Diversity issue:

The NHS Gender Pay Gap - an interview with Professor Dame Jane Dacre

On the basis of sex: speakers at Association conferences

Breaking through the glass ceiling
“Diversity is pretty in these days,” is a line from one of my favourite American TV shows, ‘The Good Fight’, which follows the workings of an all African American law firm with a token white lawyer. It is, however, a fact and more organisations including the Association of Anaesthetists are looking at diversity including all protected characteristics (Equality Act 2010). The theme of this issue of Anaesthesia News is diversity. It includes an interview with Professor Dame Jane Dacre, who is leading the NHS Gender Pay Gap Review.

Differential attainment in exams is being given serious consideration by most Royal Colleges. The RCoA has published data to show that international medical graduates from black and minority ethnic background (IMG-BME), do not do as well in the exams as UK trained doctors. Following the restructuring of the FRCA exam it is hoped that our college will relook at differential attainment in more detail. For example, is there a difference between UK-BME and UK-white specialty doctors as far as exam success is concerned?

As with good red wine, we anaesthetists generally mature well with age and again like red wine we do better if we are allowed to breathe a bit! A colleague writes about ageing anaesthetists and emphasises the need to cherish our more mature colleagues and use their expertise and experience appropriately. We have a workforce crisis on our hands for more than one reason. Due to harsh taxation of the NHS pension ‘pot’, many of our colleagues might want to retire and return to work. What puts them off is that they are expected to come back to a completely flexible working week which may require them undertaking a theatre list in an unfamiliar subspecialty after 20 years, causing unnecessary stress and making them feel poorly valued and want to leave work for good.

Here’s to celebrating diversity in all its forms…

Upma Misra
Honorary Membership Secretary
The NHS Gender Pay Gap - an interview with Professor Dame Jane Dacre

“It’s not so much about saying this is someone’s fault, or that people are bad, sexist and misogynistic. It’s just about systems and ways of doing things that have become the norm.”

The above quote is from Caroline Criado Perez [1], who in her upcoming book Invisible Women brings the discussion of male bias in the world to the fore - all through the use of data and statistics. The author and campaigner highlights how an abundantly biased gender data gap exists that disadvantages women.

In accordance with the Equality Act of 2010 men and women ought to receive equal pay for doing the same job. However, men and women can receive equal pay, and there can still be a significant gender pay gap as various factors over the course of their career mean women’s average hourly pay slips behind men. The gender pay gap is the gap in earnings between men and women accrued over the course of a lifetime. Across the UK the average gender pay gap is 8%. In the NHS, for doctors, the difference is nearly double at 15%, that translates to an estimated loss of £16,000 per year for women. “The difference is huge,” said Prof Dame Jane Dacre. “That’s one of the reasons the government chose the NHS as one of the first public services to be investigated.”

The review was born out of the furor of the junior doctors strike where women felt incrementally discriminated against. During the contract negotiations the then Health Secretary Jeremy Hunt promised to carry out a review into why a gender pay gap existed. It was thought the gap for female consultants would be greater and the review was extended to the entire NHS, she explained. The review has found, as expected, that there is a gender pay gap. A mixed methods approach was taken using qualitative data from a survey sent to a random sample of 40,000 doctors on the GMC register, along with data from the NHS electronic staff record, and the academic staff record. In addition, pay data for GPs (who are not on NHS staff records) was compiled from HMRC records and combined with interviews and surveys to form an accurate assessment.

Prof Dame Jane Dacre was cautious to qualify her statements as the review is not fully complete. But the picture that is beginning to emerge, she said, is that men are paid for extras in a way that women are not. She cited clinical excellence awards as a big contributor to the gender pay gap. “One of the reasons men receive more (clinical excellence awards) is that they are older. And there are a higher number of senior men in the profession due to the fact the number of women at entry is, of course, women do more part-time work. 24% of women work part-time compared with a mere 5% of men[2]. “Men tend to go part-time for reasons other than childcare. One of the really interesting things that I suspect will never be tackled is the cost and availability of childcare which makes a significant difference to working women, “observed Prof Dame Jane Dacre.

Blinder-Oaxaca equation

“Judging by research from other professions, female dominated specialities tend to have less political clout. As a result, their pay tends to suffer. We haven’t got the granular data just yet but I suspect female dominated specialities would be geriatrics and palliative medicine - and they would have fewer clinical excellence awards contributing to the gender pay gap,” she suggested. She said they are using the complex Blinder-Oaxaca equation to try and identify what percentage of certain components - maternity leave, part-time work, or specialty - can be attributed to the gender pay gap. There is so much data that a follow-up more in-depth report is expected in September.

Prof Dame Jane Dacre said: “Overall the way to tackle it is a long-term thing - it’s encouraging women to reach the top of the profession. Data shows that due to unconscious bias, to have a 50% chance of appointing a woman you need to have three women on a shortlist of four.” The government equality office said having more women on shortlists is the best way to reduce the gap. “Little by little, initiatives like that, and just being aware of the bias will help employers manage and get rid of them.” More sophisticated techniques of regular pay gap monitoring, would help, she suggested. But overall, she was dubious about the government’s aim to eliminate the gender pay gap in its entirety. “It’s quite a tall order. To eliminate it entirely is difficult,” she admitted.

References

1. Interview: Caroline Criado-Perez on the shockingly sexist data that shapes our lives: http://www.thetimes.co.uk/article/845f05cc-3a89-11e9-ba2e-dde2c82db60a
The (not so) ‘good old days’

Retiring from clinical practice got me thinking, or should I say reminiscing, about the changes in anaesthesia that I’d witnessed over the nearly 40 years I’d worked as an anaesthetist.

I should begin with changes to training, as it always seems that we ‘old buffers’ have firm opinions about it and are frequently heard saying: “it wasn’t like that in my day...” I had the good fortune to start my anaesthetic career in a progressive department where I was supernumerary for the first three months and assessed at the end to confirm that I was safe to ‘fly solo’ - much akin to proving basic competencies today. However, not everyone was as fortunate; it was not unusual for beginners in anaesthesia to be thrown in the deep end and fly solo with minimum hand-holding supervision. To the benefit of patient safety, things are much better now. The biggest change was the loss, over 20 years ago, of the ‘senior’ registrar (SR) grade. Following 2-3 years as an SHO, 2-3 years as a registrar, we all had to apply, often in a different part of the country for a 4-year SR job. That made a total training time of around 9 years, more than the current minimum of 7 years, but far less structured. Another difference was the out of hours work. Throughout training we worked an on-call system; in the early years we were resident and later on, we were mainly ‘on call’ from home. Either way, the total hours were much longer - a 1 in 3 rota equated to an average 82 hours per week. But, it should be remembered that even resident ‘on call’ came with an ‘on call’ room and, depending on the intensity of the job, some of that 82 hours was spent in a bed. It was a far cry from today’s shift system where the hours may not be so long on paper, but the intensity of work is far greater.

In the past 40 years I’ve seen significant improvements in the delivery of anaesthesia. Vastly improved monitoring has made anaesthesia much safer. When I started we relied on a finger on the pulse and a von Recklinghausen manometer for blood pressure monitoring. Many years have passed since the intricacy of this device has been asked in the FRCA examination, but in my day it was a common (and dreaded) question. More advanced departments had ECG monitors in theatre, but not in the anaesthetic room.

Time to get rid!

When I was an SR, I regularly anaesthetised children for dental extractions where the operators were supervised dental students and, therefore, not the quickest. There were no laryngeal masks, instead we used nasal masks, which made for a challenging shared airway. We were adept at recognising cyanosis early, when we would interrupt surgery until we could get the children ‘pink’ again. The arrival of pulse oximetry showed us that we weren’t quite as good as we thought at detecting cyanosis. We now saw that the children regularly desaturated to 70% or less, making surgery almost impossible! Fortunately, we were rescued by the arrival of the laryngeal mask at around the same time as the introduction of oximetry. Another consequence of the introduction of laryngeal masks was that our hands were now free during shorter cases. Until their arrival there were basically two airway techniques available: a tracheal tube either with the patient relaxed and ventilated or breathing spontaneously, or the use of a facemask held firmly on the face. For cases longer than a few minutes it was common to use a Clausen harness, or similar, to keep the facemask in place. I haven’t seen a harness used for many years, yet it is strange that the hooks used to attach a harness are still supplied with disposable anaesthetic facemasks - clearly a waste of plastic with environmental consequences. Time to get rid! Prior to the introduction of supraglottic airways, anaesthetists had to be adept at holding facemasks and maintaining the unintubated airway. We also developed strong forearms capable of holding the facemask in place one handed for prolonged periods.

There have been many changes to anaesthetic drugs over the near 40 years, and it has been interesting to see drugs come and go. When I started we still used curare and alcuronium (what are those? I hear you say). Pancuronium was the new kid on the block. All these agents produced good relaxation provided you used enough drug. But the biggest difference compared with the neuromuscular blockers we use today was the time it took for them to wear off. You needed to wait until there was adequate spontaneous reversal of relaxation before you could hope to reverse with neostigmine and there was the phenomenon of ‘recurarisation’ when, because of the more gradual recovery from these drugs, the effect of neostigmine would wear off before there was adequate recovery of the neuromuscular blockade and the patient would become paralysed. It was not uncommon to see inadequately reversed patients in recovery with a weak cough reflex as a consequence of re-curarisation. The commonly used current neuromuscular blockers - atracurium, cis-atracurium and rocuronium may not be perfect but they are easier and safer than the old drugs, and with the arrival of sugammadex there is the ability to reverse neuromuscular blockade without waiting for some degree of spontaneous reversal.

When I started the available volatile anaesthetic agents had many limitations. Halothane was easy to use but in addition to all the concerns about liver toxicity, it produced spectacular and worrying dysrhythmias – not good for one’s own coronary arteries; enflurane was ‘ok’ but at times of low surgical stimulation (e.g. surgeon taking too long to scrub) the patient refused to breath and had to be manually ventilated until the scalpel was applied; and, trilene could maintain anaesthesia in ventilated patients but took ages to wear off in recovery. We don’t know how lucky we are with sevoflurane.

As for TIVA there were no sophisticated syringe drivers and the barbiturate drugs available did not have suitable pharmacokinetic profiles. Althesin arrived around the time I started and looked promising, but did not last long, being withdrawn because of the risk of anaphylaxis. Almost all patients received premedication, usually as an intramuscular injection. The ubiquitous Omnopon (papaveretum) and Scopolamine produced good sedation and probably papered over many of the limitation cracks of the anaesthesia drugs we had available to us.

Pencil point spinal needles

Finally, as someone who spent most of his career in obstetric anaesthesia, arguably the greatest change for the better was the arrival of pencil point spinal needles in the early 1990s. Prior to this, spinal anaesthesia was hardly ever used in obstetrics because of the high incidence of distressing spinal headaches. Awake Caesarean section was therefore restricted to the use of epidural anaesthesia and, therefore, slow to induce and less reliable. The arrival of pencil point needles produced an explosion in the use of spinal anaesthesia and the slow demise of general anaesthesia for surgical delivery to the point where trainees are less practiced in the technique. But that’s a story for another day.

Paul Clyburn
Retired consultant anaesthetist
Immediate Past President, Association of Anaesthetists
Trainee Conference
(formerly known as the GAT ASM)
3-5 July 2019, Telford International Centre

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Call for nominations for the Association and Foundation Awards
Nominations are sought for the following awards:

The Association Award is awarded by the Board of Directors to those who have made significant contributions to the Association, its objects and goals, or its members. The award is not restricted to members of the Association. The current objectives of the Association are:

• to encourage and support worldwide co-operation to promote and support education and research in Association and Foundation Awards

The current objectives of the Foundation are:

• to advance and improve patient care and safety in the field of anaesthesia and related sciences; and
• to encourage and support worldwide co-operation between anaesthetists.

The Association Award is awarded by the Board of Trustees of the Association’s charity, to those who have made significant contributions to the charity, its objects and goals. The award is not restricted to members of the Association. The current objectives of the Association are:

• to promote and support education and research in anaesthesia, medical specialties allied to anaesthesia and science relevant to anaesthesia;
• to represent, protect, support and advance the interests of its members; and
• to encourage and support worldwide co-operation between anaesthetists.

The Foundation Award is awarded by the Board of Trustees of the Association’s charity, to those who have made significant contributions to the charity, its objects and goals. The award is not restricted to members of the Association. The current objectives of the Foundation are:

• the advancement of public education in and the promotion of those branches of medical science concerned with anaesthesia, including its history;
• the promotion of study and research into anaesthesia and related sciences and the publication of the results of all such study and research; and
• the advancement of patient care and safety in the field of anaesthesia and disciplines allied to anaesthesia in the UK, Ireland and anywhere else in the world.

Nominations should take the form of a short description of the nominee’s contributions (maximum 500 words). Self-nomination is acceptable. If you nominate someone else, you should gain their approval for your nomination. Nominations should be emailed to honsecretary@gatsm.org by 17:00 on 27 May 2019.

The Association’s Honours and Awards Committee will consider nominations at its meeting on 7 June 2019, and will make recommendations to the Board of Directors and the Board of Trustees, which will determine the recipients of the 2019 awards. The successful nominees will be informed shortly afterwards. The awards will be made at the Association’s Annual Congress in Glasgow (11-13 September 2019) or at WSM London 2020 (8-10 January 2020).

Association of Anaesthetists

Breaking through the glass ceiling

‘The unseen, yet unbreakable barrier that keeps minorities and women from rising to the upper rungs of the corporate ladder, regardless of their qualifications or achievements.’

The United States Federal Glass Ceiling Commission

Perspective is an amazingly personal thing. Perhaps this is what is meant by our sixth sense? How we see the world can only be known by ourselves. How the world sees us is a mystery. A personal perspective will change depending on the influences on us, our progress and our feelings and thoughts in the light of these factors. Society is also subject to change - just look at 80’s comedy shows we used to think were hilarious to see how dated they are now. Here and now is a President of the Association of Anaesthetists, the first female in the organisation’s 87 years.

For me the challenges are about upholding the Association’s values, looking ahead to determine strategic goals that will align with those values, legacies and opportunities and which will satisfy and develop the membership. That I am a woman doing this, does not really register. Of course, I am aware of my gender, my habits, my emotional responses and behaviours, and I recognise all of these are female and that gender has more than one meaning.

But I do wonder how I have managed to pass through life not really feeling gender. Neither as a positive that has made it easier for me than if I had been a man nor a negative which has held up my progress. I recognise that many but by no means all cultures have placed, and some still do, the female in a submissive, non-dominant or subservient role. I recognise too that many courageous females have striven to free themselves and others of gender stereotypes and subsequent constraint on activity, expression and position. And the freedom that I enjoy has come at considerable price. So why don’t I feel it?

I was brought up to believe that I could achieve anything if I wanted it enough and if I worked hard to achieve it would come at considerable price. So why don’t I feel it? Maybe I have been lucky with those who have been my peers and seniors, who took me at face value for what I could and could not do, would and would not consider doing. It could be that I have not allowed being ‘a wifie doctor’ as one of our local surgeons used to refer disparagingly to women in medicine to prevent me from being who I am or who I want to be. I wonder if that dismissive title was in some way a spur to my intent? I certainly was clear I had to stand up to and face that surgeon whatever he might wish to bully me into doing.

And so it might be that part of me is about subsumed femininity at least in the context of work and the workplace. But is it not universal? I like clothes (and shoes!), am soft about talent shows, I like having doors held open (or is that just manners?). I am fiercely protective of my daughter and son and of my husband. My nesting instinct is apparent, and I like being ‘the mummy’, or matriarch. I am not, however, a member of any gender associated groups.

Do I have any ‘words of wisdom’? I am not sure, to be honest. My approach is that women and men have differences, some obvious and some less so. The trick may lie in being aware of these and making the most of them and not getting hung up on them. Focus on the big picture - we know that women do better in medical school and score better than men in foundation ranking tests, in selection for specialist posts and in postgraduate examinations. Women account for about 60% of the more youthful half of the medical profession. Many Royal Colleges have female presidents now and in the past. Women’s achievements going forward will reflect the demographics and changes in societal expectations. It’s a matter of time, and of being sure we as people, of whatever gender, do what we know is important and worthwhile for the benefit of others as well as ourselves.

Kathleen Ferguson
President, Association of Anaesthetists

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Women have historically been under-represented as Presidents and on most Boards in anaesthesia, critical care and pain in the UK and Ireland. The Association of Anaesthetists (founded in 1932) has proudly appointed its first female President, Kathleen Ferguson in 2018. Kathleen is 1/138 of all Presidents of the Association to be female; since 1948 the Royal College of Anaesthetists have had 2/24 Presidents/Dears who are female, and the College of Anaesthesiologists of Ireland (founded 1959) have had two female Presidents. Ideally governing bodies should reflect their membership profile in terms of gender. The data on anaesthesia related boards and council is shown in Figure 3. The Association’s Trainee Committee again leads the way.

Many speakers are academics. In 2013 the British Journal of Anaesthesia published a paper that examined retrospectively the gender of authors of original research papers published in the BJA in 2011. Of 188 eligible articles the authors reported 57 (30%) of first authors and only 15% of senior authors were female. Approximately 55% of anaesthetist trainees and 33% of senior anaesthetists are female (1, 3). Our own journal is undertaking a similar review, and it will be interesting to see what progress has been made.

In anaesthetic education 7/20 (35%) of Heads of Schools of Anaesthesia across the UK are female. This is in keeping with the proportion of female consultants and may indicate that senior education roles are equally appealing to men and women within the specialty. Many speakers are from clinical management roles. In anaesthesia clinical management roles around 30% are female (personal communication) and only 1/11 of the Clinical Directors Executive Committee is female. Are medical management roles less appealing to female anaesthetists, and if so what might be done to encourage women to take on such roles?

The Association of Anaesthetists has a comprehensive workstream around member wellbeing and support (https://www.aagbi.org/professionals/welfare), and many speakers will have expertise in this area. One element of the workstream is the national mentoring programme where the Association has developed a network of trained mentors to support colleagues who have an issue they want to work through. Interestingly, of doctors currently registered as trained mentors on the Association’s scheme, 66% are female. What is it about the mentoring scheme that seems to attract so many more women than men? Is this gender stereotyping? If we are aiming to redress any imbalance in gender of speakers we should also aim to redress any imbalance in gender of our mentors.

In summary, it appears that certain roles in anaesthesia may be more popular with men. In particular research, clinical management and intensive care medicine, while other roles such as education are more gender neutral and mentoring has a strong female bias.

FICM have taken the interesting step of introducing a sub-committee called Women in Intensive Care Medicine within their careers, recruitment and workforce stream. In 2016 they released a series of short statements from inspiring women working and training in ICU. The articles were intended to encourage, inspire and support women in their career ambitions. With 55% of medical students, 39% of ICU trainees and 20% of consultants being female this seems an entirely sensible approach. Perhaps a more detailed examination of the data in relation to research and clinical management could help inform a similar approach?

The issue of increasing the numbers of female speakers at our events is a strategic issue. It may need a mentoring scheme to encourage established speakers (both men and women) to support and encourage newer female speakers. Visible leadership on the importance of gender diversity such as that shown by FICM may also play an important role. Establishing reliable systems to record and monitor gender data has been an important first step. Positive discrimination is controversial and systems of tokenism may not be appropriate or popular but some actions that fall short of a quota system may help to redress the balance.

Of utmost importance is that both men and women are encouraged to support equality and diversity in our speciality. We welcome your views on this issue. Please email us at secretariat@aagbi.org.

Katy Miller
Trainee Lead - Equality and Diversity

Tel Sheraton
Board Lead - Equality and Diversity

With thanks to Andrew Mortimore, e-education lead for data and figures

References
2. Our data on medical students and doctors in training in the UK, GMC 2017 (https://www.gmc-uk.org/static/documents/content/SmMEP_2017_ chapter_2.pdf)
Environmental sustainability: opportunity or cost for anaesthesia?

The slow realisation that we live in a world that is affected by our actions and is finite in resources has come to define the early part of this century. The industrialisation of civilisation has fundamentally changed the composition of the atmosphere, with the release of carbon dioxide and other greenhouse gases warming our atmosphere and our insatiable appetite for resources depleting our earth. By 2100 it is projected that there will be at least a 2°C rise in temperature if we continue on our current trajectory [1]. We now live at a crossroads where worldwide efforts are being taken to reverse or at least mitigate the impact [2]. These wide-ranging efforts hinge one factor, creating sustainability. Sustainability as the Oxford English dictionary denotes it, has two complementary meanings. The first is: ‘able to be continued’, with the subtext being indefinitely. The second shows us a way to achieve this: ‘not making excessive use of natural resources’.

So, for anaesthetics the question is how current practice can be continued whilst conserving resources. If this would have been thought of in the past two decades when lacking awareness of anaesthesia, the 21st perhaps will be defined by ensuring current practice can be made sustainable. Consider a routine anaesthetic procedure and look around at the equipment, how much of it will never be used again after procedure? Look closer at the anaesthetic agents stored in their bottles, how did they get to this theatre and where will they go once given to the patient and exhaled? Five percent of the carbon footprint from acute NHS activities (i.e. in a hospital environment) comes from the anaesthetic gases crucial to every operation [3]. For context, in 2004 3% of the UK’s carbon footprint was attributable to anaesthesia [4]. Physical waste is the other two-pronged benefit, the atmosphere is spared, and the life-cycle scavenging system may have a high initial cost it has a two-pronged benefit, the atmosphere is spared, and the life-cycle scavenging system may have a high initial cost it has a high initial cost, sterilising re-usable items could reduce the carbon footprint, we can at least try to soften our footprint. Low-flow anaesthesia ensures as little agent as possible is used per patient and we can perhaps look towards developing scavenging systems that capture these gases after the operation for re-use, preventing release into the atmosphere [8]. Although such a scavenging system may have a high initial cost it has a high initial cost, releasing the atmosphere is spared, and the life-cycle of an anaesthetic agent is extended many times over, creating significant financial savings in the long run. Indeed, sustainability can also compliment innovation. Xenon, an inert element has the potential to replace nitrous oxide as a co-agent without any of the associated environmental effects, yet its cost is prohibitively high [7]. Perhaps combined with meticulous low flow and scavenger protocols xenon could eventually replace nitrous oxide.

Single-use items

Single-use items too have become ubiquitous across operating theatres in a drive to reduce the risk of infection [9]. Face masks and sentinel items such as single-use, specialist items requiring expert manufacture, are now commonly only used once. Although it seems obvious that re-usable equipment would reduce the carbon footprint of constant manufacture, the primary source of energy must be taken into account. Re-usable items that require sterilisation are ultimately only as environmentally friendly as the initial power source that is used [10]. In Australia, for example, where the main producer of electricity is gas, more CO₂ is produced annually per theatre [5]. So, if we can’t remove the culprits of the anaesthetic carbon footprint, we can at least try to soften our footprint. Low-flow anaesthesia ensures as little agent as possible is used per patient and we can perhaps look towards developing scavenging systems that capture these gases after the operation for re-use, preventing release into the atmosphere [8]. Although such a scavenging system may have a high initial cost it has a two-pronged benefit, the atmosphere is spared, and the life-cycle of an anaesthetic agent is extended many times over, creating significant financial savings in the long run. Indeed, sustainability can also compliment innovation. Xenon, an inert element has the potential to replace nitrous oxide as a co-agent without any of the associated environmental effects, yet its cost is prohibitively high [7]. Perhaps combined with meticulous low flow and scavenger protocols xenon could eventually replace nitrous oxide.

Since the 19th Century, chemicals have been synthesised and unearthed that can harmlessly send unconsciousness. Termined ‘without sensation’, the Greek for ‘without sensation’ are examples of the types of chemicals that the industrialisation of civilisation has fundamentally changed the composition of the atmosphere, with the release of carbon dioxide and other greenhouse gases warming our atmosphere and our insatiable appetite for resources depleting our earth. By 2100 it is projected that there will be at least a 2°C rise in temperature if we continue on our current trajectory [1]. We now live at a crossroads where worldwide efforts are being taken to reverse or at least mitigate the impact [2]. These wide-ranging efforts hinge one factor, creating sustainability. Sustainability as the Oxford English dictionary denotes it, has two complementary meanings. The first is: ‘able to be continued’, with the subtext being indefinitely. The second shows us a way to achieve this: ‘not making excessive use of natural resources’.

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References


Congratulations to Mr Oliver Wright, a third-year medical student at the University of Manchester and the Wylie Essay Prize winner 2019. The annual prize is given to medical students on a contemporary topic chosen by the Research and Grants Committee. Oliver will receive his prize and medal at a future Association Council meeting.
Whilst us paediatric perioperative medicine devotees make up a smaller group in terms of numbers, our quest is no less important. In fact, given the potential time period over which poorer outcomes in children can influence factors such as disability-free living, patient satisfaction and resource utilisation, one could argue that long term improvements in paediatric peri-operative care could far outweigh the impact of those seen in adults. It has been long argued that children are not just small adults and it’s these differences which often leave children excluded from projects such as NELA. They are deserving of their own focused research. Yet paediatric perioperative medicine research studies are few and far between. Only six out of the last 150 National Institute of Academic Anaesthesia grants have been awarded to studies specifically designed for children. Whilst not necessarily a direct reflection of the number of applications, the award of such grants is peer-reviewed so this does suggest there is a dearth of high-quality paediatric studies applying for such funding. There are several possible reasons for this: research ethics is more nuanced in children and smaller numbers necessitate multicentre collaboration, presenting its own challenges. Nevertheless, the need for a concerted effort to address variation in practice is evident as adverse outcomes in emergency paediatric surgery have been shown to be increasing [2-4].

The Children’s Acute Surgical Abdomen Programme (CASAP) is a prospective national observational cohort study being delivered by the Health Services Research Centre (HSRC), based at the Royal College of Anaesthetists, in collaboration with the Association of Paediatric Anaesthetists and the British Association of Paediatric Surgeons. Launching in spring 2019, CASAP aims to characterise the type and quality of care being delivered to children undergoing emergency abdominal surgery in the UK. Data, to be collected on every child meeting the inclusion criteria over a six-month study period, will include information such as demographics, perioperative physiology and postoperative morbidity, and will be linked with NHS databases to continue mortality tracking for 10 years. The dataset will be used to identify independent risk factors for adverse outcomes, subsequently informing decision-making and enabling risk-adjustment for outcome reporting.

As with previous HSRC projects, such as SNAP1/2 and NELA, the engagement of the perioperative community is central to the success of this study. Achieving a comprehensive and meaningful dataset will be reliant on the hard work of clinicians on the frontline and will take us a step closer to bridging the gap between paediatric and adult peri-operative quality improvement work.

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Ramani Moonesinghe
Director, Health Services Research Centre, Royal College of Anaesthetists & Professor and Head of Centre for Peri-operative Medicine, University College London

The National Emergency Laparotomy Audit (NELA) recently reported that almost 700 lives were saved in 2016-17 compared with when data collection began in 2012 [1]. This is an astonishing achievement which will no doubt leave peri-operative medicine enthusiasts rubbing their hands together with glee.

References
Evelyn Baker Award

An award recognising the ‘unsung heroes’ of anaesthetic departments.

The Evelyn Baker award is made for outstanding competence in all areas of anaesthetic practice: clinical excellence, teaching and training and supporting colleagues. The Award recognises the ‘unsung heroes’ of anaesthetic departments.

Nominations are often described as the unspoken backbone of the department and the ‘go to’ person for clinical or other advice. Citations accompanying nominations for this award should describe how the individual being nominated demonstrates those characteristics and traits that set them apart from others. The defining characteristics of clinical excellence are technical proficiency, consistently reliable clinical judgement and wisdom, and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation. Supporting colleagues and co-workers is a valued part of clinical practice and is recognised by this award.

The award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital.

Nominations are now invited for the award, which will be presented at WSM London in January 2020. Members of the Association can nominate any practising anaesthetist who is also a member of the Association. Nominees should normally still be in clinical practice. The award is unlikely to be given to someone in their first ten years as a consultant or SAS doctor, and the nominee should not be in possession of a National Clinical Excellence Award. Nominations should include an indication that the nominee has broad support within their department.

Last year the award was won by Dr Ian Appadurai (Cardiff). Details of previous winners and further information can be found on the website www.aagbi.org/about-us/awards/evelyn-baker-medal

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at HonSecretary@aagbi.org by 17:00 on 31 July 2019.

Call for nominations for the Featherstone Professorship

Nominations are sought for the Association’s 2019 Featherstone Professorship, which is awarded to practising clinicians and scientists who have made a substantial contribution to anaesthesia and its related subspecialties in the fields of safety, education, research, innovation, international development, leadership, or a combination of these.

Applications should be submitted using the application form available on the website www.aagbi.org/about-us/awards/featherstone-professorship. Completed forms should be emailed to HonSecretary@aagbi.org by 17:00 on 27 May 2019.

The Association’s Honours and Awards Committee will consider nominations at its meeting on 7 June 2019, and will make recommendations to the Board of Directors, which will determine the recipient of the 2019 Featherstone Professorship (if any) at its meeting on the same date. The successful nominee will be informed shortly afterwards. The award will be made at the Association’s Annual Congress in Glasgow (11-13 September 2019).

Featherstone Professorships are held for two years, during which the holder will be required to deliver a Featherstone Oration at a major Association meeting.

The synergy between social media platforms, such as Twitter, and medical journals, has arguably revolutionised the way in which research and opinion is read, distributed, discussed, and implemented. It is imperative, therefore, that journals have a social media strategy, and following my appointment as the first Social Media Editor for Anaesthesia, I thought I should explain more about the role.

In 2012, the then Editor (now Editor-in-Chief) Andy Klein decided to experiment with Twitter, and the now popular Anaesthesia journal account was born. Tweets had to be interesting yet concise (140 characters), and it was possible to insert links and upload photos. Over the years, the number of followers increased significantly reaching 10,000 in 2016, and 16,300 in early 2019. In 2016, the job of ‘Tweeting’ became the responsibility of the Anaesthesia Trainee Fellow, and I took over this task from Karem El Boghdady in September 2017. Karem and Andy did an excellent job and it became clear to me that certain elements had contributed to their success. For example, Tweets focussed on one daily article with each made open access for 24 hours (#FreeForADay). Importantly, Tweets were sent on behalf of the journal and not any one individual.

During my Trainee Fellow year, Twitter increased the maximum number of characters to 280, which allowed for multiple articles to be Tweeted at once or extra detail to be added. We now Tweet around four times per day Monday-Friday with features including letters at lunchtime, classic papers on Friday, and the occasional special collection, such as our popular statistics articles. The account is monitored regularly and we enjoy interacting with our followers, answering questions, discussing papers, and promoting the work of authors. We also run successful Facebook and Instagram accounts.

TweetChats

Over the last year, we have implemented three successful ‘TweetChats’. For each, we liaise with authors to determine the key message from their research, co-ordinate a date for publication with Wiley, distribute the embargoed paper to key experts and influencers, and advertise the TweetChat (and ground rules) to our followers. The
The question of what makes a paper popular on social media is something we are always learning more about. Our most popular articles include John Carlisle’s statistics bombshell from 2017 [2], Mike Farquhar’s editorial about the need to talk about fatigue amongst junior doctors [3], and an excellent article from our 2019 supplement on the optimisation of pre-operative nutrition [4]. Each paper has an associated Altmetric score, which is a weighted count of all mentions on social media platforms, blogs, and news outlets. If viewing a paper on the journal website, there is a coloured ‘donut’ towards the right of the screen with a number inside. Click on this and you can view all the attention an article has ever received, including all the Twitter comments and links to associated blogs and news stories. This is an excellent way of testing the opinions of others and is an extremely useful tool for those presenting such papers at journal clubs. We take the attention a paper receives on social media very seriously, and we always discuss Altmetric scores at editorial board meetings.

One area where the journal has been successful over the last year is with its range of infographics (Figure 1). I design and publish each infographic, and liaise with authors about any changes they wish to make. They are designed to be viewed on a phone screen but can be printed and displayed on a wall, used with authors about any changes they wish to make. They are designed to be viewed on a phone screen within. Click on this and you can view all the attention an article has ever received, including all the Twitter comments and links to associated blogs and news stories. This is an excellent way of testing the opinions of others and is an extremely useful tool for those presenting such papers at journal clubs. We take the attention a paper receives on social media very seriously, and we always discuss Altmetric scores at editorial board meetings.

At Annual Congress we announce our ten best papers of the year, together with the winner as voted for by a panel of Editors and Association of Anaesthetics Board members. Last year the papers with our highest ever Altmetric score won [2]. This feature is extremely popular and we live tweet all the papers together with photos from the conference.

To inform the Editorial Office if you are offered or unable to take up the position, and attend the Association's Annual Congress in September 2020, and assist in the Annual Fellowship, to be submitted to the Editorial Board and either the Trainee Conference in July 2020 or Annual Congress in September 2020, and assist in the

Applications should comprise:

1. A brief (max. half-page) CV to include your current position, Association membership number and CT date;
2. A summary (max. 300 words) of a) how you meet the criteria for Fellowship and b) what you hope to gain from it;
3. In your covering email, please include: i) the name and email address of your current or immediate past Educational Supervisor, who must be available to respond within a few days of contacting you, and ii) a statement that you hereby consent to informing the Editorial Office if you are offered or unable to take up the Fellowship.

Applications must be received via email by midnight on 31 May 2019 to anaesthesia@aagbi.org
Dear Editor

A missing sloop

We would like to highlight the importance of checking surgical suction canisters during counts for missing surgical equipment. Retained sponges and instruments during surgery are a recognised medical ‘never event’ and can have catastrophic implications for patients [1].

During the count at the end of a thoracic procedure it was noted there was a missing vascular sloop (sometimes known as a ‘vascular loop’). Vascular sloops are manufactured from high quality, medical grade silicone and are designed to assist surgeons to identify, retract or occlude vessels. They are considered a ‘countable item’ - something that has the potential to be retained in a body cavity at the time of surgery. A count must be undertaken for all procedures where countable objects are used [2].

After a considerable amount of time searching for the missing sloop it was noted to be lying in the suction canister. As shown in the figure, the sloop can be easily passed through a standard Yankeur sucker (and then into the suction collection tubing and jar). When a sloop is missing from a final count of surgical equipment, the suction canister should be included as the potential location.

Catherine Poots, ST4 Anaesthetics
Royal Victoria Hospital, Belfast

References

Dear Editor

Time to change the name: return of the anaesthesiologist

I read with interest David Wilkinson’s letter in February 2019’s issue of Anaesthesia News. I too support a name change from ‘anaesthetist’ to ‘anaesthesiologist’. I appreciate that for many Association members such a name change may seem very academic and trivial, and perhaps even not worthy of debate. However, it is possible that these very same members are colleagues who have only ever worked or only work in the UK. Here in the UK we are appreciated for our specialist medical skill and knowledge, even if our role is mostly unknown to many patients and their families. In the UK the NHS has very few non-physician anaesthesia providers. However, whenever and wherever I work abroad, I introduce myself as an anaesthesiologist, and not as an anaesthetist.

This is to identify myself to my physician and non-physician colleagues and highlight the extra skill, knowledge and experience that I wish to share with them. These colleagues include the many hard-working non-physician anaesthesia providers who often provide the great bulk of anaesthesia services, and who work in healthcare systems much more stretched than the NHS. It is these same colleagues who I also learn from and support, as they often have not had the same opportunities for professional development that I have benefitted from. My non-physician anaesthesia colleagues that I meet abroad refer to themselves as nurse anaesthetists, clinical officers in anaesthesia, or simply as anaesthetists.

In an NHS that refers to some of our colleagues as physician’s assistant in anaesthesia, specialist practitioners in perioperative care and surgical care, advanced operating department practitioners, as well as the advent of non-medically qualified consultants, I feel that the term ‘anaesthesiologist’ is more cognisant of the science that our specialty is based upon. If we wish to promote our specialist medical role in a modern healthcare system both at the national and international levels, then the term ‘anaesthesiologist’ would more accurately reflect the work that physician anaesthesia providers currently perform. The term anaesthesiologist should identify those physician anaesthesia providers who have completed a specialist postgraduate training in anaesthesia and perioperative medicine, underpinned by evidenced-based medicine and clinically relevant scientific training.

I agree with Dr Wilkinson, a new name for our internationally recognised society could be the Association of Anaesthesiologists, allowing our society to be more accurately identified on the global stage.

Moiz Alibhai
Consultant in Anaesthesia
Lancashire Teaching NHS Hospitals Foundation Trust
IRC travel and project grants funding

The International Relations Committee (IRC) offer travel grants to anaesthetists who are seeking funding to work, or to deliver educational training courses, usually, but not exclusively, in low and middle-income countries.

IRC travel grants - for short visits (usually less than one month) to a maximum of £1,000.
IRC project grants - for projects involving an individual or team over a period of weeks or months.
IRC volunteer/OOPTE grants - for long-term voluntary work, generally longer than one month.

Eligible travel dates: 26 July 2019 - 26 October 2019

More information: www.aagbi.org/travel-grants

Application deadline: 21 May 2019

SAFE funding

The Safer Anaesthesia from Education (SAFE) Steering Group offers funding for appropriately experienced Faculty Leaders for anaesthetists to deliver a modular training course in obstetric or paediatric anaesthesia in low-income countries. Priority is given for projects undertaken in African countries.

Eligible travel dates: 1 July 2019 - 1 July 2020

More information: www.aagbi.org/SAFE-funding

Application deadline: 24 May 2019

Funding applications will not be considered retrospectively.

For more information, please email secretariat@aagbi.org or telephone 020 7631 1650 (option 3).

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Anaesthesia and mountain medicine

Anaesthesia, critical care and mountain medicine may seem like an unlikely combination but in 2018 we launched a fellowship at Chesterfield Royal Hospital that put all three together.

“Why?” I hear you ask. The answer will be familiar to many. Over the last couple of years our department has struggled to recruit. Training schemes were beginning to scrutinise our on-call rotas and management had expressed concerns about our sizeable locum bills. Something had to be done. The answer was to use what we had at our disposal. Chesterfield sits on the edge of the Peak District National Park and has always attracted climbers, mountain bikers and a host of other outdoor enthusiasts to work at its busy hospital. However, in recent years this had not been enough and something extra was required. At this point the hospital’s management and the Royal College of Surgeons of Edinburgh (RCSEdin) stepped up.

Diploma in Mountain Medicine

For many years the UK has led the way in providing mountain medicine education. The ‘gold standard’ qualification is the Diploma in Mountain Medicine (DMM). Overseen by the RCSEdin, more than 200 doctors, paramedics and other health care professionals have passed through its doors. The DMM is focused around four weeks of residential study. Each course starts in December at the National Mountaineering Centre in Snowdonia, and concludes eighteen months later with a week of practical assessment in the Swiss Alps. In between, the students learn a range of skills that stand them in good stead for future work on mountain events and expeditions. In exchange for study leave and payment of DMM fees (approximately £4200) the hospital benefited from the services of an enthusiastic and competent doctor for two years. The fellows felt this was a good deal (we had over 100 applicants!) and the hospital managers were pleased to reduce locum bills and fill on-call rotas.

In 2018 we took on our first two fellows - Abbi and Tom. Credit to them both, I don’t think they knew what to expect and I have to say neither did I! As someone who’s been involved in both the DMM and anaesthetic training for a number of years I knew a bit about both but I didn’t know if they’d work well together. I was concerned but in the end I needn’t have been. Tom, a seasoned trainee, and Abbi, a novice, both fitted in perfectly. Outdoor, mountain types find the stress of the operating theatre or ITU fairly easy to deal with. The pressure of technical procedures is nothing compared with rock climbing hundreds of metres above the ground, or in Tom’s case, flying his paraglider over the Peaks! Fortunately, the DMM coursework and assessments went well too. Once the shock of the syllabus (600 hours of study recommended!) and size of the reading list had passed, coursework deadlines were comfortably met - helped in no small part by Louise our administrator who was somehow able to conjure up bits of informal study leave at short notice!

Whilst their main priorities had always been delivering excellent clinical care and studying for the DMM, the fellows jumped enthusiastically into the world of mountain medicine. Thanks to the publicity generated by our blog there’s been no shortage of offers to write, research and present on a wide range of mountain medicine topics. In 2020 we plan to run a two day ‘Mountain Medicine Festival’ in the Peak District and there will be plenty to keep our fellows busy!

As the number of trainees continues to fall, hospitals will need to come up with novel ways to recruit and retain new staff. A mountain medicine fellowship is just one of many options. By working together, clinicians, managers and providers of postgraduate education can develop opportunities that offer real benefits to junior doctors and the hospitals in which they serve.

For information on the Mountain Medicine Fellowship see https://deathzone.7thwave.io

Jeremy Windsor
Consultant in Anaesthetics and Critical Care
Chesterfield Royal Hospital
SAS professional development grant 2019

The Association of Anaesthetists awards this grant to enthusiastic SAS doctors who are Association members, for training and professional development opportunities.

The grant is intended to enhance the individual’s experience, for example in attending clinical management, leadership and other educational skills courses or acquiring new skills which are relevant to the workplace, in particular where this improves the quality of patient care and improves service development. The total fund available is £2,000 and the awarding Committee may decide to grant multiple awards within the total available but in exceptional circumstances may award the full amount to one applicant.

The grant must not fund routine CPD activities which should be funded through normal study leave budgets, nor examination fees, exam preparation courses or college related fees.

For more details and to apply visit the website www.aagbi.org/research/awards/sas-grade-anaesthetists

We need to talk about on-call

We are all by definition ‘ageing anaesthetists’ and having attended a joint meeting between the RCoA and the Association of Anaesthetists at the end of last year, I left a focus group discussion on how we support the ‘ageing’ anaesthetist through the latter stages of their career with many thoughts, one being ‘We need to talk about on-call’.

This phrase always brings back unpleasant memories of the film ‘We need to talk about Kevin’. This was one of those films that left me a sense of unease and fear. For those of you who are not film buffs, to summarise in one line ‘teenager goes all Robin Hood at school in a very bad way’! I mention this because I get a sense of fear and unease when I think about on-call. As we gain more experience in work and years I start to dread on-calls, not because of the work but because of the impact they have on me both physically and mentally. This is summed by one key phrase that kept cropping up at our table ‘I do not want to work in this way any more’.

We are no longer ‘on-call’ but working out of hours. There are still specialties for whom being ‘on-call’ means just that, and they do not step foot in the hospital overnight. There is an unwillingness to address this with the senior members of the directorates because ‘on-call’ is almost viewed as a ‘test of one’s ability to cope’ - almost our own bush tucker trials. In the acute specialties ‘on-call’ means you no longer have a life in the evening and cannot pop to dinner or to the gym, there just is not the opportunity. Certainly, in a large DGH where the trainee blanket is pretty thin at times, I am becoming more and more frequently resident by stealth. We are all acutely aware of the blanket is pretty thin at times, I am becoming more and more unwilling to ‘the work needs to be done and there are not enough people already’. I do not doubt that, but the current arrangements will, and are, damaging the workforce of the future.

In the currently developing workforce crisis, which is only going to get worse according to all predictions, many of our colleagues are leaving the profession early; the reasons for this are multifactorial including the punitive pension arrangements. We need to find ways of keeping those who wish to stay by making the workplace fit for them, because losing a large chunk of experience every time someone leaves cannot be a good thing and we do not have enough trainees to fill the gaps created.

What is clear is that the Association and the RCoA need to provide guidance as to how the senior anaesthetist can work in the latter stages of their career to keep them and their valuable experience in our specialty.

Name supplied
An ‘ageing’ anaesthetist and intensivist

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An ‘ageing’ anaesthetist and intensivist
Evidence for compromised data integrity in studies of liberal peri-operative inspired oxygen

Myles PS, Carlisle JB, Scarr B

In 2016, the World Health Organization (WHO) made a strong recommendation that adult patients undergoing general anaesthesia with endotracheal intubation for surgical procedures should receive an 80% fraction of inspired oxygen intra-operatively and, if feasible, in the immediate postoperative period for 2–6 h to reduce the risk of surgical site infection. This was taken as gospel by many, in spite of emerging concerns regarding the association of liberal oxygen therapy with mortality in people who are acutely ill. Indeed, no anaesthetist was present on the WHO guideline group. The tension between potential beneficial effects on wound healing weighed against what many anaesthetists felt to be excessive oxygen administration has frequently been a source of conflict in operating theatres. It would also have led potentially to feelings of despair in resource-poor countries where oxygen was a relative luxury, and anaesthetists felt that they were unable to do the best for the patient and may have led to other needy patients being denied this scarce resource.

But what if the data that informed that strong recommendation were at best incorrect, and at worst fraudulent? The authors of what can only be described as another earth-shattering study have made use of the Carlisle methodology to investigate both randomised and observational studies by an Italian surgeon, Mario Schietroma, and his group, many of which described the benefits of liberal oxygen therapy, and which had originally helped to inform the WHO statement. The statistical methodology studies the baseline data of participants in trials that can show whether they are inconsistent with participants chosen randomly, as they should be. Out of 184 calculable p values, for baseline variables or results, 179 (98%) were incorrect, ranging from three orders of magnitude too small to ten orders of magnitude too large. In addition, 21 graphs occurred 81 times in 23 out of 40 papers. When asked where his records of the studies, including evidence of informed consent, were, Schietroma claimed that they had been destroyed in an earthquake. Redoing the meta-analyses without these data showed no benefits of liberal oxygen therapy on the incidence of wound healing, and the authors conclude that Schietroma’s work should not inform practice until investigated.

Differences in the definition of brain death and their legal impact on intensive care practice

McGee A, Gardiner D

The practice of intensive care medicine has always been challenging, and amongst the things intensivists frequently must do is to diagnose death. For decades this has included making a diagnosis of death by neurological criteria. Over this period, the medical criteria and their implications have remained relatively consistent over time. What has been changing, however, is public acceptance of death in general, and diagnosing death by neurological criteria in particular. This is especially true in the USA, where the diagnosis of whole brain death is made, as opposed to the UK diagnosis of brainstem death. There have increasingly been instances of legal challenge in the USA, and this thoughtful editorial explores the reasons for this, eventually concluding that the WHO operational definition, namely ‘the permanent loss of capacity for consciousness and all brainstem functions, as a consequence of permanent cessation of circulation or catastrophic brain injury’ should be used. This is effectively the same as our practice in the UK, but in an age of fake news and social media, those who work within intensive care units can expect to have their judgement and diagnoses questioned.
If you would be willing to share your experiences in an observational study, please visit www.enventure.co.uk/BEAT

By participating in BEAT you will be asked to complete a short, confidential online questionnaire about your experiences.

BEAT is supported by an OAAn research grant and is being conducted by R. Alder, H. Kemp and S.M. Yentis. For further enquiries please contact r.alder@nhs.net

Our new site will make it easier to discover key member benefits like access to the internationally respected journal, Anaesthesia and members-only online CPD through Learn®, our online learning platform.

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Each Journal will publish a series of invited editorials and reviews discussing state-of-the-art advances in surgical and peri-operative care of patients aimed at surgeons, anaesthetists, intensivists, pain specialists and any healthcare professionals caring for patients in the peri-operative setting from around the world. The Special Issue will be published online-only, and will be entirely free to read.

**Call for submissions**

Both Journals invite authors to submit original articles and reviews of surgical and peri-operative care to be considered for publication in the Special Issue. The Journals are seeking papers that cover the range of peri-operative care, including pre-operative preparation, intra-operative management, and postoperative care including pain management. Authors may choose to which Journal they submit their article, but must follow Author Guidelines for the relevant Journal.

For submissions to *Anaesthesia*, please refer to the following Author Guidelines: [www.anaesthesia-journal.org/guidance](http://www.anaesthesia-journal.org/guidance)

For submissions to *BJS*, please refer to the following Instructions to Authors: [www.bjs.co.uk/for-authors/bjs-instructions-authors](http://www.bjs.co.uk/for-authors/bjs-instructions-authors)

Informal enquiries can be made via the *Anaesthesia* editorial office (anaesthesia@aagbi.org) or the *BJS* editorial office (bjs@wiley.com).

The closing date for submissions is 31st July 2019.

[www.anaesthesia-journal.org](http://www.anaesthesia-journal.org)  
[www.BJS.co.uk](http://www.BJS.co.uk)
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