



THE NEWSLETTER  
OF THE  
ASSOCIATION  
OF ANAESTHETISTS  
OF GREAT BRITAIN  
AND IRELAND

# ANAESTHESIA NEWS

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## GAT ISSUE

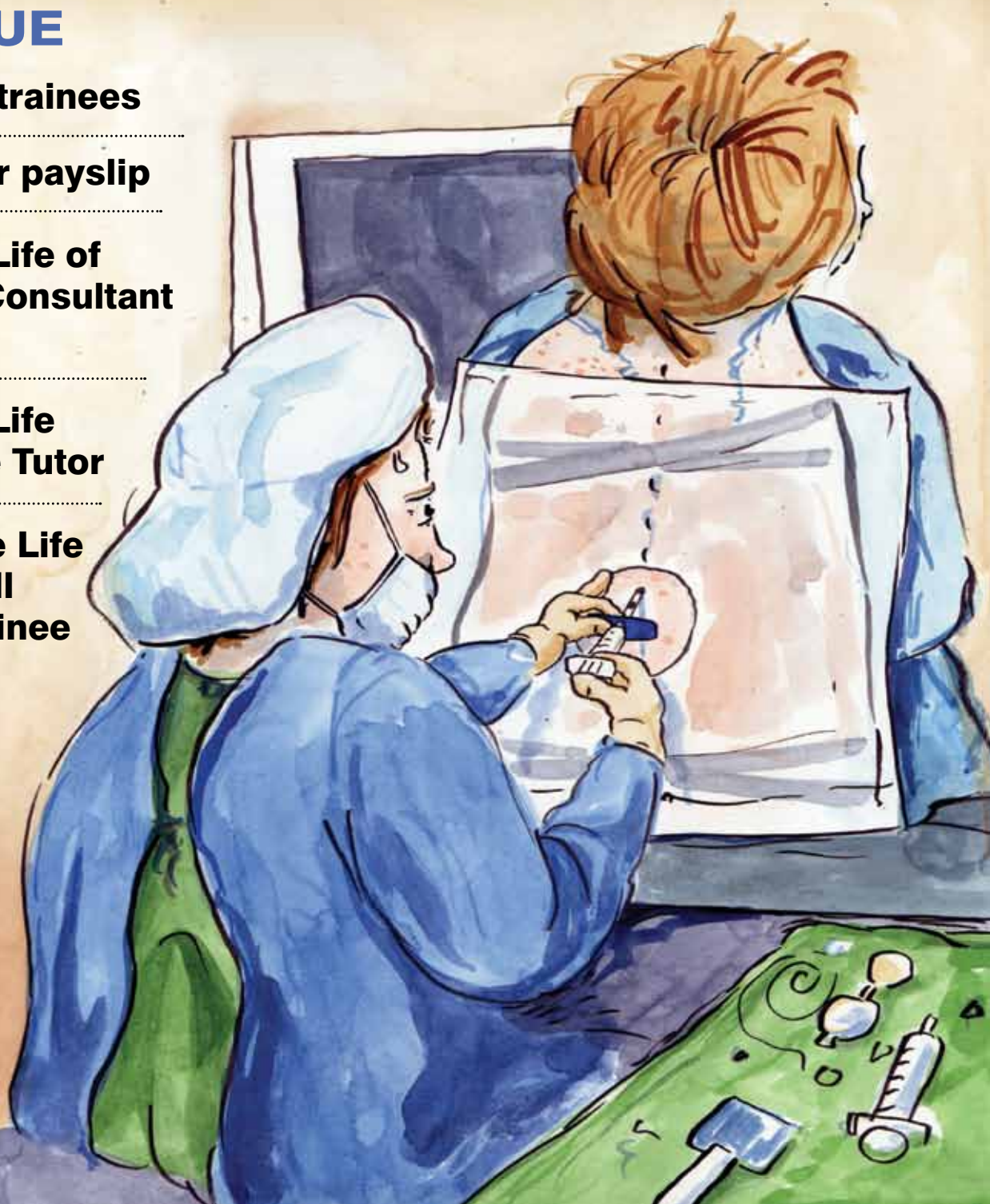
**SPA time for trainees**

**Knowing your payslip**

**A Day in the Life of  
an...On-call Consultant  
Anaesthetist**

**A Day in the Life  
of a...College Tutor**

**A Night in the Life  
of an...On-call  
Obstetric Trainee**



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# Editorial



Welcome to this annual trainee issue of *Anaesthesia News*. The Group of Anaesthetists in Training (GAT) Committee is committed to the welfare of all our members. We recognise that morale has remained low within the whole healthcare environment; reasons for which are complex and multifactorial. However, within this Special Issue of *Anaesthesia News* we wanted our readers to remember why we practice this great specialty by publishing a series of short, witty articles about the lives of anaesthetists with differing roles.

Presented within the issue are eight humorous 'A day/night in the life of...' articles. I would like to take the opportunity to thank every author for their contribution. Some authors have chosen to remain anonymous, their contribution is equally acknowledged.

I would also draw your attention to the article titled 'Knowing your payslip' by Tom Wojcikiewicz (GAT Committee Elected Member). I know Tom has worked tirelessly to research and make clear the sometimes confusing topic of what all the information on our payslips *really* means.

Additionally, Mohammed Akuji and Bernadette Lomas explain an SPA time initiative in the North-West deanery. I would be interested to know if similar initiatives are taking place elsewhere.

Finally, I would like to personally thank Eoin Kelleher (GAT Committee Elected Member) for illustrating this issue. Eoin is immensely talented and his illustrations capture the content of an article visually. I am pleased that his work appears on the front cover.

The content and style of this issue is different from the usual style of *Anaesthesia News*. I encourage readers to send in their views on any of the articles published.

I hope you enjoy reading this issue as much as I have. I also hope as many of you as possible will make your way to Glasgow for the GAT Annual Scientific Meeting, from 4–6 July. See you there!

## Satinder Dalay

*Elected Member, GAT Committee*

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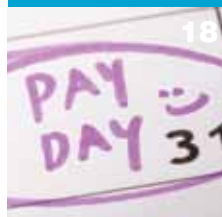
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## Up to £750

Applications are invited from medical students studying in Great Britain and Ireland (subject to confirmation of eligibility) to apply to the AAGBI Foundation for funding towards a medical student elective period taking place between October 2018 and March 2019. A further round of funding will be advertised in the Autumn for electives taking place from April 2019 onwards. Overseas students should ensure that they are permitted to apply for charitable funding. Grants will only be awarded to applicants who intend to spend time away from their base academic institution and whose travel, accommodation and subsistence costs are increased as a result.

Preference will be given to those applicants who can show the relevance of their intended elective to anaesthesia, intensive care or pain relief. A key focus of the AAGBI is support for projects in the developing world, hence elective placements supporting work in low and low-resource income countries are given priority.

For further information and to apply please visit our website: [www.aagbi.org/undergraduate-awards](http://www.aagbi.org/undergraduate-awards), email [secretariat@aagbi.org](mailto:secretariat@aagbi.org) or telephone 020 7631 1650 (option 3)

**Closing date: 13 July 2018**  
for consideration at the Sept 2018  
Research & Grants Committee meeting



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# Travel grants/IRC funding

**The International Relations Committee (IRC) offers travel grants to anaesthetists who are seeking funding to work, or to deliver educational training courses or conferences, in low and middle-income countries.**

Please note that grants will not normally be considered for attendance at congresses or meetings of learned societies. Exceptionally, they may be granted for extension of travel in association with such a post or meeting. Applicants should indicate their level of experience and expected benefits to be gained from their visits, over and above the educational value to the applicants themselves.

To check eligible travel dates and apply please visit:  
[www.aagbi.org/international/irc-fundingtravel-grants](http://www.aagbi.org/international/irc-fundingtravel-grants)  
or email [secretariat@aagbi.org](mailto:secretariat@aagbi.org) or telephone  
020 7631 1650 (option 3)

**Closing date: 24 August 2018**



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# EVELYN BAKER MEDAL



THE ASSOCIATION OF ANAESTHETISTS  
*of Great Britain & Ireland*

## AN AWARD FOR OUTSTANDING CLINICAL COMPETENCE

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the 'unsung heroes' of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be 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.

Nominations are now invited for the award, which will be presented at WSM London in January 2019. Members of the AAGBI 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 an SAS doctor, and the nominee should not be in possession of a national award. Nominations should include an indication that the nominee has broad support within their department.

Last year the award was won by Dr Michelle Soskin. Details of previous award winners and further information can be found on the website [www.aagbi.org/about-us/awards/evelyn-baker-medal](http://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](mailto:HonSecretary@aagbi.org) by 17:00 on Friday 31 July 2018.**

# A Night in the Life of an... **On-call Obstetric Trainee**

And so it begins. I arrive at 2000 for handover and there's an epidural to do in room one. The day person was asked at 1955 so plays the relay epidural trick. As soon as I am scrubbed, get the epidural trolley set up, and start to paint the chlorhexidine on her back, there's *that* announcement, 'I need to push'. Still, I suppose that's one less dural tap.

A few minutes later I gatecrash the evening Labour Ward ward round. The obs reg knows me well and has already gone to the mess so he can present me with a large latte on my arrival; before proudly announcing what he has lined up. It appears that every high-risk lady in the region has decided to appear tonight. It's okay though. I breathe a sigh of relief as I am told they have all visited the obstetric anaesthetic clinic. I go to the clinic letter folder to have a read as I am sure it will tell me what to do. Unfortunately, they only attended last week so the letters haven't been filed yet. It's okay though because as the first patient is wheeled in they start waving a very detailed six-page clinic letter detailing *exactly* what I should do. Bloods, two big cannulae, an art line and an early epidural. They seem to be missing the final page of the letter as I can't find the bit that tells me what to do at 0300 when their epidural stops working, they're going to theatre, declining any further attempt at regional anaesthesia and demanding a general.

Six hours, four epidurals and five sections later, I am called by the Labour Ward midwife in charge, 'we may or may not be going to theatre, not just yet but possibly at some point in the next six hours, can you hang around *just in case*'.

Eventually, we get to theatre with our next patient and position perfectly for the spinal, but while I set my trolley up there's a contraction. 'Okay, okay, so if you just sit up straight for me. Okay, maybe need to tilt right again, okay, okay, a bit left, okay just a bit right again, oh, you've got another contraction have you...'

After 30 minutes of doing the spinal position boogie and several spinal needles later, we mutually agree that I will swap the hyperbaric levobupivacaine for some isobaric thiopentone and suxamethonium, with an endotracheal tube chaser.

As per the norm, we end up with back to back sections. Thankfully my spinal this time is slick. I look like a pro, beautiful block and great chat with the parents. All of a sudden panic ensues within the room 'Catch the baby! Catch the baby! Catch the baby!!' is all that can be heard. Followed by 'T-I-M-B-E-RRRRRRRRR...' Dad has hit the floor. Luckily I catch the baby. In the meantime, the student midwife has called 2222 and in charges the medical registrar, the medical F1, the ICU CT2 and a CCU nurse, all confused as to what exactly they should do in obstetric theatre. Immediately, they are informed by the theatre sister that they are not wearing a hat and sent on their way.



It's 0700, nearly time for handover, the end is in sight, the midwives have been rewarding me for every bleep with a shot of espresso. I start to feel a bit funny and decide to check my heart rate on my iPhone; 300 bpm and regular. Allergic to Labour Ward? Over-caffeinated? Has to be the former, surely, quick fetch the adrenaline. I am a self-respecting anaesthetist after all.

Twelve hours later: 11 double espressos, 10 trial of forceps, 9 caesareans, 8 spontaneous vaginal deliveries, 7 epidurals, 6 fully and pushing, 5 third-degree tears, 4 general anaesthetics, 3 'tricky veins', 2 dural taps and an anaesthetist in SVT.

## **Lyndsey Forbes**

*Fellow in Paediatric Anaesthesia, Royal Manchester Children's Hospital*





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<https://www.ed.ac.uk/clinical-sciences/divisionpgdi/anaesthesia/events/workshop-on-fibre-optic-intubation-sep-2018>

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**28-30 November, Edinburgh, Scotland**

✉ [das2018@abbey.ie](mailto:das2018@abbey.ie)



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@dasedinburgh18



# A Day in the Life of a...

## Consultant Obstetric Anaesthetist

---

**0800:** Receive SAFERR (SAFER + Rest?) handover from overnight resident. Congratulate/commiserate after another crazy night, check they're safe to get home.

**0810:** Jostle for position seeing elective sections with multiple other professionals. Realise consultant privilege is a thing of the past.

**0835:** Because of previous lack of privilege, appear five minutes late to theatre brief clutching illicit cup of coffee, incurring considerable wrath of theatre sister.

**0836:** Recognise 'TUBAL LIGATION' missing from theatre list, again. Ask for a reprint.

**0837:** 'TUBAL LIGATION' now appears as leading surgeon. Request reprint.

**0838:** Patient now listed for 'CAESAREAN SECTION and NOITAGIL LABUT'. Reprint.

**0845:** Attend multidisciplinary risk management in attempt to temper natural surgical tendencies.

**0900:** Supervise new CT2 performing first ever obstetrics spinal. Share delight when CSF appears on first pass.

**1000:** Supervise CT2 doing second ever obstetrics spinal. Sympathise and empathise over repeat passes while scrubbing hands, secretly suspecting one would have had it long ago.

**1030:** Realise through tears of frustration that one definitely would not have had it long ago. Call senior colleague.

**1045:** Recognise senior colleague would have had it hours ago. Thank senior colleague profusely and apologise to patient effusively, while silently fuming and despairing of own ineptitude.

**1100:** Regain composure after sending trainee for coffee.

**1130:** Greet familiar patient from clinic. Recap anaesthetic and delivery strategy, carefully crafted with multidisciplinary team and patient collaboration over preceding weeks.

**1215:** Masterly execute complex anaesthetic with minimal fuss and remember this is what it's all about.

**1230:** Briefly turn away because of 'something in my eye' when complex anaesthetic and delivery plan produces gorgeous, bawling baby to the delight of everyone in the room. Remember this really is what it's all about.

**1300:** Consume a lunch consisting entirely of Delivery Suite chocolates.

**1430:** Leap into action as the emergency alert sounds while teaching medical students. Race to attend an arrested parturient, before practically fainting with relief on seeing a manikin. Hold it together for the rest of the drill. Try to convince the team during debrief that it wasn't panic on one's face.

**1500:** Rush to theatre with a real postpartum haemorrhage. Briefly marvel again at the improved laryngeal view with roc rather than sux before launching into resuscitation mode and coordinating successful multidisciplinary obstetric haemorrhage management.

**1600:** Confirm resuscitation endpoints using Point Of Care testing before waking patient up. Congratulate and praise our team during debrief while sensitively discussing learning points for future cases.

**1615:** Cup of tea and a handful of Heroes.

**1630:** Attempt follow-ups, find half have gone home.

**1745:** Category 3 section for unsuccessful induction in 5ft tall patient. Agonise over height-related, utterly insignificant modification of spinal Marcain dose. Momentarily also consider adjusting universal 300 mcg spinal diamorphine; dismiss out of hand.

**1800:** Open two theatres as cord prolapse is rushed through just as Category 3 section started. Induce anaesthesia, thrill as baby cries on delivery. Wake patient after quadratus lumborum blocks. Familiar prickle of eyelids as mother is emotionally hugely relieved to meet a healthy baby.

**2000:** Join evening obstetric ward round.

**2100:** Sign off for the night, leaving labour ward in the capable hands of the night resident and pray for a quiet on-call.

**0600:** Check phone is not on mute after alarm signals another day on labour ward.

### Postscript

I genuinely love my job as an obstetric anaesthetist. It can be easy to be sniffy about obstetric anaesthesia but I personally find the combination of technical proficiency, multidisciplinary cooperation, patient collaboration and high drama extremely gratifying.

Come and give us a go!

### Danny Morland

*Consultant Anaesthetist, Royal Victoria Infirmary, Newcastle*

# A Day in the Life of a... **Training Programme Director**

---

I'm awake before the alarm goes off. I listen to the news headlines while having a quick look at my emails.

Good news: a trainee is 16 weeks pregnant after several rounds of IVF. I am delighted for her and her husband.

Bad news: there'll be a gap in the rotation plot when she goes on maternity leave.

## **Cycle to work.**

Good news: get a green light roll most of the way there and only encounter one red light.

Bad news: it's raining.

## **Head to the changing room.**

Good news: I'm early, it's empty and I don't have to make polite conversation.

Bad news: the scrub machine has been filled in a random fashion and my scrub top is a different colour to the trousers (my anaesthetic OCD kicks in).

## **Review the emergency list.**

Good news: there are some interesting cases on it and I'm on with an enthusiastic and knowledgeable trainee.

Bad news: the list is a complete work of fiction and will change at least three times before 0830.

## **Head to the coffee room.**

Good news: there's an empty chair and my can of Diet Coke is really cold.

Bad news: the night staff look absolutely frazzled. It's been a monster of a night and they've had two theatres, obs, neuro and the cath lab running overnight. The on-call consultants have been in and there are lists that will need covering as they head home to recover. We have a chat and a quick debrief as they hand over the patients on the emergency list.

## **Get on with the emergency list.**

Good news: I love my job, I really do.

Bad news: lots of interruptions.

## **Pop down to the office.**

Good news: I have my own desk in the office.

Bad news: my colleague's paperwork is metastasising across my desk from hers.

## **Look at the programme plot.**

Good news: I've got lots of folk coming back from OOPT/E/R. I think time out of programme is so important for those who wish to

take it. It's an opportunity to gain experience and training to shape their CV for the consultant post they want and they bring back a new take on ways to do things.

Bad news: fiddle with my multicoloured rotation plot (Joseph's Amazing Technicolour Dreamcoat has nothing on my Excel spreadsheet) and sort out the next job changeover. There are gaps. We will cope. I would much rather have the right trainee in the right job at the right time for their life and their training rather than just having a bum on a seat.

## **Stick my head in the admin office.**

Good news: our admin staff are superb and support the consultants and trainees so well.

Bad news: no biscuits.

## **Back to theatre.**

Good news: only one more case to do before handing over to the on-call team.

Bad news: it's going to be smelly...

## **Cycle home.**

Good news: it's stopped raining

Bad news: every traffic light on the way home is red.

## **Check my email:**

Good news: the ARCP panels have been filled. I enjoy ARCPs and seeing the trainees face to face is so valuable. It's a chance to review the year, both the highs and lows. I like to celebrate excellence and give encouragement where change is needed. The panel reviews the CV and makes suggestions and we can plan the next couple of years of training.

Bad news: HEE want to move to in absentia ARCPs.

That's me done for the day. I'll leave you with my three things to remember for life as an anaesthetist:

1. 'No' is a complete sentence.
2. Always know when your next lot of annual leave is.
3. No one ever said on his or her deathbed 'I wish I'd spent more time at work'.

*Name and address supplied*



# A Day in the Life of a... **Clinical Director**

In strict chronological order, Friday morning begins at 0600 – like Ken Dodd said, I do all the exercises – up, down, up down, then the other eyelid. Some of my colleagues clearly have the time management schtick sorted, read the book etc – ‘Look at your email only once a day, set aside 30 minutes in the morning’ – the phone is pinging by 0630 from this crowd – I feel the smugness radiate from these messages as the inbox levee once more threatens to break. No problem – ‘you’re always behind the curve, never in front, if you think you’re on top of it you’ve forgotten something massive’ – this from the surgical CD during his gentle induction when I started a year ago. Big slug of coffee and we’re on the bike, wind behind me, across the town moor to the big hospital in toon in the shadow of the Gallowgate.

You would think that 74 consultants, six specialty docs and 38 trainees should be enough to get the work done but this is a bums on seats game – and we have not enough posteriors for the chairs of anaesthesia. This week we have 300 lists to cover and have 15 empty sessions staring at us next week, the shame of an anaesthetic cancellation implicit in their stare. I have weapons at my disposal to cajole my colleagues into the extra work – cash, charm and threat – but I am mostly good at the first two. The ‘in-house waiting list’ is our euphemism for the overtime payments – good for the ski holiday for many, bad for the work-life balance of a few – I am grateful my colleagues stick their hands up.

OK – some morning problems to see off; that study leave payment is NOT WHAT WE AGREED, the locum payment hasn’t arrived, there is a new car parking machine and ParkingEye is now going to charge us £2 for an on-call shift (oh no you’re not), the commissioners WILL NOT PAY for those facet injections any more, the awkward colleague has looked at a trainee funny overnight, HR are hassling for the retire and return irregularity, ‘can I see you for a job I might want in two years?’, the grumbling orthopod whose list went down for an organ retrieval bleating from the ethical low ground, the computerised expense system to swear at. A text from the MD saying well done for something; nice, wherever you are on the food chain we all like a stroke.

In our stride now, it’s meeting time, ideally titled by acronym to confuse those not invited – CPG, SIRM, DCGM, AMSC. Choose a strategy – the quiet man to pay attention to when they speak or the bossing alpha – don’t worry I’ve done this course – seek the win-win position, which in your head is really I win you lose.

The best bits now, plotting a project with a pal over a coffee, squeezing baby Gwyneth (that’s enough mat leave surely though now mum!), sorting a job plan to make Tuesday at home easier for somebody, chatting and listening to someone having a hard time, hopefully leaving them feeling better, smiling with my ITU friends who now think they’re architects.

I have a proper job too though don’t forget – into the hubbub of theatre for the afternoon and the pride and pleasure of working with such fantastic colleagues. I slip into the anaesthetic room for the familiarity of the checklist, the cannula, the white medicine and the scope. Away from email for a bit and thoughts of that pint waiting later in The Trent. A proper Friday hospital pub for a proper great department.

## **Gus Vincent**

*Clinical Director, Peri-Ops and Critical Care, Consultant in ITU/Anaesthesia, Royal Victoria Infirmary, Newcastle*



# A Day in the Life of an...

## On-call Consultant Anaesthetist

---

**0530:** *Tap on the shoulder* 'Daddy – wake up! I've got an important question'. At this dreadful hour on a Saturday, I already know that my four-year-old daughter and I will disagree on the definition of 'important'. 'What's the fastest thing in the world', she is wondering, 'Is it a bullet train, the fastest car in the world, or Ed Sheeran?' As my mind boggles, I remember that I am on-call from 0800 and could have done with at least another 90 minutes sleep.

24 hours on-call – a complete lottery. A nightmare for the control freak inside every anaesthetist who wants to be able to plan everything to the last detail, but also (I'm pleased to realise after six years as a consultant) still a source of excitement – who knows when you might get to do some properly good, consultant-level life-saving stuff?

**0800:** Booked – a peri-anal abscess in an obese, bearded chap, an appendix in an eight-year-old girl and a 'hot' lap chole. Possibly not consultant-level life-saving stuff, but I have a CT1 on-call with me for theatres and there's nothing that I can fairly let them do entirely on their own. I need to balance allowing them develop their own skills and confidence, the provision of training, and patient safety.

**0900:** Sent for 'the abscess'. Wondering why we don't say 'the patient with the abscess', I wander up to the labour ward to review the patients on the obstetric HDU and to ensure the locum has arrived. Like many departments, we are carrying gaps in the trainee on-call rota. Regular locums who know the unit are a real help, but a locum doing their first shift who is not familiar with local processes can really add to the consultant's workload. Today's one is a regular, but I've not met him before.

A chap in scrubs with a non-Trust ID badge has his feet up in the handover room. 'Are you the obstetric anaesthetist?' I ask. He looks at me. I haven't got changed yet, and am wearing jeans and a leather jacket (because I am cool). 'Yes. And who are you?' comes his airy reply. I tell him I'm the on-call consultant anaesthetist. His spine straightens and his feet return to the floor. I ask a midwife if she thinks the jacket makes me look younger and am disappointed with the answer.

**1200:** Abscess and appendix are done and we have induced the (patient who needs a) lap chole. The CT1 is engaged in some rather vigorous mask ventilation. I remind him that we should minimise the pressure as much as possible to avoid insufflating the stomach before laparoscopy. 'Don't worry', he tells me, 'I'm getting the hang of this now'.

**1215:** 'Can we have a nasogastric tube please' asks the general surgeon. The CT1 has the good grace to look sheepish. I tell him not to worry and suggest he goes for lunch while I attempt the most challenging procedure in anaesthesia – siting a nasogastric tube after a patient is intubated. Luckily it goes straight in, but the whole theatre team agree that when the trainee comes back,

we'll pretend it took forever and there's now blood in the patient's airway and I have done my back in. I worry about bullying and harassment claim.

**1315:** The gall bladder has been identified but remains resolutely intra-abdominal when the doors between the anaesthetic room and theatres suddenly swing open like a Western saloon. The outline of the on-call vascular surgeon is framed in the doorway. The general surgeons pause, the image on the stack system pauses, even the ventilator pauses mid-inflation...

'The paramedics have called ahead to resus – there's a query leaking AAA on the way in'.

I wonder whether I should point out that it's a *patient with a query leaking AAA* but he's already gone.

Cue an uncertain 20 minutes where it's not yet clear if we'll need to open a second theatre, which scrub team will need to be called in, and who will anaesthetise this potential AAA. Can I leave the CT1 to finish the lap chole so that I can start off? Maybe, but I will still need a second pair of hands. Is my ICU colleague in the building? Yes, but still doing the ward round while the registrar is seeing some referrals. Will I have to 'phone a friend' who's not on-call?

Luckily it becomes clear that the lap chole is coming to an end, and there's no news yet about the AAA. I tell the trainee to beware of 'phantom' cases on emergency lists and to consider ignoring pretty much all cases until booked. Before that, they are just rumours.

**1400:** The lap chole is extubated and I still haven't heard about the AAA. I wander to ED resus. The patient has already gone to SAU. They've had a CT abdo. I look at the images with the radiologist, pretending I can interpret them. Yes, they do have an aneurysm. No it's not leaking, but yes, they do really, really need a poo (the patient, not the radiologist). Maybe I'll wait a bit longer for lunch. The vascular surgeon calls me to let me know that the aneurysm is not coming to theatre.

**1500:** Although I live just a few miles from where I work, I cannot reliably get back across town to the hospital in the stipulated 30 minutes on a Saturday afternoon. Therefore, I am imprisoned. A good opportunity to make progress with the endless amount of admin that comes with being a consultant.

**1930:** I walk to the canteen to get some dinner. The shutters are down. Opening times 'Saturday 0800 – 1900'. Sigh.

**2015:** Home. Eating.

**0400:** *Ring ring. Ring ring.* 'Hello doctor, it's switchboard, I have the theatre anaesthetist on the phone for you'.



**0430:** I'm back in. A young lad, after an extremely refreshing volume of alcohol, got bored of waiting for a taxi and decided to drive himself home. This went well until his progress was impeded by several parked cars and a rather immovable brick wall. Because he had managed to climb out through the shattered windscreen and his vital signs were stable, the ambulance has brought him to our Trauma Unit, rather than taking him directly to the nearest Major Trauma Centre. However, in the three hours that he's been in ED, his lactate has risen, his blood pressure has fallen and he's becoming less responsive to fluids. The consultant surgeon is in and wants to take him for an emergency laparotomy. The ICU and theatre trainees have assumed he is bleeding, cross matched blood, repeated gases overnight and prepared drugs for RSI and haemodynamic support. I meet everyone in the anaesthetic room, including the patient who remains strongly self pre-medicated. Judging by his age, I wonder if he was out celebrating passing his driving test.

The case goes well, but we do need to replace blood after a couple of litres of his own is removed from his peritoneal cavity, having oozed out of some ruptured mesenteric vessels. It appears clotted, so we agree that running a TEG is not necessary.

**0700:** We're coming to an end, and it dawns on me just how tired I am; the adrenaline surge of the emergency has gone. I get a text from the incoming consultant anaesthetist, asking what is booked and saying that they'll come in for 0800 if I'm in theatre. I gratefully take her up on her offer and reflect how glad I am that we split on-call weekends to ensure that none of us work more than 24 hours straight.

**0830:** Home again for a rest. A fairly typical on-call, I suppose. Some major stuff, some minor stuff, some rest, some stress, some plate-spinning, some really impressive trainees and some good humoured team working. I have mostly enjoyed it, but I'm also glad that, by definition, it's the longest possible time before my next weekend on-call. Maybe I'll go to bed for a quick nap, but what is this small figure running towards me? 'Daddy, I've got *another* important question...Is 20 a big number?'

Maybe not!

*Name and address supplied*



# A Day in the Life of an... **Anaesthetic Registrar**

---

The alarm wakes me at 0600. I lie there contemplating whether I really need this job. Maybe I can save enough money by living off the land *Good Life* style, cancelling Netflix and sewing my own clothes from hemp?

I get up and put the kettle on.

Long day today, starting with a big elective vascular case. No need to worry about that though because I stayed last night to see the patient and spent a good hour swotting up on the finer details of complex open aneurysms. I'm ready.

After parking in the next county and walking in from the pouring rain, I grab my scrubs. Today's selection is the same as yesterday. One size fits none. I decide that I can style out pink bottoms and an orange top with sleek to the cleavage area and head to theatre four.

'Bad news, no ITU beds. Aneurysm is off.'

Noooo!!! This was going to be my CBD extraordinaire. Mr Jones is such a lovely patient too.

'No beds for non-urgent electives either. We are helping with CEPOD'.

This isn't terrible news. I love the emergency work. It's why we came into anaesthetics, isn't it? The thrill of the thio-sux-tube (or propofol-roc for those born this side of 1985).

First up is a six-year-old boy for an appendicectomy. The bread and butter of anaesthesia. I visit him on the ward, chat to mum and dad, and explain about the hedgehog milk (it prickles!). I even remember to prescribe EMLA.

'Have you got any questions for me Joshua?'

'Yes. Why have you got hands like skeleton's hands?'

I love kids.

With Josh safely in recovery it's off to see the next. A lovely elderly chap with an incarcerated hernia. He lives alone, he tells me, since his wife passed away. He describes to me how he cared for her and how her favourite flowers were peonies. I smile and tell him I will see him soon.

'Thank you, nurse!' he calls after me. That'll do.

At the lunchtime meeting I'm presenting a case. I ram a pork pie from the kindly drug rep into my mouth, listen respectfully to her chat about the latest in transdermal analgesia and hit the PowerPoint. It goes ok, I think. No one seems to have noticed that I'm not the world leading expert on Brugada syndrome. As long as no one asks any questions.

Returning from lunch I'm asked to go down to resus. An out of hospital arrest is en route. I get there and set up, writing 'GAS' across my plastic gown in marker pen. Two minutes later our

patient arrives. She is grey, pale and asystolic. The team set about their roles like clockwork. I intubate, the others site venous access, give adrenaline and time cycles of CPR as a scribe writes it all down. This one we do not win. The team leader asks if anyone objects to stopping and thanks us all. Like always we pick ourselves up and head on to the next job.

The consultant and I crack on with a toe amputation. It takes me three attempts to get the spinal in and I start to question my own existence. Once the patient is on the table the consultant sends me for a much-needed coffee. The customer in front of me orders a small, decaf latte. I ponder what the point of that is and chug down my flat white with an extra shot.

At 1700 I collect the on-call bleep. For a while things plod along. There's a PCA to refill, an epidural to review on the ward and a patient with difficult veins needs a cannula. The CT2 and I decide to divide and conquer. I always feel the absolute business when I bang a Venflon in on the ward so I volunteer. Unjustified when it's purely all down to practice, but I'll take these small victories. As I'm popping the Tegaderm on my bleep goes off.

'PROCEED IMMEDIATELY TO RESUS'.

I hate these calls! I'm running now, imagining the airway from hell or a sick baby...it's a ruptured AAA. This I've done before. I know the drill. My junior colleague is there already and I see the look of relief in her eyes. Your first one is always memorable and terrifying. I forget to tell her she's doing a great job and ask her to phone blood bank while I call the consultant.

The patient arrives in theatre at the same time as the boss. I realise I'm giving her the same look of relief that I'd witnessed in A&E. In a couple of years that will be me. That's a scary thought. The patient has an unexpected difficult airway. I put my hand out to the right and the ODP (which I believe is Latin for guardian angel) hands me the video laryngoscope needed for the job. As a rule of thumb, if you're ever unsure of which bit of equipment you need, it's usually the one in the ODP's hand.

This one we do win. At least, we get them as far as ITU and hand over the reins. I apologise to the nurse about how tangled all the patient's lines are for the 4276th time this week. She smiles and says she will sort it.

It's now past the end of my shift and time to go. I'm dog-tired climbing into my clapped out old Golf GTI (#Moet medics!). An exhausting but great day is done and I think the team did some good things today. If only we could do it all again tomorrow.

What's that? We can?

Marvellous.

**Natalie Mincher**

ST6, Royal Gwent Hospital, Newport, Wales  
(All cases included are fictitious).

# A Day in the Life of a...

## College Tutor

The day dawns bright and the predictable tussle with two uncooperative children, an equally uncooperative husband and the dog, ensues. They all seem surprised that once again we have to leave on time for school/work/walk (delete as appropriate). Work starts with a morning list and I have one of the more senior trainees with me. It's a relief when they inform me they don't want (need?) to do any workplace-based assessments and so we have a lovely morning with a bit of teaching and a bit of a catch up.

The time, however, is punctuated with visits and calls. A visit from a Clinical Supervisor asking for advice about some documentation they are preparing to support delivery of their unit of training locally. A telephone call from the Deanery to see how I'm getting on with the tasks I was given at the last Training Committee meeting. (I'm not getting on very well. I bluff it. I think she falls for it). A visit from a senior trainee to ask if I will act as a referee for their forthcoming consultant job application. I've been their College Tutor for a significant part of their training and am delighted. It always feels like an absolute honour to be asked to support an application for any post.

After lunch I head to my office to begin reviewing my trainees' portfolios ahead of the forthcoming ARCPs. I say office. It's actually a glorified, windowless, broom cupboard I share with one of my colleagues. We have to be careful not to push our chairs back from our desks at the same time or we could end up in a very compromising position.

I log onto the e-Portfolio but not long afterwards there is a knock at the door; one of the Educational Supervisors wants to discuss a trainee's progress with me. Then the Regional Advisor arrives to see how I'm getting on with my Training Committee tasks. (I'm not. I bluff it. They don't fall for it and give me a deadline).

Then a trainee pops in to discuss their portfolio ahead of the forthcoming ST interviews. Their portfolio is excellent, but the real reason for the visit soon becomes clear. The trainee explains they are married to a doctor and both of them are applying for ST jobs. Clearly upset, they tell me that to complicate things further one of them is entering the lottery of dual training and limited job availability in their preferred region. I sit and listen; having worked away from my husband for almost three years during my training I really sympathise but it felt like we had a bit more control back in my day. I offer vague suggestions interspersed with clichés. 'Everything happens for a reason.' The trainee leaves looking slightly happier.

Back to the portfolios. I review and make notes on them to present at the ARCP, to help both my ailing memory and the summary we produce afterwards. As ever I'm amazed at just how much trainees do these days. Then the 'bing' of a text.

'Mum, where are you?' (1709)  
'Mum?' (1710)  
'MUM?' (1711)  
'MUM??' (1711)



Text-nagging. I shoot out of my office back to my other life, but as I shut the door I catch sight of a bright A4 lever arch folder in the corner. My RITA file. Eight years of training evidence in one file. Those were the days.

Back at home, after tea, I have a look at my emails and see one from the trainee I spoke to earlier. 'Thank you. We both feel so much better.' I reflect on this. (Something else new to me. Should I be writing it up for my appraisal?). All I really did was listen, but sometimes that's all that's needed.

*Name and address supplied*

# A Day in the Life of an...

## On-call ICU Registrar

---

The identity of a dual trainee in anaesthesia and intensive care can at times feel quite conflicted. How do you describe yourself when asked? Which role do you say first and in front of whom? Which conference should you attend with your limited budget (GAT ASM of course!)? And which e-Portfolio are you filling in today!

It can feel like trying to please two parents, who are sometimes not exactly experiencing marital bliss. However, through adversity comes strength!

The day of an ICU registrar begins not unlike those of many other registrars; the pain of exiting a warm bed, the infusion of caffeine and the donning of ill-fitting, and on occasion, paper-based scrubs. Work begins with the handover, a cathartic process for those on overnight and the time to plan the day's likely activities. I currently work in a relatively large unit, meaning this can take some time; by patient no. 20 some of us have started to nod off a little, or are lost when trying to remember if the patients are still on vasopressors, sedation or even ventilated. However, this is the point in the day when it can all go wrong...the worst thing that can happen to an ICU trainee's day is when at this precise moment the medical registrar decides the patient they have sat on all night has *now* reached the point of referral! That or the early morning stabbing has turned up in the ED, just to ruin the plans you had started to make.

Arriving on a medical ward to review a patient can go two ways, either you are greeted by an eager trainee keen to tell you all about the patient and show you every chart possible. Perhaps they have a secret desire to become an intensivist, that or they think I am taking away their nightmare patient. The other way is equivalent to discovering a castaway on an abandoned atoll, often starved, wearing rags and who has had little to no human contact for several days. Written notes are often particularly sparse, apart from the ubiquitous, 'for full active treatment' after the previous consultant review.

After rescuing the castaway who has now had the requisite lines placed, latest bundles prescribed and the tome of admission paperwork completed, you can rightly reward yourself with a circular discussion on the ward round about the innermost workings of your long stay patient's bowel movements and debate the latest contradictory paper released on an intensive care topic.

For many non-ICU trainees, the removal of the ward round from their daily activity is one of the great joys of anaesthesia and the return to the wander round at the end of the bed is a chore. So for those who feel like this, remember you can play games with those of us who specialise in the vague, throw away mentions of 'should we try some steroids?'. Or the simple one liner of 'levosimendan?' will simultaneously generate rage and inquisition and allow you to deflect any unwanted questions.

Communication, as ever, is key, and as the day goes on you find you have communicated with relatives, colleagues, visiting specialties, a variety of surgeons, often a radiologist, and the daily update from microbiology on a new unpronounceable and highly resistant bacterium your patient has cultured. But one of the great oddities of intensive care is the one person we communicate with least is often the patient themselves; for some, the talking ICU patient is unfamiliar and the more difficult one to manage.

It is these discussions and endless variety, though, that intensive care is at its most rewarding. Having the expertise in communicating, discussing, re-reviewing and actually having the time to properly assess and make the decisions the patients' need is where the skill in intensivism lies.

As the day draws on, prophetic discussions can continue. One such discussion I had with a fellow dual trainee one evening broached the topic of how ICU may have changed us as people.

Yes, being a medical doctor is certainly, for most, quite a defining part of our psyche and how others see us, but how your choice in specialty has altered your personality wasn't something I had thought about. The breath between life and death seen, discussed and decided upon daily in ICU does change one's perspective and thought processes as well as the emotional toll of being involved in these discussions. These aren't necessarily always negative experiences and making difficult decisions is what ICU is all about. But making these decisions, and increasingly becoming responsible for them, well, I had to agree with my colleague; yes, it has changed me, but undoubtedly for the better.

**Alastair Hurry**

*ST6 ICM & Anaesthesia, Queen Elizabeth University Hospital, Glasgow and GAT ASM 2018 Local Organiser*



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Pawa A, Wright J, Oncwochei DN, et al.

## Combined thoracic paravertebral and pectoral nerve blocks for breast surgery under sedation: a prospective observational case series

*Anaesthesia* 2018; **73**: 438–43.

### Introduction

With the use of ultrasound, precision and reproducibility of peripheral regional anaesthesia for awake surgery is continuously improving and is becoming a more acceptable way to provide anaesthesia [1]. The authors' aim for this case series was to share their experience of how they provided adequate anaesthesia for breast surgery with good patient and surgeon satisfaction.

### Method

Sixteen patients from one centre between August 2016 and September 2017 underwent breast surgery under regional block plus sedation either by choice or it was clinically indicated. Prior to the blocks they were given midazolam and fentanyl; they then received a thoracic paravertebral block at T2/3 or T3/4 followed by a pectoral nerve (PECS-2) block [2], with 20 ml and 30 ml of a 50:50 mixture of levobupivacaine 0.5% and lidocaine 2% with 1:200000 adrenaline, respectively. The maximum dose of local anaesthesia was not exceeded. Patients were then given a propofol target-control infusion, fentanyl boluses, paracetamol and dexamethasone, unless contra-indicated.

### Results

Procedures included wide local excision, axillary node clearance, sentinel node biopsy, mastectomy and exchange of implant. Fifteen out of sixteen cases were completed under regional block plus sedation. One patient was converted to a general anaesthetic as the block did not cover the medial chest wall. Thirteen patients had no pain, 2 had mild pain and 1 had moderate pain. One patient did not have cover over the inframammary fold but additional local anaesthesia from the surgeon provided adequate cover. All patients said they would have this type of anaesthetic again. The surgeons were extremely satisfied in 13/15 cases and satisfied in the remaining 2.

### Discussion

This technique is a useful way of delivering anaesthesia for breast surgery, especially for patients who are at high risk under general anaesthetic. The authors put forward the benefits of reduced opioid requirements, faster ambulation, avoiding volatiles and possibly improving cancer survival [3], as well as the reduction of chronic pain. Limitations included a small sample size and the inability to comment on outcomes and complications; large doses of local anaesthesia, and failure to cover the medial chest wall.

### Conclusion

This paper gives an insight into how regional anaesthesia can work well. Key to any regional technique is the communication between the surgeon and the anaesthetist, along with an awareness of its limitations. Pawa et al. describe their experience with this technique and the issues that occurred. This technique is certainly worth considering for breast surgery.

Stephen Sarno<sup>1</sup>, Mruthunjaya D. Hugar<sup>2</sup>

<sup>1</sup>ST6 Anaesthesia, <sup>2</sup>Consultant Anaesthetist, Wrightington Hospital

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Frykholm P, Schindler E, Sumpelmann R, Walker R, Weiss M

## Preoperative fasting in children: review of existing guidelines and recent developments

*British Journal of Anaesthesia* 2018; **120**: 469–74.

### Background

It is nearly 20 years since the ASA published guidelines for the minimum periods of pre-operative fasting at 6–4–2 hours for food, breast milk and clear fluids, respectively; replacing the 'nil by mouth from midnight' mantra. Despite this, children are still often subjected to excessive fasting times. The recorded incidence of pulmonary aspiration associated with anaesthesia in children is low and some centres already have experience of using a more lenient approach to pre-operative clear fluids without adverse long term outcomes.

### Methods

This is a review of the evidence supporting current pre-operative fasting guidelines for children and includes a summary of the physiological, epidemiological, and practical aspects of pre-operative fasting with regards to providing safe anaesthesia for children.

### Results

The authors reviewed the literature related to several aspects of pre-operative fasting in paediatric practice.

A systematic review of the evidence supporting current pre-operative fasting guidelines found that high-level evidence only exists for minimising peri-operative fasting, 2 hours fasting after clear fluids and restarting oral intake early postoperatively.

They discuss the evidence enumerating the incidence of pulmonary aspiration in children under current pre-operative fasting guidelines. A multicentre study of UK specialist paediatric centres found this to be 2 and 2.2 per 10 000 cases for elective and emergency cases, respectively [1]. Two older studies suggested it may be higher at 4.7 and 10.2 per 10 000 cases, respectively [2,3]. In the large multicentre study, APRICOT, where incidence of bronchial aspiration was 9.3 per 10000, this did not appear to have any long term consequences [4].

The authors discuss important risk factors for pulmonary aspiration, citing a large multicentre trial in children where the incidence of aspiration was similar whether the children were fasted or not [5]. They also give an overview of the physiology of gastric emptying, the association between fasting intervals and gastric residual contents and possible consequences of prolonged pre-operative fasting.

Lastly, they discuss a study which successfully reduced excessive fasting times [6], a centre with 15 years' experience of not limiting clear fluids in children, which maintained a low incidence of pulmonary aspiration [7] and a QI programme that achieved both with a 1 hour fasting limit for clear fluids [8]. The authors suggest revising guidelines for pre-operative fasting in children based on the current literature.

### Discussion

The authors make four main points based on evidence they reviewed: i) That children are often fasted for too long; ii) that this may have detrimental metabolic and behavioural effects in small children; iii) that evidence exists to support questioning the 6–4–2 hour limits; and iv) that it may be possible to safely reduce fasting intervals within or even beyond the current 2 hour limit. They note that some centres have reduced or mitigated the requirements for clear fluid fasting. The authors conclude that, based on the current evidence, other paediatric surgical centres should consider doing the same, ideally, as part of a large multicentre audit.

Andrew Selman

ST6 Peri-operative Medicine Fellow, UCLH, London

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# Knowing your payslip

In August 2017, anaesthetic trainees in England moved to the new 2016 junior doctor contract. The new terms and conditions of service are now adopted by all trainees, but those who were ST3 and above on 2 August 2016 continue to be paid under the 'old system' of increments and banding [1].

Changing posts and rotating to new Trusts always cause problems, but this training year seemed to be exceptional with anecdotal reports of many anaesthetic trainees being paid incorrectly, late or not at all. The BMA reported a 26% increase in queries regarding pay from junior doctors in August 2017 compared to 2016 [2].

In response to these problems, the AAGBI, in collaboration with the RCoA, conducted a trainee survey to gather information about the problem. The results are yet to be analysed but will be released in due course. In addition, the AAGBI and RCoA released a joint statement that recognises the problems caused [3].

What has also become apparent is that doctors, in general, are not the most financially savvy bunch! I have heard of colleagues being

underpaid for months without realising, being incorrectly taxed or only realising errors when they finally decide to open the backlog of payslips that have been gathering dust in their pigeon hole.

This article aims to explain what all the numbers on that little piece of paper mean and where you can find the correct information if you spot any errors. It focuses on the England and Wales payslips 2002 and 2016 (England and Wales share a common payslip but only trainees in England are on the 2016 contract). There are differences for trainees in Scotland and Northern Ireland and information is accessible using the references provided [4-7].

Disclaimer: I am by no means a financial expert, nor do I have any formal financial training. I have just learnt the hard way after 11 years of rotating through Trusts and many incorrect payslips!

## Payslip 2002

1.ASSIGNMENT NUMBER		EMPLOYEE NAME				LOCATION	
DEPARTMENT		JOB TITLE				5.PAYSCALE DESCRIPTION	
NHS		3.SAL/WAGE	4.INC. DATE		STANDARD HRS	PT SAL/WAGE	
		TAX OFFICE NAME	TAX OFFICE REF		6.TAX CODE	2.NI NUMBER	
7.PAY AND ALLOWANCE (- = MINUS AMOUNT)					8.DEDUCTIONS (R INDICATES REFUND)		
DESCRIPTION	WKD/EARNED	PAID/DUE	RATE	AMOUNT	DESCRIPTION	AMOUNT	BALANCE C/F
9.Year to date balances (This employment only)					This Payslip Summary		
GROSS PAY		TAXABLE PAY			PENSIONABLE	TAXABLE PAY	
NI LETTER		TAX PAID			PAY	NON-TAXABLE PAY	
NI PAY	OTHER NI PAY	PREVIOUS TAXABLE PAY			TAX PERIOD	TOTAL PAYMENTS	
NI CONTS	OTHER NI CONTS	PREVIOUS TAX PAID			FREQUENCY	TOTAL DEDUCTIONS	
PENSIONABLE PAY		PENSION CONTS			PERIOD END		
		EMPLOYEE NO.			DATE	10.NET PAY	
					PAY DATE		
					PAY METHOD		



## Your payslip explained

### 1. Assignment number

This is specific to the Trust you are working in; it's your own unique 'ID number' while employed by this Trust. HMRC has access to this too. If you have joined the hospital's 'Bank' then you may have another separate assignment number. Often it's the same as your main one but ends in -2 or -3 etc.

### 2. NI number

Your National Insurance number. Pretty obvious but worth checking it's correct.

### 3. Salary/wage

Your basic salary is based on 40 hours of work (or the hours specified in the 'Standard Hrs' box) at your 'pay point' (the level of the pay scale you have reached), and excludes banding supplements or any other allowances (e.g. London allowance). It's not uncommon for doctors to unknowingly be paid the incorrect basic salary. It's worth checking that what you see on your payslip is what you should be receiving. You can refer to the BMA pay scales to do this [8, 9]. Pay and conditions circulars for medical and dental staff are published by NHS Employers every year [10]. These tell you of any changes to basic pay that have been made. Increases have most recently been either frozen or increased by just 1%. This year's increase was as per the Doctors' and Dentists' Review Body's recommendation. Pay scales for Specialty and Associate Specialist doctors are also accessible within the pay circular.

### 4. Inc. Date

This refers to the Increment Date, i.e. the date that you go up the pay scale or the date you reached the maximum point (for those long-serving registrars and speciality doctors out there!). This is commonly August but depends on your date of entry into the pay scale. Another reason for incorrect pay is not having received your increment, so it's important to check this.

### Pay scale description

This is commonly 'Specialty Registrar', for those in training, or Specialty Doctor, depending on whether you are in or out of training.

### 5. Tax code

Your tax code is important. It tells your employer how much tax to deduct from your pay. If it's wrong you could end up paying too little or too much tax. The numbers in your tax code refer to how much tax-free income you get in that tax year (April to April) [11].

Currently, as of April 2018, you do not pay any income tax on the first £11,850 of earnings. This value is set by the Government through HMRC and is referred to as your 'personal allowance' [12].

Tax is then paid at 20% on earnings between £11,501 and £45,000, 40% on earnings between £45,001 and £150,000 and 45% on any earnings above £150,000 [12]. For example, if you earn £50,000, you pay 20% tax on your earnings from £11,501–£45,000 and 40% on £45,001–£50,000.

Your personal allowance decreases when you earn over £100,000 and is removed completely when you earn more than £123,000. Details of how much tax you've paid in the tax year are found on the P60 form sent to you in the Spring.

A personal allowance of £11,850 equates to a tax code of 1185L (L meaning you are entitled to the standard tax-free allowance), and this is what most junior doctors will have as their tax code, although it can vary if you have not been working in the UK for a period recently, for example. The 'emergency tax code' is often given to employees when they change employment as the new employer will not have the details of their previous tax code. This emergency tax code usually has W1 or M1 at the end, for example '1150L W1' or '1150L M1'.

A common scenario is being on an emergency tax code for the first month of employment and then reverting to your proper tax code in the next month. This is either because you yourself have contacted HMRC to inform them of an incorrect code or Medical Staffing has updated your records via HMRC. Being on the emergency tax code, even for just a month, may well mean you didn't pay the right amount of tax for that period and will need to reconcile this with HMRC at some point (best spotted and fixed sooner rather than later!).

Your personal allowance can be increased by claiming for tax relief on 'Professional Fees and Subscriptions' [13] meaning you can claim if you have used your own money to buy things which are needed for your job. Common relevant subscriptions include: GMC, BMA, RCoA, AAGBI, MDU and MPS. There are others listed but these are the most common among anaesthetists.

Totals of up to £2,500 can be reflected in your tax code thereby increasing your personal allowance. Above this, which isn't that common for fees and subscriptions, the completion of a tax return is required which does involve more effort.

Claiming is actually very straightforward and can be done by either phoning HMRC or completing a P87 form. You can also claim for the previous four tax years. It's important to have all the fees to hand. Most organisations will readily provide you with a receipt for recent years' subscriptions. The AAGBI has previously produced a tax-relief guide which summarises the ways to claim [14].

## 6. Pay and allowances

These are the payments you receive. Often seen are your basic pay, banding, additional hours, study leave reimbursement, mileage and London allowance (if applicable). 'Wkd/earned' refers to the hours you've worked, 'Paid/due' show the hours you have been paid for and 'Rate' is the hourly rate you receive.

## 7. Deductions

Statutory and other deductions are listed here. PAYE (Pay As You Earn – income tax), NI (National Insurance) and pension are all seen. Additionally, student loan, car parking permit and mess fees might also be listed. The presence of an 'R' indicates a refund from a previous amendment, you lucky thing! Deductions (that aren't taxes) made here without your permission are unlawful and you can challenge them, for example if you did not request or agree to the cost of a car parking permit being deducted from your payslip.

## 8. Year to date balances

This refers to the totals in this tax year to date and shows your total gross pay (money earned before tax), NI contributions, pension contributions and tax paid.

And finally...

## 9. Net Pay

What you get in your bank at the end of the month. Happy spending!

## Payslip 2016

The skeleton of the new payslip is essentially the same as the 2002 one but with differences when it comes to the way your pay is broken down using the 2016 contract's pay calculations. What is essential is to meticulously go through all the same elements outlined and numbered in the 2002 payslip example. Payroll departments have struggled to get the calculations right for large numbers of doctors this training year, and it's in your interests to check their working!

## Description

Under this heading you will see a breakdown of how much you get paid for the work you do. As anaesthetists, you are likely to see:

**Basic pay:** this is calculated based on an average of 40 hours of work per week and corresponds to the relevant nodal pay point for your grade. CT1 = nodal point 3, ST3 = nodal point 4 [8]. Try not to get too depressed when you see what your basic hourly rate is!

**Additional rostered hours:** any additional contracted hours over 40 (most commonly, up to a maximum of 48 in total)

**Night duty:** unfortunately (fortunately?!), the majority of us do night duty, and night-time hours are paid at an enhanced rate of 137% of your hourly basic pay.

**Weekend allowance:** this is a set percentage of your basic salary for the weekend work that you do, spread evenly over the year's 12 pay slips. On the sliding scale used, most trainees will get 7.5% on a standard trainee rota. This equates to < 1:2 weekends worked, up to and including 1:4 weekends worked. You should see this breakdown clearly. The maximum is an additional 10% for working 1:2 weekends.

**Cash floor protection:** your protected cash floor amount, calculated as your basic salary the day before you transitioned onto the new terms and conditions of service, plus a banding supplement for the rota you were working the day before transition.

## Conclusion

The problems that have surrounded pay have only added to the frustrations and low morale that is felt by a large proportion of junior doctors. Unfortunately, the current guidance regarding exception reporting does not include the reporting of pay problems [15], but in-house advice and support should come from departments in the form of clinical leads, educational supervisors and college tutors. The BMA also offers employment advice and support for its members, and trainees should seek out this service if required. Failure to pay you properly is essentially a breach of contract and can be pursued for you through formal channels by the BMA on your behalf if need be, but early intervention by the local Industrial Relations Officer normally resolves things promptly. Change is often difficult without the evidence. I would encourage discussions with both your departments and Medical Staffing and follow up any conversations with a quick email.

When someone has been significantly underpaid or not paid at all, Payroll will sometimes say that they can't do anything about it until the next month's payslip – this is simply not the case, and all Payroll departments are quite capable of paying people weekly (many non-clinical staff are paid in this way) and they can also make 'emergency' payments if they are sufficiently motivated, for example by the BMA getting involved! Don't let yourself be fobbed off 'until next month'. Being paid correctly should not be viewed as being 'lucky', it's something we have a right to and therefore any problems should be escalated accordingly. Many doctors don't like to think about money very much, but we work hard and do our best for our patients and deserve to be paid correctly.



**Tom Wojcikiewicz**  
*GAT Committee member*

References available online at: [www.aagbi.org/anewsjunerefs](http://www.aagbi.org/anewsjunerefs)





### Analysis of the distribution and scholarly output from National Institute of Academic Anaesthesia (NIAA) research grants

El-Boghdadly K, Docherty AB, Klein AA.

This important article is accompanied by two editorials, to mark the 10th anniversary of the National Institute of Academic Anaesthesia (NIAA). While no doubt this will be marked by some celebrations within the national organisations, El-Boghdadly et al. have conducted a dispassionate analysis of the grants awarded by the NIAA. Since awarding research grant support is the major (if not only) function of the NIAA, it seems reasonable to expect there already to exist a comprehensive database as to what scholarly output resulted from the support given. Perhaps surprisingly (or disappointingly) the authors discovered that the NIAA does not formally track research outputs, focused as it is on inputs. A second result of this paper is that, once outputs are tracked, there is considerable variation in the apparent 'cost-effectiveness' of different research groups. Some appear very well funded with relatively little to

show for it; others appear to produce considerable outputs with relatively little funding. (Interested readers should peruse the online supplementary data for the geographical location of these respective units). Reassuringly, there was no bias towards any particular research group(s) or any gender bias: generally awards were granted in proportion to the number of applications. The accompanying editorials expand on themes raised by this paper. One of these deals with the concept of 'research waste'. This is the concern that if precious funding is not used strategically to support developing careers in targeted ways, the research capacity of the specialty will inevitably shrink. The NIAA does an excellent job in distributing research grants by a traditional competitive mechanism. It might need to think about more innovative ways of supporting research groups and researchers before they are irrevocably lost to the specialty.

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### Associations of postoperative mortality with the time of day, week and year

Kork F, Spies C, Conrad T, et al.

Famously, it was a bizarre and twisted logic that led to the most damaging event in recent years in UK healthcare. A small study suggested a 'weekend effect' in hospital mortality; Jeremy Hunt, the UK Secretary of State for Health, concluded that this was due to fewer consultants available at weekends, so to promote his ideal of '7-day services' he sought to change the contracts of...junior doctors who responded by going on strike. Regardless of political views on the matter, the train of logic rests on whether a 'weekend effect' exists or not. Other papers from the UK have subsequently questioned that it exists. Now this paper from Germany finds that, in their setting, mortality at the weekend was the

same as during the week. The mortality odds ratio after operations started in the morning (08:00–11:00) were lowest and highest for operations started in the afternoon (13:00–17:00). There was no seasonal variation in mortality. Longer term analyses showed higher mortality odds ratio in winter and lower mortality in spring. The authors conclude that their data might help plan capacity for hospitals over the longer term. They do not directly address the question of whether their lack of weekend effect might be explained by differences in employment contracts in their hospital vs. the NHS.

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### Editorial: Big data: breaking new ground in airway research

Greenland KB.

This editorial accompanies a fascinating article about an airway app designed to capture information, at international level, on emergency front of neck access (eFONA) in airway management. The editorial touches on wider issues, such as ethical considerations and the technology required to create large datasets. There is every reason to suppose that large datasets are useful: the National Audit Projects (NAPs) are after all really nothing other than intermittently created datasets around a specific condition or question. The ideal is surely that the data of every patient undergoing anaesthesia or a surgical procedure are entered into

an anonymous database, from which different researchers can extract what they need to try and answer important questions. However, let me leave you with two thoughts. First, in relation to FONA, it may not be the details of patients undergoing FONA that matter, but the details of those that did not receive FONA, and these will not be captured. Second, 'science' consists of stating a hypothesis and designing an experiment to test that hypothesis. A big dataset is not an experiment; so big data is not 'science'. We may need a new word (and underlying philosophy) for what is going on.

# SPA time for trainees

Supporting Professional Activities (SPA) are defined as activities that underpin direct clinical care. Many of these are required for revalidation and the time taken to undertake them has long been recognised within the consultant and SAS contracts. The terms and conditions of the consultant contract outline the many activities that may be undertaken during SPA time, many of which are also carried out by junior doctors during their training.

The Annual Review of Competence Progression (ARCP) requires trainees to show evidence of continuing professional development as well as involvement with audit and quality improvement. The curriculum for advanced trainees includes management and leadership, innovation and education. It is anticipated that much of this can be achieved within training hours and planned study leave. A recent report on trainee morale and welfare from the RCoA highlighted that anaesthetists in training reported overwhelming pressure to undertake these activities, with almost all done in their personal time [1].

## Our solution

To help address this, the specialty trainee committee in the North-West deanery has introduced 16 SPA sessions for senior trainees per year. These are evenly distributed throughout the year with a maximum of four sessions to be taken per three-month block (pro rata for less than full-time trainees). Pre-fellowship trainees utilise the majority of their study leave for exam-related purposes and for this reason they are currently not entitled to SPA time.

Trainees must request SPA sessions in a similar manner to study leave arrangements. This ensures the approval of the educational supervisor and rota coordinator locally and allows the training programme director to monitor its use. Trainees are expected to discuss their plans for SPA time with their educational supervisor at the initial supervisor meeting and the request can be refused if it is deemed unreasonable or it is felt to be at the expense of achieving core learning outcomes.

Below are some examples of what SPA time may be used for. This is not an exhaustive list and approval remains at the discretion of the educational supervisor. There may be some overlap with activities that may also be requested as study leave.

### Examples of SPA activity

- Audit and quality improvement projects
- Development of Trust guidelines
- Research including online GCP Training
- Publications (with appropriate senior guidance)
- Preparation for regional/national posters/presentations
- Management – e.g. shadowing senior management and attending board meetings
- Organising and running simulation sessions
- Organising and running local teaching for medical students/junior trainees
- Attending to previously missed training opportunities
- Working towards MSc/PgDip/PgCert



## Alternative Models

Allocation of non-clinical time for trainees will vary depending upon local rota pressures and stage of training. SPA time can be allocated in advance alongside the on-call rota, reducing flexibility for the trainee but allowing departments to plan ahead. Trainees on advanced modules may require one session a week to meet their non-clinical commitments but this would have to be negotiated at a local level.

## Potential Problems

There have been concerns voiced regarding the loss of training time with many senior trainees not achieving the minimum of the three supervised sessions per week recommended by the RCoA. It is unclear whether this has historically ever been achieved but there is no doubt that the average number of cases performed by a trainee prior to becoming a consultant has fallen significantly [2]. The current study leave allowance within our region is 30 days per annum, which is rarely fully utilised post-fellowship. We therefore appropriated SPA time from within the study leave budget on an optional basis, preventing a reduction in time within the clinical environment.

## Conclusion

This simple intervention has been universally welcomed by trainees as recognition of the contribution they make outside of the clinical setting. The use of SPA time will be monitored from the trainee and departmental perspective and the terms adapted as needed prospectively. We hope it enables more flexibility for trainees in terms of the pressures of achieving required non-clinical work outside of work time, and consequently has an impact on their wellbeing and training experience.



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Fig. 1



Fig. 2



Fig. 3

## Dear Editor

While extubating a patient in theatre, I noticed a potential for harm that I had not anticipated, and which could easily go unnoticed. It is routine to check for the degree of reversal by using a nerve stimulator at the end of any case where the patient has received a non-depolarising muscle relaxant. The ECG dots used to connect the nerve stimulator are commonly produced stuck to small, transparent and annoyingly static pieces of plastic (Fig. 1). In this instance, I found a piece of plastic sitting on the inside of the face mask that was about to be used (Figs. 2, 3). Although no harm came to this patient, it had the potential to partially or completely obstruct either the breathing circuit or the patient's oropharynx.

Many cases have been reported of blocked anaesthetic circuits due to rubber bungs, caps, wrapping and cleaning rods lodged in angle pieces, circuits and reusable laryngeal masks, and have resulted in serious harm [1–5]. In 2001, a case resulted in death of a 9-year-old boy when a transparent cap completely occluded an angle piece. Lessons from that case included using single-use equipment appropriately and not unwrapping until needed, dissemination of safety information (a similar incident had recently happened), and amendment of the AAGBI's checklist to include checking the patency of all parts of the circuit that will be used [6, 7].

In my case, the face mask and ECG dot plastic were single-use pieces of equipment that although opened appropriately and not faulty, shouldn't come into contact with each other. As safety checking of the breathing circuit and anaesthetic machine routinely happens at the beginning of a case, we should be vigilant at checking our equipment at times when altering the circuit during the case. This case also highlights the importance of having a tidy workspace and disposing of rubbish appropriately. Changes that have occurred in previous cases include bright colouring of disposable plastics to aid detection, and introduction of a hole in the centre of the plastic to reduce the chance of complete obstruction.

**Roisin Flanagan**

CT3 in Anaesthesia, Royal Gwent Hospital

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## 'AAGBI PRESIDENT'S BLOG'

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## Dear Editor

### #FightFatigue

We would like to congratulate Rob Charles et al. on their audit regarding fatigue and commend the authors on highlighting such an important issue [1]. Was the response rate of 37% indicative of attitudes about fatigue in the workplace as a profession, or itself an ironic product of 'survey fatigue'?

Like many NHS Trusts, clinical and administrative space is a premium. Despite this pressure, and ostensible concerns of 'sleep inertia' impairing the first few minutes of performance once woken, our department has always strongly advocated suitable and dignified rest facilities for our anaesthetists. We genuinely believe that fatigued doctors are a great threat to both patient and staff safety, and education for clinicians and managers on effective fatigue management is fundamental to provision of high quality care and system resilience.

We are lucky to be a forward thinking Trust with patient and staff safety advocates throughout the organisation. Thus we have ensured a modest but private bedroom, close to the maternity unit, for our obstetric anaesthetists.

It is widely held that the medical profession lags behind other safety-critical industries with regards to fatigue management. Anaesthetists appear at the forefront of specialties addressing this issue, and should relish the challenge in leading the way. We fully support the AAGBI, RCoA and FICM campaign to **#FightFatigue** and hope other Trusts follow our example.

**William Birts and Richard Kaye** *Consultant obstetric anaesthetists Buckinghamshire Healthcare NHS Trust*

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## Dear Editor

### 'Lazarus come forth!' before confirmation of death

Jesus supposedly resurrected Lazarus four days after his death and burial (Gospel of John, Chapter 11: 1–44). Lazarus phenomenon is the delayed unassisted return of spontaneous circulation after its cessation, either after termination of cardiopulmonary resuscitation or withdrawal of life sustaining therapy [1, 2]. Fifty percent of French emergency physicians claim to have encountered it [3] and one-third of Canadian intensivists have seen it at least once [4]. In a comprehensive review from 2010, 32 cases of Lazarus phenomenon were identified from 16 different countries over a 26-year period (1982–2008) [1].



According to ALS guidelines, a patient must be observed for a minimum of 5 min before confirming death [5]. Since most cases of Lazarus phenomenon occur within 10–15 min, consideration should be given to extending this period to 15 min with ECG monitoring before certifying death or informing the family [2, 6, 7]. While anaesthetists will usually encounter death confirmation in a continuously monitored environment (A&E, ITU or theatre), it is reasonable to delay examination for confirmation of death to 15 min post cessation of circulation (spontaneous or artificial).

### Eid Hussien

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