ANAESTHESIA POINTS WEST

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THE SOCIETY OF ANAESTHETISTS OF THE SOUTH WESTERN REGION

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https://saswr.wildapricot.org

ANAESTHESIA POINTS WEST

Contents

Editorial

I am delighted to be writing my first editorial for Anaesthesia Points West. A recent graduate from the Peninsula School, I have completed all my anaesthesia training in the South Western region and strongly believe in working together across borders, sharing ideas and linking up with old friends and colleagues. To me SASWR really embodies this sentiment. I would like to thank Ben for his hard work in this role over the last three years, his detailed handover and his patience in answering all my endless questions! He has also acted as assistant editor for this edition to smooth the transition. From the next edition we welcome back Mark Pauling as assistant editor.

These are exciting times for SASWR. Please take the time to read about changes to the website, membership and event registration in "Cloud Surfing", written by SASWR webmaster Ben Howes. Ben and the committee have been working tirelessly behind the scenes to update the website and maximise the use of technology to strengthen our Society. Although we are in a transition phase, I am confident that in time this will transform how members interact with the Society.

The South Western region is home to some inspirational leaders from our specialty. This is exemplified in Dr Muchatuta's excellent portrait of SASWR president, Dr Mike Kinsella. We are very fortunate to have someone of his calibre in our Society.

The 'News of the West' feature continues to provide some very entertaining glimpses into the workings of other departments around the region. You can read all about the impressive work of the first and second prize winners from the Autumn meeting, two South West anaesthetists give us an interesting insight into training in pre-hospital medicine and what anaesthetists offer, Charlie Pope gives us plenty to think about when it comes to airway training and our fantastic trainee research networks are going from strength to strength. Last, but by no means least, regular wine columnist Tom Perris branches out with an excellent summary of all things whisky. So much so, it was enough to inspire me to venture out and pick up a single malt with my new-found knowledge.

I hope you find this latest edition of APW interesting and informative. If you have any ideas for future editions please do not hesitate to get in touch.

Now, shall I add water to this or not…

Johannes Retief – Editor

New SASWR Trainee Representatives

After a competitive process involving several high-quality applications, we are delighted to announce the new SASWR trainee representatives:

Dr Sarah Dolling	Severn Deanery
Dr Helen Williams	Peninsula Deanery

We very much looking forward to working with them. A big thank you also to Drs Ruth Greer and Tom Nightingale, outgoing trainee reps, for all their hard work and enthusiasm.

Future Meetings of the Society

Winter 2019
Bristol
21-22 November 2019

Spring 2020
Truro
14-15 May 2020

News of the West

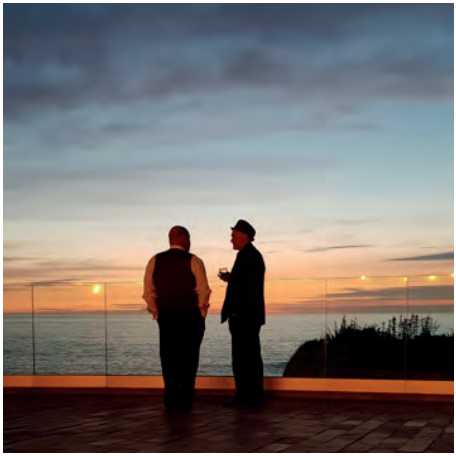
Linkpeople of the Region

This is where you are kept up-to-date on all the news and gossip from each department in the South Western region. The name of the correspondent appears at the end of each contribution and he/she is also the SASWR LINKPERSON for that department. Anyone wishing to find out about more about SASWR, or wishing to join, should search out the local linkperson, who will readily supply details. In addition to other benefits, each member will receive the twice-yearly edition of APW- free! Please also visit the new website (https://saswr.wildapricot.org) for loads of information and joining instructions.

Barnstaple

Greetings from North Devon. Thank you for reading this! It's spring and the wisteria on my patio is looking fabulous, a bit small, like our department, but full of colour and character! Talking of characters, Jan Hanousek, recently departed for the Czech Republic, has had a baby! Great photo of him with babe in arms with an expression that says it all. Welcome….and congratulations too Jan and Jana.

Preparations are well underway for the SASWR meeting at Saunton and I am anxiously waiting to see if anyone turns up! I know that Ricky Dell and his band are going to be one of the main attractions and hope that he has enough groupies to fill the room. With the new online registration system and up-front membership fee it feels like opening a box of chocolates.



I wonder who has started since last going to press? Let me see…opens rota and scrolls down the list for new names… yes, so Gorki Sacher has accepted a substantive job in Anaesthesia and

Chronic pain after some consideration and we are very happy that he and Annalena have settled in Ilfracombe with their 3 kids and not hit the high road for Yeovil and beyond. Annalena is still our sim fellow and we have yet to replace Mel so if you know anyone who is keen for a bit of a break and a CV buffing experience look no further than North Devon and get hold of Joerg da Fonseca our ebullient Sim lead. Joerg organised a sim table at the recent doctors' ball which was held at Tunnels Beaches in Ilfracombe. It's a fabulous venue, evidently one of the top places to get married which might explain why I have not been there before. There was a gourmet BBQ that has to be one of the best BBQ's I have been to (this is an ex South African speaking) and the setting is superb - a beautifully designed restaurant perched just above a secluded beach reached by way of a tunnel! It's like discovering a secret garden. We sipped champagne as the sun set over the sea, a wonderful cliché. There was a band after dinner, a fire pit, giant marshmallows and sparklers. An altogether capital event organised by the mess committee. I spent the latter part of the evening retrieving my hobo-esque top hat from various drunken dancers while a posse of our ITU physiotherapists "we don't get out much," swayed unsteadily around the dance floor swigging champagne straight from the bottle.

Also newly started are Rosemary Hartley and Stuart Cooper who are ACCS Emergency Medicine trainees starting out of sync in the hope that they are up to speed by the time we exchange our current cohort of trainees for a totally new bunch of novices. Vishal Pai has joined us straight from India where he was accustomed to anaesthetising 14 lap choles in a day so I hope he copes with the ever so slightly slothful pace of the NHS in North Devon.

Recently started as Associate Specialists are Moemen Abouelsaad and Susan Hanson. Mohamad Wanas has sadly moved on to take up a post in Harrogate. I hope he has better luck riding his bicycle there!

Rob Conway is settling in well and efficiently sorting out everything paediatric, that yours truly should have done a while ago (the beauty of imperfection is the opportunity for improvement!).

Simon Hebard has passed the poisoned chalice of Lead Clinician to Dave Beard and has recently been spotted celebrating on a beach with his kids!

Congratulations to Pete Rogers, Shun Yamanaka, and Stuart Frankland who have passed the primary and Pete who has secured a Reg job in South Wales, closer to Welsh rugby and his fiancée. Aislinn Browne is off to New Zealand to escape the oppressive paperwork of the UK training system. James Back is staying put in North Devon and Ed Gerrans is off to Taunton.

Nick Love has produced our new rota for ITU and this is currently bedding in. Soon we will be going to a 1 in 9 rota when Gareth Moncaster starts in June. The trainees are meeting for a regular touch rugby session at Instow beach. Pete struggles to avoid the full contact version.

Dave Beard completed his trip around Lake Victoria albeit on the back of a truck for the last bit. He'll be back on his bike by special request to lead a posse of cyclists from Tiverton to Saunton for the SASWR Spring meeting…fingers crossed.

Regards

Guy Rousseau

Bath

Strong and Stable Anaesthesia:
Regardless of your political affiliation or personal ideology, I think few would argue that the ground feels a little unsteady underfoot. It is as if the busiest, most unpredictable trauma list ever met with the longest laparoscopic colorectal case imaginable and together, they became the nightmare that is the Do-We-Don't-We Deal-or-No-Deal Show.

I am grateful therefore that I am able to draw strength from working in an absolutely fabulous department of Anaesthesia, Critical Care and Persistent Pain Management.

Our strong and stable department has been recently bolstered by the appointment of two new consultants, Dr Tim Cominos and Dr Rebecca Leslie. We welcome them and hope that they flourish in Bath. We have also had the consultant body strengthened by the appointment of Dr Damien Wood as a consultant (he has been a member of the department for many years) and Dr Claire Cameron who has joined us from the military. We hope that they too will thrive as consultants in Bath.

While I appreciate this is an anaesthetic journal, I would like to mention the retirement of a Bath surgeon. Mr Jeremy Tate has been a fantastic colleague and I have certainly enjoyed working with him over the past 18 years. He is living proof that the likelihood of booked theatre and actual surgical time correlating is directly proportional to the speed of the surgeon.

We have had one of our own beloved anaesthetic consultants embark on a year of R&R. I believe Jenny Tuckey misunderstood, and rather than enjoy some Rest and Recuperation, she has Retired and Returned and suitably Reinvigorated, she is single-handedly project managing the refurbishment of the department of anaesthesia.

Rather naively she has suggested that the inhabitants of 'The Swamp' tidy their little corner of Bath such that the decorators can actually achieve something worthwhile. However, 'The Swamp' may forever be magnolia with a carpet reminiscent of one of Dr Handel's ties.
We congratulate Dr Sara Cook on her appointment as a consultant in intensive care medicine in Cardiff and wish her all the best in her future career and Dr Stuart Younie who was appointed as a consultant anaesthetist at University Hospitals Bristol.

Congratulations to Dr Ben Savage and Helen on getting married. Also, congratulations to Dr Clare Hommers on marrying Bath's most deluded elite athlete and anaesthetist extraordinaire.

Dr Billy Headdon and Dr Mark Sheils passed their FFICM and Dr James Dalton passed his primary OSCE/viva. Congratulations to all of them. Dr Alice Gerth secured a training number in the Oxford Deanery and we wish her well with her future registrar programme.

We all enjoyed Dr Gold's chagrin when he misdirected a local Turkish Barber. It turns out the difference between a "skin fade" and an acceptable hair cut is a week's holiday.
Sadly, neither I nor our very own captain sweat patch from ITU will know either ever again. Best we can hope for is a decent tan.

Thank you to our own Wonder Woman and College Tutor Dr Mel McDonald and Uncle Tom Simpson who chased me around the Slaughterford Nine and then the Bathalf and enabled me to turn fifty at the same weight (10% margin of error) I turned forty.

Sadly, the department of anaesthesia was soundly beaten by the Maxillo-Facial Surgery department in the

Bathalf. I'd like to believe we will beat them next year....
We are after all, a strong and stable department, as illustrated by Lucy Whitton.

Malcolm Thornton

Cheltenham and Gloucester Hospitals

Busy busy in North Gloucestershire recently. The 'will they, won't they' with our proposed elective colorectal and emergency bowel surgery move from CGH to GRH has had us guessing over the last few months with various 'blue on blue' surgical missiles being exchanged down the A40. For now, the plan is on hold for public consultation with a few sighs of relief shared as GRH continues to operate at maximum black escalation tilt come summer or winter. The mood has been somewhat furrowed by the recent 'theatre hat gate' with first names being branded on cotton hats for all at GRH, much to the consternation of some corners of the department!

Our trainees have had a particularly good time of it recently. A clean sweep at the last round of Primary FRCA torture for Debs Mann, Lucy Duggal and Kat Stratton with Tom Hickish proving top dog and coming home with a Gold Medal, many congratulations! Whilst the Severn Deanery continues to be a seemingly impenetrable wall, there was success for Harry Craven with an ICU number in Oxford and Debs Mann crossing to God's country for ST3 and beyond. Further up the line, Jeannine Stone secured a locum post at Southmead and Sophie Jacobs likewise at the BRI, both richly deserved.

Having recently been through an uncharacteristically barren patch without a new recruit we were back to business as usual with the upgrade of Matt Martin's ICU locum to a substantive which is excellent news, many congratulations! We also welcomed back Clare Newton-Dunne from maternity leave after the birth of her little boy Alexander - great to have you back! The interview panel will be fired up again later this month in pursuit of another new General Anaesthetic consultant colleague. Good luck to all those slugging it out for the post.

On the department front Farmer Dave Windsor has assumed the throne as cross county ICU Lead. He's promised us he'll always have beds and has lifted the ban on doing the ward round in wellies. He'll clearly be excellent and we wish him all the best in his new role. In the departure lounge (of the department!), a CGH stalwart is leaving the ranks. A few words from Mike Copp: David Goodrum will be retiring at the end of July. David joined the department at Cheltenham in 1992 after finishing as a Senior Registrar on the Southampton rotation. He quickly established a close working relationship

with John Mackinnon a newly appointed orthopaedic surgeon which remains in place to day. David's attention to detail made him an obvious candidate for Clinical Director and he succeeded Peter Ritchie in this role within five years of his appointment. During his tenure as CD, David negotiated the move to new office accommodation in Alexandra House. The introduction of the national new Consultant Contract in 2003 presented a significant challenge. David's fastidious approach made him the ideal person to oversee the implementation of the new Contract and Job Planning for the Trust. David took on this role with enthusiasm and continued with responsibility for Job Planning in the Trust as the Associate Medical Director, a position he took on after finishing as CD for Anaesthesia. We wish him well for a long and happy retirement.

Jennifer Daley, our secretarial maestro at CGH, got married recently and went away to enjoy a well-earned break in Liverpool. It's amazing the lengths she'll go to to get away from the office! We wish you all the very best Jen.

It's been a rough time recently for our Lead College Tutor Dr Hunton. A helmetless Hugo, clearly thinking his floppy mop would protect him, recently got on his bike. A headbutt of the road and a trip to A&E to have a 6-inch head laceration sewn up swiftly followed. We're waiting to see if it's improved his chat; so far the signs aren't looking good….

I leave you with a public service announcement. I'm reliably informed that all the off licences in Cheltenham and Gloucester will be struggling to stockpile enough red wine throughout June and may well run dry by July. Tom Perris is hitting the big 50. You have been warned.

Sam Andrews

Exeter

We have had a flurry of new appointments in Exeter. Simon Marshall has been tempted away from Taunton, Helen Gilfillan has joined us from Oxford, and Marika Chandler is about to join us, also from Oxford. In addition, Emily Howells has been appointed to ITU. Welcome to you all. And welcome back to J-Lo, after what feels like several years in the Australian outback. And yet, somehow, we are still short of people. And the list crisis is compounded by several people

being stung for pension tax, and the rest of us worrying about whether we might be stung. Hence hardly anybody is volunteering to cover the gaps. But life goes on. “Four Eyes” are working with us, to make us more efficient. I’m sure we paid somebody else to do this work a few years ago, but no doubt it will be different this time.

Cathryn Matthews has stepped up to replace Harry Pugh as college tutor, but now Kath Meikle has announced that she will be stepping down as the other college tutor, after this year’s round of ARCPs. Many thanks to Kath, for all her hard work during the past 3 years. I, meanwhile, have fallen on my sword, and taken on the role of clinical lead, to support Quentin as CD. It also gives me an opportunity to once again wave my choppy hand with gay abandon. Welcome to new babies for Chris Copplestone, Tom Woodward, Nim and James Cockcroft. All girls, and all not sleeping – I keep telling them that babies aren’t supposed to sleep.

The department has moved house. In order to create space for the behemoth that is MyCare (also known as EPIC), we have been evicted from our offices. To be fair, they weren’t used maximally by the members of our department. We now have a holiday house in the carpark, lovingly, and actually, known as West Cottage. It is a fraction of our former office space, but seems to cover our needs. We are about to install a bed, to replace a consultant on call room, which has been lost to provide more office space for…. MyCare. I think it will soon become a go to holiday destination. There might even be scope to raise some funds for our department, by advertising on Airbnb.

The Christmas party was held in The Hole In the Wall this year, as our wilderness years without the Clarence continue. Apparently, it will be restored by 2020. This year was a little bit down market, darling, but at least we had a reasonable turnout. The regular invasions into our party by the uni ladies hockey team were met with mixed response – depending on whether you were a young man or not. The dance floor had a leak (it was a very rainy night) and so kept pooling with water. Being health and safety conscious, and up to date with my mandatory training, I was worried about slips, trips and falls, so found myself mopping the floor between songs. At least it afforded an opportunity for Ros, Alex Mills’ wife, and I to recreate “I want to break free” by Queen. Who knew that I know all the words? I have a new level of respect from the trainees now (in my dreams). I now also know that Alex Mills was “quite a good DJ” at med school. That will be useful information in the future, I’m sure.

The girls in our department have caused a degree of upset and suspicion by having “a girls’ night out”. Clearly boys are not invited, and clearly all we talk about is the boys. Friday Night Beers seems to be alive and well, as a quick destress at the end of the week.

And finally, I’m pleased to report exam

success for Joel Prescott, Helen Williams and Connie Chen in the primary.

That's all from Exeter for now.

Pippa Dix

North Bristol

Exciting times at NBT, with the latest round of consultant appointments producing a record number of applicants. All of us who have substantive posts are breathing huge sighs of relief that our posts are substantive as our CVs are, by today's standards, at about CT2 level compared to the new generation!

We are delighted to appoint Helen Johnstone and Ruth Greer to the substantive ranks and Drs Nickell, Steed, Howells, Harris and Stone as locums.

Excitement at the above news is tempered slightly by the impending CQC inspection that awaits us. You can always tell something like this is in the offing when whiteboards and folders with titles like 'all you ever needed to know about governance' and 'this is where you can find the policy on hand washing in the event of Martian invasion' written in bold.

James Nickells has informed the team that he is stepping down as departmental lead in the next few months. I wouldn't say there has been a stampede to fill his shoes which is, in my opinion is due to two main reasons. One, that he has done an immense job that makes him a hard act to follow and, two, the fact that there isn't anyone who has worked out if taking on any additional roles or responsibilities at the moment makes fiscal sense or will result in a grey envelope from HMRC and having your house repossessed.

In terms of end of eras we are about to enter the last few weeks of John Leigh's NBT career. John has been a stalwart of the department for many years and has delivered astounding anaesthetic ability and acerbic wit in equal measure as well as being an inspiration to many of us who are now his colleagues. John will be sorely missed by one and all (with the exception of the odd manager or two who have 'benefitted' from John's thoughts).

Peter Klepsch's Austrian wine importing business delivered its latest shipment recently. Judging by the number of cases distributed to colleagues I will be disputing the NHS claims that as a nation the alcohol consumption figures are continuing to show a decline. Talking of wine one of our trainees has just managed to get invited to join the wine buying committee of the Royal College of Physicians (who said MRCP was a waste of time). We're hoping she may smuggle some of the College cellars in NBT's direction.

Simon Lewis continues to lead his team in the dark arts of POAC. There are so many people now referred for iron infusions that he was last seen moving his extensive share portfolio more towards mining companies and smelting works.

Khaled Moaz has returned from the Middle East (he tells us for the final time) and is doing his very best to live up to his new (self-named) nickname “the early Dr Moaz” as he attempts to complete a rebranding exercise.

The rota writing team continue to conjure up quarts from pint pots, though the number of pleading e-mails barometer does seem to be pointing to a high pressure situation at the moment.

On the national stage Ed Morris continues his work at the GMC, Fiona Donald at the RCOA and Sam Shinde at the RSM and AAGBI respectively.

In ICU Matt Thomas is pushing back the research boundaries and is Empire building at a rate not seen since the second series of Game of Thrones. On a serious note, what he’s achieved is impressive and shortly NBT and research powerhouse will no longer be an oxymoron.

There’s plenty of sporting activity as always. Curtis ‘Ancient Mariner’ Whittle managed to enter the NHS regatta and not crash or sink his boat. Gareth Wrathall has organised a walk around Wales and many of us continue to cycle up and down hills with apparent gay abandon. Some have just returned from a conference where a bit of cycling may have taken place but those who went are not at liberty to divulge either name or location for fear that others may find out about it.

As usual all our trainees are wonderful, extremely dedicated, hardworking, pass lots of exams and all deserve consultant jobs.

Ben Walton

Plymouth

There have been a few departures from the department leaving various sized holes that are bigger than expected. The motives and desires of those leaving the department are unified by the theme of spending more time doing the things that they passionate about in the places that

they love. Those who have left us are Chris Seavell, Lorenzo Dimpel and Kevin Patrick. The local impact of the increasing tax and decreasing pension swung the balance in favour of retirement for Chris. After careful calculations about exactly how much he will need to be able to afford to follow the sun and wind throughout the year, and considering how much he will need to replace the various essential pieces of kit that may break in the next years of serious fun, the balance swung in favour of having more fun…. and paying less tax. Unfortunately for the rest of us (mere mortals) this will give Chris even more time to train and become fitter, rather than allowing a graceful decline into some post middle age spread. This seems to be the fate for many more in the department, and it may surprise some that lycra doesn't hide this. We look forward to hearing about some of his new personal bests and toys.

Also, one who has never hidden his physique, Lorenzo is heading off to spend more time riding his horses into more sunsets, whilst squeezing in some charitable working excursions to various destinations around the world. Never one to follow convention, Lorenzo's challenge to the sometimes-lazy thinking of those around him will be missed, and we will be losing a wonderful character from the department. We are still trying to persuade him to come back and do some work in between his trips. It isn't true that we just want to hear some good anecdotes and see the photos.

Kevin's reasons for leaving (again) are different, but the rumours that he was wavering before he had even left the country are unfounded. The 5 months he spent saying farewell to the Dolphin were nothing to do with a challenge to drink the Dolphin dry or with the fact that he couldn't tear himself away from Plymouth. Anyone passing through New Zealand will be welcome to pop in and see him although this could be a time limited offer. The sweepstake has started about how long he will be away this time so you may need to move quickly to take advantage as he may continue to oscillate back and forth between the two hemispheres. All three have been stalwarts of the department and will be greatly missed with their advice and support, "colleaguability" and friendship and we wish them well for their future exploits.

A greater source of sorrow was the very sad news in February that Jane Kehoe passed away. The Back bar is a much quieter place but the cheerful memories of her laughter ringing around the coffee room will stay with all who knew her. She was a wonderful colleague and friend whose passing has left a big hole.

On a happier note, the babies have been limited to just three since the last news, but my ability to find out their names hasn't improved even with the decreased number. Congratulations to Rosada Jackson (baby girl), Sarah Droog (baby boy) both in December and to Rob Arr-Woodward (baby boy) in April. There were exam successes with Primary passes and

congratulations to Rob Arr-Woodward (it could have been a tricky few months otherwise as working for exams with a new born baby is allegedly quite demanding…), Joe Wallace and Felicity Miller. There were written passes for Juleen Fasham and Bijal O'Gara and FRCA successes for Zach Jeffrey, Jeremy Hunter, Chris Gillett and Anna Ratcliffe.

David Adams has decided that he has steered the department for long enough and, despite numerous requests that he should do a second term, he has decided to step down and hand over to Justine Elliott. He has done a sterling job in navigating some difficult times and in continuing to get jobs approved and appoint some brilliant new colleagues. Whilst we wait for the next appointment process to run its course, we are delighted to welcome Lindsey Arrick and Natalie Smith who have started as locums and are already lighting up the department. After the handover of these responsibilities and the finalisation of the last lingering job plans, Dave is looking forward to reacquainting himself with his wife, children and fine wine cellar. Rumours that the procurement process for the replacement of all of the anaesthetic machines has driven one part of this reacquaintance may be true. We are all extremely grateful to him for his hard work on our behalf and wish him every success, in using all he has learnt during this time, for his next challenge of training his dog.

Matt Hill

Swindon

It's been a quiet few months for Swindon so writing this column has been put off and off. An overriding theme is that the juniors are achieving more and more whilst the seniors are drifting sideways or downwards! Top achieving junior goes to 'Professor' Jon Barnes who, after arriving at the Great Western Hospital as a novice, is now Primary positive, dual ST3 positive and has just published a cutting-edge systematic review in April's BJA. Close behind is Andrew Smith who alongside his CT2 day job is setting up a BSc in remote medicine at Imperial College. Exam success has also been achieved by Jonny Harrison and Vicky Hawley.

This all contrasts with the seniors. Jeremy Astin has taken up a new set of tools and is crafting himself a double garage. Post retired but still very much present, Neil Campbell is now qualified to teach cycling as well as working towards an Open University degree in French and Italian. I took my skills into the community when my mother tripped and cut her scalp. After contemplating hours spent in A&E I opened her sewing box and stitched it myself. What would the GMC say?? On the downwards (downhill skiing specifically) is Zoe Ridgway. This March she gained the hat-trick by ending a third winter sports holiday in injury. This time she ended up with a bruise on her face that looked like mixed plasticine…

Moving into the department has been Francesca Ker-Reid, Naomi Cassells

and Sarah Dunn. We will also shortly be joined by a new ITU consultant, Sian Moxham. Moving out are Charlie Dickinson, Matt Govier, Ed Miles, Liam Scott and Layth Tameem. Our pain consultant, Senthil Viuayan, has found a job closer to home at Moorfields and will be off soon. Thankfully it's not all movement, best demonstrated by Mike Entwistle and Helen Jones who have both received long service awards. Our islands in the stream!

Ed Bick

Taunton

Well, it seems like 5 minutes since I started in MPH and, having resolutely decided to follow the wise advice of my senior colleagues to get settled into the department without jumping into extra roles, I find myself writing our latest SASWR Newsletter! A lot has happened in the past 6 months or so down/up in sunny Somerset. There have been appointments, retirements, resignations, babies, weddings, exams and promises of a shiny new surgical building which will rocket us into spacious, state of the art theatre suites.

I began here in the heatwave of last summer, along with Tom Teare and Mark Abou-Samra. We were welcomed into the department with open arms (especially since our arrival coincided with the school holidays) and haven't had to wait very long to move on from being the newest members of the team. Ed Keevil has made Suzie Carty incredibly happy by joining her quest against pain recently, and even more recently we welcome Dan Shuttleworth (ICU and general) who is sensibly hoping to move to the North Curry (yes, that is a real place) countryside in the near future. Meanwhile Ben Plumb (ICU and general) will soon be starting, having made the wise decision to move further Southwest and we will be forced to wait a little longer for Madhavi Keskar (general) to join us later in the summer.

On the other hand, one or two of us were mildly sorry to see one of our consultant colleagues leave for the greener grass of another nearby Trust. Simon….er, was that his name?... Marshall moved to Exeter at the start of the year. Simon contributed hugely to the department in the relatively short time that he was here and has already been much missed. None more than by Boris (new POAC lead) and myself (new airway lead, and SASWR rep)! Sadly, the planned cyclopuffathon event (pub/cycle/pub repeat) that was to be his leaving party had to be postponed due to inclement weather, and probably mainly because Simon was worried about being thrown into the canal! Perhaps we will still be able to celebrate when the weather - and water - is warmer?

There have been a number of babies born recently and congratulations to Ian and Charlotte Davies, Adam Green, Abi Hine, Lawrence Helliwell, myself (!) and Richard and Claire Allan. Between us, we have been striving to boost the number of deliveries at MPH – which ultimately has been the driving factor in the promise of funding for another tier of on call cover. Well done Helen

Hopwood and I'm glad that we were so instrumental in your business case! Special mention should go to Richard Allan, who suspiciously swiftly after having his 57th (?!) child announced that he was urgently required far abroad in an undisclosable location by order of the military. Now that is a lot of nappy changes owed. We are all glad to see him return safely, if a little envious of his suntan and carefree demeanour! Since then he and Claire eloped to get married in Scotland so presumably all is forgiven, and not long before that Steve and Becky Harris were married in March.

Elsewhere, Hoppers and Rich Gibbs continue to lead us admirably, whilst Justin Phillips was appointed as Medical Director to the Trust and has become seriously important. Fortunately, he still maintains some clinical sessions and so can be found attached to a laptop in theatres and the department from time to time! Mitesh Khakhar has moved from CT to TPD and Nicky Campbell to CT. Julie Lewis has teamed up with Boris in control of CLW, Alice replaced Ally in the office to join Sam, and well done if you followed all that. Congratulations to them all.

As always, we have had an excellent group of trainees and were sorry to see those move on in February but glad to welcome new faces, Katharine Smurthwaite, Steph Pauling and Ben Hearne. Well done to Rose Arkell, Owen Thomas and Alice Bryant for Primary success, and Juliet Drummond for MRCP. We have particularly appreciated your support and willingness (seemingly!) to cover shifts when gaps have appeared at short notice. Thank you.

Tom Barrett

Torbay

After a snow free winter in the Bay the outdoor departmental summer sports and activities are happily recommencing.

Winter pressures have been compounded by problems with our theatre infrastructure but we roll on as best we can. Ongoing works to upgrade some of our oldest theatres will hopefully come to an end soon which will be a welcome relief. We continue to keep our fingers crossed for progress with theatre expansion, putting our case forward when requested. Our gallant leadership team remain the same with Omar Islam as our CD, Richard Hughes as Chairman, and Richard Eve at the helm of ITU.

Our social events included a lively Theatres Christmas party held in a Torquay hotel. Much fun was had by all but the Pappin kitchen has never been quite the same and is now being refurbished.

In terms of trainee transitions, we welcome Claire Attwood, Emma Endean, Al MacKenzie, Matt Julian and Rebecca Marsh and say goodbye to Lexie Humphreys, Louise Schönborn, Nat Smith and Simon George who will all be great assets to any departmental rota they may grace. On the CT rota we also have Alistair

Joyce and John Taylor. Rebecca Dyar, Will Hare, Sarah Shaw, Jen Moran and Drew Weir have all landed ST jobs in a hugely competitive field- well done to them! Congratulations also go to Andrew Woodgate who has had a baby boy, Harry.

Five consultant appointments have occurred since last writing. David Levy and Johannes Retief who will be great assets to our POM team, David Hutchins who will be a much appreciated addition to the pain team and hot off the press: Pippa Squires with her POM and Obstetric hats. We are also delighted to welcome Nikki Freeman as an ICU (and anaesthesia) consultant. We are very lucky to have made so many recent dynamic appointments.

We said a fond goodbye after Christmas to Andrea Magides whose commitment to our pain service cannot be underestimated. She developed and revolutionised many pathways and constantly strived to update our approach to managing post op pain. Her commitment to the acute pain team was a huge legacy which continues to go from strength to strength.

Maree Wright has also hung up her ITU clogs but will be continuing in anaesthetics. Her incredible contribution, in particular her commitment to support for and understanding of patient's psychology post discharge from ITU have been ground breaking. She leaves yet another legacy to support patients during an incredibly important time.

There is daily departmental excitement around the exploits of two of our department members who are undertaking an around the UK sailing expedition. Katie Flower (Skipper) and David Snow (previous sailing novice) purchased a boat and set off a few weeks ago for Cornwall. Their blog makes for a great read and brilliant distraction to our everyday work. Several members of the department are going to be joining them on various legs of the trip and we wish them all the best of luck! I believe they are now somewhere between Ireland and Scotland.

Here's to a great summer.

Theresa Hinde

Truro

Zoe The Beast has arrived! But no, you can't touch her until you have done the mandatory training and have shown you have the milk stretch skills certificate to use it! This wonderful contraption means The Barista of the Day ... (the emergency floor anaesthetist) is able to distribute a cup of joy to those in need!

If you say abracadabra...

We congratulate Russ Evans and Thys de Beer on their joint appointments to CD role and Ali Moore as Governance lead.

In Truro style we welcomed Chris Smith with a curry at the tandoori a day before he actually arrived! Oops. He delayed his start by a couple of years, stopping off in Dorchester, but this keen triathlete and his family have already been enjoying Cornwall's sights and RCHT hospitality!

Hot stuff

The selection committee were not swayed by Carlen Reed- Poysden's mug in his interview- he starts with us soon!

Subliminal sipping

Many congratulations on Primary success goes to Stuart Maxwell, Ben Parish and Alex Lomas! Brilliant Final written passes for Sam MacAleer, Kate Palmer, Chris Pritchett and the lovely Brid Hughes!

Meanwhile a few of us are getting ready for the NHS regatta. Denzil May is the lone surgeon leading a crew of 8 Anaesthetists what could possibly go wrong?!

Commander Matthews never missing a marketing opportunity

SAFE paeds is being organised by Lara and Ann so come and join us in July for some sun and surf!

Becky Brooks

UHB

Things are going splendidly up here in Bristol. The recent CQC visit to the BRI was heralded by a catastrophic failure of literally all IT systems within the trust (we have been spending wisely as a global digital exemplar). It wasn't a good look. With all hatches now firmly unbattened following the latest CQC visit life at the BRI has now

returned to normal.

It seems life has been tough recently for our clinical fellows trying to get training posts in the South West so we were delighted that Susan Tetlow, Sam Scholes and Natalie Constable all secured posts in Severn in the most recent round of interviews. Having said this, some extremely able candidates were not lucky this time round and we keep our fingers crossed for them in future. As trainees they will be able to enjoy the recently re-vamped trainee room in the department. Refurbished on a shoestring, because the estates department quote was enough to rebuild the entire BRI, all was successfully achieved within budget, and only a small hole in the orthopaedic department roof remains as collateral damage. It provides an essential microcosm of zen in these times so rife with burnout. There have been complaints from some members of the department though - apparently the 65-inch TV is sited too high on the wall for the older, more arthritic consultants. It would appear they also need their annual eye check, missing the 'Trainee Room' sign on the door....

On the retirement front Tim Lovell is hanging up his syringe of etomidate and leaving the Bristol Heart Institute with a Dr Lovell sized hole. His knowledge and dedication to the GUCH patients will certainly be missed by this non-cardiac anaesthetist whom he advised and assisted many times. We wish them all the best.

As usual Drs Molyneux, Rasburn and Middleditch are planning some sort of event whereby they have to run around in a forest in Scotland flashing what they refer to as their 'dibbers'. This is followed by a huddle round a campfire and then a night in a 1-man tent. Whatever you enjoy I suppose. I'll leave you to draw your own conclusions.

At the non-uber-competitive end of the scale (no mountainous ultra-marathons here) there is talk of a new covert departmental Gardening Club. Led quietly by its secretive overlord (FF) they have undertaken such high-octane events as visiting RHS Malvern Flower Show, a tour of members gardens and planting succulent gardens in bin lids. Competition to enter this group is fierce and the bar high (the initiation ceremony is said not to be printable in a mainstream publication such as this).

And lastly, hot off the press, we are delighted to welcome Stuart Younie to the department as a new consultant.

See you all in Saunton……

Ben Gupta

Portrait of the President

Dr Mike Kinsella

There comes a moment for every consultant when you think: 'I've finally made it'. Mine came the day I received a phone call from Mike Kinsella, who wanted to ask my clinical advice about an obstetric patient he was looking after. When I'd recovered from the initial shock (and retrieved my jaw from the floor), I listened to the story carefully, and proceeded to give my considered opinion. He murmured thoughtfully as I dispensed my advice, and thanked me for my help. Hugely buoyed by my new-found status as an obstetric anaesthetic guru, I made sure to track down Mike the next time I was on Labour Ward to ask him how things had gone. 'Oh, it went really well' he replied… my chest puffed up with pride… 'I decided not to do any of the things you suggested!' For me, this story sums up so much about Mike: his calm and considered work ethic, his renowned obstetric anaesthetic expertise, and his playfully wicked sense of humour.

But it's fair to say that his future as the considered statesman of obstetric anaesthesia was not obvious when he was a long-haired teenager, tearing up the roads of 1970s Barbados on his beloved motorbike. His love of all things with two wheels – be it cycling or on his trademark *Moto Guzzi* – remains a passion of his to this day. As does a fondness for travel: whether it is wandering through temples in Indonesia, perusing markets in India, or tramping the hills in Ireland – his spiritual second home. This wanderlust is probably not surprising, given that Mike's father worked in the diplomatic service for the British High Commission for many years. This upbringing led to an exotic start in life for Mike: born in Germany, growing up in Israel and the West Indies, before settling into school life in…South Yorkshire. Mike is characteristically understated when comparing schooling in Tel Aviv with boarding in the UK: apparently the Yorkshire Dales has fewer 'jackals howling at night'.

Once he'd completed his school years, Mike headed to St George's Hospital in London for medical training. After he qualified as a doctor, Mike was initially unsure which speciality to apply for; it was only after witnessing 'hair raising attempts' at anaesthesia in a GP practice that his mind was made up. Surely anaesthesia could, and should, be delivered and taught with more safety and skill.

Mike remained in London and its surroundings for most of his

subsequent anaesthetic training, including spending over two years as a clinical research fellow at Queen Charlotte's Hospital. He enjoyed a fruitful year at Thomas Jefferson Hospital in Philadelphia, by now with a wife and three children in tow. This was a hugely stimulating time, both professionally and personally. He soon discovered, though, that the financial reality of life as a jobbing resident, as well as the bread-winner for a young family, required some improvisation. It transpired that investing in museum season tickets during a bitterly cold East Coast winter can go a long way in terms of child-care!

Upon returning to the UK he moved to Bristol, taking up his consultant post at the BRI and St Michael's, soon becoming an invaluable member of the department. For Mike, though, Bristol will always be associated with family. He's successfully managed to navigate the tricky balance of working with his spouse: Deirdre was a midwife when they first met in London, and now works in Recovery at the BRI. Together they have raised three impressively accomplished children: Therese, an obstetrician; Joseph, an anaesthetist; and Cormac – a biologist currently studying for a PhD at the University of Amsterdam ('he's the real scientist' claims Mike).

However, Mike isn't exactly a slouch when it comes to scientific endeavour. Early in his anaesthetic practice, he was identified as having an aptitude for physics and clinical measurement. An idle visit to Westminster Hospital's Clinical Measurement Department one afternoon turned into an impromptu interview, and concluded with him leaving with a year-long contract to work there. At a time when anaesthetic monitoring often consisted of a finger on the pulse, Mike worked at the cutting edge: helping evaluate and construct technologies, such as capnography, that have now become commonplace in the operating theatre. The precision, experimentation and attention to detail that this required was perfect preparation for a lifetime that would be spent contributing to the body of anaesthetic clinical research.

His research credentials now include over 70 peer-reviewed journal articles. He has been the Honorary Secretary of the Obstetric Anaesthetists' Association (OAA), an editor of *Anaesthesia*, and helped develop the long-awaited international guidelines for failed intubation in pregnancy. He was recently invited to give the prestigious Bruce Scott Memorial Lecture at the OAA on supine hypotension, a subject on which Mike is probably the preeminent world expert. As his career highlight, though, Mike picks developing the categorisation of caesarean section by urgency: from Category 1 to Category 4. Ever self-deprecating, this little 'communication tool' he helped introduce is now ubiquitous, and it is hard to imagine an obstetric operative delivery without referring to it.

Of course, there are other reasons that the phrase 'Category 1 caesarean' will forever be associated with Mike. His

vigilance in following up virtually every general anaesthetic ever given at St Mikes is legendary. As is his ability to glide in stealth like behind you any time you try to bend the rules – day or night ('not wearing a hat whilst inserting an epidural *again*, Dr Rasburn…!'). And it is no accident that inserting spinal anaesthetics in right-lateral, the natural position for a left-hander like Mike, has become a St Michael's trademark.

With Mike as President, SASWR is in incredibly safe hands. His ambitions for the Society include attracting more young members, and developing a framework to support ongoing research opportunities for trainees. Considering the focus and commitment which Mike gives to everything, it promises to be a productive tenure.

Dr Neil Muchatuta

Report on the Society of Anaesthetists of the South West Region Autumn Meeting

The Apex Hotel, Bath 6th and 7th December 2018

Dr Pippa Dix, Honorary Secretary

The meeting was held at the Apex Hotel, for the first time. After a few issues with the cloakroom (it opened after the meeting began), the meeting settled into the usual well-run affair. As usual there was a late flurry of registrations, and final delegate numbers reached an impressive 135. Many thanks to Rob Axe, and the organising committee of Jonny Price, Clare Hommers, Fiona Kelly, Tim Cook and Jerry Nolan for an excellent meeting. After the AGM, Andy Burgess handed over the presidency to Mike Kinsella. Kathy Holder was announced as Mike's successor as president.

Dr Jonny Price chaired the first session, Resuscitation and Pre-hospital care. Professor Jerry Nolan, Bath intensivist, opened the session with a summary of the Paramedic2 trial. This thought-provoking trial was conducted after an observational study in Japan suggested that adrenaline compared with no adrenaline for prehospital arrest, might improve survival at the expense of neurological outcome. Adrenaline improves global brain perfusion but possibly worsens microcirculation. After some tricky issues around consent, 8016 patients were enrolled, and in summary, adrenaline resulted in 3 times as many patients reaching hospital, and more patients survived to discharge. However, 30% of survivors had a poor neurological outcome, compared with 17% in the no adrenaline group. The results should not be extrapolated to in hospital arrest. The study has been published in NEJM.

Professor Jonathon Benger, from UBHT, followed Jerry. He presented the findings from the Airways2 trial. This was another prehospital arrest trial, looking at airway management during cardiac arrest. Some observational studies have suggested that patients have better outcomes if they receive basic rather than advanced airway management. However, we also know that patients have better outcomes after a short arrest, which is more likely to be managed with basic airway techniques. This large randomised trail recruited around 9000 patients, randomised to receive an i-gel® or tracheal intubation. The paramedic randomised the patients at scene, and everybody else beyond ED was blinded to the initial airway management. In summary, there was no difference between the i-gel® and intubation, in terms of neurological score at 30 days, regurgitation and aspiration rates. However, SGA were

used more often and achieved better initial ventilatory success.

The third speaker in this session was Dr Alex Manara, intensivist from North Bristol. He discussed the management of the patient with perceived devastating brain injury. He described the previous situation when relatives of patients with a devastating brain injury on admission were approached about organ donation. Patients who were potential donors were admitted to ITU, patients who were not had treatment withdrawn. However, some patients admitted to ITU recovered, while those who were not admitted did not have the opportunity to recover. As a result, all patients were admitted to ITU, reassessed at 24 hours, and the discussion about organ donation delayed to 72 hours. Their experience has been an improvement in diagnostic accuracy, better end of life care for patients and relatives, reduced pressure on ED and facilitation of best practice in organ donation. Another thought-provoking talk.

After the coffee break, Dr Stuart Gold chaired the next session on emergency surgery. Simon Noble, from the Royal Gwent Hospital, began with Palliating the Acute Abdomen. His take home message was that palliation is not a bad option, if managed well. However, his explanation of antiemetics, based on his past exploits at Bog Island, a top Bath night spot, frequented by many generations of RUH trainees, will stay with me forever. As will the photo of the Elvises.

Mark Edwards followed, with an interim update on FLOELA and fluids for emergency surgery. This trial aims to recruit 8000 patients, comparing patients managed with or without a cardiac output monitor, looking at mortality, length of stay, and cost effectiveness. After 1 year, the trial is behind on recruitment numbers, but with good adherence to protocol and low patient refusal, with a good representative patient group. We are doing well with recruitment in the South West. So, watch this space.

Professor Tim Cook was the final speaker in the session, talking on the Challenges of Sustaining High Quality Emergency Laparotomy Outcomes. He outlined the improvements seen in the management of emergency laparotomies since the launch of NELA, but also the persistent shortcomings. The Bath experience was that after initial improvements following the launch of the Emergency Laparotomy Collaborative, all measured outcomes returned to the baseline. They have now relaunched it, with a Trust agreement to stop elective operating if emergency work is waiting. Lunch provided an opportunity to check out the trade stands, and also the large poster display. I was pleased to see so many posters by medical students.

Paul Hersch chaired the first session after lunch, the SASWR Intersurgical oral prize presentation. We heard four excellent and varied presentations by trainees. Nick Dodds described his audit of patients following oesophagectomy, and the relationship

between anaemia and readmission to ITU. Alex Jones presented his findings on current practice in estimating depth of central line insertion. Katie Samuel described how she set up a MOOC (massive open online course). This free perioperative medical course has 15,000 learners in 140 countries, in English and Spanish. Ben Whatley described how he used nudge theory to reduce tidal volumes in theatre, by making the default option the best option. The Intersurgical trainee prize was presented to Katie Samuel, with the runner up prize to Ben Whatley.

Tim Cook chaired the fourth session on Current Research. Professor Nigel Harper from Manchester outlined the methodology and findings from NAP6, and the trends in perioperative anaphylaxis. 75% anaesthetists have seen a case of anaphylaxis, 1 in 7.25 years of practice, and 32% use a test dose of antibiotic, despite there being no evidence that it reduces the risk. The commonest triggers are antibiotics (47%; cefuroxime is much lower risk than teicoplanin or co-amoxiclav), NMBA (32%; rocuronium and atracurium are approximately equal), chlorhexidine (9%) and patent blue (3.4%). Remember to think of using glucagon in the management of beta-blocked patients with anaphylaxis.

Gary Minto, from Derriford followed with Mind the Gap. He was encouraging us to engage in large-scale research, as small studies can be confounding. He argued that by doing things that sound plausible, but with no evidence of benefit, we might actually be doing harm. The Bridge study was a good example.

Ramani Moonesinghe from UCLH completed the session with the early results of SNAP-2. This is focussing on the epidemiology of critical care after surgery. So far 245 hospitals are involved, capturing about 23000 surgical episodes. There are 2.7 critical care beds/ 100 hospital beds, 2.3% hospitals have a PACU, 72 hospitals have enhanced care wards, of which 45% are looked after by surgeons. 1 in 7 inpatients are cancelled on the day, with increased risk if a critical care bed is required, and if the hospital has an ED or an enhanced care ward. The next questions will be around whether we should look at seasonal planning, with more elective surgery in the summer than in the winter, and whether critical care provides a benefit in its current form, if patients are at high risk of cancellation.

The final session of the day, introduced by Mike Kinsella, was the Humphrey Davy Lecture. Carol Peden, formerly from Bath, currently working at the University of Southern California, spoke on International Perspectives on Enhancing Quality and patient Outcomes in Healthcare. Carol spoke eloquently on enhancing patient care at the micro, meso and macro level. She argued that the best way to predict the future is to create it, and while improvement needs change, not all change results in improvement.

The society dinner was held at the Roman Baths, although not in our

usual rooms, due to a prior booking by a water company. This caused some confusion for both parties. The drinks reception was held in the underground museum, which was interesting, and the dinner was held on the terrace, with an amazing view of the bath. Local band, Mid Wife crisis, provided the entertainment. Their trousers were tight. Andy Burgess and his wife were the mainstay of the dancing, despite their various hip and knee complaints.

Friday was another excellent day, with a more clinical focus. Dr Andy Georgiou chaired the first session, Advances in Airway Management. Fiona Kelly, from Bath, opened with the Role of Human Factors in Airway Emergencies. Ergonomics make it easy to do the right thing and almost impossible to do the wrong thing. Humans will make mistakes, and human factors are only one component of patient safety. Her top tips were to value the power of first names, which improve communication and flatten hierarchy, good technical skills enable good non-technical skills, and in crisis management, the incident needs to be announced, the leader should be named, and they need to stand back with their gloves off.

Dr Philippe Le Fevre from Melbourne, followed with Training for Emergency FONA. He argued that Simulation for FONA is very good, but not suitable for an obese neck. In people the average distance from skin to cricoid membrane is 1.8cm, while the distance in models is only 2mm. He presented his work on simulation with models that have pork belly overlying the model neck to simulate obesity and fake blood to simulate real life. The obese models took longer to successfully ventilate, with fewer punctures through the cricothyroid membrane (but more elsewhere in the airway), and were more likely to have multiple punctures. He suggests that slim models are good for initial training, but we all need to practice with obese mannequins, with simulated blood.

Viki Mitchell from UCLH completed the session with Videolaryngoscopes: the UCLH Experience. Viki is on the DAS committee. Part of the DAS guidelines state that a videolaryngoscope should be immediately available and all anaesthetists should be trained in the use of the videolayngoscope. Studies suggest you need to use the VL 76 times to become good at using it, more so for the D blade. As your first attempt at intubation is usually the best, you need to be sure that you are good at your second technique, especially if that is VL. Viki suggests that we should teach VL to novices, as it is easier to learn, and then teach direct laryngoscopy.

After the coffee break and another opportunity to visit the many trade stands, Dr Stuart Younie chaired the pre-lunch session, Advances in Anaesthesia. Mike Swart from Torbay began with Shared Decision Making – where, how and why. Patients and doctors underestimate risk and overestimate benefit. Patients don't always feel involved, even when doctors think they are, and doctors don't know what patients want. The

SDM clinic is a chance for people to plan in advance what they want to ask, and to think about what is important to them.

Kim Gupta from Bath followed, with Monitoring Neuromuscular Block – Why Bother? Kim managed to make a potentially dry subject both interesting and entertaining. It turns out that the dose of neostigmine isn't always 1 vial. Worse, clinical signs of reversal are poor, as is the naked eye estimation of TOF ratio. Single doses of muscle relaxant have very variable pharmacokinetic properties, and neostigmine can cause muscle weakness if it is used when the block has worn off. It matters where you place your nerve stimulator, and also which way round you place the electrodes. Who knew?

Finally, Helen Maria from Bath reported on her experience of a patient blood management system. By using the 3 pillars of optimising the patient's own blood, minimising blood loss and optimising the tolerance of anaemia, her team managed to reduce blood use from 200 units in 6 months to just 14 units.

After lunch, the Aguettant Poster prize was awarded to joint first prize winners, Dr S Watson for her poster, Social Media and Anaesthesia – a week curating @ NHS, and Dr D Choudhuri for their poster, A Hip New Enhanced Recovery Guideline. Dr Malcolm Thornton chaired the final session, Resilience, Wellbeing and Performance. Dr Tom Evens from Imperial College Healthcare and London Air Ambulance, spoke on High Performance and Healthcare. He drew on his experience as rowing coach for the British women's rowing team. Performance is doing the things you need to do to get the results you want. In the heat of the moment, you can't change people's skills or knowledge, only their performance. Within the NHS we need to focus on good outcomes as well as poor outcomes.

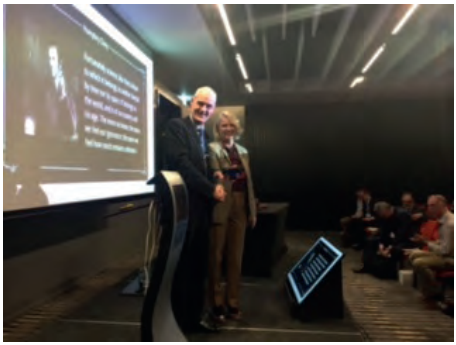
Dr Elaine Wainwright from Bath Spa University spoke next on A Qualitative Analysis of Professional Satisfaction and Wellbeing among Specialty Trainees in Anaesthesia; results from the SWeAT Study. An RCoA survey suggests that 85% trainees are at risk of burnout. The SWeAT (Satisfaction, Wellbeing in Anaesthetic Trainees) study sent out an initial survey, followed by a telephone interview, to look for risk and protective factors for burnout. There were many things that trainees value in being an anaesthetic trainee, including 1 to 1 teaching, a flat hierarchy and consultant interest in teaching and learning. However, the demanding non-clinical burden, the feeling of being signed off but not fully competent, and the changing view of doctors by society are among the stresses of being an anaesthetic trainee. The solutions are less clear.

Dr Michael Farquar, consultant in sleep medicine from Evelina Hospital, followed, speaking on Circadian Rhythms, Sleep and Anaesthetists' Wellbeing. The effects of fatigue are becoming increasingly prominent, with

deaths and near misses occurring with increased frequency. Most people in the general population are about one hour sleep deprived per night, with sleep deprivation negatively affecting the life time risk of type 2 diabetes, obesity, cancer, Alzheimer's and more. For patient safety we need systemic changes in how we work, encouraging breaks at work, power naps during night shifts, and changed sleeping habits for night shift workers. Consultants are poor role models if we don't take breaks. We are not superhuman.

The final speaker for the day and the meeting was Prof Ravi Mahajan, President of the Royal College of Anaesthetists. He gave us his views on trainee and senior wellbeing. The RCoA is aware of the pressure on the NHS generally and anaesthetists specifically. Consultants are acting down in almost half the anaesthetic departments to cover trainee rotas. A recent RCoA survey highlighted the problems of mental health, work pressure, lack of beds, etc. The solutions lie at several levels. At a DoH level, the CQC could include facilities for rest, food, naps in its inspection. Maybe there could be a tariff for a happy work force. At College and Association level, work is ongoing lobbying the DoH. Work force wellbeing could be included in GPAS. At an employer level, we need cultural and contractual changes. And on a personal level, we need to be aware of our wellbeing, and try to prevent things deteriorating before we act.

That brought a very successful meeting to a close. Thanks again to Rob Axe and his team. Once again, I have failed to take many photos, although I did almost take a selfie instead of Mike Kinsella thanking Carol Peden for the Humphrey Davy Lecture.



Mike Kinsella and Carol Peden

Cloud Surfing: Changes to website and membership

Dr Ben Howes, SASWR Webmaster

The SASWR committee is embracing technology to take away some of the repetitive manual tasks that go on behind the scenes. For many years, our tireless administrator Kate Prys-Roberts has been responsible for the small details essential for running a large society. It may be surprising to members how much work this entails. The fact that we never hear of admin problems is testament to her success. However, we need to look forward as a Society and take measures to develop a sustainable future for SASWR.

Keeping tabs on who is a member and who pays subscriptions is harder than it sounds. A membership audit showed a significant mismatch between individuals we considered members, and annual subscription payments. Many individuals had an out of date status – for example having been appointed as consultant, or retired. We are certainly not looking to replace Kate, rather to better use her time to the benefit of the Society. She has been central in planning and rolling out the change. The time has come to move to a 'cloud' based platform for running the society.

The benefits of a cloud-based administration include:

- We can keep an accurate database of active subscription-paying members. This helps us with communications, subscriptions collection, and other Society functions.
- Reliable subscription income pays for Society administration and production /printing of the journal
- New members can easily join or leave the Society at the website.
- Members can manage their own details, updating addresses, places of work etc. This is especially relevant with modern Data Protection laws.
- Processes such as annual subscriptions can be automated
- Sharing tasks and workflow with the SASWR Committee
- Using an IT service is more secure and more reliable than the piecemeal approach we currently use.

The argument against moving to the cloud is that it causes some inconvenience to members, and we may lose some along the way. It is a substantial piece of work for us volunteers to undertake. It costs some money. We think the benefits outweigh the risks.

The Cloud

Most computing happens on the 'cloud' in 2019. It's so commonplace, it's not really in common parlance. In essence you are interacting with a distant computer

more so than your local machine. If you have a webmail address (iCloud, Hotmail, Gmail etc.) or if you use any kind of file sharing, music streaming or smartphone apps, then you are cloud-computing. Moving SASWR functions online is the way of the future.

We first considered developing our existing 'open-source' Wordpress website and various other bits of software we have tacked on over a few years. However, we were feeling uncomfortable about how to manage issues of data governance and security. As an unsupported system, there were also concerns about reliability of the process – nerds on internet forums can only help so much. The other option was to use an internet delivered (cloud) service. After much research and consideration, we chose Wild Apricot (http://www.wildapricot.com), a Toronto-based company that specialises in non-profit organisations like SASWR. They are one of the most popular solutions for societies like ours, and the prices are quite reasonable compared to business software, which is similar. Importantly, as a delivered service, they have a team to maintain and update the software with the latest security measures. Wild Apricot offers everything we need to run SASWR in 2019 and beyond:

- Website
- Membership management
- Online payments
- Event registration and management
- Email communications

These functions are available in one package using a common interface. This is essential for administration team working. After committing to Wild Apricot, your loyal admin team got to work with exploring the service, rebuilding the website in the new location, understanding the various functions, etc. This was many late night hours of work on the laptop, and we are still learning. Please bear with us if things aren't as slick as they should be.

The Transition

We wish to create a contemporary database of members which is connected to an automated annual subscription payment process. We have to move across from the legacy systems. The committee discussed the transition process and agreed:

- Everyone who wishes to become or remain a member will need to register and pay subscriptions at the new website.
- There is an 18-month period (October 2020) to register before we cease to consider legacy memberships valid.
- Meeting registration will only be available to members registered at the new website. This will assist with buy-in to the transition.

This approach will result in loss of some members who are no longer interested. On the other hand, it will generate new subscribing members when we hold meetings twice a year. To avoid disadvantaging

current members excessively, we are allowing a substantial time period for the transition. In October 2020 we will cease to recognise memberships that have not been subscribed on the website. We recognise that some members may be out of pocket from unused subscription payments if they register now and overlap with their old subs. This will always be under £40, and in most cases less than £20. It is vital to point out that **members must cancel their standing order at their bank** after they register on the new website. We cannot cancel this on your behalf.

What does all this mean for me?

A society is not a society without its members. We hope to retain the vast majority of you during the transition. We now have two sets of members in parallel, 'cloud' members and 'legacy' members. Of course, we want to encourage all legacy to come over to the cloud. **You can do this anytime from right now**, but your legacy membership will cease in October 2020. If you want to go to a meeting – and we very much hope you do - you must register as a cloud member first and pay your subs. You can then access the meeting registration. Registration is only available to someone logged in at the website – this is a deliberate ploy to recruit and retain our members. Guests can come to a meeting but they will need to join first, then cancel a recurring subscription in the cloud.

As a cloud member, you will have access to your personal details on the website, via the head & shoulders icon. Only you and the administrator can access these, please keep them up to date so we can keep in touch. You can cancel your membership and subscriptions any time you like. The cloud will remind you when subs are due, they should be automatic unless your card expires. Remember to cancel your standing order at your bank when you move to the cloud. As more members move to the cloud, we can investigate functions such as discussion forums, surveys and other networking options if they are desired by members.

All systems were go in April when we launched the new website. At the time of writing we were in progress with meeting registration for Saunton Sands and the cloud membership is growing quickly. We've had very few glitches and have gained confidence in the system. There are plenty of areas to improve on, especially on the public website. Please let us know if you encounter problems or have ideas for development. We especially need some graphic design input to make it pretty!

If you want to join or re-join SASWR, please visit https://saswr.wildapricot.org

For more information about the member's area of the website, go to https://gethelp.wildapricot.com/en/articles/119

Creation, uptake and global reach of a free perioperative medicine course – improving patient care through the multidisciplinary team

Dr Katie Samuel, ST7 Bristol School of Anaesthesia and Lead Educator for the RCoA/UCL Perioperative Medicine in Action Course

Introduction

Studies have identified that high-risk surgical patients are at significant risk of perioperative complications and death, and that their care could be improved upon on a global scale[1]. The practice of perioperative medicine (POM), employing the expertise of the multidisciplinary team (MDT) and integrated medical care, aims to optimise the clinical pathway of these patients by providing a clear structure of care[2]. There is a relative paucity of high-quality postgraduate courses in this emerging speciality that are freely available to all members of the MDT, without which widespread adoption of its key principles may be hindered.

Methods

In 2016, funding was secured to build a Massive Online Open Course (MOOC) entitled 'Perioperative Medicine in Action'[3]. The course was created to provide an overview of the importance of POM in improving standards of care for the high-risk surgical patient, and to be applicable and accessible to all members of the MDT free of charge. Hosted online, the course provides flexible learning over 4 weeks.

Following a review of the current evidence base for POM, the course content covers key topics (*table 1)* in addition to showcasing examples of excellent perioperative care. A mixture of media is employed throughout the course, including contributions from over 50 perioperative medicine experts representing over 30 institutions globally. Social learning is encouraged in the course's forums, enabling students to share experiences, ideas and learn from each other (*figure 1*). Promotion of the course has been undertaken globally, with translation of all course content being made available in English and Spanish to improve access worldwide.

WEEK 1	**The surgical epidemic:** The need for change and perioperative care pathways

WEEK 2	**Risk assessment and shared decision making**: Risk assessment tools and whys shared decision making is so important
WEEK 3	**Protocols in surgical care**: Enhanced recovery, emergency protocols and engagement
WEEK 4	**An age old problem**: Unique perioperative problems of the elderly, and perioperative medicine as a value proposition

Table 1: Course content overview

Results

Following 2017 launch, the course has to date attracted learners from 140 countries, with 17,000 learners enrolled. 80% of learners were anaesthetists, with equal numbers of consultants and anaesthetists in training, although all members of the MDT were represented. The course has been commended for its global reach, popularity (280,000 learning steps completed, 21,000 forum posts), high completion rate and high learner retention index (0.475). The course has had universally positive feedback from learners with 84% reporting that it will 'improve their patient care'. Qualitative analysis of post course survey comments identified that learners thought the course was of 'very high quality', 'beneficial to the MDT' and 'an outstanding innovative mode of education'. The courses quality has been recognised with endorsement from the Royal College of Anaesthetists, World Federation of Anaesthesiologists, Colombian Anaesthetic Society, and International board of POM.

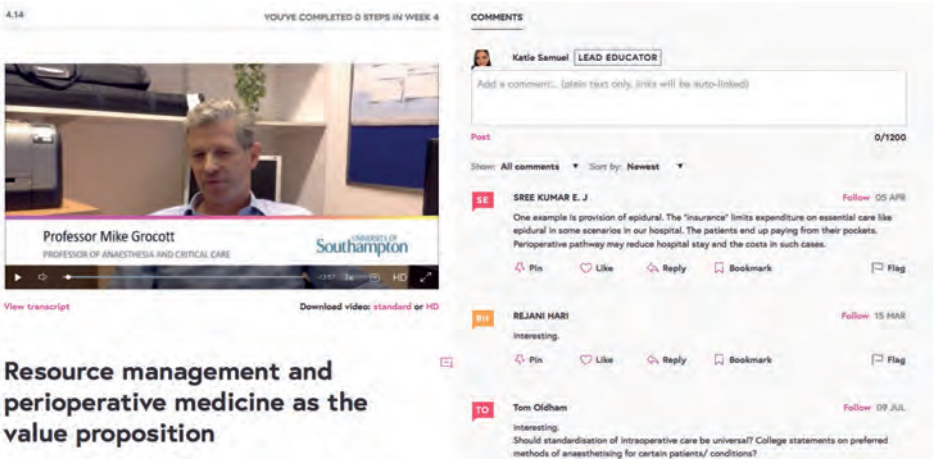


Figure 1: Example of online learning material

Conclusion

The Perioperative medicine in action MOOC is an effective educational tool to reach a massive audience of healthcare workers worldwide. It has successfully raised awareness and knowledge of the key issues in providing high quality perioperative care, and is one step in improving surgical outcomes globally.

References

1. The International Surgical Outcomes Study group. Global patient outcomes after elective surgery: prospective cohort study in 27 low-, middle- and high-income countries. British Journal of Anaesthesia, Volume 117, Issue 5, 1 November 2016, Pages 601–609,

2. The Royal College of Anaesthetists. Perioperative Medicine – the pathway to better surgical care. 2015 (available at https://www.rcoa.ac.uk/sites/default/files/PERIOP-2014.pdf)

3. Perioperative Medicine in action course (https://www.futurelearn.com/courses/perioperative-medicine/4) - Accessed 1/9/18

Using nudge theory to improve ventilation volumes in Torbay operating theatres

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Dr Sarah Shaw, Trust Doctor in Anaesthesia, Torbay

Background

There is an increasing body of evidence to support a ventilation strategy using tidal volumes (TV) of 6-8ml/kg of ideal body weight (IBW) when mechanically ventilating a patient. Initial studies have focused on intensive care patient populations, with evidence of its benefit in patients with and without ARDS.[1,2] More recent evidence has shown improved outcomes in surgical patients when ventilated intra-operatively with this 'low tidal volume' strategy. A meta-analysis by Wan-Jie Gu et al found that it reduced lung injury and pulmonary infection, with no difference in atelectasis or mortality, while the latest Cochrane review on the subject found decreases in postoperative pneumonia and the need for postoperative ventilatory support.[3,4]

In alignment with this evidence our department recommended that intra-operatively patients should be routinely ventilated at 6-8ml/kg. Various attempts had been made to improve concordance with this policy, but had thus far been of limited effectiveness. This project aimed to improve concordance with current best practice using Nudge theory.

Nudge theory is a concept in behavioural science that gained prominence in 2008, with the publication of Sunstein and Thaler's book 'Nudge'.[5] It gives a mechanism by which the behaviour of individuals can be influenced, without removing the individual's choice. This is achieved by offering decisions to individuals in such a way that the 'right' option is offered as the default, or easy option. It has since been used in many spheres including finance, retail, and public health.

Pre-intervention

We completed a six-month retrospective audit of adult patients in Torbay Hospital's operating theatres who were recorded by the anaesthetist as having received IPPV via LMA or ETT. The mean TV, and IBW were calculated for each patient episode. Data was gathered from an electronic anaesthetic record (PICIS). Patient episodes were excluded if there were fewer than 10 values for TV recorded or mean TV was >1.5L. This found that of the 558 patients included 22.4% had received tidal volumes of >8 ml/kg IBW.

The 'Nudge'

We noted that the default settings for theatre ventilators were TV 500ml and RR 10. These settings provided excessive tidal volumes in 49% of our patients. We theorised that reducing the default volumes (whilst increasing RR to maintain minute volume) could nudge anaesthetists to avoid excessive tidal volumes. Changing the defaults would not force any anaesthetist to use any particular ventilation strategy, as the settings remained alterable, but may prompt the anaesthetist to consider suitable tidal volumes, or if they did not, that the preset volume would more likely be within a suitable range.

The mean IBW of all patients in our initial audit was 64.4kg, with a right skewed distribution. In light of this a tidal volume of 350mls was chosen as the default for theatre ventilators. After agreement from the anaesthetic department, all the defaults on the ventilators were changed to the new setting.

Post-intervention

Repeating the six month retrospective audit post intervention identified 638 patient episodes with 8.8% of patients ventilated at >8mls/kg IBW, a significant decrease ($p<0.01$ chi-squared). See table below for full comparison of results.

	Pre Intervention (2016)	**Post intervention (2017)**
Total number of patients	559	638
Mean Ideal Body weight (kg)	64.4	65.9
Percentage of patients ventilated at:		
>10 ml/kg (%)	4.7	1.1
>8 ml/kg (%)	22.4	8.8
6-8 ml/kg (%)	55.9	48.7
<6 ml/kg	21.7	42.5

In the post interventional group the mean IBW was significantly higher ($p<0.01$ students T-test). To allow for this, weights of the pre-intervention group were mathematically adjusted. A statistically significant reduction in tidal volumes >8ml/kg remained following this adjustment.

Discussion

We successfully used Nudge theory to decrease the proportion of patients ventilated intra-operatively with tidal volumes of >8mls/kg by adjusting the default ventilator settings in our theatres. There are some weaknesses with our findings. The data used were retrospective from the hospital PICIS

computer system. It could be argued that measurements obtained did not truly represent the average tidal volume (for instance by including the spontaneous ventilations at the end of a case), however the same data source was used for both pre and post intervention, hence any problems should not detract from the differences observed.

As can been seen from the table above in addition to decreasing the rate of excessive tidal volumes, there was a significant increase in patients ventilated at <6ml/kg. We do not have evidence that this is of detriment but it may be of concern to some. However, there were no barriers stopping anaesthetists increasing TVs in these patients had they felt it was required.

There may be value in repeating this project at other trusts. A survey of default ventilator settings in the region found that 8 of the 13 hospitals have defaults tidal volumes of 500mls, although there may be differences in IBW between areas that could justify this. Nudge theory could also be used more widely to obtain improvements in other areas of healthcare

In summary, this simple, cost free, and repeatable intervention has been associated with a significant decrease in the proportion of patients ventilated with tidal volumes of >8mls/kg IBW.

Acknowledgements

With thanks to Dr Ben Ivory for the initial idea, and ongoing support of this project.

References

1. Meade MO et al, 'Ventilation strategy using low tidal volumes, recruitment maneuvers, and high positive end-expiratory pressure for acute lung injury and acute respiratory distress syndrome: a randomized controlled trial', JAMA 2008 Feb 13;299(6):637-45

2. The Acute Respiratory Distress Syndrome Network, 'Ventilation with Lower Tidal Volumes as Compared with Traditional Tidal Volumes for Acute Lung Injury and the Acute Respiratory Distress Syndrome', N Engl J Med 2000; 342:1301-1308

3. Gu W, Wang F, Liu J. Effect of lung-protective ventilation with lower tidal volumes on clinical outcomes among patients undergoing surgery: a meta-analysis of randomized controlled trials. CMAJ. 2015 Feb 17; 187(3): E101–E109.

4. Guay J, Ochroch EA, Kopp S. Intraoperative use of low volume ventilation to decrease postoperative mortality, mechanical ventilation, lengths of stay and lung injury in adults without acute lung injury. Cochrane Database Syst Rev. 2018 Jul 9;7:CD011151.

5. Thaler RH, Sunstein CR. Nudge: Improving Decisions About Health, Wealth and Happiness. Michigan: Caravan; 2008.

Training in Airway Management: Opportunities and Challenges

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Airway management is the scaffolding upon which the whole practice of anaesthesia is built[1] and requires a career-long process of skill acquisition and reinforcement. The Fourth National Audit Project (NAP4) reported that although airway emergencies are uncommon, the incidence of subsequent death or permanent brain injury is significant, with the commonest contributory factors being poor judgement and training[2]. Training in airway management provides huge opportunity as there are enormous degrees of complexity. A core trainee can teach airway opening manoeuvres at a basic level, whilst senior anaesthetists will need to regularly practice complex or infrequently used skills such as awake fibreoptic intubation (AFOI) and emergency front of neck airways (FONA) to prevent skill decay. Novel techniques such as awake laryngoscopy and video-assisted fibreoptic intubation are increasingly described and need to be learnt in an appropriate environment. Unfortunately, these training opportunities are frequently beset by challenges. Airway training in the UK remains highly variable in its provision, target audience, frequency, content and whether it is mandatory or voluntary.[3]

Decreased opportunities

Trainees have fewer opportunities than their predecessors due to shortened training and an increased emergency workload[4]. The European Working Time Directive has limited the number of hours worked whilst increased emergency work has meant that a disproportionate number of failed intubations and emergencies occur out of hours and in trainees' hands[4]. Increased theatre time constraints in conjunction with increased patient complexity (aging population, increasing obesity and co-morbidity) have led to a decrease in training opportunities on lists[4]. Increasing use of regional or neuraxial anaesthesia and supraglottic airways translates to fewer opportunities for intubation[4]. Limiting the use of supraglottic airways, or intentionally worsening laryngoscopic view to increase difficulty (e.g. poor patient positioning) has been suggested to address this, but would increase risks through the use of neuromuscular blocking drugs, potential airway trauma and complications, making it ethically questionable[4]. Where previously difficult airways might have required an AFOI, videolaryngoscopy has meant that some of these cases can be managed without AFOI. It is likely that fewer are being performed as a result, subsequently decreasing opportunities.

Videolaryngoscopy

The rapid advancement of airway technology provides a fresh set

of challenges and opportunities with new skills for anaesthetists to acquire and retain[3]. The advent of videolaryngoscopy in 2001 provided one of the most significant developments in airway technology of recent times. The uptake of training in videolaryngoscopy has been widespread, and a survey of all UK NHS hospitals in 2013 found it was 'always/ sometimes' taught in 92% of airway workshops[3]. Videolaryngoscopy provides the technical benefits of a better view of the larynx whilst requiring less force to intubate, leading to decreased incidence of trauma compared to a conventional laryngoscope[5]. The non-technical benefits allow the team to view the larynx and adjust cricoid force in real-time[5]. The biggest training advantages of videolaryngoscopy are realised when using a device with a remote screen[5]. The trainer can observe a trainee performing laryngoscopy, enabling real-time coaching on blade position and anatomical landmarks, making it more likely that the trainee will be successful without the trainer intervening. If required, the trainee can intubate without looking at the video screen to learn and maintain skills in direct laryngoscopy. Studies demonstrate that training novices in direct laryngoscopy is more effective when using videolaryngoscopy.[5]

Infrequently used techniques

Further challenges are posed by techniques that are complex or infrequently practiced. Emergency FONA is one such example. Every procedure has a 'learning curve' and anaesthetists usually need to complete a certain number of procedures before they can become proficient. FONA is performed very rarely, with many anaesthetists never undertaking it during their career. As such, learning the technique through 'osmosis' would lead to inadequate experience. It is necessary to train and maintain the technical (and non-technical) skills[3] and the majority of this training takes place on manikins. Learning FONA on a standard manikin is unlikely to prepare the anaesthetist for our current patient demographic with epidemic levels of obesity in the Western world. NAP4 showed that serious airway morbidity occurs disproportionately in the obese and percutaneous tracheal access fails frequently in the hands of anaesthetists[2]. As such, a modified manikin may be appropriate for realistically simulating the difficulty encountered when dealing with obesity in clinical practice[6]. Howes simulated an obese neck by modifying a standard manikin with pork belly infiltrated with red chlorhexidine solution to represent bleeding[6]. Success rates and times to successful FONA were more comparable to events reported in NAP4 when a modified manikin was used, rather than a standard 'slim' manikin[6], suggesting current manikins are not realistic enough. The above example highlights a common criticism of manikins as having a perceived lack of realism. Cognitive processing and motor skills are known to decline under stress[7], so to be fully prepared for an airway emergency perhaps we should be simulating similar levels of

stress? High fidelity simulation allows anaesthetists to practice core skills and rescue techniques under pressure. Practicing in a stressful environment could lead to improved performance when faced with a real emergency. Simulation is known to entail high costs and logistical difficulties, but should be something for the airway training community to aspire to.

Ethics

A final challenge is the ethics of airway management. The need to teach and learn is conflicted by the principles of patient autonomy, beneficence, non-maleficence and justice[8]. If the four pillars of medical ethics were followed exactly then we should only ever allow airway experts to manage the airway. Issues pertinent to airway management involve patient consent, informing patients of the involvement of medical students or trainees in their care, our duty to society to deliver skilled airway providers, maintaining airway proficiencies and the obligation to do no harm[8]. We must ensure that ethical principles are not overlooked in favour of the benefit of the physician or the broader benefit of society at large[8]. This need for training may conflict our duty of care to an individual patient. Airway training can be fraught with potential complications. Doctors must balance the essential task of training with their responsibility to provide the best and safest care to their patient.[8] The AAGBI recommends "that when training in practical procedures, the anaesthetist should make every effort to minimise risk and maximise benefits"[8].

The solution?

Despite these challenges there are also many opportunities. Twenty years ago Mason[1] made recommendations that have stood the test of time, such as the local delivery of training in dedicated airway teaching rooms equipped with suitable manikins and appropriate equipment. Furthermore, a consultant with the appropriate expertise should be identified as training coordinator[1]. Airway leads were recommended by NAP4 and endorsed by RCOA and DAS and are now in 100% of hospitals. The local delivery of teaching has been adopted widely. A 2013 survey found that 84% of hospitals provided workshop-type manikin based airway training. However, 38% offered workshops only to trainees[3] excluding other members of staff, meaning the majority of trained UK anaesthetists do not have access to local workshop training[3]. The largest barrier to training was inadequate time and enthusiasm, suggesting that pressures to maintain 'service provision' are impacting on the ability of departments to deliver training[3]. Ideally a workshop should involve the regular, multidisciplinary teaching of core airway management and non-technical skills using locally adopted algorithms for the management of airway emergencies, such as those provided by the Difficult Airway Society. The benefit of training with local team members using local equipment has obvious technical and non-technical benefits. These workshops offer advantages over national training courses, which tend to focus on advanced skills and are

impractical for training the majority of anaesthetists[4].

The frequency and mandatory nature of workshops remains a discussion point with no specific guidance from national bodies like the RCOA or AAGBI. A strong argument can be made for compulsory training in emergency airway management, as is already recommended by the Australia and New Zealand College of Anaesthetists[3]. Life-support courses are mandatory every 4 years for UK anaesthetists. Regular training is emphasised to ensure retention of technical and psychomotor skills. Only 42% of hospitals offer biannual workshops and in less than one-third training was mandatory and registered[3]. Without national guidance training remains ad-hoc and in some settings will be absent or inadequate[3], exposing anaesthetists to a 'postcode lottery' for airway training. Only by mandating training can we achieve equitable opportunities for all anaesthetists. Workshops provide huge training opportunities, but most anaesthetists agree that teaching on manikins must be re-enforced with targeted elective training lists in consenting patients[4]. Audit and review of morbidity and mortality also helps to maximise learning.

Conclusion

In summary, the landscape of airway training is scattered with obstacles. But with enthusiastic airway leads willing to commit to regular, multidisciplinary workshops to train and maintain current skills and novel techniques, then airway training will be in safe hands. By mandating airway training for all anaesthetists and introducing the routine use of high fidelity manikins and simulation in training workshops, the UK could become a future exemplar in airway training.

Acknowledgements

I would like to thank Dr Fiona Kelly and Professor Tim Cook for their help with preparing this essay

References

1. Mason RA. Education and training in airway management. Br J Anaesth. 1998 Sep; 81(3): 305-7

2. Cook TM, Woodall N, Frerk C. Major complications of airway management in the UK: results of the Fourth National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. Part 1 Anaesthesia. Br J Anaesth 2011; 106: 617 – 31

3. Lindkær Jenson N H, Cook T M, Kelly F E. A national survey of practical airway training in UK anaesthetic departments. Time for a national policy? Anaesthesia, 2016; 71, pages 1273 – 1279

4. Cook T M. (Still) time to organise training in airway management in the UK. Anaesthesia, 2006; 61, pages 727-730

5. Kelly F E, Cook T M. Seeing is believing: getting the best out of videolaryngoscopy. Br J Anaesth, 2016; 117, (S1): i9 – i13

6. Howes T E, Lobo C A, Kelly F E.

Rescuing the obese of burned airway: are conventional training manikins adequate? A simulation study. Br J Anaesth, 2015 Jan;114 (1), pages 136-42

7. Frerk C, Mitchell S, McNarry A F. Difficult Airway Society 2015 guidelines for management of unanticipated difficult intubation in adults. Br J Anaesth, 2015; 115 (6): pages 827–848

8. McCarthy S, Cooper RM. A primer on the ethics of teaching and learning in airway management. Anaesthesia, 2018. doi: 10.1111/anae.14313. [Epub ahead of print]

Anaesthetists in Prehospital Care

Dr Lauren Weekes, HEMS Clinical Fellow
Dr Matt Beardmore, Specialty Trainee in Anaesthesia and Prehospital Emergency Medicine

Doctors working in prehospital medicine isn't new. GP Dr Ken Easton starting responding to accidents from his home and surgery in 1967, later forming the British Association for Immediate Care (BASICS) as other doctors began to do the same.

Prehospital medicine has evolved significantly since those early days, and it is now a recognised sub-speciality of Emergency Medicine, Anaesthesia, Intensive Care Medicine or Acute Medicine. Formal training in Prehospital Emergency Medicine (PHEM) began in 2015, and many of the first cohort are now in NHS posts with a job planned component of prehospital medicine.

The ethos of 'critical care without walls' as delivered in acute hospital trusts can now be extended to the prehospital phase of a patient's journey. Most commonly this occurs in the setting of air ambulance organisations, although other arrangements such as BASICS schemes and retrieval/transfer organisations (Wales and Scotland) do exist. Extended training for other prehospital practitioners such as Masters qualifications for paramedics has contributed to advancement in this area.

What do anaesthetists bring to PHEM?

Many of the higher-level prehospital interventions such as alternative analgesic techniques, sedation and anaesthesia are obviously within our everyday scope of practice. The out-of-hospital environment can be deeply stressful in terms of decision making, communication and cognitive overload; having these core clinical skills embedded in our muscle memory frees up bandwidth. Recognition and understanding of abnormal physiology, making rapid interventions and considering risk: benefit decisions are also part of our core skillset and are highly relevant to the prehospital arena.

Personal perspective 1: Lauren Weekes

I am a South West Peninsula anaesthetic graduate, having obtained my CCT in November 2018. I had an early interest in prehospital care; I'd been working in motorsport medicine since 2007 and had started responding for BASICS Devon in 2010, attending incidents from home as a solo responder. I somewhat missed the boat on formal PHEM training, but I strongly felt I wanted to further my skills and experience in prehospital care. I applied for and got a standalone post with the Air Ambulance Service in the Midlands to start post-CCT, and lasting for nine months.

Challenges

There were the normal, mundane challenges of working in a new organisation. New faces, new standard operating procedures, the usual administrative issues (although I will have it noted they paid me correctly, and on time; take note, NHS!). I'm also living away from my family during the week, which has been tough for everyone.

The steepest learning curve for me were the aviation procedures. Having only rarely flown in a helicopter before, there was a huge amount to take in. Starting with a) getting my flight helmet on and off without taking my ears off too; b) how to get in and out with the rotors running, and not have my head chopped off and; c) how to find a grid reference on the correct OS map before we've got to the scene, in an aircraft that can fly at 180mph…

Having not previously provided prehospital anaesthesia (I can't guarantee a trained assistant when responding for BASICS), there was a learning curve there too; it was not the technical provision thereof, but the when to do, and when not to do. Time is of the essence when caring for the very unwell, and dividing tasks up among your team is enormously important. It's been a hard pill to swallow that sometimes interventions are performed more quickly when I get out of the way!

Benefits to my anaesthetic practice

I will take back several lessons hard learned to anaesthesia. Firstly, I will try my hardest to adopt the wise words of Sidney Dekker when trying to understand someone else's actions:

"Did the assessments and actions of the professionals at the time make sense, given their knowledge, their goals, their attentional demands, their organizational context?"

Prehospital medicine is a very 'public' speciality whereby everyone will have an opinion on what you did or did not do. I am happy to defend my actions and accept constructive criticism but sometimes it's not been an altogether positive experience! Secondly, I have had new insight into the power of taking a moment to think strategy. On the way to incidents, I'm learning to think beyond the clinical; which hospitals are available, and what services do they have? What are the risk:benefits of flying the patient versus accompanying by road? Thinking about these things before I get to the patient means that momentum isn't lost once key interventions, e.g. anaesthesia, have been performed. This has clear parallels for treating

the critically ill or injured inside the hospital; don't relax once you've been to CT, where are they going next? What interventions will that patient need in the coming minutes/hours? Thirdly, I have developed a healthy scepticism for dogmatic practice. More than many other areas of medicine, PHEM is an evidence-based vacuum and the void is often filled with opinions strongly held. There is fantastic work being done in conducting large-scale RCTs in prehospital care (AIRWAYS-2, PARAMEDIC) but there's much in current practice that isn't based on good evidence. When there is evidence, at what point do you adopt it? I read a NEJM paper on early vs delayed PCI for patients who had presented in cardiac arrest with shockable rhythms and no STEMI on ECG; no difference in any important endpoint. Within an hour of reading it, we went to just such a patient; should I be allowing that trial to influence my decision making? Assimilation of research knowledge into clinical medicine is a challenge for us all and I will be considering such issues carefully in future.

Summary

What I've really learned from this fellowship is that prehospital medicine isn't about the sexy stuff. The medical boundaries are being pushed by prehospital ECMO, prehospital REBOA, whole-blood transfusion, and stroke thrombolysis; and these interventions may eventually benefit a handful of patients per year. But what **all** ill and injured patients need, inside or outside the hospital, is the very unsexy basics doing well. Stopping bleeding. Keeping patients warm (and also taking all their clothes off, surprisingly difficult to do in January). Providing analgesia and reassurance. Taking them to the right place first time. Putting your big girl pants on and making difficult decisions when you believe it to be the right thing for the patient in front of you. And, naturally, try not to get your head taken off by the rotor blades.

Personal perspective 2: Matt Beardmore

A Peninsula ST6 Anaesthesia trainee at the time of writing, I'm currently on 'out-of-programme' training in West Midlands deanery pursuing PHEM training in a 2 year 'blended' training programme. But before I delve into the nitty gritty of the application process and what the job is like, a bit of background on how I ended up here…

Why PHEM?

Like Lauren, I've had a long-standing interest in the delivery of pre-hospital care. As a final year medical student in 2009, I spent 2 months full time in the Paris area as an 'externe' with their physician-led PHEM teams. This experience made a profound and long-lasting impression upon me. Being part of an elite and close-knit team, debriefing each tasking with an open

safety culture, systematically critiquing *every* case *every* day with one's peers and changing SOPs *that same day* when needed. Compared to what I had seen in hospital placements I was impressed. Since then I've worked gradually towards working in PHEM as a senior trainee. The aim: bringing hospital care to the scene of an incident as part of a well-oiled team in a highly integrated system providing timely interventions and seamless ongoing care.

Application to PHEM Training

Open to post-FRCA trainees ST5+, the training programme consists of 1 year whole-time-equivalent PHEM done either as a single block or blended with anaesthetic placements over 2 years. While there are jobs all over the country, numerically the majority are in the Midlands and East of England areas, so some geographical flexibility is almost essential. The person specification is available via the IBTPHEM website and probably needs a few years to gradually attain the required elements (http://www.ibtphem.org.uk). While experience in PHEM or retrieval medicine is not necessary it does significantly boost an application. Similarly, related audits, publications and qualifications (DipIMC, Dip RTM) show commitment to specialty. Crucially, 6 months' experience in ED and Acute Medicine at CT1 or above 'in posts approved for training' are soon to be mandated entry requirements making ACCS training a real advantage for applications.

The PHEM training experience

With a large curriculum to cover, hefty WBPA requirements and 2 mandatory exams (DipIMC and FIMC with RCSEd) PHEM training is a busy time. Add in moving home, arranging OOPT, co-ordinating Higher/Advanced anaesthesia modules and the many demands on study leave requires quite some organisation. It is all worth it though; the training and clinical supervision is some of the best you will ever have. A week-long residential training course to start, crew resource management (human factors) training, regular simulations and drills at base, cadaveric Emergency Surgical Skills tuition to name a few. Not to mention what a huge privilege it is to regularly get into a charity-funded helicopter, fly in priority airspace to highly triaged and varied taskings to perform critical care skills. One aspect for which hospital medicine prepared me poorly was the injury demographics seen – by virtue of our rapid response we see the 'immediate' and 'early' death group of trauma patients described in the literature. Adding that to scenes being in patient's homes or their relatives being present removes the separation we can sometimes feel in-hospital.

Summary

PHEM training is a competitive and challenging but hugely rewarding programme which opens up many opportunities both during and after completion. Timely CV development is required to build a strong application and hard work to see it through. The rewards: an array of advanced clinical emergency, team-working and leadership skills and getting to meet interesting, inspirational people.

STAR Update

Dr Katie Samuel – STAR executive chair

STAR has had an exciting start to 2019, launching our regional Perioperative Quality Improvement project, as well as preparing for the 2nd STAR Annual Research Congress in June.

STAR has been one of the first national groups to use the Perioperative Quality Improvement Programme (PQIP) data in our '**P**erioperative **A**naemia **M**anagement in **S**evern (PAMS) Project – A Quality Improvement Initative'. Led by STAR committee and Helen Williams, the PAMS project has looked at data relating to anaemia from the four PQIP centres within STAR's geographical borders, as well as gathering additional data on local perioperative anaemia testing and treatment protocols. At the time of writing, the project will be submitted to the RCoA Anaesthesia conference in May, and will mark the beginning of some meaningful QI using the data collected.

Our AGM at the winter SASWR meeting in Bath was well received, with our trade stand and display of recent posters (along with pens and lanyards for members) proving popular with trainees. As well as hearing presentations from both our STAR fellow and DALES study lead, we were delighted that both the Intersurgical oral presentation and Poster prize were won by STAR committee members (myself and Sethina Watson respectively)! We were also able to again thank in person the SASWR committee for their ongoing support of STAR.

The 2nd STAR Annual Research Congress at the time of reading has hopefully (!) been a great success (running on the 12th June at North Bristol Trust). We are delighted to be including a number of national research experts in the programme, including NAP7's lead Jas Soar, Profs Cook and Nolan, and leads for the national projects SNAP-2, FLOELA and RAFT. This year's event will also have included the first 'STAR project pitches', welcoming home grown project ideas from regional trainees to compete to be chosen as the next STAR regional project.

Our STAR research fellow, Sethina Watson, continues to go from strength to strength in both her personal projects as well as harbouring a research favourable environment for trainees at North Bristol Trust. She continues work on the Delphi process for the GALORE trial - General, Local, and Regional

Anaesthesia in Emergency Surgery (GALORE); A project to develop mode of anaesthesia as an intervention in emergency surgery and inform future trials. She has also worked hard as local lead for the FLOELA trial and has significantly improved recruitment numbers as well as facilitating trainee involvement. Through setting up the Southmead Anaesthesia Research Group she has helped trainees to identify and get involved with local research opportunities, and continues to conduct work related to the 'theatrecapchallenge' with a recent publication in the RCoA GAS newsletter.

The last 6 months have also seen another change in committee members, and we are delighted to welcome Jon Bower as our new membership secretary, Paul Watson as our IT and social media lead, and Chris Newell as our Consultant Supervisor. It is therefore with sadness that we have said goodbye to those who have moved on, but I particularly want to mention Ronelle Mouton, our previous Consultant Supervisor. She has helped guide STAR from its initial set up, and has given so much of her time and knowledge to help STAR achieve the success it now enjoys. As chair, I have also now taken on the role of Chair of the national trainee research body RAFT, and hope that this role will help to strengthen STAR's links with the HSRC as well as other trainee research networks around the country.

Our STAR website **(www.anaesthesiaresearch.org)** secure 'members' area' for trainees continues to develop, with local STAR leads adding details of local research and QI projects – a great resource for trainees starting at a new Trust and looking for projects to get involved with. We have also introduced the STAR 'Excellence in Leadership and Management award', to be awarded annually to the STAR local lead with evidence of the greatest engagement and growth of STAR locally.

We have an active following on Twitter **(@STAResearch** and **@STAR_Research)** with over a thousand followers; follow us for research and QI updates as well as the odd comedic tweet. If you would like to join STAR and be involved in great research projects (medical students and foundation doctors are also eligible) just sign up for free via our website.

Have an idea to pitch? Want to get more involved with STAR? Drop us an email at **stargroupresearch@gmail.com**

SWARM update

Dr Debbie Webster
SWARM Chair

Well, what a great turn out we had at this year's Research Training Symposium! Fantastic to see so many new faces keen to get involved with trainee research. The meeting was held at Buckfast Abbey on the 18th March and welcomed inspirational speakers from the South West and helped to strengthen links between the Clinical Research Network and SWARM. We were pleased to welcome Seb Brown (ex-SWARM Chair) back to talk about his fascinating innovation and what motivated him to follow that dream. John Carlisle worked his wizardry with statistics and Adam Revill gave us a great run down on Quality Improvement. It was wonderful to hear Professor Taylor (Research Design Service), Jo Taylor (CRN) and Maxine Hough (Study Support Service) speak to us about what support and resources are available for SWARM to tap into when planning future studies. We are very thankful to our speakers for their time and support, and to Buckfast Abbey Conference Centre for another wonderful buffet!

Andrew Woodgate, this year's SWARM fellow, has been busy recruiting patients to COMPASS (Cognitive Monitoring in Planned Arthroplasty Surgery Study) at Torbay whilst we are very thankful to the excellent research nursing staff at Derriford for doing the lion's share of recruitment to date. COMPASS is a portfolio adopted feasibility study aiming to use an online tool to map cognitive function in patients undergoing arthroplasty surgery and in matched controls. The study is aiming to recruit 150 patients before January 2020 so we are very keen for more keen beans to get involved with this process – please talk to Andy Woodgate if you would like to help at Torbay or Jo Burrows/Debbie Webster if you can help at Derriford.

Anna Ratcliffe won the Regional Training Symposium Hive of Ideas in 2017 with her plans for AFAR (Accelerometers for Assessing Recovery). After a busy preparatory period during which Anna secured an Academic Clinical Fellowship, ethical approval, NIAA funding and CRN portfolio status, she has now completed recruitment to the study and is entering follow up phase. Anna has also been collecting qualitative data regarding the acceptability of the technology to patients through focus groups.

SWARM have contributed to national trainee network projects over the last few years. DALES (Drug Allergy Label in the Elective Surgical population), a RAFT study (Research and Audit Federation of Trainees), completed recruitment earlier this year (results eagerly awaited). PAPAYA was conducted by PATRN (Paediatric Anaesthesia Trainee Research Network) and audited rates of unplanned admission following paediatric day case procedures and results are about to be published.

SWARM continue to collaborate with STAR. The bi-regional ATOMIC (Assessment of Tracheostomy Insertion and Care) study showed relatively high rates of tracheostomy complication and variable practice across the South West. Consequently, ATOMIC 2 has been adopted as a national RAFT project and will be running late 2019 or 2020 pending funding.

The 2018 Hive of Ideas project will assess the incidence of perceived inappropriate intensive care provision. Increasing evidence links this to workplace stress and burnout so we would like to see how significant a problem perceived inappropriate care is within our intensive care units. We hope to collaborate with STAR to collect data across both Peninsula and Severn. This study is currently going through ethical approval and funding applications.

Many congratulations to James Womersley who is 2019's Hive of Ideas winner! His project will look to identify long term survival following intensive care admission in each Trust in the Peninsula region. This will involve retrospective analysis of patient outcomes following ICU admission. The project is currently being submitted via IRAS (Integrated Research Application System) so watch this space and do contact James or your site lead if you are keen to help him with this piece of work. Other projects presented at the Hive also sound exciting. SWARM will also support Ben Whatley's project to minimize volatile pollution by encouraging us to safely minimise flow rates.

We are very pleased that Johannes Retief (Anaesthesia Consultant, Torbay Hospital and previous SWARM Chair and Fellow) has agreed to become a Consultant Director for SWARM. Johannes brings with him a huge amount of experience and enthusiasm for getting the best out of SWARM so we are really appreciative to have him on board.

As you can see, SWARM is busy, but more project ideas are very welcome. If you have ideas or want to get involved with any of the projects due to start recruitment, please contact your local lead (see below).

Keep SWARMing!

@ukswarm
https://www.ukswarm.com/

SWARM Local leads:

Barnstaple – Aislinn Brown
Exeter – Tom Woodward
Plymouth – Jo Burrows
Taunton – Owen Thomas
Torbay – Will Hare
Truro – Dave Kotwinsky

The Wine Column

By Tom Perris

The Juice of the Barley

I've been on my travels again and for once I didn't visit a wine-producing area but went to the West of Scotland. Despite being far too an inhospitable climate for grape growing, I have to say the area has much to recommend it not least the seafood and the scenery. If only the weather was as reliable as Tuscany, I'd consider going more regularly. However, the Scots are hardy and have produced several innovations to effectively keep out the chill. Porridge is as fine a breakfast as a man could ask for and a stout tweed jacket is not only a smart outfit for race-week but keeps the chill wind at bay very nicely.

But neither of these is quite as well designed as Scotland's most famous winter-warmer. Plainly, I am discussing whisky (without an "e" as we are neither talking of Irish or American products). Accounting for over 4 billion pounds of sales revenue and a quarter of all UK food and drink income, it is big business and growing fast. Exports grew 87% in the last decade mostly to the French and US markets. There are currently over 120 (official) distilleries in Scotland with several more being planned or re-opened. My highland sources inform me that there remains a thriving home-brewing tradition in the more rural spots away from the prying eyes of the revenue. Incidentally, the Scots blame the English for the tax on whisky as it was introduced in 1707 after the Act of Union. After this the amount of moonshine produced rose exponentially until over half of all whisky produced was made illegally! Not till 1823 when distilleries became licensed (for a fee) did the production on Moonshine decrease. At least there wasn't a war. George Washington himself plus 13000 troops rode to Kentucky and Pennsylvania to suppress the Whiskey Revolution after unwelcome taxes were imposed on distillers there.

The process of making whisky starts remarkably similarly to making beer in that malted barley is heated with lots of water to extract the sugars from the grain, making wort. Malted barley is made by warming and soaking the grains to start germination which turns the stored starch to more fermentable sugars. The malt is dried over peat smoke which accounts for some of the flavours in the end product. The wort is then fermented to an alcohol content of about ten percent -considerably higher than beer- and without the hops. It's more of a barley wine that a beer, but it's pretty disgusting to look at and to taste at this stage. Distillation extracts the various aromatic alcohol compounds plus a variety of other flavouring compounds. Acetaldehydes are prominent amongst these but over 300 other compounds have been noted in the analysis of Scotch. A second distillation allows the more toxic elements to be separated and a spirit containing about 70% ethanol

is then placed in charred oak barrels for a period of at least 3 years to gain colour, flavour and maturity. It's only whisky after this time and most producers keep their product in barrel for ten years or more. Practically, little is gained in terms of flavour after about twenty years in wood but marketing plays a major part in the price of whisky and older must be better, right? No, just more expensive! The age you might see on a bottle of whisky is the amount of time it's spent in a barrel, not a glass bottle. There is no detectable change in the quality of whisky, no matter how long you leave it in the bottle, unlike wine which continues to develop for years after bottling, sometimes to its benefit, sometimes not.

A word on nomenclature: Single Malt refers to whisky made from one type of malt (there are many) from one distillery only. Malt whisky means that all the spirit is made from fermented malted barley whereas a blended whisky can be made from spirits derived from other grains (wheat, sorghum and rye chiefly). Most distilleries will blend different barrels of different ages to produce a consistent house style so there is rarely "vintage" single malt from a single year although it is occasionally produced. The age on a bottle refers to the youngest spirit contained in the mixture.

There are five designated whisky-producing areas: Lowland, Speyside, Highland, Campbeltown and Islay (including all the other islands, not just Islay itself) and they have distinct regional identities plus substantial individual variation. To describe them is too difficult and pretentious to attempt but I will say that I had not appreciated the sheer variety of colours and flavours until I spent a long and happy evening in the company of some senior colleagues at the Scottish Whisky Society on Queens Street in Edinburgh. It's not to everyone's taste though. To quote Adrian Mole, "if whisky was medicine, people would tip it down the sink!"

If you enjoy a lively discussion, then ask a true Scotsman either his favourite brand or how best to drink it. You might be there some time but I'll suggest the following…

Pour some whisky into a glass - be generous. You want to taste it and you deserve it. Use a nice quality tumbler or tulip shaped glass to concentrate the flavour. A tin cup has been suggested for an authentic old-time experience but the bloke was pissed so maybe not!

Take a sip of the neat Scotch to appreciate the unadulterated flavour and consider adding a splash of spring water or an ice cube. Some say the flavours are enhanced "by an angel's tear" but again this discussion took place late at night so add a pinch of salt. To your discriminatory faculties, not your whisky! I tend to drink mine neat.

Don't add coke.

Enjoy.

Letters

Dear Sir,

Dr Ormerod's paper "Improving Management of Intravenous Lines after Anaesthesia" (APW Autumn 2018, **51;** 2 31-34) is unusual in addressing a clinical issue that is actually relevant, using a simple experiment to provide useful information and then applying those findings to the real world! I hope APW will find space to publish the audit results once the effect of the handover tool has been assessed in normal practice, following its introduction to the trust's standard care pathways.

The picture board showing dead spaces for I.V. cannulae and connectors is a simple and effective way of raising awareness amongst staff. Professionals are odd people (NHS managers please note). We do the right thing once we understand that it is the right thing. Telling us to do things will often result in a sort of Newtonian rebound once the person giving the orders has moved on. The picture board educates without badgering us—very good management practice.

Non-depolarising muscle relaxants held in the dead space are worth considering too. If the next drug to be given is the reversal, it may not work quite as well as one might expect. Flushing is good practice after every drug administration.

In these times of Brexit, I recall a happy time in France at the start of my training, when nobody used ported cannulae, because they were considered to be an infection risk. Instead, patients all got a non-ported cannula and an I.V. infusion and the drugs were injected via an injectable rubber bung on a three-way tap on the I.V. line. I dropped the injectable bung idea, having skewered myself a couple of times on-call in the middle of the night, but remained with the I.V. Result: all the drugs are fully flushed through as a matter of course and if you are worried, you can flush the open hub by turning the tap towards the I.V. bag before capping it again. When you see your patients in recovery and on the ward, have you ever noticed how the cap on the cannula is almost always left open, scraping-up bacteria-laden squames from the bedclothes, ready to be injected with the next I.V. injection? Perhaps the old French anaesthetists were on to something after all!

Yours faithfully,

Gareth Greenslade MBA FRCA FFPMRCA

Notice to Contributors

All articles should be sent by email to the editor (see below for address). Scientific articles should be prepared in accordance with uniform requirements for manuscripts submitted to biomedical journals (British Medical Journal 1994; 308: 39-42) i.e. as used by Anaesthesia. Please ensure that references are complete and correctly punctuated in the required style. The approved abbreviations will be used for journal titles. Photographs should be sent as separate attachments. All articles should be sent as Word documents, and especially not PDFs, pages documents etc. Please send photos separately and label appropriately. The deadline for submissions is usually 10 weeks before the next meeting of the society.

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