs to have worked over a set minimum number of hours and have documentary evidence of having attended at least five study days (the nursing equivalent of CPD). They also must pay a fee, which has recently increased substantially. Does this sound familiar?

Whilst these checks on fitness to practise are far more basic than those proposed for doctors, I believe they are appropriate for the majority of nurses. More stringent checks will not necessarily protect patients, but will inevitably keep nurses away from patient care, the consequences of which for an NHS already short of nurses are obvious. Unlike many doctors, it is uncommon for nurses to be working in isolation without daily informal peer review. Nursing level of responsibility is thus reduced and their clinical work is protocol driven.

For nurses with extended roles, their supervision is less and responsibility is greater – for example, nurse consultants with extended prescribing rights. The front page of *The Sunday Times* recently carried a scare story about nurse prescribers.¹ The article stated that nurse prescribers were the latest target for drug companies, with free meals and accommodation being offered for the chance to influence their prescribing habits. It is important for these nurses

to be sufficiently trained in their chosen field so as not to be unduly influenced. The onus is on us all. However, a few more scare stories and the NMC will start to enjoy the headlines previously only reserved for the GMC. The NMC will need to be seen to take a proactive role and be seen actively to revalidate their nurse consultants, as the GMC is now trying so hard to achieve with doctors. The NMC website provides no reassurance.

J Norman, SpR, Wythenshawe Hospital, Manchester

Reference

- 1 Drug companies target nurses. *The Sunday Times* 27 February 2005.

Madam, – Mrs M Wang, Chairman of the PLG, describes the purpose of Revalidation (and it does seem to be a proper noun and merit a capital R) as ‘to create public confidence that all licensed doctors are up to date and fit to practise’ (*Bulletin* 30, March 2005, pg 1500). To my mind either this is a somewhat Freudian slip or terribly insightful honesty, as surely this statement ought to contain the words ‘to ensure that’ as opposed to ‘to create public confidence that’.

This may seem a little pedantic but I find this slip indicative of the situation in which we now work. As far as our political masters are concerned Mrs Wang’s statement would appear to be absolutely the whole point of this exercise and if Revalidation does somehow actually result in our keeping up to date and being fit to practice (as opposed to simply making the public think that we do this) then that may simply be an added bonus.

Regarding Mrs Wang’s suggestion under the heading ‘...and more!’ that we should ‘be reassured that Anaesthesia Practitioners’ roles and responsibilities

are presently overseen by a national Modernisation Agency stakeholder board’, I simply say ‘should we?’

J Gibson, SpR, Addenbrookes Hospital Cambridge

What’s in a name?

Madam, – I wish to add a further comment to Peter Simpson’s idea – it is not yet a proposal – that our title as medical specialists might be modified from anaesthetist to anaesthesiologist (*Bulletin* 28, November 2004, pg 1385). Adding the Greek suffix *logos* to our traditional name may have significance in some circles. It certainly does for our American colleagues who must distinguish themselves from non-physician practitioners.

However, there is a deeper problem in our name: the whole word itself turns out to have been a poor choice. For a century-and-a-half we have accepted willingly the name proposed by Oliver Wendell Holmes, whose literary competence was not questioned in his day. So in 1846 anaesthesia seemed a good choice; it brought together two congenial Greek roots and connected us with classic scholarship. But tools available to us today tell a different story. In recent years a formidable database has been assembled at the University of California, Irvine, and in it are included all of the ancient Greek texts. It is known by its Latin name *Thesaurus Linguae Graecae*, and the database can be searched for every occurrence of any particular word. Learning about this resource, I wondered if the word anaesthesia was known and used in Ancient Greece. And if so, what did this word mean to the classic authors?

With help from expert staff, searching the TLG database was easy and quick – and breathtaking. That name we got from Holmes was clearly

a familiar old word, widely known and used by ancient authors. My search yielded some 620 citations, including 15 from Aristotle, four from Plato, two from Hippocrates, eight from Philo, and 54 from Galen. Then if it was so widely used, what did this word actually mean to the ancient writers, and are we using the word appropriately today? My answer is yes and no. Some ancient uses of the word were indeed close to ours. But there were other meanings that were not complimentary, ones we would prefer to disown if applied to our field of expertise. From comparing the reliable English translations in The Loeb Classic Library I have identified the following shades of meaning in ancient texts:

- 1 total absence of sensibility, oblivion (as in Epicurus: ‘...the mere insensibility of death’)
- 2 insensibility to any physical sensations, not pain only (as in Plato’s ‘Timaeus’)
- 3 incapacity to enjoy physical pleasure (as in Aristotle: an impoverished quality of life)
- 4 destitute of culture and morality, callous (as in Demosthenes, speaking of the Thebans: ‘...those blockheads...’)
- 5 without common sense, without tact, stupid (as in Thucydides, in ‘The History of the Peloponnesian War’)
- 6 dense, obtuse, dull-witted, simple-minded.

What can be done with a name that is firmly established by generations of use, but which is now seen to be inadequate? Not only does it leave no room for the newer sciences of critical life support and pain medicine, but at its roots it has connotations that are demeaning. Who aspires to be professor of stupidity? A rose by any

other name might smell as sweet, but a specialty that embraces this name does itself a disservice. Holmes, where are you?

B Brandstater, Clinical Professor in Anesthesiology, Loma Linda University

.....

What WILL the New Year bring?

Madam, – I respond to our President’s address (*Bulletin 29, January 2005, pg 1435–1437*). It is obvious what the New Year will bring.

At the Retired Fellows’ lunch in May I shall spearhead a fundraising initiative to provide – no, not splendour for Churchill House but – a washing machine, dryer, iron and ironing board for the President’s accommodation. Some retired Fellows, perhaps enlightened males as well as females, will be prepared to educate and train the President in the art and science of laundry, and to conduct RITA assessments thus ensuring that neither he nor any future President returns home at the weekend with a case full of dirty laundry.

Still, it is heartwarming to realise that our Presidents are really Peter Pans at heart!

R Macdonald, Retired Anaesthetist and Postgraduate Dean



Warmest congratulations to the College’s Editorial Officer, Mandie Kelly, who has taken time out from producing the Bulletin to produce baby Anna (with the help of husband Paul)

CORRECTION

We would like to apologise for any misunderstanding which may have arisen as a result of an error which appeared in the March 2005 issue of the Bulletin. The logo of the European Society of Regional Anaesthesia (ESRA) appeared linked to the results of the election to the Scottish Board (page 1525). The logo that should have appeared here is that of the Electoral Reform Services (ERS), and it should be noted that ESRA do not have any involvement in these elections.

THE MERSEY SELECTIVE

Lectures & Tutorials designed to address those more esoteric areas of the syllabus not covered well in the textbooks and thus considered to require special attention and elucidation, the aim being **to explain and to simplify**.

Including for instance:

- Two Pharmacokinetics Lectures
- Pharmacodynamics
- High Pressure Physiology
- Low Pressure Physiology
- Damping & Friends
- Acid Base Made Easy
- Pain for the Primary
- Statistics for Anything
- Isomers & Actions
- Three Physics Lectures
- Mechanisms of Breathing

Extracts from Assessments of the The February Selective

*'As good/useful as rumours suggested. *****'s 17 day course has nothing on this'*

'Thank you very much'

'All topics well covered'

'Excellent'

'Excellent course – MCQs good. Food FANTASTIC'*

'Excellent facilities ... The standard of lectures was excellent'

'The course included the majority of the difficult topics – most of the lectures were excellent'

'Food and catering – excellent. Daily MCQs excellent'*

'I am very happy I have come to this course'

'At least I know what is required at the exam!!!'

(Are you glad you came) 'YES! YES! YES!'

'Daily mcq practice was excellent for fine-tuning the brain through the week'*

***In response to suggestions in the Feedbacks of earlier courses, it was decided to include an exercise in MCQ analysis at the close of each day. So successful was this innovation, it is to included henceforth.**

3pm Sunday 22 May – Friday 27 May 2005

Liverpool Medical Institution

Registration fee: £400 – includes Refreshments & Lunch. For details and an application form please visit our website: www.msoa.org.uk.

FINAL FRCA VIVA WEEKEND 3

2 pm Friday 10 June – 4pm Sunday 12 June

The aim of the weekend is to suffuse the candidates with so much exposure to Viva Practice that, on the day, they will be immune to the **stress and stupidity** that so often spells disaster.

Feedback from Viva Weekend 2

'Nothing beats talking-the-talk.'

'Course was helpful to practice the viva technique, and also made us aware of gaps we have in our knowledge.'

'Organisation was excellent.'

'Helped improve technique and mannerisms not only when being examined but also when playing the examiner.'

'This course has saturated me with more formal vivas than I could ever have arranged myself.'

'Excellent to go through long cases – very difficult to practice.'

'Well organised. Has allowed me to improve and also let me know how boring it is listening to long streams of candidates!'

'I would recommend this course to my peers as I feel it improves one's probability of passing by double.'

'Very relevant viva material, good mix of clinical and science vivas.'

'Will regard as essential practice before the exam'

'To be recommended to everyone preparing for the viva!'

'Tough weekend but worthwhile.'

'Helped me consider my own technique and how I might appear to the examiner.'

'The course format and repetitive practice at speaking is extremely useful.'

'Quite ingeniously organised.'

'The course definitely achieved it's objective, my presentation skills have improved.'

'Excellent preparation – scary and intensive!'

'My heart-rate now doesn't go beyond 85bpm before and during vivas.'

'Long and short cases were brilliant.'

'Excellent practice, plus covered lots of the syllabus!'

'My sympathetic systems were in less of an overdrive by the end of the course'

'(This course will) benefit future generations of anaesthetic trainees.'

'I felt more able to say 'I don't know' and forget about previous mistakes after this course.'

'I regret that I didn't do this course last time as I imagine I failed due to my bad viva technique'

'Very helpful – makes me feel confident of facing the examiner on the big day.'

'Good course to improve your confidence and make you speak and learn by observation.'

'I feel much less panicked by thought of vivas.'

'Very useful experience.'

'Fantastic course. Definitely the best ever intense viva practice that one can have in the limited time!'

NB: This course will only be of value to those candidates who have earned an invitation to London following the SAQ & MCQ papers. Please consult the website for details of the rather complicated administrative mechanism.

Venue: University Hospital Aintree

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

The 2005 BUPA Foundation Awards – *Call for entries*

The 26th annual BUPA Foundation Awards are made to healthcare and medical professionals in recognition of excellence.

The awards are designed to encourage innovation in different areas of healthcare. Current award categories – each with a £10,000 reward are:

- **Care Award** – for excellence in the development of care for older people.
- **Research Award** – for the best emerging medical research in the UK.
- **Epidemiology Award** – for excellence in the study of chronic disease.
- **Clinical Excellence Award** – for work that demonstrates an improved clinical outcome for patients.
- **Health at Work Award** – for excellence in occupational medicine.
- **Communication Award** – for effective communication between health care professionals and patients.

Applications are open to healthcare professionals who are resident and working in the UK.

Closing date for entry is 4 July 2005

For full details visit the **website** www.bupafoundation.co.uk.

For applications **tel** 020 7656 2246 or

email iona@chessells23fsnet.co.uk

ULTRASOUND-GUIDED VENOUS ACCESS

A practical workshop for anaesthetists and hospital clinicians

Westonbirt Arboretum, Tetbury, Gloucestershire
23 June 2005

This is a one day course aimed at teaching hospital doctors how to use ultrasound guidance for line placement. It comprises five morning lectures covering: **1** Critical care/anaesthetic perspective, NICE guidelines, **2** Central venous line placement – technique and complications, **3** Ultrasound – how it works (basics), **4** Seeing the needle, **5** Pleural fluid, Ascites and more advanced applications.

In the afternoon teaching is in small groups: The ultrasound machine – knobs and buttons. Practical 'hands on' sessions using ultrasound machines, models, phantoms and volunteers.

Course Organiser: Dr R Hopkins, Cheltenham General Hospital, Gloucestershire. Further information is available from: Postgraduate



Medical Education Centre,
2 College Lawn, Cheltenham,
GL53 7AG **tel** 08454 223038
or **fax** 08454 223242

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purposes by the Royal
College of Radiologists**

Bristol Medical Simulation Centre



Forthcoming courses for 2005

5 May – Paediatric anaesthesia course (SJM), for occasional paediatric anaesthetists (£150)

19–21 May – Society for Europe for Simulation in Applied Medicine (SESAM) for simulation enthusiasts and users

25–26 May – Team training for core critical incidents, for nurses and clinician (£270)

9 June – Senior consultant refresher course, for consultant anaesthetists (£150)

24 June – Advanced beginner anaesthetist course (Novice II), for SHO anaesthetists (£110)

28–29 June – Transport for the critically ill course, for anaesthetists and EM staff (£275)

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

For bookings please contact Alan Jones, Centre Manager, The Bristol Medical Simulation Centre, UBHT Education Centre, Level 5, Upper Maudlin Street, Bristol BS2 8AE **tel** 0117 3420108

email alan@simulationuk.com; and/or visit the **website** at www.simulationuk.com (this contains course details)

The Association of Anaesthetists of Great Britain and Ireland

22–24 June 2005

GAT 2005, Oxford.

20–23 September 2005

Annual Congress 2005

Manchester

19–22 September 2006

Annual Congress 2006

Aberdeen

More detailed information can be obtained from the Association of Anaesthetists of Great Britain and Ireland, 21 Portland Place, London WC1B 1PY **tel** 020 7631 1650

fax 020 7631 4352 **email** meetings@aagbi.org

website www.aagbi.org

Bernard Johnson Adviser in Postgraduate Anaesthetic Studies: Overseas Trainees

The Royal College of Anaesthetists invites applications for the post of Bernard Johnson Adviser in Postgraduate Anaesthetic Studies which has become vacant on the retirement of Dr Preman Jeyaratnam.

The post holder will be principally involved with providing career advice and counselling to overseas trainees and advising the Training Committee on policy matters. There may, however, be some cross-over of duties with the other Bernard Johnson Adviser who oversees the College's flexible trainees. The post carries a small honorarium.

Applications, including a letter explaining your reasons for applying for the post, a full CV, and the names of two referees, should be submitted to:

President's Office
Royal College of Anaesthetists
48/49 Russell Square
LONDON WC1B 4JY

before 31 May 2005. A job description is available upon request from the President's Office, or from the College **website** www.rcoa.ac.uk

British Journal of Anaesthesia / Royal College of Anaesthetists

RESEARCH GRANTS 2004

The following project grant awards were made in 2004:

- Spinal glutamate receptor function in an experimental model of bone cancer pain. *Prof S Fleetwood-Walker and Dr L Colvin, University of Edinburgh (£49,968)*
- Mandatory insulin therapy to reduce mortality in critically ill patients: pilot study to investigate safety and mechanisms. *Dr D Young, University of Oxford (£48,800)*
- The role of myocardial work and cardiac redox potential in TNF induced cardiomyocyte apoptosis. *Dr M Nirmalan, University of Manchester (£15,634)*
- Investigation into changes in endogenous opiates and receptors on peripheral blood mononuclear cells during the course of septic episode. *Dr J Thompson, University of Leicester (£9,196)*

Applications are invited for BJA/RCoA project grants to a maximum value of £50,000, with a submission deadline of **Friday 29 July 2005**.

Further details and application forms can be found at the **website**: <http://www.le.ac.uk/anaesthesia/>. Advice can be obtained from the Grants Officer:

Dr D G Lambert,
Division of Anaesthesia,
Critical Care and Pain Management,
Leicester Royal Infirmary,
Leicester LE1 5WW

tel 0116 258 5291

fax 0116 285 4487

or **email** DGL3@le.ac.uk

APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS

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

New Associate Fellows

January 2005

Dr Gudrun Kunst
Dr Krishnan Askan
Dr Thomas Johannes Mohler
Dr Abhiramy Arnold
Dr Helmy Ezzat Abdelmoty Mohamed

New Members

December 2004

Dr Nagarajan Kovvali

Dr Nassif Tawadros Abd-Mariam
Dr Tapanmay Deb

January 2005

Dr Paul Hynam
Dr Melanie Jayne Keel
Dr Justine Sahrah O'Neill
Dr Sarah Elyse Kondogiannis

February 2005

Dr Miriam Rosa Baruch
Dr Venkata Ramana Alladi
Dr Cezary Dariusz Zugaj

New Associate Members

January 2005

Dr Stephen Richard Laver

February 2005

Dr Moe Thant
Dr Usama Ibrahem Ali Mahfouz



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College Secretary

Mr Kevin Storey

Deputy College Secretary and Training and Examinations

Director

Mr David Bowman

Professional Standards

Director

Mr Charlie McLaughlan

Courses and Meetings

Mr Amit Kotecha

020 7908 7347

Miss Chantelle Edward

020 7908 7340

ansaphone 020 7813 1888

fax 020 7636 8280

email educ@rcoa.ac.uk

Educational approval for Schools of Anaesthesia and hospitals

Ms Marianne Innocenti

020 7908 7339

Examinations Manager

Mr John McCormick

020 7908 7336

Individual Trainees

Mrs Gaynor Wybrow

020 7908 7341

IT Manager

Mr Richard Cooke

Membership Services

Miss Karen Slater

020 7908 7324

Subscriptions

020 7908 7329

DEATHS

The College regretfully records the deaths of the following Fellows:

Sir E Holden, North Yorkshire

Dr F Holmes, East Lothian

Dr P R Degotardi, Australia

Dr A D Scott, Bournemouth

Dr E G A Jackson, Surrey

Dr P Stuart, Carlisle

APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

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

Dr Helmy E A Mohamed, Chase Farm Hospital, London

Dr Virginia M Knowles, Russells Hall Hospital, Dudley

Dr Anthony Y W Addei, St George's Hospital, London

Dr Mark R Nash, University Hospital of North Staffordshire

Dr Thusith Wickrama, Oldchurch Hospital, Romford

Dr Ramiz Idriz, Cumberland Royal Infirmary, Carlisle

Dr Gowry Rasi Simon, Royal Wolverhampton NHS Trust

Dr Ian Robert Anderson, Derriford Hospital, Plymouth

Dr Ben Fitzwilliams, Guy's and St Thomas' Hospitals Foundation Trust

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