Anaesthesia News

No. 235 February 2007

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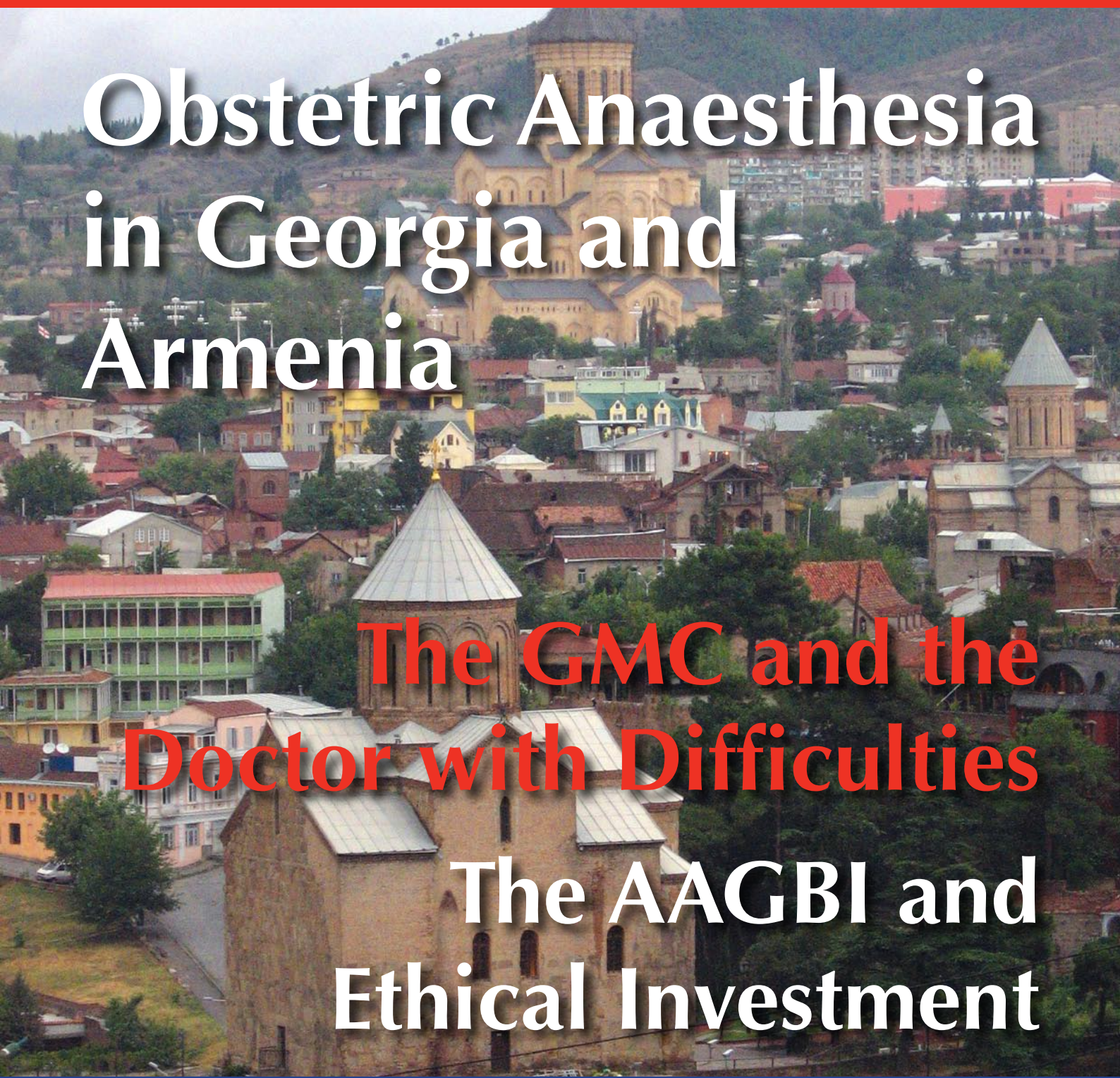

Obstetric Anaesthesia in Georgia and Armenia

The GMC and the Doctor with Difficulties

The AAGBI and Ethical Investment

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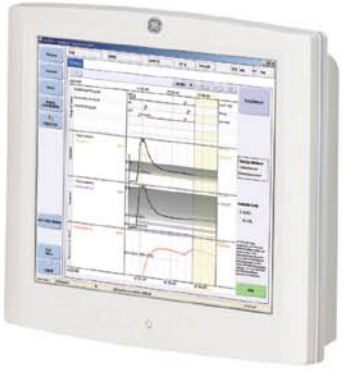

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GE imagination at work

Obstetric Care in Georgia and Armenia

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The Association of Anaesthetists of Great Britain and Ireland
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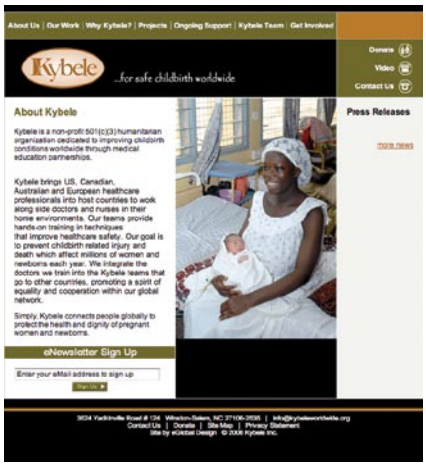
The author (L) with some of the paediatric staff in Georgia

Last year I was able to go to Georgia and Armenia with Kybele (www.kybeleworldwide.org), a US based humanitarian organisation dedicated to improving childbirth conditions worldwide through medical education partnerships. The charity organises in-country programs to improve essential treatment, technology and training of health care workers to make childbirth safer and less painful. There is also a continued commitment to member partners as an information resource. Although the charity provides support with in-country transport and accommodation, the trip is otherwise self-funded by the participants. It was a huge benefit to be supported by an AAGBI travel grant which allowed me to join a team promoting modern safe anaesthetic practice, disseminating evidence based practice goals, and encouraging audit and continued education.

I travelled with a team on their recent visit to the countries of Georgia and Armenia in the Caucasus. We visited 19 hospitals (13 in Georgia, 6 in Armenia) in 2 weeks. We were able to gather information and provide clinical teaching in regional



anaesthesia. Clinical instruction was done in the labour wards and operating theatres with informed and consenting patients. The techniques that were taught included spinal anaesthesia for caesarean section, epidural and combined-spinal epidural labour analgesia. We were granted a full spectrum of liberties, including bringing the support person (husband or mother) into the delivery or operating room, a practice that is not routine. Team members were able to demonstrate analgesia for a primiparous patient, who delivered without pain or motor block, with her husband at

her side. Patients and family members were grateful for this opportunity and thanked us profusely. We were featured on a Georgian television program. The film team were personally moved by this experience because they had all had poor birthing experiences.

We gave three short medical education conferences (in Tbilisi and Kutaisi, Georgia; and in Yerevan, Armenia). Conferences were interactive and attended by more than 120 physicians. Translators were utilized and in some cases slides were translated into the local language prior to our arrival. Healthy debate did not require encouragement - the process appeared very constructive, and allowed different interested parties to air their position. At the Kutaisi conference the Deputy Health Minister was present and participated fully himself, having been a physician before; but he also had to explain the Government's position on licensing and funding.

We obtained Ministry of Health approval in Georgia to import bupivacaine (plain and hyperbaric), ephedrine and phenylephrine for teaching demonstrations. Currently these drugs are either not available or available only on the black market. The only local anaesthetic widely available is 2% lidocaine. Healthcare providers in Georgia have requested our help to gain approval for long-acting local anaesthetics and ephedrine in their country. This would be a great step forward in the development of regional and obstetric anaesthesia. Regional anaesthesia supplies, textbooks and other teaching materials that the team had brought with them were donated to various units.

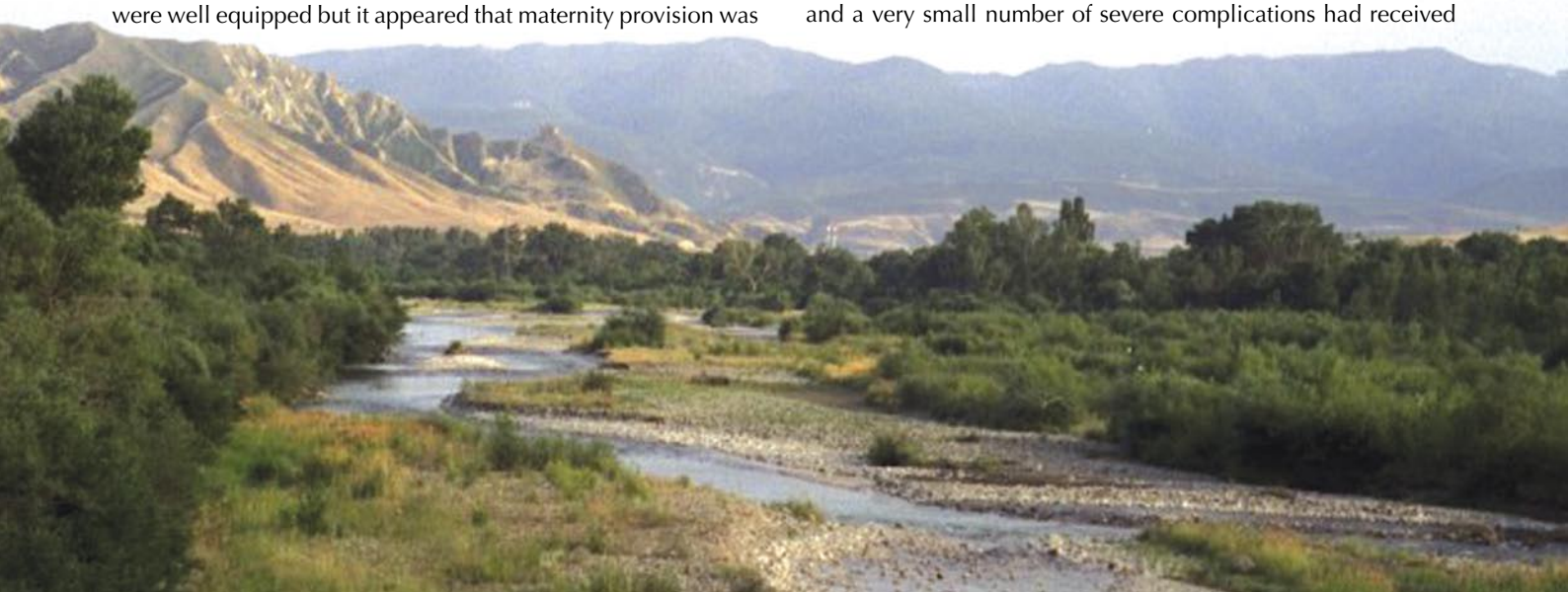
We observed that anaesthesia conditions were much worse than expected in both countries. In Georgia, anaesthesia monitors were limited or non-existent. We observed entire lists performed with only an occasional finger on the pulse (no BP, SpO2 or ECG). In Armenia, monitors were more available but they weren't always used - there was little sense of the importance of the use of anaesthesia monitors during surgery. A few hospitals were well equipped but it appeared that maternity provision was

The visiting Kybele team with our hosts in Armenia

universally poor. In some cases available anaesthesia monitoring consisted of only of manual blood pressure measurement; even then it was used rarely, if at all.

For caesarean section, general anaesthesia was most commonly used. We noted the use of diazepam as a pre-med. There was neither pre-oxygenation, nor antacid prophylaxis, nor the use of rapid sequence induction as we recognise it. Left lateral tilt to reduce aorto-caval compression was not utilised. Maintenance was with intermittent ketamine and relaxant.

Regional anaesthesia was utilized for obstetrics in only a few hospitals. This was partly due to limited availability of local anaesthetics and equipment, and the very limited regional anaesthesia training. Implementation suffered due to a lack of subsequent education of mothers, obstetricians and paediatricians. Public perception was another aspect. The physicians stated there was little public desire for regional techniques, however no prenatal education or information was offered. Mothers would encounter strong negative peer pressure and a very small number of severe complications had received



large media coverage. This was further confounded by the financial implications of an extra service in a culture placing little value on the abolition of labour pain.

There were many leftovers from the Soviet Union days, such as very old Russian ventilators, and myopia as an indication for caesarean section through fear of retinal detachment. There appeared to be inadequate sterile technique both for surgeons and anaesthetists. Surgical drapes were applied with bare hands; in some cases spinal anaesthesia was done without gloves, drapes, hat or mask. We found two operating tables in the same operating room, with questionable separation of equipment and personnel. The availability of any recent medical texts and journals was very limited, although we did meet the creator of the fledgling online medical informatics service in Georgia.

We felt that we had learned much. We also felt that we had made strong connections, imparted some of our views on intra-partum care, as well as promoting a desire for review and audit, both personal and institutional. The interaction does not end here. The group will continue to work with local contacts having obtained a better perspective on local needs and desires. Already we are investigating avenues of improving medication supply and licensing, and are approaching various bodies with regard to providing more modern equipment. Future plans are for longer visits within this improved environment to allow the full implementation of modern obstetric anaesthesia care. We are also aiding local audit and research, encouraging submission to international meetings and supporting exchange educational visits. I have personally gained much from this trip. It is humbling to see what educated, dedicated people can achieve with extremely limited resources. It was a delight to be able to provide information and knowledge to enthusiastic physicians, and also to participate in debate.

Simon Millar
Consultant Anaesthetist, Paisley

The view from the cathedral in Yerevan, Armenia

Members' welfare and AAGBI's new scheme to help doctors with difficulties

The AAGBI has a long history of caring for its members. This care has included helping doctors with difficulties - previously described as "sick doctors". The "AAGBI Sick Doctors' scheme" comprised senior members of the specialty who were available for these doctors to contact, with a view to advising and supporting them in finding appropriate help. Contact with this senior anaesthetist was usually made via the AAGBI secretariat.

Over the years this service has provided valuable help to many doctors. Nevertheless, we have been concerned that it was not accessible on a 24-hour basis. A lack of doctors approaching this service recently at a time when we know that there are still doctors out there with difficulties has necessitated a review our entire approach.

As a result of this review, Council of AAGBI decided last summer to convene a new standing committee with the specific remit of caring for members' welfare. I am proud to have been appointed as the first chairman of this committee.

The committee plans to improve members' welfare in a number of ways. Firstly we are going to raise the profile of the whole subject of doctors with difficulties. The aim is to demonstrate that many of us will have problems at some time during our working lives. Given this fact, our next objective is to equip members with the skills to cope with these problems and difficulties in the best possible way. Finally the committee will oversee the new scheme to help doctors with difficulties.

We plan to have regular articles in *Anaesthesia News* written by experts who can help in specific areas in which doctors are known to have problems. These include depression, which is a major problem area, and alcohol and drug abuse, and we will look at the various stresses which could have provoked doctors to develop these problems. In this month's issue, David Hatch outlines the GMC's procedures for assisting doctors whose performance may be impaired, while protecting their patients.

We also plan to publish a series of *"dilemmas"*, of the type which may face us all at some time or other, in *Anaesthesia News*. A response will be provided by our panel of experts and published in the same edition. You may not agree with the experts' replies and we look forward to hearing your opinions of how the dilemma could have been approached. Members can also submit dilemmas of their own. These will be published anonymously and some details may be changed slightly to prevent identification. This will, I hope, give us the opportunity to air some really difficult topics without drawing attention to individuals.

There will be seminars at 21 Portland Place and workshops at our major meetings to provide members with the opportunity to learn relevant life skills to cope better with the stresses of daily life. If there is sufficient demand we may also be able to provide regional seminars.

Finally, I want to explain the new scheme to help and support doctors with difficulties.

After careful thought we have decided to integrate with the BMA "Doctors for Doctors" scheme. This scheme was described in detail by Mike Peters in *Anaesthesia News* in December 2006. It provides the 24-hour access to a trained counsellor which we feel should be available. Doctors contacting this service will be given the opportunity by the counsellor initially taking the call either to speak at more length to a trained counsellor or to be given contact details for a doctor advisor. The caller will be able to decide if they wish to speak to a doctor in their own or another specialty. If the initial contact feels the doctor concerned is very distressed they will ensure that the caller is put through immediately to a counsellor.

AABGI support of this scheme will enable **all** AAGBI members to access the "Doctors for Doctors" scheme **even if they are not BMA members,** so about one third of our membership will now have access to this service which they did not previously. Two senior doctors from AAGBI are training to become doctor

advisors, so that callers can speak to another anaesthetist should they so wish. In certain circumstances, there is no doubt that an individual from the same specialty is better able to empathise with a situation, while in others the caller may wish to speak to someone outside their own specialty, in case the counsellor is known to them.

All members wishing to access our new scheme for doctors with difficulties should therefore call the contact number for the "Doctors for Doctors" scheme via BMA Counselling **(08459 200169)**. If members call us at 21 Portland Place, our staff have been instructed to give you the "Doctors for Doctors" telephone number. We will also be placing regular advertisement boxes in Anaesthesia news with this number and it will also be placed on our website. This service is, of course, entirely confidential.

Finally, we want to support members as well as possible. We won't be able to do this if we are not told about problems and about the extent of these. While members with difficulties may well be reticent to share these, it really is the best way to solve them. So do please try to make this approach. We do treat all such approaches with strict confidentiality. We are also exploring ways in which we can obtain entirely anonymous feedback from a wider selection of our members in the future, possibly by postal questionnaire or at meetings.

Diana Dickson
Chair, AAGBI Welfare Committee

AIRWAY MANAGEMENT – Training the Trainers

One day symposium for Consultants and College Tutors
Friday 2nd March 2007
Mary Sunley Building
St Catherine's College, Oxford

This is not an airway workshop. This is a course to empower trainers with the knowledge and practices to optimise airway training in the face of reduced trainee hours and training opportunities. At a time when airway training is under such pressures, we need to develop radical training methods which optimise every training opportunity to equip our trainees with the appropriate airway management skills.

Experienced Faculty will cover the following sessions;
Basic airway training (SHO)
How to assess airway competency
Advanced airway training (SpR1 to SpR4)
The use of simulators for airway training
Where do airway workshops fit in?
Teaching fibreoptic intubations on each other
The college curriculum – a work in progress
Is there the capacity to deliver airway training?
Timetabling 'airway training blocks' for SHO/SpR1
Advanced airway fellowships – SpR4/5

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

Course Fee - £150
Cheques made payable to *Oxford Difficult Airway Group*
Registration and enquiries
Mrs M Scott 01865 221591
marguerite.scott@orh.nhs.uk
Course recognised for 5 CPD points

12th Oxford Difficult Airway Workshop

Mary Sunley Building
St Catherine's College
University of Oxford

Thursday 1st March 2007

The Difficult Airway Workshop is for trainees and consultants wishing to refresh and update skills in managing patients with a difficult airway.

The course aims to discuss the management of the anticipated and unanticipated (including the can't intubate, can't ventilate) scenarios. There are lectures, videos and interactive discussions, and over 3 hours of hands-on workshops to re-enforce the theory, and to refine manual dexterity.

The workshops cover a wide range of fibre-optic assisted techniques, ILMA and trans-tracheal access. There is a high faculty to delegate ratio (1:3) to allow maximum opportunity to interact and interrogate the faculty.

Included in the registration fee are refreshments, a course manual, and lunch.

Course organisers - Dr Mansukh T Popat and Dr Stuart W Benham
Registration fee - £150 Recognised for **5 CEPD** points

All enquiries - **Marguerite Scott, Nuffield Department of Anaesthetics, John Radcliffe Hospital**
Oxford, OX3 9DU marguerite.scott@orh.nhs.uk
Telephone 01865 221590
Cheques to be made payable to 'Oxford Difficult Airway Group'

Donaldson, glossies and bikes

Donaldson

Most anaesthetists will have noted the publication last year of Chief Medical Officer Sir Liam Donaldson's report entitled "Good doctors, safer patients". Many of you will have shared with me the conviction that the first draft of the report was probably entitled "Better doctors, safer patients" but good sense and a desire not to alienate the medical profession any more than absolutely necessary obviously prevailed. I too read the summary and balked at the prospect of reading all 218 pages of the full report but, spurred on by a sense of duty to the AAGBI's members and a couple of particularly long femorodistal bypass grafts, I ploughed through every word of it. The Department of Health graciously invited responses from representative bodies, and I was charged with constructing a response from the AAGBI. Fortunately, this job was made a lot easier by Immediate Past President Mike Harmer, who lobbed me a draft response that took very little tweaking to turn it into a final version that received Council's approval and was sent to Sir Liam. It can be accessed via the website: http://www.aagbi.org/news.htm#10, and a shortened version appeared in January's *Anaesthesia News*. Our overall views can be précised thus:

- Changing the standard of proof from the criminal (beyond reasonable doubt) to the civil (the balance of probabilities) standard may be justifiable for some GMC hearings. It is not acceptable when a doctor's registration, and therefore both reputation and livelihood, is at stake in a hearing that results from a single adverse clinical incident. This happens all too often to anaesthetists.
- The GMC has done a lot to get its act together since Bristol, Alder Hey and Shipman; there is no need to emasculate it for what may be perceived to be political benefit. To make its members political appointees and to remove the election of doctors by doctors to the Council will not enhance its reputation in the eyes of doctors or their patients; indeed, the reverse will probably be the result.
- The bodies that are to be awarded extensive new responsibilities, e.g. PMETB and NCAS, have not yet proved themselves fully "fit for purpose"; they should be allowed to prove that they can do what they were asked to do in the first place before being given significant additional duties.
- The introduction of local GMC affiliates may destabilise Trusts that already have effective systems for the investigation and management of complaints against doctors.

It will be interesting to see what becomes of this report. There is already whispering in corridors that includes the words "back" and "burner". Let us hope that it is not all ignored, as there is much that is good in it, not least of which are the separation of the investigation and adjudication of complaints against doctors, the introduction of mandatory language tests for all overseas doctors, and the setting of clear standards for each area of specialist clinical practice.

Glossies

One of the most popular benefits of membership of the AAGBI is the programme of printed guidelines or "glossies" that we produce on a regular basis. Members find these concise and authoritative documents very useful in helping them to ensure that the facilities for the safe care of patients are in place in their hospitals. Three glossies are currently at the point of being released; two are updates of previously published guidelines and one is completely new. The fourth edition of "Recommendations for standards of monitoring during recovery and anaesthesia" has been produced by a Working Party chaired by Vice President Dick Birks. Although the changes since the third edition are not great, they are significant, and the evolution of this glossy has provided invaluable assistance to departments seeking to ensure that appropriate monitoring is available to patients in all environments in which anaesthesia is provided. The single-sided laminated guidance sheet on the management of malignant hyperpyrexia has rightly become a ubiquitous attachment to anaesthetic machines throughout the country. Prof Phil Hopkins from Leeds has assisted the AAGBI in updating this guidance, and it remains an invaluable guide for the treatment of this rare condition. The brand new glossy is called "Peri-operative management of the morbidly obese patient", and the Working Party chaired by Alastair Chambers has produced a document that we hope will help anaesthetists ensure that all the appropriate training, experience, organisation and equipment are made available to provide safe care for the increasing number of morbidly obese patients presenting for elective and emergency surgery. Following close on the heels of these three guidelines will be a glossy on Independent Practice. Modesty prevents me from singing the praises of the chairman of the Working Party, but we hope that the document's clear statements on standards in the private sector and the relationships between anaesthetists and their private patients will help our members in an increasingly difficult environment.

Council of the AAGBI has established four new Working Parties that will report later this year. The topics being covered are: do not resuscitate orders, the treatment of local anaesthetic toxicity, the safe introduction and use of anaesthetic related equipment, and synchronising terminology for mechanical ventilation. Once the Working Parties have produced final drafts, the documents will be posted on the AAGBI website and comments from members will be invited. We will tell members when the draft guidelines are placed on the website by putting a posting in the AAGBI Closed Forum of Doctors.Net. If you do not yet have access to this Forum, an email to members@aagbi.org will point you in the right direction. So far, we have followed this process with two guidelines, and the comments submitted by the members have been very useful indeed. Ideas for new Working Parties come from many sources, and we particularly welcome suggestions from members. If you would like to suggest a topic for a new glossy, please email me on honsecretary@aagbi.org.

Bikes

Avid readers of this illustrious and ever-enlarging organ will by now be sadly familiar with the photograph of three paunchy, middle-aged bikers that appeared in Anaesthesia News in both the August and October issues last year - for those who have mercifully forgotten, it is reprinted here. After this photograph was taken, the three intrepid individuals pictured (Phil Bayly from Newcastle, Iain Wilson from Exeter and yours truly) enjoyed a breathtakingly beautiful journey from the ESA meeting in Madrid through Northern Spain and the Pyrenees, and then through France to the UK by "the roads less travelled", stopping at sundry leafy auberges *en route*. Undeterred by aching backs and a peculiarly unpleasant form of neuropathic perineal pain that seems to accompany long stretches on a vibration-prone two-cylinder motorcycle, we plan a reprise of this experience. This year's ESA meeting takes place in Munich and finishes at noon on 12th June 2007. We plan to return to the UK via a range of mountains that lies between Munich and London and which is apparently called "the Alps". The man Wilson is in charge of navigation, thereby guaranteeing a circuitous route that will undoubtedly include the very best of hairpin bends, tortuously twisty lanes and long, straight, poplar-lined rural French roads taken at speeds you would not wish to admit to your loved ones. We will probably take three or four days to wend our way home, and we will be able to accommodate bikers of all abilities and inclinations, including slow and careful (H-G), fast and occasionally careful (Wilson) and very fast but also very interested in an immaculate image at all times (Bayly). Pillion riders with good life insurance and even better sphincter control are also welcome. If you are interested in this two-wheeled odyssey, register your interest by emailing me on middle.age.crisis@btinternet.com (really!) and I will copy you into all the information about the trip.

That's it for now. I will continue to plough the lonely furrow that is the Honorary Secretary's lot in life, but I will be reappearing in March's issue with an article encouraging members to stand for election to the Council of the AAGBI.

Will Harrop-Griffiths
Honorary Secretary, AAGBI

Dear Editor...

SEND YOUR LETTERS TO:
The Editor, Anaesthesia News, AAGBI, 21 Portland Place, London W1B 1PY
or email: anaenews@aagbi.org

Due to the volume of correspondence received, letters are not normally acknowledged.

BUG in the system

A typing error during a search for anaesthetists returned this:

Anaesthetis 

Anaesthetis testacea is a common species in Europe. It develops in dead tiny terminal twigs of deciduous trees and shrubs. Does this describe our humble origin, the answer to our expected recruitment problems following introduction of MMC or the result of financial cut backs and the withdrawal of 'T' from the department?

Dr Alan Thompson
Dr Namartha Thiagarajan
Dr Jane Goddard
Dr Beena Varghese

The Glass Ceiling

I would like to thank Dr. Chris Rowlands for an inspiring SAS article "The Glass Ceiling" (*Anaesthesia News,* Dec 2006). I agree wholeheartedly with his disappointment that the proposed new contract has not addressed issues which prevent artificial barriers to career progression. The expansion of Foundation Trust status will only add to this situation. I too had hoped that the new contract would incorporate many of the points raised by the 2003 Choice and Opportunity document. The lack of realistic educational opportunities and the closure (rather than amalgamation) of the associate specialist grade are disappointing elements in the proposed contract.
However as Chris has shown, enthusiasm comes from within and it is possible for all of us to be innovative and to make a real difference – even if not always readily rewarded by our Trust. Chris was recently presented with the Humphry Davy award by the RCoA which he richly deserves.

Dr. Roger Laishley
Associate Specialist
Bournemouth

360˚ assessment visited

I recently started at a new hospital as a year 4 SpR. As trainees, formal appraisals are a regular occurrence in our lives. Indeed, as anaesthetists we are very fortunate to have such an organised appraisal/assessment system. Our educational supervisors would normally canvas the opinion of other colleagues, mainly consultants, to find out how we are getting on. Evaluation by trainers therefore seems to be the most traditional source of trainee feedback. However, appraisal programmes that rely solely on the ratings of trainers are less reliable and valid than those that use a variety of other rating sources. It is also extremely rare to get feedback from patients.

At the start of my hospital placement, my educational supervisor handed us all forms/questionnaires for a 360 ˚assessment. Not surprisingly, we were somewhat taken aback as most of us had never experienced this before.

360˚ feedback is a process whereby you are rated on your performance by the people who know something about your work, and is a useful way of giving objective positive feedback to trainees. It involves using a variety of sources (trainers, peers, subordinates, patients, self) to provide the best picture of performance, but it is not always necessary or appropriate to include all of the feedback sources in a particular appraisal program.

In 360˚ feedback, peers are often the most relevant evaluators of their colleagues' performance, with subordinates' ratings providing valuable data on performance associated with supervisory/managerial roles. Patient feedback serves as an 'anchor' for almost all performance factors, and self-assessment is important because it encourages us as trainees to take responsibility for our development.

Feedback usually consists of a report, the design of which should be kept simple. The report is designed to help trainees be more aware of their relative strengths and developmental areas. Ideally feedback should be received as soon as possible after it has been collated.

I gave ten questionnaires to various sisters/charge nurses, staff nurses, nursing students, physiotherapists and the domestic assistant. In order to ensure validity, a 360˚ degree assessment should be based on a large enough sample. Seven to twelve respondents are usually sufficient in terms of reliability. The questionnaires asked for positive and negative feedback relating to job performance. The completed questionnaires were to be returned to my educational supervisor. I failed to give questionnaires to patients; this being difficult as they were critically ill. I also failed to give questionnaires to other medical colleagues including the junior ones whom I regularly supervise simply because I ran out of the forms. However, I am sure that verbal feedback would have been sought from them. My appraisal took place shortly afterwards and was a positive and helpful experience.

The benefits of 360˚ feedback include encouraging personal development, providing an opportunity to learn how others perceive you, increasing self-awareness and most importantly it can be a powerful trigger for change. With increased focus on teamwork, patient satisfaction and personal development, the emphasis has shifted to employee feedback from a full circle of sources. It is this multiple-input approach to performance feedback that is called '360˚ assessment' as it connotes a full circle.

Simona Labor
SpR Anaesthesia
Blackpool Victoria Hospital

Correction:

The gremlins got at the January edition of *Anaesthesia News* Firstly, I have committed the ultimate faux pas of getting an author's name wrong. The article on Vancouver entitled "Overseas Fellowship – cultural experience or culture shock?" was written by Dr W Allister Dow, not Gow, as stated in the article.
In addition the wrong adverts for the Oxford Difficult Airway Group courses were included – the ones which should have appeared in January now appear on page 7 of this issue. Apologies all round. Ed.

Paranoia Watch – advice for the anaesthetist

Having read your article in December's *Anaesthesia News* (P9), I supply the following:-

Recently, I had occasion to anaesthetise a 4 yr old child for exodontia as a day case who had a history of reflex anoxic seizures (RAS), a vagally mediated syncope provoked usually by a frightening or painful experience, with an incidence which has been suggested at 0.8% in preschool children and whose anaesthetic management has been described (1). My surgical colleagues discussed this case with me some time previously and had very assiduously acquired some information on this condition from the Syncope Trust And Reflex Anoxic Seizures (STARS) website (2). The STARS group is an information and support group whose aims include the improvement of public and professional awareness of the condition.

Their "Questions and Answers" web page includes the following in respect of dental anaesthesia:- "The advice is always tell the anaesthetist that the child or adult has, or did suffer from RAS, and insist that all anaesthesia is administered while the patient is lying flat". Check the site, I do not jest. I am sure we would never have thought of that! Further, their leaflet, Information for Anaesthetists, Dentists etc. contains this astounding information:- "Induction of anaesthesia especially by endotracheal incubation (sic) causes rapid increase in vagal discharges.", and "The anaesthetist should be informed in simple terms (my italics) that the patient has Syncope or Reflex Anoxic Seizures..." , as well as "Thus ALL people with Syncope and Reflex Anoxic Seizures should be anaesthetised lying down rather than standing up.....". The STARS group appears to contain no anaesthetist! Paranoid - Moi?!

David Fell
Consultant in Anaesthesia,
Leicester Royal Infirmary

1. Onslow JM, Burden J. Anaesthetic considerations for a child with reflex anoxic seizures. Pediatric Anesthesia 2003; 13: 552- 553.
2. www.stars.org.uk

Roast potatoes – a miracle cure?

Sandwiched neatly between Potassium guaiacolsulfonate and Povidone-iodine in Professor Frank Shann's 'Drug Doses' (thirteenth edition 2005) we were interested to stumble across the humble roast potato!

Potatoes, roast. *Oven 230°C (210° fan-forced), pan with 5mm peanut oil in oven; peel potatoes, boil 30 min until friable on outside, drain, put in hot oil, cook on top shelf of oven for about 90min until crisp (baste every 20 min)*

An unusual place for a recipe to turn up you might say. On contacting Professor Shann it would seem this is his own tried and tested recipe, placed in the book to "fill a gap." We have put it to the test and can confirm that Sunday lunch was tasty as a result!

Ritoo Kapoor
Helen Jewitt
SpRs in Anaesthesia
Wales

There was another example in one of Scotland's national daily newspapers recently. A short article gave details of the recently published will of Professor John Stenlake who, among other things, developed atracurium. The headline?
"£5m left by scientist who boosted surgery"
Ed

January Suduko Solution

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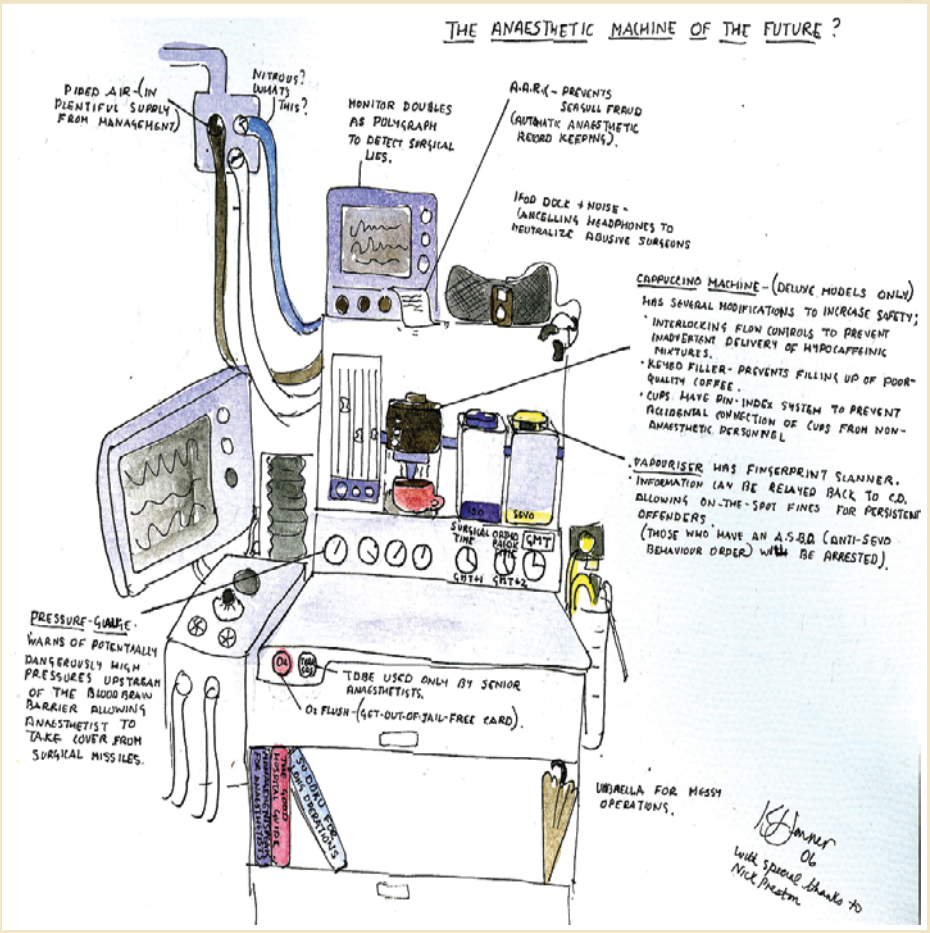

Cartoon courtesy of: Kathy Smith, Associate Specialist, Exeter.

GAT Page

Understanding Trainee International Medical Graduates in Anaesthesia

Conflict of interest: *The author came to England 26 years ago as an overseas doctor. He has been a College tutor, appraiser, RITA assessor and overseas doctor advisor. He is an elected member of the council of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Bernard Johnson Advisor (Overseas Doctors) of The Royal College of Anaesthetists (RCoA),London. The views expressed in this article are solely of the author and do not reflect the views of AAGBI or RCoA.*

Diversity and the NHS

Most countries have increasingly diverse populations in terms of race, language, religion and culture. The National Health Service in the United Kingdom employs such a diverse group of people and has depended on visiting doctors for many decades. The UK is also an established destination for visiting trainees, including anaesthetists, from all parts of the world, although changes are occurring which will make this more difficult in the future. It is predicted that NHS will require the services of non-UK qualified doctors until 2010 and will then have an adequate supply of home medical graduates.

International Medical Graduates (IMGs) wish to come to the UK because of the reputation of the British model of higher medical education and UK specialist qualifications. They may have already met UK-trained teachers during medical training in their home countries and used British textbooks. Other reasons may include lack of opportunities in training and employment and the social or political situation in their home countries. Although visiting trainees receive training and provide unquestionably good service to the NHS, they may have particular problems and many go through financial hardship and stress.

Requirements for working as a doctor in the UK

Doctors who wish to practise medicine in the United Kingdom must be registered with the General Medical Council and possess satisfactory immigration status.

Registration

One of the registration requirements for all doctors who qualified outside the EEA is that they must show that they have the necessary knowledge of English by obtaining a satisfactory score in the International English Language Testing System (IELTS) which is conducted in many countries. Doctors must then pass the two-part examination of the Professional and Linguistic Assessment Board (PLAB). Part 1 is also conducted in many countries but part 2 only in the UK. Those accepted on the Overseas Doctors Training Scheme and certain other categories of doctors may be exempted from the PLAB examination provided they obtain a satisfactory score in various sections of the IELTS.

Immigration status

IMGs coming to the UK must obtain satisfactory immigration status. Immigration laws are complex and subject to inconsistent interpretation. From 3rd April 2006 doctors and dentists in postgraduate training are considered for immigration purposes to be in employment rather than in training. Permit-free training is no longer available and those who don't have right of residence in the UK or EEA require a work permit to undertake employment. This will only be issued if the post cannot be filled by a doctor with right of residence in the UK or EEA. Those who come to the UK to take PLAB must use the remaining time on the PLAB visa to seek a suitable training post. The immigration rules are very clear that one must leave the UK if employment is not obtained unless appropriate immigration status can be obtained. Many IMGs come with a visitor or student visa. Change of immigration status costs money, and the constant threat of deportation causes stress.

Any existing leave to remain will continue, so a doctor in training can continue in their current post and take up any further training posts until the leave expires. Interpretations of interim immigration rules are difficult. Some doctors have Highly Skilled Migrant Programme (HSMP) status which is a point based assessment of skills and achievements but interpretation of this rule is also subject to controversy.

Problems before, during and after PLAB test

Many IMGs have unrealistic expectations about employment prospects in the UK. In their home countries, they often lack information about the NHS training structure and guidance such

as advice about studying for the PLAB examination. They have to find the finances to fund examination fees, travel expenses and living expenses in the UK. Language, climate, food, religion, social and cultural mores may be very different and adaptation to the new environment can be slow.

Obstacles to securing a job may include tough competition, poorly structured curriculum vitae, lack of a local referee, lack of familiarity, and poor interview technique. A clinical attachment may help trainees understand the British hospital environment, improve communication skills, build confidence and acquire local referees, but arranging an attachment can be equally difficult. Some hospitals charge for processing applications for clinical attachments, thus increasing financial pressures. A good hospital induction programme helps – many aspects of life in a UK hospital will be very different to past experience and can be usefully covered during this time.

Many doctors will remain unemployed for a considerable length of time and may have to keep borrowing money from friends and relatives in the hope of finding a job eventually. This leads to further insecurity and stress as well as increasing financial debt.

Stress, insecurity and worries during training

The new and very different work environment, frequent competency checks and worries about passing examinations are the commonest cause of stress for IMGs, but poor communication, cultural differences, attitude & behaviour, family and social priorities and religious conflict also add to the problem.

Competencies & examination

Most doctors have to undergo basic and anaesthetic competency checks in the first three months of the job. Many overseas doctors have additional stresses in that they are likely to be unfamiliar with some UK drugs & equipment. Experienced trainees may feel frustrated at "starting again". IMGs have higher failure rates in the FRCA examination due to the different system, clinical working practices and poor communication[1, 2, 3]. Many fail to progress after repeated failure at examinations, contributing to low morale and stress.

Communication

Good communication is the key, and confidence is related to ability to communicate effectively with colleagues and patients. Communication is a major issue for IMGs with English as a second language. Even if English is a first language, dialect and accents may vary. It is not unusual for trainees, trainers, and other healthcare professionals to find that sometimes they do not understand each other.

Chandra Kumar

Cultural differences

Respectful treatment of others is a basic value in all cultures [4]. Cultural differences may lead to misinterpretations. Trainees may show respect to their seniors during emergency and difficult situations by taking a less active role – in the UK this may result in trainees being labelled as uninterested or unassertive. Many doctors are timid and introverted and wrongly labelled as hesitant or under-confident. They may address patients and staff inappropriately. It is customary in many countries to address the seniors as "Sir" and it may be unusual to have female seniors.

Many cultures do not value time management skills which are deemed essential in the UK. Differences in body language can be striking – for instance, moving the head constantly when a senior is talking is a sign of respect in some cultures, or it may be taken as an offence if one does not stand up every time a senior stands up. Disagreeing with seniors is also seen as disrespect in many cultures - in some countries doctors are considered as gods and are not used to having their views questioned. In other cultures looking directly at the person's eyes while speaking is considered disrespectful and this may give a UK senior the impression that the doctor is hiding something or not telling the truth. They might have the reputation of seeming rude to patients, nursing staff, and female colleagues as they come from a male dominated society. Some speak very loudly as in some countries it is not unusual for doctors to shout or raise their voice to get work done. Many lack simple etiquette but British culture expects one to say please when one asks for something and say

thank you when the work is done. Some do not listen to others patiently and sympathetically. Many mumble during stressful situations. All this may be culturally normal in the doctor's home country, but failure to adjust behaviour to UK mores leads to misinterpretation.

A local guardian or mentor is known to be helpful in any trainee's career. They must be approachable, respected and a good listener, and a person of similar cultural background may be appropriate, certainly during the initial training period when they may be invaluable in advising with regard to some of the cultural differences as well as career issues.

Other conflicts

Family and social priorities impose further conflict. Many do not spend enough time with family and children due to the demands of duties and studies. Many have limited social contacts as they hesitate to mix with people of other backgrounds, and if their culture or religion forbids alcohol, many social events may be off limits. Religious duties may be of paramount importance for some.

Later years in training

Satisfactory progress in training, appraisal, RITA, audit and clinical complaints are a source of stress for all doctors in training, but especially so for IMGs. After a few years in training if the FRCA is passed and progress of training is satisfactory, the future may look brighter. Considerable social, religious and cultural adaptations usually occur but stress continues as there are conflicts arising from the decision whether to stay in the UK, return home or move to other destinations [5].

Inequality and discrimination

Diversity is about recognition and valuing of differences in its broadest sense[5]. It is about creating a working culture and practices that recognize, respect, value and harness differences for the benefit of the organisation and the individuals. *Equality* is about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential - all persons under consideration are treated in the same way. Although diversity and equality are different terms, these are erroneously used interchangeably. Inability to interpret the difference may be one of the reasons of perceived discrimination. Discrimination occurs when a person is treated less favourably than another because of their race, sex or martial status [6].

Various published research [1, 2, 3] has shown that the IMG is less likely to be successful at work, more likely to fail examinations, and many end up as trainees with difficulties. A disproportionate number face disciplinary action, fail to reach the top of training ladder and many believe discrimination is one of the main reasons.

The NHS has a role to play in overcoming these inequalities by ensuring it is a good employer, and by striving to eliminate prejudice and discrimination[7] .

Conclusions

Many IMGs in anaesthesia will continue to come to the UK for higher training. Finding training jobs has become difficult due to changes in the immigration law and increasingly tough competition. Gathering appropriate information before leaving home countries is essential. Many IMGs go through financial, cultural, social and religious hardship and suffer constant worries and insecurity. It is important to understand and appreciate the difficulties faced by IMGs and increased understanding on the part of both trainers and trainees can only help making the training period pleasant and beneficial for all.

Professor Chandra Kumar, Consultant Anaesthetist,
Middlesbrough,

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2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007~ 2007

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- **Professor Gavin Kenny,** Remifentanil: The perfect peri-operative opiod
- **Dr Ross Kerridge,** Implementation of peri-operative systems: an international perspective
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- **Professor Mervyn Maze,** Anaesthesia: A molecular conundrum
- **Professor Don Poldermans,** Peri-operative medication
- **Dr Andy Rhodes,** Anaesthesia for bariatric surgery
- **Dr Neil Soni,** An ideal peri-operative fluid
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Contact: Siobhan Mythen, Event Administrator on behalf of Centre for Anaesthesia, UCL,

E-mail: SiobhanMythen@btinternet.com

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The Association of Anaesthetists
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New Seminars

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Thursday 10 May 2007
Held in Association with the Royal College of Anaesthetists
Organiser: Dr R Alladi, Lancashire

- Anaesthetic considerations in the elderly
- Current trends in anaesthesia for orthopaedic surgery - joint replacements
- Ultrasound in regional anaesthesia- practical issues
- Temperature regulation and hypothermia in anaesthesia
- Anaesthesia for day case surgery- current trends and future
- Can we use LMAs in obese patients?

WORLD ANAESTHESIA CHALLENGES, SUCCESSES AND OPPORTUNITIES

Wednesday 16 May 2007

Organisers: Dr M Bill, Belfast & Dr K Henderson, Brighton

- Anaesthesia in a war zone: Iraq
- Surgery in a war zone: Afghanistan
- Disaster anaesthesia: Darfur, Sudan
- Developing services: Ethiopia
- Teaching: Long term: Malawi
- Teaching: Short term

OPTIMISATION OF HIGH RISK PATIENTS

Tuesday 22 May 2007

Organiser: Dr R Alladi, Lancashire

- Preoperative optimisation – Can we prove it makes a difference?
- Organisation of assessment and optimisation
- Patients with respiratory diseases
- Patients with hepato-renal diseases
- Patients with diabetes
- Patients with cardiac diseases for non-cardiac surgery

ANNUAL UPDATE ON THORACIC ANAESTHESIA

Thursday 24 May 2007

Organiser: Professor F Gao, Birmingham

- What can we learn from the UK pneumonectomy outcome study?
- Anaesthesia for thoracic spinal surgery
- Anaesthesia for paediatric thoracic surgery
- Anaesthetic management for oesophagogastrectomy
- Thoracoscopic lung resection
- Post thoractomy chronic pain syndromes
- Case discussion: elective and emergency thoracic surgery

SAFE TRANSFER OF CRITICALLY ILL PATIENTS

Wednesday 6 June 2007

Organiser: Dr P Farling, Belfast

- Safe transfer of patients with brain injury
- NICCaTS - A centrally based transfer service
- Transfer and the ambulance service
- Paediatric transfer
- Air transfer

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ANAESTHESIA FOR PATIENTS WITH ENDOCRINE DISORDERS

Wednesday 4 July 2007

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- Anaesthesia for patients with diabetes mellitus
- Anaesthesia for patients with thyroid disorders
- Anaesthesia for patients with disorders of the parathyroid glands
- Anaesthesia for patients with a phaeochromocytoma
- Anaesthesia for patients with endocrine disorders of the pituitary gland

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CARE OF HEAD-INJURED PATIENTS IN NON-NEUROSURGICAL CENTRES
Joint meeting with the Neuroanaesthetic Association of Great Britain & Ireland
Thursday 22 February 2007

MANAGEMENT OF MAJOR TRAUMA
Monday 26 February 2007

PERIOPERATIVE MYOCARDIAL INJURY: IMPLICATIONS, DIAGNOSIS AND MANAGEMENT
Wednesday 28 February 2007

GAT: PAIN SEMINAR
Tuesday 6 March 2007

SCOTTISH SEMINAR TO BE HELD AT SCONE PALACE, PERTH CLINICAL EPIDURAL ANAESTHESIA
Thursday 8 March 2007

SCOTTISH SEMINAR TO BE HELD AT SCONE PALACE, PERTH ANAESTHESIA AND THE ELDERLY
Friday 9 March 2007

THE 'CATEGORY 1' CAESAREAN SECTION: DELIVERING SAFETY FROM CHAOS
Wednesday 14 March 2007

FIBREOPTIC ENDOSCOPY AND INTUBATION
Thursday 15 March 2007

CARDIOTHORACIC INTENSIVE CARE – UNIQUE PROBLEMS II
Thursday 29 March 2007

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Wednesday 18 April 2007

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General Medical Council Health Procedures

Professor David Hatch
Chairman, GMC Health Review Implementation Group

In 2003 the General Medical Council commissioned a review of its procedures for dealing with doctors whose fitness to practice is impaired by ill health. The review, conducted by the Health Review Group (HRG), under the Chairmanship of Dame Deirdre Hine, was completed in 2005, and made ten recommendations.

After consultation with relevant bodies including AAGBI, the GMC accepted all ten recommendations. This article outlines the main workstreams flowing from the HRG recommendations and our progress in their implementation.

Most doctors who are ill never come to the GMC's attention, and quite rightly so. Where there are good local systems to support and supervise sick doctors there is no need to refer to the GMC. However, we do need to have effective procedures in place where local arrangements are no longer working. We currently have around 300 doctors with GMC restrictions in respect of their health, most of whom have either substance misuse or mental ill-health diagnoses. Of these, 17 are anaesthetists.

Our implementation of the HRG recommendations falls into 5 main areas:

- Chemical testing
- Sharing information
- Support for doctors
- Guidance
- Operational issues

Testing

Arguably the most sensitive issues contained within the report concern doctors with health problems related to alcohol or drug misuse. The HRG recommended that the GMC develop guidance on unannounced chemical testing, including testing at the doctor's place of work and that unannounced chemical testing should be a component of the supervision arrangements where the impairment concerns alcohol or drug addiction or misuse.

The GMC does not advocate random drug testing for all doctors and is mindful of the recent study by the Rowntree Foundation[1] which concluded that there is no justification for drug testing simply as a way of policing the behaviour of a workforce, nor is it an appropriate tool for dealing with most performance issues. However, in the case of doctors with known drug or alcohol addiction, whose practice is restricted by the GMC, we do need to make sure that the doctor remains substance-free. Any pre-booked testing arrangements are clearly open to abuse, and whilst the numbers of substance misusers seeking to evade detection are low we must take steps to ensure our own systems are as rigorous as possible. Our new policy therefore sets out a risk based approach to testing for the presence of drugs and/or alcohol which may include unannounced testing in the rare cases where the case examiners, who are medically qualified, feel this is needed to protect patients. Case examiners will also decide on the frequency and nature of such tests (blood, urine, hair etc.), which will be carried out within the NHS whenever possible.

Sharing information

The HRG recommended that the GMC develop a clear policy on the circumstances in which it should share conditions and undertakings that relate to a doctor's health with others.

Doctors who have been examined by 2 medical examiners and found to have impaired fitness to practise due to their ill health receive medical supervision arranged by the GMC for the entire period of their restricted registration. This may be for a year or two or may run for many years, depending on the nature and severity of the doctor's condition. Doctors providing this supervision do receive details of the impairing condition/ treatment and any treatment related restrictions. Similarly we do provide information on the treatment related restrictions to the treating doctor.

We do not share information with doctors' employers, or with those providing clinical supervision at work on the doctor's health, treatment or treatment related restrictions without their consent. This is because doctors in this situation are patients too, and confidentiality principles apply to them as with any other patient.

We will however tell the doctor's employer or contracting organisation that we have taken steps to restrict the doctor's registration, and share the practice related restrictions with them. Often we find that employers are already aware of health problems, however we will not discuss these with them without the doctor's explicit consent.

Support for doctors

The HRG recommended that services for the treatment and rehabilitation of affected doctors should be developed by the DoH, in partnership with the profession.

Whilst the GMC's primary role is to maintain the register of doctors who may practice medicine in the UK, we are aware that the operation of our fitness to practice procedures can be an extremely stressful and difficult process, particularly for doctors who are ill. Whilst Dame Deirdre's review mainly focussed on our procedures for dealing with sick doctors she clearly took a broader approach & also considered issues such as propensity to addiction, the pressures on sick doctors undergoing GMC investigation and the availability of support mechanisms.

The GMC obviously cannot be a provider of support or rehabilitation; however we do have close links with many organisations, including the Association of Anaesthetists, who provide such services, and consult with them. The main aim of our fitness to practice procedures is to protect patients; however we are proud that our procedures for dealing with doctors who are ill, which have been developed over more than twenty years, have assisted a great many doctors to remain in or return to active practice. This is in no small part due to the professionalism and dedication of our medical supervisors.

Guidance

Three of the HRG recommendations concerned the development of guidance. We now have detailed guidance in place to support affected doctors, employers/contractors, decision makers and staff.

Operational issues

A series of improvements to our operations, such as drafting restrictions more appropriately, dealing with doctors who are indefinitely suspended from the register, and clarifying the roles and responsibilities for all those involved in responding to sick doctors were also recommended by the HRG. These have now all been implemented successfully.

A full list of the HRG recommendations, along with a copy of Dame Deidre's report, is available from Blake Dobson, Head of Case Review. Blake is also happy to discuss any aspect of the operation of the fitness to practice procedures in relation to doctors who are ill. He can be contacted by telephone on 0161 923 6462 or by email – bdobson@gmc-uk.org.

Reference;

1. Drug testing in the workplace - report of the independent enquiry into drug testing at work. Joseph Rowtree Foundation, 2004. (www.jrf.org.uk)

From toothache to pain medicine

A resumé

The History of Anaesthesia Seminar was held at 21 Portland Place in October 2006. Eight lectures traced the discoveries and events which shaped the development of pain medicine into a specialty. The speakers included four professors (Tony Wildsmith, Ian Power, Tony Dickenson and Alastair Chambers), Dr Ed Charlton and myself.

Humphry Davy described the pain of a wisdom tooth, yet on discovering the analgesic properties of nitrous oxide in 1800, focussed on the recreational use – the time was not ripe for the interaction of ideas. However, the excruciating pain of toothache put *dentists* at the forefront of the breakthroughs in anaesthesia: Horace Wells with nitrous oxide in 1844 and William Morton with ether in 1846. The idea of patient controlled analgesia (PCA) was proposed as early as 1847 by William Hooper, but this was ahead of its time.

Self-administration of laudanum orally was commonplace in the mid-19th century. The innovation of the syringe with needle by Alexander Wood in 1855 heralded the parenteral route – it also set the stage for nerve blocks once the local anaesthetic properties of cocaine were demonstrated by Carl Koller in 1884.

The first account of neuropathy came in 1872 from S Weir Mitchell, who worked with amputees from the American Civil War. The introduction of aspirin by Felix Hoffmann in 1897 was a major addition to available analgesics. By 1906 Sir Henry Head had mapped dermatomes and matches to spinal roots, while CS Sherrington provided the first concept of nociception and integrated mechanisms in the nervous system. Erlanger and Gasser in 1929 described peripheral nerve fibre categories as well as pressure and cocaine block of these fibres.

Felix Hoffman *John Bonica*

Neuraxial techniques developed alongside the above discoveries in neurophysiology. Neurolytic agents were introduced: alcohol by Schlosser (to treat tic doloureux) in 1905, phenol by Doppler for sympathetic block in 1925. It was the superb book *Regional Anaesthesia; Its Technique and Clinical application* by Gaston Labat (1922) which popularised spinal analgesia – this work is still a worthy reference today! The use of intrathecal alcohol in the management of intractable pain was first introduced by Dogliotti in 1931. It took many years for the problems of neurolytic blocks to be realised.

A landmark publication was the gate control theory by Melzack and Wall in 1965: in essence, low threshold impulses are subject to modulation. Wall then advised the rejection of the mechanism of pain as a fixed rigid modality – instead suggesting a *plastic* process. In the 1970s came the discovery of opioid peptides (probably released in pain-relieving manoeuvres), followed by the elucidation of opioid receptors.

Organisation of pain services in the UK dates from 1967 when Cecily Saunders opened the first hospice in London. In the same year Mark Swerdlow in Manchester wrote to colleagues at the few existing pain relief clinics and instigated the founding of the Intractable Pain Society (IPS). The first International Symposium

on Pain was organised by John Bonica in Seattle in 1973, thereby creating the International Association for the Study of Pain (IASP). The IPS became the British Pain Society, which is now the largest national chapter of the IASP.

PCA with IV opioid was pioneered in the USA by Philip Sechzer over 1968-71. The first commercially available PCA device in UK was the "Cardiff Palliator", launched after a paper on its prototype in 1976. Use of epidural opioid was described in 1979. Despite these advances in analgesic techniques, provision of postoperative analgesia remained parsimonious right up to the 1980s. The first account of an Acute Pain Service came from Brian Ready in Seattle in 1988. A Working Party chaired by Professor Alastair Spence produced the landmark UK report *Pain after Surgery* in 1990. This addressed the shortcomings in the British Isles and stimulated the emergence of the first Acute Pain Teams incorporating Clinical Nurse Specialists in UK hospitals. Attempts at standards were made by the Audit Commission *(Anaesthesia under Examination)* in 1997 and the CSAG *(Services for Patients with Pain)* in 1999.

Training in pain medicine in the UK received a boost when in 1993 the Royal College of Anaesthetists proposed its development as a specialty within anaesthesia. This was approved by the Conference of Medical Royal Colleges and their Faculties. A Pain Management Committee was set up by the College under the chairmanship of Dr Douglas Justins with representation from the AAGBI and the Pain Society. Hence training in pain medicine for trainees in anaesthesia became more structured. The IASP published a 'core curriculum' and the application of this was orchestrated by Dr Ed Charlton. Most recently the creation of a Faculty of Pain Medicine within the RCA was approved.

All in all, it proved a very interesting day with much to be learned. Don't miss the 2007 seminar!

Alistair McKenzie
Consultant Anaesthetist, Edinburgh
(Hon Librarian, AAGBI)

Diary date - the 2007 History of Anaesthesia Society Seminar will take place at 21 Portland Place on October 16th . Further details will be available in Anaesthesia News and on the AAGBI website later this year.

Wrestling with Ethical Investment

The Association operates as two organisations, the Association of Anaesthetists of Great Britain and Ireland Limited (AAGBI) which is a company, and the Association of Anaesthetists of Great Britain and Ireland Education and Research Trust Limited (E&R Trust) which is a company and a registered charity. Proper financial management, Charity Commission guidance and to some degree company law, mean that each company requires some financial reserves which must be properly invested and regularly reviewed. In practice, the portfolios are monitored by the Investment Committee and supervised by the Honorary Treasurer, the Finance Committee with support from a professional financial adviser and retained investment manager. Investments are spread across cash, equities within managed funds and property. In this way we can capture growth in the stock market without undue risk. In the past, the successful investment of surpluses provided the resources to purchase 21 Portland Place without a direct appeal to members, and the income from investments makes an important contribution to funds. The E&R Trust is far from being financially self-sufficient and until it can build substantial reserves will continue to rely heavily on the Association's subscription income.

What constitutes a good investment and should we only be concerned with stock market performance? In June 2005, the Finance Committee, headed by the Treasurer, reviewed our investment strategy and determined to progressively disinvest from the tobacco industry and to consult with members about a broader strategy of ethical investment. Many charities invest ethically in line with their aims, so tobacco exclusion is a logical response for the Association as a medical organisation. We do not currently have any direct shareholding in the tobacco business (i.e. no shares in BATS, Phillip Morris etc), however, we have significant investments in managed funds, many of which contain holdings invested in tobacco. Furthermore, in managed funds, the composition of the fund is at the discretion of the fund manager and a fund which is tobacco free one day may be a shareholder the next. Accordingly, disinvesting in tobacco is not entirely straightforward and requires a comprehensive portfolio analysis together with a managed programme of disposals and reinvestment. To assist us in this process we have switched our investment advice to an organisation with appropriate expertise and we are progressing the necessary disposals and reinvestments over a period to avoid a 'fire-sale'.

The response of Association members to our questionnaire was diverse and reflected many individual opinions on ethical investment. Some members are sharply businesslike and feel that the Association's money should be wherever it can achieve the highest return regardless of the sector in which it is invested. However, the clear majority indicated their interest in the Association pursuing an ethical investment policy and would like us to exclude a wider range of activities. Mindful of these varied opinions the Finance Committee is exploring the next steps in ethical investment.

Ethical investment is not new - it has been around for about 25 years, but only in recent times has the investment industry realised that ethical companies tend to be better managed and it is no longer the case that investing ethically means having to accept lower returns. A wider approach to ethical investment might take us in directions that are "mission related" i.e. to make investments in medicine and health (the Charity Commissioners are strongly encouraging mission related investment). Other considerations include corporate social responsibility (customers, communities, employees and the environment) and good management i.e. company reputation and governance, avoidance of

litigation, fines, exploitation and "fat cat" remuneration. Individual companies may be analysed for "negative activities" and "positive themes", some of which are listed in table 1.

Table 1.

Negative Activities	Positive Themes
Tobacco Manufacture	Alternative and renewable energy
Armaments	Community and charity involvement
Animal experimentation (non life saving)	Education
Alcohol manufacture	Environmental protection and control
Biotechnology (abusive practice)	Financial security
Exploitation of natural resources	Healthcare
Gambling (major activity)	Healthy eating
Nuclear processing	Leisure and relaxation
Pornography (major activity)	Provision of vital products and services
	Quality goods and services
	Safety and security

When companies have both positive and negative features, ethical investment is not as simple as it might at first seem! The skill is in the analysis that allows "ethical compromise" decisions to be made. For example, if we wished to take a stance against alcohol we might decline to invest in manufacturers and off licence chains but maintain investments in supermarkets because although they sell alcohol, it's a minor part of their business turnover and not a primary function.

Ethical compromise can be taken a stage further and each individual company carefully scored against key elements identified in table 1. An example of how this might be applied to two supermarkets is shown in table 2.

So where does this leave AAGBI and the E & R Trust? Are there enough good businesses to allow us to invest ethically? If we review the entire UK investment market place i.e. FTSE 100 and FTSE Mid 250 plus available UK managed funds then approximately 25% of these opportunities might meet normal investment criteria as good investments, irrespective of whether the companies contain positive themes or negative activities. If we are more selective and only include those that are strictly positive, then maybe 10-15% will be appropriate.

Table 2.

Supermarket Chain A	Supermarket Chain B
Positive themes	*Positive themes*
Product quality from ethical sources	Good customer service, environmental policy
Emphasis on healthy eating, GM free	Good employment conditions
Good customer service, environmental policy	Special focus on supporting schools and communities
Negative activities	*Negative activities*
Previous pollution fines	Building stores on greenfield sites
Checkouts offer snacks and confectionery	Poor pollution record
	Tobacco kiosk arrangement
	Products sourced from oppressive regimes

Out of this selection, a well-balanced portfolio can be constructed for medium term returns, but as with all investment in the stock market performance is not guaranteed. Ethical investment can lead us towards well-managed companies involved in good businesses. It will also tend to lead us away from investing in, say, an oil company which faces higher costs due to a history of environmental and safety issues, making it possibly liable for substantial compensation and fines, eg the current situation with BP over its Texas refinery and its Prudhoe Bay pipeline.

What should happen next? At present we are actively progressing with tobacco exclusion and are currently neutral on other sectors. Our options include developing a progressive bias towards "positive themes" (see table 1 above) and this is favoured where we have an investment choice in the same business sector between a company that is seen as ethical and one that is not. Council could go on to consider selective exclusion of certain negative activities (e.g. armaments, alcohol) and perhaps subsequently move to a full exclusion of "negative activities". The Treasurer will progress this complex decision making process through the Finance Committee and Council with the help of our specialist ethical investment adviser and remain as always interested in the opinions of our members.

Rob Sneyd, AAGBI Council Member,
Francis Wirgman, AAGBI financial adviser

NICE Technical Guideline issued: Sweets in the Operating Theatre

From our correspondent Scoop O'Lamine

AAGBI spokesman Dr I Rabiton reports on the latest NICE guidelines issued in response to confusion over the best sweets for anaesthetists to eat in theatre. "Some members are risking their lives sucking and chewing inappropriate confectionery in a mistaken attempt to increase patient safety in the operating theatre. NICE experts have been able to take account of any published research or Cochrane reviews and issue clear effective guidance of this controversial area."

Scoop is amazed to learn that choosing the wrong type of sweet can cause significant sleepiness associated acutely with the release of insulin and long-term with obesity; not to mention the risk of acute dental injury and chronic toothache. On a more positive note, research has clearly shown an increase in morale from a carefully selected sweetie at a tiring moment.

"It is important that the sweet chosen is matched to the clinical situation confronted. For example boredom is best relieved by a multi-flavoured hard sucking sweet, where interest can be stimulated by the rolling action of the tongue. On the other hand a difficult anaesthesia dilemma should be managed by a sticky toffee, fruit pastille or American hard gum as it has been clearly demonstrated that the intense chewing motion increases cerebral blood flow to pre-frontal gyrus area 671, the area identified on CT scanning as the part of the brain used to solve difficult problems. For anaesthetists who are toffee intolerant due to caries and poor dentition, a multiple dose of extra-strong mints is acceptable. A hard sweet with liquid centre can promote a feeling of intense satisfaction on crunch and release, particularly if this moment coincides with the resolution of a clinical crisis."

Anaesthesia News discussed these recommendations with a number of experienced anaesthetists. "It's good to know that NICE is carrying out such important work" explained Dr Jeremy Auldfawt, "although from personal experience I would say that not much beats a mint humbug in theatre for a sticky situation."

NICE also issued an important note for surgeons: a big expensive box of chocolates for the theatre staff to share will invariably ease tension in the case of a list overrun, planned or otherwise.

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For further information and an application form
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or telephone 020 7631 1650.
Application forms should be forwarded to the Honorary Secretary, The Association of Anaesthetists
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WORLD INSTITUTE OF PAIN

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  Dr. J. Van Zundert MD PH.D FIPP
  Ziekenhuis Oost Limburg, Genk, Belgium
- **Epidural Adhesiolysis-the evidence**
  Prof. Gabor Racz MD FIPP
  Texas Tech University, Lubock, Texas, USA
- **Intervertebral Disc Interventions- the evidence**
  Dr. P. Finch FIPP
  Director, Perth Pain Medicine Centre, South Perth, Western Australia
- **Epiduroscopic Procedures-the evidence**
  Dr. J.W. Kallewaard MD
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  Prof. M. Day MD FIPP
  International Pain Institute, Texas Tech University HSC. Lubock, Texas USA
- **Vertebroplasty-the evidence**
  Dr. R. Benyamin MD DA FIPP ABIPP
  President, Millenium Pain Center, Bloomington Illinois, USA
- **Intrathecal Pumps-the evidence**
  Prof. S. Erdine MD FIPP
  Dept. of Algology, Faculty of Medicine University of Istanbul, Istanbul, Turkey
- **Spinal Cord Stimulation-the evidence**
  Dr. A. Al-Kaisey MD FIPP
  Guy's & St. Thomas's Hospital, London, UK
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  Prof. M. Sjuijter
  Consultant, Pain Unit, Swiss Paraplegic Centre, Notwil, Switzerland
- **Epidural Steroids-the evidence**
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  President, Millenium Pain Center, Bloomington Illinois, USA
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FURTHER INFORMATION

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The African Flying Doctors Service: an elective experience

An emergency evacuation in process.

I am currently a foundation year house-officer in Anaesthetics and Intensive care. My medical elective was based in Kenya and Tanzania working with the African Medical and Research Foundations (AMREF) Flying Doctors Service. In particular, I was interested in the acute care and transportation of critically ill patients.

The Flying Doctors Service (FDS) was established in 1957 by Sir Michael Wood, a British surgeon, and is now incorporated under the umbrella of AMREF. Today AMREF is the largest independent, non-profit, non-governmental organisation in Africa. The FDS provides emergency evacuations and care services to all parts of Africa. The service is based at Wilson airport, Nairobi and operates 24 hours a day, seven days a week. It communicates with over 120 base camps in Africa via high frequency radios. It has a fleet of helicopters, turbine and jet aircrafts, all of which are modified to provide and monitor life support. In addition, specific ambulances are used to transfer patients from the aircrafts to respective hospitals. On my trips, the crew comprised the pilot, flight nurse, doctor and myself. The crew rotated on an on-call basis and were ready to fly within fifteen minutes. The doctors were at least of registrar level, with a background in intensive care.

Essential life support equipment on board the aircraft was prepared and checked on a daily basis. This included oxygen cylinders, defibrillator, suction, spinal vacuum and a trauma Thomas pack. Evacuations were necessary for a variety of conditions including road, rail or air traffic accidents, war and tribal injuries, medical or surgical emergencies, infectious diseases or animal attacks. This unique workload is a challenge to the crew and is further increased due to time constraints and physiological changes occurring during the flight.

The AMREF team at base

Our youngest emergency evacuation was a one day old girl who was born near the Somalian border. After a successful vaginal delivery, the local doctors noted a protruding mass from the baby's mouth. This mass was identified as a neoectodermal tumour and required urgent surgery, which was only possible in Nairobi, a three day journey by road. The baby was assessed and found to have a 7x8cm firm, non-pulsatile mass originating from her palate. The airway was secured using a nasal tracheal tube and the baby was transferred to the aircraft. She remained stable throughout the flight and was in Nairobi within two hours, where she underwent reconstructive surgery.

Kenya is well known for its wildlife: although a great tourist attraction, wild animals can pose a danger. One such occasion was an evacuation call from a game reserve in Gilgil, outside Nairobi. An English tourist was on a walking safari when he was attacked by a buffalo. The initial impact forced the man to the ground, after which he was stamped upon by the buffalo. Further nuisance was caused by animals as our plane could not land due to an elephant obstructing the makeshift runway! On arrival our primary survey focused on any penetrating injuries the man may have suffered from the horns of the buffalo. Thankfully there was no sign of such an injury, but he required fluid resuscitation, and was placed on a spinal board using the scoop and vacuum technique. He remained stable during the flight and was transferred to the trauma centre in Nairobi. The man's injuries comprised lumbar soft tissue damage and a rib fracture, but had escaped a potentially fatal attack. He later recalled that he had remembered to remain calm and lie flat (prone) on the ground in order to protect his abdominal organs – useful advice should one ever come face to face with an angry buffalo!

The elective period provides an opportunity for medical students to explore a variety of specialities, medical practice and culture beyond that of the NHS. My elective enabled me to gain an insight into anaesthetics and transportation of critically ill patients. Furthermore I was exposed to a variety of cases which I could only experience in a developing world environment.

However, anaesthetic-based electives are not popular with medical students as a whole. Reviewing the data at Leeds University it is apparent that over the previous three years only 4% of medical students had undertaken an anaesthesia - based elective. There may be a number of reasons for this trend. The Leeds medical course offers only a two week placement for medical students throughout their five years, which may also be the case in other medical schools. Alternatively anaesthetics may be viewed by many students as routine day surgery in theatres, which they may not view as the ideal elective experience in a tropical country! A period of experience in anaesthesia combines practical skills, applied physiology and management of critically ill patients, all of which provide learning beyond the medical school curriculum and are essential for life as a junior doctor.

As university fees and student debts continue to rise, there may be a lack of funding for anaesthesia electives. Therefore medical schools and anaesthetic departments should be encouraging students to pursue electives in a variety of anaesthesia - based environments. Students should be made aware of the funding provided for medical electives by national bodies such as Association of Anaesthetists.

The AMREF flying doctors service provided me with a unique opportunity to experience acute critical care and the challenges

One day old baby with oral tumour

of transporting patients in flight. My elective enabled me to also appreciate the work of anaesthetists beyond the theatre and encouraged me to pursue this as a foundation year one doctor.

Dr Milap Rughani
Foundation Year One Doctor - Anaesthetics and Intensive care
St James's University Hospital, Leeds

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Delegates may wish to attend one or both days

Course Fee:

• Days 1 & 2	= £ 100
• Day 2 only	= £ 50
• Dinner at a local restaurant on 17th April	= £ 20

For further information, please contact:
Adrienne Fitt-Williams, SIP Course Co-ordinator
Paediatric Intensive Care Unit, Bristol Royal Hospital for Children
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Tel. 0117 342 8843 • Fax. 0117 342 8910
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'Would never have done amount of multiple choice questions on my own'
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'I would highly recommend this to anyone coming from outside the region'
'Well worth coming'
'Exhausting but oddly enjoyable'
'Well organised'
'Course duration – long, but could not have done as much as this at home'
'Good bright answer references – keeps you awake & positive'
'I am now more prepared to face the MCQ paper'
'Good course'
'Highly recommended'
'Very good variety of questions'
'Highly recommended course'
'Excellent course'
'Good variety of MCQs'
'Definitely increased my chance of passing'
'Well worth attending the course'
'I fell so much better prepared, therefore much more confident too. Thank you'
'Yet another tiring week but hoping it will be all worth it! Certainly would not have gone through so many (questions) if not for the course. Thank you again!'
'I liked the variety of papers'
'Definitely worth coming'
' I would have never done as much work in a week left to my own devices'

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De Quincy
Brave New World & IMGs

One of the few good things about MMC, at least as advertised when it was first being trailed, was how those who transferred from one specialist training program to another would not have to start at the bottom again. They would get credit for competencies acquired in their first speciality, and not have to 'reacquire' them if they transferred to another speciality. How forward looking, we all thought, though wondering whether it would affect training for anyone except flexible trainees. How good not to require someone taking up acute medicine after a year's anaesthetics, for example, not to have to relearn BLS[1], or someone going into ICM after a year's surgery not to have to relearn, say, tying knots to tie CV lines in. How good - it will shorten training by several hours for the three trainees a year allowed by the State to change specialities.

Then there was the change to Equivalence assessments. This arcane art is beyond most of us, but involves working out, from documents alone, whether the applicant has the competencies s/he would have acquired in the CCT program. Some have never worked in the UK, and have had shorter training programs than ours, yet are admitted to the Specialist Register if the evidence is that they have the required competencies. Now don't get me wrong, I'm not knocking this: it was a scandal when a doctor who had been in independent practice for decades, at the same or higher standard than here, could not practise here because his/her training in the 1970s was a year shorter the current 7 years, when those trained in the 70's might have got accreditation after 5 years. The new system is a big step forward, especially as where documentary evidence is uncertain, there can be an assessment, not allowed under the old system.

So we have two brave new ideas in our New Labour world that allow recognition of competence acquired elsewhere, in other specialities or in other countries' training programs. Good stuff, inclusive, eh? So, what would we expect to be the attitude to partial training acquired overseas which is not enough for equivalence? If they are in the UK, perhaps put them into those parts of the speciality training program they lack, and bring them to a CCT in a year or so? A good way of getting more fully trained doctors quickly? For those from outside, with maybe competences to ST4 or 5, let them apply to enter training at that level, perhaps? At least be able to recognise more than the year of overseas training that anaesthesia has always recognised? Of course, you reply, must be so, how can it not be considering the inclusiveness and good sense of the other new ideas.

So what's the answer? How much overseas time/ what range of foreign acquired competences can be recognised as contributing enough to training to shorten it significantly? The answer is none. Zilch. Not a jot. Not even the year they are currently (till January) allowed. Not a day!

I was astonished when I heard this. It is completely opposite in principle to the other changes. How can it be so? PMETB will no doubt tell you it is in their governing order, and they don't have an option to ignore that, and I suspect that is true, though irrelevant. Why has this been allowed? How can it be fair that someone with overseas training, perhaps to the maximum standard attainable locally, has to start again if they come here? Admittedly, it is of a piece with the removal of permit free training, which also seems designed to keep foreigners out, and makes me wonder if that is the explanation: the State has a racist agenda, bent on excluding foreigners. The only problem with that is that (a) the population of Europe can come in, without Equivalence testing, under mobility of labour provisions; and (b) if that is the case, why make Equivalence fairer?

It is easy to say that the State is not consistent, and cock-up is always more likely than conspiracy. But perhaps there is a plan. Perhaps the State's plan *is* to exclude international medical graduates, the concessions for equivalence and transfers being a diversionary stratagem, numerically insignificant. But why not write to your MP[2] and ask, Why is foreign training not counted on entry to MMC specialist training programs?

And while we are on conspiracies, I note with interest that the view that the State's intention is to rid itself of turbulent consultants is now fairly widely held. When, then, can we expect the next step, official announcement of the inception of sub-consultant specialist posts, to 'absorb the energies of all those unemployed CCT holders'?

Dr de Quincy.
(Dr de Quincy is a consultant at a DGH near you.)

[1] Basic Life Support. Interesting, though, that this provision does not apply to consultants, where I am supposed to have annual BLS refreshers, perhaps by attending a study day run by one of my own department's current SHOs!

[2] If you write to anyone else in the State apparatus, they can just bin it, and do: the MP *has* to take it up with the Minister, who *has* to reply.