SPECIAL ISSUE: GLOBAL HEALTH

The work of the WFSA Project India: Making a difference at both ends

Obstetric anaesthesia and maternal mortality
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Editorial

Welcome to September’s Anaesthesia News, which this month focuses primarily on Global Health; an important reminder that for all our challenges and problems in the UK healthcare system, we live in a very well resourced and regulated country.

The WFSA estimates that more than 70% of the world’s population do not have access to safe anaesthetic and surgical care, resulting in avoidable harm and death; we are fortunate to be some of the lucky 30%. This month’s issue is also an inspirational reminder that many healthcare workers across the globe still put patient care above all else, and that they are willing to give freely of their own time to help others.

I am writing this in mid-July, when reading national and international news is a confusing and depressing occupation. It seems we are to leave Europe, and Scotland threatens again to leave the UK. Much of the Brexit debate was at best unedifying, and in my opinion failed to show the UK in the best light. Politicians are resigning right left and centre, washing their hands of the whole business and leaving us in a sorry mess. It would appear that the weekly £350 million pounds promised by Nigel Farage will not be making its way to the NHS coffers – did anyone really think it would? – and with the UK economy allegedly crashing, all is doom and gloom.

Hopefully you will find reading this issue uplifting; it gives a refreshing look at the work of some of the individuals and organisations in the international network of selfless people prepared to work hard to improve the lives of those born in countries with fewer resources. I recommend Rachel Collis and Isabeau Walker’s inspiring accounts of the SAFE projects, which help local trainees to improve training in anaesthesia, and to improve outcomes. Many UK trainees have contributed by undertaking fellowships, and Nick Owen and Jolene Moore give accounts of their overseas experiences. Sanyoj Deshpande et al describe the admirable work they are involved with concerning rural healthcare in India.

On a larger scale, many organisations, including the AAGBI, OAA and WFSA, have pulled together to progress the United Nations Millennium Development Goals, and Nuala Lucas and Rachel Collis reflect on the improvements in maternal health in low- and middle-income countries, though there is still much needing to be done. The global work of the WFSA is explained, and their huge contribution to improving global access to safe anaesthesia and surgical care. In particular they work hard to raise awareness of the importance of anaesthesia to so many aspects of patient care, and in promoting improvements in the education of anaesthetic trainees across the globe.

I hope you find this month’s issue as inspiring and thought provoking as I have. And as I sign off I hear that UK politics may be stabilising...for now. We have a new Prime Minister, and an interesting choice of Foreign Secretary. And – the icing on the cake – Andy Murray won Wimbledon. I feel better already.

Elizabeth McGrady
Elected Member, AAGBI

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Editorial

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Delight at more writing time became disbelief then despair; my bonus weeks filled with a bewilderment, seemingly endless succession of events, each so significant, the cumulative impact (whenever that is) they’ve not stopped will be momentous. The UK’s future is less certain, less secure, less united than at any time I can remember. All of our lives changed.

President’s reports vary – event reviews, rants, homilies, tributes, and personal views. My personal view is the only view I can give, when reporting to members the background or relevance of an issue. This final report posed a ‘Brexit’ dilemma: should I note, narrate, describe or direct? Or ignore? Events evolved quickly (what was ‘Mr Cameron’s term ends a month after mine’ is now ‘new PM Theresa May’. So my view will soon be out of date, all will share it (never did, never will), but I have only this chance. The AAGBI is political but not party political, I may mention parties but will comment only on politicians. I pretended nothing happened; it didn’t help.

My term began with one referendum; another has dominated my last months. A President’s comments on a Prime Minister carry risk, but with little time left now he’s gone (delete as appropriate) I throw caution to the wind; David Cameron and referendum…not a good mix!

Electoral success by the Liberal Democrats forced the first referendum (Scottish Independence); if you must have one, keep it simple, and don’t muck it up. Electoral success by the Conservatives in 2015 left Mr Cameron with a working majority to deliver his party’s manifesto. Two ‘bargaining chips’ pledges – the EU referendum and NHS seven-day services – hijacked the PM’s agenda and then forced his early exit from office. Mr Cameron may regret at issue how his short-term ‘success’ in the first two referendums led to the third, but we’ll pay the price for years.

The PM should have known the Rules of Referendums: 1) Don’t hold more referendums; 2) Don’t hold referendums if your parties are not united; but we’ll pay the price for years. My term began with one referendum; another has dominated my last months. A President’s comments on a Prime Minister carry risk, but with little time left now he’s gone (delete as appropriate) I throw caution to the wind; David Cameron and referendum…not a good mix!

The EU referendum result is history; the result of the referendum is history; the result of the referendum is history; the result of the referendum is history; the result of the referendum is history; the result of the referendum is history.

Words may matter more than facts. Today, couples in a civil partnership have their name (and £45); ‘affiliated with’, not ‘Member of’, the EU perhaps? Words may matter more than facts. Today, couples in a civil partnership have their name (and £45); ‘affiliated with’, not ‘Member of’, the EU perhaps?

We only needed to raise £96,000!

Lord Coe lent his support and a quote, and the campaign also included a name check in Seb’s ‘Made in Britain’ speech, and autobiography, and ‘All stations from Edgware Road to Rio; an Olympic Journey’, the AAGBI’s only previous fundraising campaigns, which had been to buy an experiment. No current member of Council or staff was involved in a group, and I’m sure each version was different. Perhaps the two most accurate short versions are: ‘Experiencing 7/7 the day after London wins 2012 Olympics, leads to participation as a London 2012 Gamesmaker, a life choice, and becoming AAGBI President Elect (fundraising idea needed)’. So was born Lifeboxes for Rio, combining the themes of volunteering, international, equality in excellence, training and practice with the target £25k is a lot of money. But there are lots of you. 11,000 of you, members by Lifebox, funded by

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Lifeboxes for Rio – the journey ends (almost)
President, AAGBI
Dr Andrew Hartle

All downhill now…Pension – 15 years, 9 months, 9 days, and counting…’well done’ to. I’m going to miss it, but the time is right to hand over. It’s smiles on the faces of people you thank, award, congratulate or just say fun, occasionally sad, but always an honour. Nothing can match the gone. Plan for the future but don’t rely on it.

Two years have flown by; without my diary, I’d not believe we actually packed so much in. Those two years have changed my personal and political priorities, live for today as much as tomorrow, but yesterday has eaten, Lifeboxes bought.

AAGBI did more than just deal with referendums and strikes for two years, (they were ‘extras’); we delivered more CPD in anaesthesia than anyone, made revalidation easier with Learn@AAGBI and the VideoPlatform. The National Essential Anaesthetic Drugs list was updated, we reached out to Europe and the ESA first in Berlin, then welcomed Euroanaesthesia to London (who says irony is dead?). We published joint position statements with the RCoA on contracts, welfare, CPD, PNA/s, and anaesthetic room cupboards – better together, our two terms of Reference, and ketamine protected; cakes baked, sold and eaten, Littlexes bought.

My report lands on your doorstep as we fly back to the UK from this year’s Common Issues Group, and the WPSA World Congress in Hong Kong. Soon Paul Clyburn becomes President. Hon Secretary Samantha Shinde hands over to Mike Nathanson, Kathleen Ferguson and Nancy Kong. Soon Paul Clyburn becomes President; Hon Secretary Samantha Shinde takes over as Immediate Past Hon Membership Sec (and next President of the OAA – huge congratulations). Behind the scenes of Annual Congress, Tighe’s term as Vice President ends; he leaves Council, as will Felicity Plaat, Immediate Past Hon Membership Sec (and next President of the OAA – huge congratulations). Before the scenes of Annual Congress, AAGBI staff will be in control in Birmingham, under Executive Director Karin Pappenheim. Thanks to each and every one for your support.

Two years have flown by; without my diary, I’d not believe we actually packed so much in. Those two years have changed my personal and political priorities, live for today as much as tomorrow, but yesterday has eaten. Plan for the future but don’t rely on it.

Being President wasn’t always ‘my plan’; it’s very hard work, mostly great fun, occasionally sad, but always an honour. Nothing can match the smiles on the faces of people you thank, award, congratulate or just say ‘well done’ to. I’m going to miss it, but the time is right to hand over. It’s all downhill now…Pension – 15 years, 9 months, 9 days, and counting…
In 2015, The Lancet Commission on Global Surgery’s findings [1] confirmed a huge shift in global health. More than 70% of the world’s population does not have access to safe and affordable anaesthesia, and people are dying as a result. Specifically, 16.9 million people every year, which is three times the number of people dying from tuberculosis, HIV/AIDS and malaria combined.

We are moving into a new era in global health. Deaths from non-communicable diseases (e.g. cancer and diabetes) are higher than deaths from communicable diseases (e.g. malaria and HIV) and new health challenges are becoming increasingly clear. These challenges have a much wider impact on populations, societies and economies, and must be tackled head on. Non-communicable diseases deliver programmes that facilitate learning and promote the highest standard of anaesthesia care around the world.

Improving access to education

In low- and middle-income countries, high mortality rates in the operating room and immediately after are often related to a lack of infrastructure, essential equipment, monitoring and drugs, as well as a shortage of trained personnel.

The WFSA began offering fellowships to young anaesthesiologists from low- and middle-income countries in 1996 as part of a wider mission to improve patient care and access to safe anaesthesia. Twenty years later the programme has successfully trained more than 250 fellows from countries across Africa, Asia, Europe and Latin America.

The WFSA is able to offer fellowships to anaesthesiologists from lower income countries at no cost to themselves. But successful applicants can only access these opportunities if their travel and living costs are supported. It is essential that we make these opportunities available to anaesthesiologists who are already working in the countries that need their expertise and leadership the most.

The WFSA is expanding its Global Fellowship Programme in order to help tackle the shortfall in skilled anaesthesiologists, with the goal of training 500 fellows and reaching over 1 million patients by 2020.

Raising the profile of anaesthesia

In the August 2014 issue of Anaesthesia News, then-President Dr William Harrop-Griffths so eloquently explained the large and varied role of the anaesthetist:

‘Anaesthetists are not only excellent at the administration of straightforward anaesthetics, but we are also very good indeed at a number of other things. We can bale others out of simple anaesthetics that go rapidly and disasterously wrong. We can give highly complex optimisation, postoperative care, high dependency care, and the recognition and management of sick ward patients. In fact, if you look at the surgical patient pathway as a whole, we are pretty darn good at every single bit of it bar the easiest bit: the knife work, which we can readily leave to the surgeons.’

One of the biggest challenges is educating decision makers on the role of the anaesthetist: ‘Anaesthetists are not only excellent at the administration of straightforward anaesthetics, but we are also very good indeed at a number of other things. We can bale others out of simple anaesthetics that go rapidly and disasterously wrong. We can give highly complex

More than 30% of the Global Burden of Disease stems from conditions that could be treated through surgical intervention and each year at least 77.2 million disability-adjusted life-years could be averted by providing basic, life-saving surgical care. ‘Just three operations – for compound fractures, laparotomies and obstructed labour – would meet most of the demand.

The World Federation of Societies of Anaesthesiologists (WFSA), as the world’s foremost global alliance of anaesthesiologists, is ideally placed to intervene and improve access to safe and affordable anaesthesia and surgical care. Through our network of hundreds of thousands of anaesthesiologists in more than 140 countries, we deliver programmes that facilitate learning and promote the highest standard of anaesthesia care around the world.

In 2015, the World Health Assembly in Geneva unanimously approved a resolution entitled ‘Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage.’ [2] in a landmark decision to address this previously ignored global health crisis. The WFSA addressed the 193 Ministers of Health who make up the Assembly saying, ‘We can address the combined elements of workforce, drugs, equipment and infrastructure that not only ensure a safe provision of anaesthesia, but contribute to strengthening health systems and improving health outcomes in a manner that is affordable, life-saving and an outstanding return on investment.’

The WFSA was an integral part of the support for this resolution and is committed to ensuring access to safe anaesthesia. We will be launching a global campaign entitled ‘Safe Anaesthesia For Everybody – Today’ ‘SAFE-T’ at the World Congress of Anaesthesiologists in August, ensuring safe anaesthesia is an international priority for individuals, organisations and industry in the years to come.

For more information about the WFSA and its programmes please visit www.wfsahq.org

References


Julian Gore-Booth, Chief Executive Officer of WFSA (UK), explained ‘Supported by leading hospitals and dedicated WFSA volunteers, the WFSA is able to offer fellowships to anaesthesiologists from lower income countries at no cost to themselves. But successful applicants can only access these opportunities if their travel and living costs are supported. It is essential that we make these opportunities available to anaesthesiologists who are already working in the countries that need their expertise and leadership the most.’

From 28 August to 2 September 2016, the WFSA, along with the Society of Anaesthetists of Hong Kong, will host the 16th World Congress of Anaesthesiologists, the foremost global gathering of our specialty for those interested in learning, networking and engaging in open dialogue on important topics in the field of anaesthesia. The high profile nature of the Congress will be an opportunity to openly discuss the role of anaesthesia in relation to global health. Dr Atul Gawande, surgeon, bestselling writer and public health researcher, and Tore Laerdal, Director of the Laerdal Foundation and Managing Director of Laerdal Global Health, will give the Harold Griffith lecture on Wednesday 31 August 2016 on this topic. As two innovators in the field of medical care and global health, their insights will be invaluable in promoting our profession on a world stage.

Ninadini Shrestha, from Nepal, was awarded a WFSA Pain Fellowship in Kamineni Hospital, Hyderabad and was prominent and immediately after were often related to a lack of infrastructure, essential equipment, monitoring and drugs, as well as a shortage of trained personnel. From Nepal, was awarded a WFSA Pain Fellowship in Kamineni Hospital, Hyderabad and was prominent and immediately after were often related to a lack of infrastructure, essential equipment, monitoring and drugs, as well as a shortage of trained personnel.
On my current rotation, I’ve been asked a few times which hospital I’ve just come from. This casual question from consultant colleagues and fellow trainees usually serves as a springboard to other topics fairly quickly. However, my answer to the question has been followed by raised eyebrows and a somewhat longer discussion than is perhaps usual: the answer is Jimma University Specialised Hospital, Oromia, Ethiopia [1].

From August 2015 to February 2016 I worked in Ethiopia as the inaugural Lifebox/AAGBI Fellow. My remit? 50% clinical and education and 50% quality improvement. I had a fairly good introduction to where I would be working some months before I started as I taught on a Safer Anaesthesia From Education (SAFE) Paediatrics course [2] in April 2015, which doubled up as a recce of Jimma and accommodation finding mission for my upcoming Paediatrics course [2] in April 2015, which doubled up as a recce.

So what is the Lifebox Fellowship and why did I want to undertake it? On my current rotation, I’ve been asked a few times which hospital I’ve just come from. This casual question from consultant colleagues and fellow trainees usually serves as a springboard to other topics than is perhaps usual: the answer is Jimma University Specialised Hospital, Oromia, Ethiopia [1].

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My role was as previously defined but with the renowned laid back attitude that is characteristic of Africa, it soon became apparent once the rigours of postgraduate medical training and exams took hold immediately post university years that became a distant memory. Combining those two points made the decision to apply for the Lifebox Fellowship a fairly easy one.

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It’s difficult to know how to sum up my six months in Ethiopia. In many ways, a lot of improvisation, adaptation and general winging it was required, as one of my early projects was to facilitate the improved utilisation of the Jimma University Specialized Hospital (JUSH). My role was to integrate the components of the Lifebox teaching and evaluation programme into a simultaneously running surgical and anaesthetist training course from a Welsh-based consultant contingent. Through multiple meetings, draft checklists, repeated feedback and local engagement, a Jimma checklist was introduced and formative six months in my anaesthetic training and I would urge all post-graduate anaesthetic trainees to consider a developing world stint.

Pensions, tax and the anaesthetist: significant implications for workforce planning

Pandit JJ

These complementary pieces challenge dogmas concerning how best to approach ‘work’. They may cause some readers to undertake a fundamental reassessment of both their career and their financial circumstances. For those of a certain seniority, the AAGBI Working Party ‘Age and the Anaesthetist’ offers extremely valuable practical advice and resources on how to approach job planning and better achieve work-life balance towards the later years of a career. The accompanying paper on pensions and tax emphasises how we all (regardless of seniority) will need to careful plans from now, if we are to make the best of our working lives. Unfortunately, the logic of the analysis leads to the conclusion that, for most of us, this almost inevitably will mean reducetion of the remuneration for the NHS (i.e. the NHS service delivery). The response of the readership to both these pieces will be fascinating.
MRS CAROLYN CANFIELD
Carolyn Canfield collaborates as an independent citizen-patient internationally with clinicians, patients, managers, researchers and educators to embed the patient voice in improvement processes.

A/PROFESSOR DAVID CANTY
Dr David Canty is an Anaesthetist and Director of Simulation and Senior Lecturer for the Ultrasound Education Group, University of Melbourne, with a particular interest in echocardiography.

PROFESSOR OLLE LJUNGQVIST
Professor Olle Ljungqvist received his medical degree and obtained his PhD on glucose metabolism in hemorrhage at the Karolinska Institutet in Sweden.

PROFESSOR STANTON NEWMAN
Professor Stanton Newman is Professor of Health Psychology and Dean of the School of Health Sciences at City University London.

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Anaesthetist and pub landlady

There are mornings I wake up and am unsure where I am or what profession I will be practising that day. Some days I dress in whites and others in blues. Since last July I have had two full-time jobs – the first being consultant anaesthetist at Queen’s Hospital, Burton-upon-Trent, and the second as landlady of the Crown & Glove pub in Stannington, Sheffield.

As a GP friend of mine said, it’s really the same job; handing out drugs and being nice to people. In fact there are a number of similarities between being a doctor and being a publican; the long antisocial hours, working evenings and weekends, working as a small team in a high stress environment and dealing with the general public while they are not in their best state.

So how did I end up running a kitchen one day and anaesthetising the next?

Since I qualified, my career has not exactly been conventional. For example being tasked to RTAs, and being side-tracked with pre-hospital medicine and mountain work in pre-hospital medicine, an amalgamation of my love of the mountains and my work in pre-hospital medicine, and I spent two seasons working as a mountain medic in the Everest region of Nepal. Finally I worked with Médecins Sans Frontières for two missions, in Papua New Guinea and Pakistan. In the five years after I qualified, I never spent more than seven months at one time back in the UK, using this time to locum and catch up with some UK professional development.

I probably would have carried on the same path had I not met my partner, Henry.

Henry had been managing pubs in London for a few years and was more than ready to take the next step of running his own place. There were a number of reasons we decided to take the big step of running a pub together. Although I still enjoy anaesthesia, I wasn’t getting the buzz from working as a consultant within the NHS. I also did not want to spend my life as a pub widow as he probably would have continued the same path had I not met my partner. Henry had been managing pubs in London for a few years and was more than ready to take the next step of running his own place. There were a number of reasons we decided to take the big step of running a pub together. Although I still enjoy anaesthesia, I wasn’t getting the buzz from working as a consultant within the NHS. I also did not want to spend my life as a pub widow as he probably would have continued the same path had I not met my partner.

In March 2015 I got a one year locum contract at Queen’s Hospital, Burton-upon-Trent, and the second as landlady of the Crown & Glove pub in Stannington, Sheffield.

On the back of this experience I got a post CCT Fellowship with the newly inaugurated Emergency Medical Retrieval Service in Glasgow. At the same time I was completing the UK UICC Diploma of Mountain Medicine, an amalgamation of my love of the mountains and my work in pre-hospital medicine, and I spent two seasons working as a mountain medic in the Everest region of Nepal. Finally I worked with Médecins Sans Frontières for two missions, in Papua New Guinea and Pakistan. In the five years after I qualified, I never spent more than seven months at one time back in the UK, using this time to locum and catch up with some UK professional development.

Throughout my higher training in Edinburgh I had one goal in mind, since I qualified, my career has not exactly been conventional. For example being tasked to RTAs, and being side-tracked with pre-hospital medicine and mountain work in pre-hospital medicine, an amalgamation of my love of the mountains and my work in pre-hospital medicine, and I spent two seasons working as a mountain medic in the Everest region of Nepal. Finally I worked with Médecins Sans Frontières for two missions, in Papua New Guinea and Pakistan. In the five years after I qualified, I never spent more than seven months at one time back in the UK, using this time to locum and catch up with some UK professional development.

The process from the first viewing to signing on the dotted line was long and stressful especially as I had no previous experience in the business world. There were numerous meetings with the Regional business manager, we had to write and present a business plan and then attend more meetings until we were accepted as ‘partners’ for Punch Taverns. Then the really hard work started. My job was to set up the kitchen. I wanted our kitchen to be about fresh, homemade, good quality pub grub. To this end I spent a lot of time researching local suppliers in the area, I talked to farmers and vegetable wholesalers, talked to other publicans in the area and got some samples which I tested on friends and family and eventually came up with a list of quality local suppliers that didn’t break the bank. My next job was to devise an initial menu, which involved not only coming up with a balanced menu but also costing out all the dishes to see if they would be economically viable. My search engine on my laptop was constantly asked questions like ‘how much does an average potato weigh?’ or ‘how much juice do you get from an average lemon’?

I was also putting in my clinical hours at the hospital and using my SPA time to contribute towards the running of the department. After years of doing locum work, it was satisfying to be part of a department again. Over the eight months we were setting up and opening the pub I did a prospective clinical audit on our orthopaedic enhanced recovery programme and, using my previous experience, wrote a set of site-specific guidelines on transfer and overhauled our transfer paperwork and equipment organisation. There has been no such thing as a day off for the last year!

In mid-July 2015 we moved our house in Matlock and ended up semi-locuming in our pub, which was still a building site while it was being renovated. Having had no experience of the private sector before, I was shocked at the poor communication and inefficiency I witnessed during this renovation process. The first six months I have gone from being completely stressed out in the kitchen to being able to do a dinner for 30 with relative calm and efficiency. A few months after we opened, an anaesthetist friend asked me what was more stressful – running a dinner service or running an emergency list. I said the first – after all, I trained for seven years to do the second!

As someone who went straight from school to medicine, and who previously never had any interest in business, the whole thing has been a massive challenge from start to finish. From writing a business plan to making planning applications, finding suppliers to interviewing staff, learning how to run a busy Friday night service to handing cash it was all way out of my comfort zone. The first six months were probably the most stressful of my life. On the upside, reading a review from a recent diner, working alongside my partner and standing behind the bar as the pub buzzes with happy punters is extremely satisfying.

There are a number of transferrable skills from medicine that have really helped me:

• Experience in dealing with the public and communicating with those from all walks of life
• Planning and organisational skills, for example keeping the kitchen supplied and services running smoothly especially at busy times like Christmas
• Problem solving
• A basic understanding of health and safety and the need for a paper trail and the tenacity to just keep going no matter how knackered and stressed you are!

These days things are more settled but I am generally still working seven days a week. Most weeks the days at the hospital are less stressful than those in the pub. Even when I am at the hospital in the evenings you will generally find me on my laptop paying the wages, ordering food or designing a poster or Facebook post. I have recently done part-time in the hope Henry and I can finally get the odd day to go out and enjoy the area around us.

Sitting up a business with your partner is challenging but I don’t think we’ve done a bad job!
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Project India: Making a difference at both ends

During a holiday to India in 2005, Dr Sanjay Deshpande visited BKL Walawalkar Hospital in Dervan. He was astounded at the dedication and commitment of the medical staff despite the relative poverty of the surrounding area and difficult working conditions.

The following year, he started work on the India project and it has gone from strength to strength, acquiring charity status in 2009. Project India is a group of UK healthcare professionals who volunteer for 10 days each year to provide a surgical camp in Walawalkar Hospital in Dervan. Over the past 10 years, the UK team has provided expertise across a range of specialties including anaesthesia, surgery, orthopaedics, urology, ophthalmology, maxillofacial surgery, radiology, intensive care, pain and midwifery. In addition, a team of biomedical engineers accompany the group. Their presence is invaluable as they support local staff in the maintenance and servicing of anaesthetic and surgical equipment, promoting patient safety.

Until the 1970s, having the lowest per capita income, Dervan had many of the stereotypical features of a neglected Indian village: a lack of basic necessities such as food, clean drinking water and educational opportunities. The population mainly consists of landless labourers and their families who have chosen to stay in the village. Many younger male family members have migrated to cities for employment.

BKL Walawalkar Hospital is a 300-bed multi-specialty hospital, owned by Shree Vitthalrao Joshi Charities Trust and aims to provide the best modern medical facilities and high quality medical care to the poor local population in Konkan region, at highly subsidised rates.

They performed and supervised a total of 114 operations, which included 63 cataract excisions and 24 general surgery cases, with the remainder being gynaecology and urology operations. There were interesting anaesthetic challenges – equipment, environment and patient comorbidities. The surgical and nursing staff experienced challenges too, but were motivated by the enthusiasm of the local staff and outcomes from the surgery performed. Overall, the team felt hugely satisfied with the work and received great appreciation for the quality and standard of their work.

Dervan lies almost at the midpoint between Mumbai and Goa, in the state of Maharashtra. BKL Walawalkar Hospital strives to provide modern medical facilities and high quality medical care to the poor local population in Konkan region, at highly subsidised rates.

During the ten years that the UK team has been visiting, the hospital has developed and expanded its range of services.

They have a good rapport and trusting relationship with the local villages. Word of mouth has been key in promoting the annual visits and this is enhanced by local publicity campaigns. This allows potential patients to visit the hospital in advance of the surgical camp and discuss treatment options.

The patients mainly speak the local language Marathi, so local medical and nursing staff provide translation services in order to obtain patient history, allow examinations and to explain treatment plans. Patients are also pre-assessed by the individual junior surgical team the day before surgery. All specialised blood tests and scan reports are available at the time of the examination.

The concept of healthcare in a rural setting is very different from that in the UK. Patients are often suspicious of hospitals and initially try local remedies to treat a surgical condition and will only visit a hospital as a last resort. Patients generally do not have money for travelling long distances so invariably present in the late stages of illness.

Consent

The concept of going to the hospital is different from that in the UK. Most patients do not know much about their illness, their treatment options or any risks involved with either the surgery or the anaesthetic. Patients tend to be deferential and assume that what the doctor says is correct. Often local doctors do not spend a lot of time discussing the medicolegal risks associated with the surgical processes but written consent is the norm. Over the years, a lot of training has
been done with the local teams and continued improvements in communication and consent has been seen. The UK team introduced the WHO surgical safety checklist for all theatre cases to improve patient safety and this is now used routinely.

Anaesthetics

The hospital pharmacy stocks the most commonly used anaesthetic drugs - propofol, fentanyl, atracurium - in addition to emergency drugs. During the 2015 visit, it was noted that the emergency resuscitation trolley was disorganised and lacking essential equipment for management of cardiorespiratory emergencies. Although a biphasic defibrillator was available, there was little airway equipment present and no emergency drugs. The trolley was reorganised into an ABC arrangement, similar to that of an NHS hospital, and theatre staff given training on the new layout and content. A biphasic defibrillator was available in theatres to deal with emergency situations.

The practice of regional anaesthesia is developing within the hospital and this was built on during the 2015 visit. Neuraxial blocks are commonly used for orthopaedic procedures. Nerve stimulators are available for performing nerve blocks and it has become common practice for lower limb blocks to be performed for all major joint replacements to supplement general anaesthesia. Ultrasound is available at limited intervals. Wound infiltration and local anaesthetic techniques are often utilised for surgical procedures such as laparoscopic cholecystectomy, hernia and appendectomy surgery. Over the last few years, a Pain Sister from the UK team has worked with local nursing staff to promote education on the management of postoperative pain. This has greatly benefited patients by facilitating early physiotherapy and rehabilitation.

January 2016 and the future

Over the last 10 years, 2,029 operations have been carried out during visits to the hospital. The UK team departed from Newcastle on 29 January 2016 to begin another surgical camp in BKL Wafeeskar Hospital. Consultant and trainee anaesthetists within the Northern School of Anaesthesia collected textbooks for donation to the local students.

Another new initiative is the Medical Projects. This is aimed at aspiring UK students who wish to pursue a career in medicine or nursing. It allows them to witness healthcare in a developing country and see cases that are not often encountered in the UK. More details can be found at http://www.medicalprojects.co.uk/

Sanjay Deshpande
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PFA UK Team 2015

Government Medical School, Dervan, established August 2015
The global maternal mortality ratio has fallen from 330 per 100,000 live births in 2000 to 210 per 100,000 live births in 2013. In southern Asia, the maternal mortality ratio declined by 64% between 1990 and 2013, and in sub-Saharan Africa it fell by 49% [1]. However, there are still a quarter of a million maternal deaths every year and 99% of these occur in low- and middle-income countries [2].

In September 2015, the United Nations announced a follow on project to the Millennium Development Goals, the ‘2030 Agenda for Sustainable Development’ [3]. This new universal agenda seeks to build on and complete what the MDGs did not achieve. This project contains 17 ‘sustainable development goals’ and 169 targets and aims to improve maternal health and reduce maternal mortality by 75% between 1990 and 2015. While not completely successful in meeting this goal, there have been dramatic improvements in maternal health, with a significant reduction in maternal mortality since 2000. Despite the relative success of the MDG 5, the challenges of obstetric care in the under-resourced world are enormous. The focus usually falls on the major direct causes of maternal mortality, particularly haemorrhage and pre-eclampsia. The provision of appropriate anaesthesia services in these situations is of international concern.

But what of anaesthesia-related mortality itself? Although widely and comprehensively studied in the resourced world, till now there have only been limited reports, attributable to anaesthesia in low- and middle-income countries. Earlier this year the first systematic review and meta-analysis of anaesthesia-related mortality in low- and middle-income countries was published [4]. The authors found that anaesthesia accounts for 2.5% of all maternal deaths in these settings and 13.8% of deaths after caesarean section. The highest rates were seen in sub-Saharan Africa but there were significant regional differences (Figure 1) and unsurprisingly the risk of death from anaesthesia was higher in rural than urban settings. Compared with neuraxial anaesthesia, administration of general anaesthesia tripled the odds of maternal death with mortality rates of 5.9 per 1,000 for general anaesthesia, administration of general anaesthesia and 1.2 per 1,000 for neuraxial anaesthesia. The authors highlighted that there were fewer studies included in their analysis from low-income countries outside sub-Saharan Africa. Therefore the actual rates of anaesthesia-attributed deaths are probably even higher than their estimates because of scarce data from other low- and middle-income countries with high maternal mortality and poor healthcare resources.

Although numerical analysis is strikingly different from the resourced world, what of the underlying causes of anaesthesia-related maternal mortality? The authors were able to identify the underlying causes in 24 of the included studies. The themes are the same wherever you work, with maternal deaths occurring due to airway complications (difficult or failed tracheal intubation, oesophageal intubation, bronchospasm, ventilation difficulties, and hypoxia), pulmonary aspiration and high spinal anaesthesia, issues related to staff competency, pre-assessment, the lack of intra-operative monitoring and equipment failure were also highlighted.

The United Nations Millennium Development Goals (MDG) were launched in 2000 and MDG 5 specifically addressed the importance of tackling inequalities in maternal health. Its aim was to improve maternal health and reduce maternal mortality by 75% between 1990 and 2015. While not completely successful in meeting this goal, there have been dramatic improvements in maternal health, with a significant reduction in maternal mortality since 2000.
In recognising that anaesthesia contributes disproportionately to maternal mortality in low- and middle-income countries, it behoves us to seek ways to effectively reduce anaesthesia-related maternal mortality. The success of the UK Confidential Enquiries into Maternal Death over the last 65 years underlines the value of careful and systematic analysis leading to changes in care. This approach has proved to be effective in South Africa where it has also been adopted. Differences in the quality and reporting of outcomes between these two situations may provide useful lessons for other parts of the world.

Although the study by Sobhy et al [4] is the first to highlight, with scientific rigour, the significant contribution of anaesthesia to the maternal mortality figures in low- and middle-income countries, this is a truth that is well understood by any anaesthetist who has worked or taught in this environment. However, highlighting the problems relating to anaesthesia can help in a number of ways, particularly to inform granting bodies of the importance of safe anaesthesia. Investing in education through courses such as SAFE and providing equipment such as pulse oximeters through the Lifeline charity, with an educational package and basic checks prior to anaesthesia and surgery with the WHO checklist, can further assist. How much money and effort can be justified if it is not shown that there are measurable improvements? The commitment of the AAGBI and partner organisations, including the OAA, WFSA and DAS, to improving anaesthesia in low- and middle-income countries represents a commendable step in the right direction. However, this meta-analysis was carried out to see the relative effects of brachial plexus blockade achieved with these three approaches and the success rates with different numbers of injections under ultrasound guidance.

Methods

The authors meticulously searched MEDLINE, CENTRAL and Embase to January 2015, restricting results to human randomised controlled trials written in any language. All the trials included in the study compared methods of brachial plexus blockade under ultrasound guidance for distal arm surgery: one approach versus another; or one vs multiple injections. The primary outcome, extracted independently by two authors, was the rate of successful blockade (≥ 70 min after the administration of the needle, defined as supplemental local anaesthetic injection or general anaesthesia, or intravenous sedative drugs in excess of time related by the authors). Along with this the authors looked for specific secondary outcomes.

Statistical methods e.g. REVMan and comprehensive meta-analyses, were used to analyse the results, which made the methodology of the study very robust.

Results

A total of 22 randomised controlled trials were included in this systematic review. It was found that the mean (95% CI) rate of successful brachial plexus blockade was 92% with no differences between the approaches. One injection was equivalent to a single injection technique in all subgroups. The overall rate (95% CI) of procedural sensory neurological deficit was 1.7% with no postoperative motor deficit in any of the trials.

The LockIt Plus resulted in the least catheter migration during intrapartum epidural use.

Discussion

Although the study by Sobhy et al [4] is the first to highlight, with scientific rigour, the significant contribution of anaesthesia to the maternal mortality figures in low- and middle-income countries, this is a truth that is well understood by any anaesthetist who has worked or taught in this environment. However, highlighting the problems relating to anaesthesia can help in a number of ways, particularly to inform granting bodies of the importance of safe anaesthesia. Investing in education through courses such as SAFE and providing equipment such as pulse oximeters through the Lifeline charity, with an educational package and basic checks prior to anaesthesia and surgery with the WHO checklist, can further assist. How much money and effort can be justified if it is not shown that there are measurable improvements? The commitment of the AAGBI and partner organisations, including the OAA, WFSA and DAS, to improving anaesthesia in low- and middle-income countries represents a commendable step in the right direction.

A systematic review of ultrasound-guided methods for brachial plexus blockade

A brief brachial plexus blockade using anatomodirectional infraclavicular and suprACLavicular are used for surgeries of the distal arm. Ultrasound-guided plexus blockade are more successful compared to injections guided by surface anatomy [1] or electrical stimulation [2].

This meta-analysis was carried out to see the relative effects of brachial plexus blockade achieved with these three approaches and the success rates with different numbers of injections under ultrasound guidance.

Methods

The authors meticulously searched MEDLINE, CENTRAL and Embase to January 2015, restricting results to human randomised controlled trials written in any language. All the trials included in the study compared methods of brachial plexus blockade under ultrasound guidance for distal arm surgery: one approach versus another; or one vs multiple injections.

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The LockIt Plus resulted in the least catheter migration during distal arm surgery: one approach vs another. or one vs multiple injections.

Discussion

Intraoperative epidural management is a common and potentially preventable problem with significant impact on both patients and anaesthetists. It is caused by several factors, including loss of the adhesive dressing (by bed sheet or dressage or unwrapping) by patient movement.

Outward migration of a 2.5 cm wound resulted in least one epitaxial migration into the epidural space, potentially resulting in suboptimal analgesia (intraoperative or postoperative) and postoperative sensory neurological deficit such as migration into a blood vessel [3] or the subarachnoid space [4].

The LockIt Plus resulted in the least catheter migration, both outward and inward, by ≥ 2 cm migration per catheter. This is less to ded leaking or dislodgement when compared to the Tegaderm and Epi-Fix dressings which rely solely on skin adhesion.

Conclusions

Limitations of this study included the sealed envelopes (rather than central randomisation) and the lack of blinding. However, to avoid double blinding, effectiveness of the study was already validated. Thus, these limitations were deemed acceptable. Although the LockIt Plus was shown to reduce catheter migration, the authors concluded that a large study is required to compare dressing types to epidural failure, rather than just catheter migration.

References


Critical care in East Africa

I had always been keen to pursue overseas work, but had already taken time out of programme and knew it would be difficult to commit to any lengthy period of time, something which many organisations required. I began contacting organisations enquiring as to how I could become involved and this led to my first experience of anaesthesia in East Africa, a clinical placement in Hoima, Uganda. While making enquiries and arrangements I learnt that there were a number of activities at my university and this led to my ongoing involvement in developing critical care services and a multiway partnership with Bahir dar, Ethiopia.

Obstetric anaesthesia in Hoima, Uganda

Hoima Regional Referral Hospital is a busy hospital in the north west of Uganda. I undertook a short placement, focusing on obstetric anaesthesia and organised through the Ugandan Maternal and Newborn Hub, which encompasses a number of UK-Ugandan partnerships. The placement required some preparation prior to going, including obtaining registration with the Ugandan Medical Council and attending the Anaesthesia in Developing Countries course in Oxford to familiarise myself with some rather unfamiliar equipment that I remembered reading about for the FRCA!

There were three nurse anaesthetists in Hoima and two operating rooms with three tables. As far as possible all surgery was performed under spinal anaesthesia. Due to lack of vasoressors, these were often low dose. I discovered the University of Aberdeen had registered charities undertaking projects in a number of countries. The University was also developing global health within the undergraduate medical curriculum which I was able to become involved with, and subsequently became coordinator on the global health course and a medical elective and exchange scheme which was being developed. Facilitated by The Soapbox Collaborative, my first visit to Bahir dar involved developing the student elective scheme with Bahir dar University and a critical care needs assessment at Felege Hiwot Referral Hospital (FHRH). Over the past two years the partnership has developed and now involves both universities and associated hospitals with bi-directional staff and student exchanges, and I have taken the roles of lead for education and training and critical care. I have now visited FHRH four times and co-ordinate numerous activities remotely.

Critical care in Bahir dar, Ethiopia

I became involved with working in Ethiopia during an out of programme teaching fellowship. While researching options for overseas projects I discovered the University of Aberdeen had registered charities undertaking projects in a number of countries. The placement required some preparation prior to going, including obtaining registration with the Ugandan Medical Council and attending the Anaesthesia in Developing Countries course in Oxford to familiarise myself with some rather unfamiliar equipment that I remembered reading about for the FRCA!

Anaesthesia practitioners are usually from a nursing background and have undertaken a 1 year BSc in Anaesthesia, with a small number also completing a BSc. Many procedures are performed under spinal anaesthesia and there are modern anaesthetic machines for general anaesthesia with halothane as the primary inhalational agent. Despite the modern machines, monitoring and airway equipment is in limited supply. Oxygen is all by cylinder supply and power outlooks are common. Endotracheal tubes are re-used and oropharyngeal airways, laryngeal masks and other adjuncts are limited. The surgeon will usually act as anaesthetic assistant and all surgical residents rotate through anaesthesia during their training. The ICU is physician-led and has capacity for functional carbon dioxide monitoring.

Throughout the past two years I have led a number of projects and training at FHRH. In obstetrics we have introduced postoperative care guidelines, and a number of challenging cases. In obstetrics we have introduced postoperative care guidelines, and a number of challenges typical to a low resource setting serving a high population from a broad geographical area.

There are four operating theatres with nine tables providing general, orthopaedic, urological, gynaecological, ENT and ophthalmic surgery coupled with a large volume of trauma. Over 5,000 operations are conducted each year and there are currently 17 anaesthesia practitioners. There is a 6 bed ICU (currently expanding to 10-12 beds) and a separate maternal and child health facility on site with its own operating room.
early warning score system which has been in full use for over a
year, have worked with the WHO Safe Childbirth Collaboration
to pilot the WHO Safe Childbirth Checklist and implement locally
and have provided training in obstetric emergencies and neonatal
resuscitation. We are now rolling out early warning scores to the
general recovery and ward areas.

In the emergency room we have introduced a sepsis management
bundle and provided life support training alongside the development
of resuscitation stations containing first line equipment. In the ICU
we have provided ventilation training and introduced ventilation
monitoring charts. We have also conducted hand hygiene and
pain management training across the hospital. Later this year we
plan to focus further on postoperative care and airway and trauma
management.

The elective scheme allows medical students to partake in projects,
particularly auditing for needs assessment, and re-auditing following
interventions. They are often able to participate in training sessions
too. Repeated visits and continued contact via the partnership allows
for follow-up and contributed to the sustainability of interventions.
Recently we have assisted with developing a quality department at
FHNH for risk management, incident reporting and audit and research.

Practicalities of working overseas

Initially it felt like it was difficult to find opportunities to get involved
in overseas projects, but I later realised there were activities locally
that I just hadn’t heard of. Since becoming involved with global
anaesthesia and critical care, I have made contact with many other
anaesthetists involved with projects and partnerships overseas. My
two experiences have been very different and have enabled me to
explore the type of overseas work to which I am most suited.

I’ve learned that it is entirely possible to become involved in overseas
work without having to commit to a lengthy time period, and
returning to one place can be extremely rewarding; knowing
the set-up and the staff can allow even short placements to be very
productive. I have been fortunate to see FHNH develop over time,
and recently the hospital won an award for top performing hospital
in Ethiopia. Being a part of that has been wonderful. I have also
been fortunate to obtain study leave to enable me to undertake this,
although I also utilise my annual leave regularly. I’ve become an
avid travel grant seeker to enable this work, applying to multiple
societies for assistance, and obtaining project funding from the
Tropical Health Education Trust to facilitate a year-long project in a
particular area.

I’ve learnt so much from the overseas work and am exceptionally
grateful to all those who have supported me and very proud of all
those I’ve worked with.

Acknowledgements

With thanks to SEA UK, the AAGBI IRC, the Scottish Society of
Anaesthetists, the BMA and the Tropical Health Education Trust.

Jolene Moore
STR7 Anaesthesia, NHS Grampian

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Dear Editor

The Angled-Handle trap!

While performing an emergency endotracheal intubation in the intensive care unit, I was anticipating some difficulty and in such cases I prefer to use a McCoy blade laryngoscope. I asked the ITU nurse to prepare a McCoy Blade 3 and was told we use the single-use McCoy blades on a reusable handle, which he showed me from where he stood at the end of the bed. I could see from my position at the top end, that the bulb of the laryngoscope was well illuminated when the blade was mounted on the handle and the tip of the McCoy blade was functioning (Fig 1).

After placing the blade into the patient’s mouth, and while lifting up when the tip reached the epiglottis, the angle between the blade and handle snapped open to an obtuse angle and the lever of the McCoy tip lost its function as there was no space for the lever to move (Fig 2). It was then that I realised I was holding a Polio-style laryngoscope!

I could still intubate the trachea and it wasn’t as difficult as I expected. However, using a McCoy blade would have spared a lot of BURP to improve the view.

After stabilising the patient I tried to work out why I ended up with a Polio-style laryngoscope when I asked for a McCoy. These were my conclusions:

- The McCoy blade was mounted on a Heine F.O. Angled-Handle laryngoscope, a piece of equipment which I was unaware of, not to mention its existence on our intubation trolley
- The ICU nurses who were helping admitted that despite adequate training for preparation and assistance in such situations, they seldom had a doctor asking for a McCoy laryngoscope.
- And, as expected, they were also unaware of the Angled-Handle one
- As both the blade and the handle were fiberoptic, the bulb could be illuminated with minimal contact between both in a 90°position. Ironically, the manufacturer’s recommendations for Heine F.O. Angled-Handle laryngoscopes state clearly that it can be used with any F.O. blades except the Flexi Tip (McCoy) [1].
- This is an example of equipment misuse that could turn a potentially difficult situation into a definitely difficult one. We had all the necessary equipment for difficult intubation/ventilation available, but using the wrong tool to start with could waste an attempt when every attempt counts. So some things to consider:
  - An anesthetist should always keep him/herself familiar with different pieces of equipment in all clinical areas they are likely to work in. Re-oriente yourself after returning to a clinical area, especially after a long time off or rotation!
  - It is naive to assume that nursing staff, no matter how experienced, are well trained in setting up all airway equipment; especially rarely used items. Issues with equipment, including lack of training, were identified by NAP4 as other reasons for failed airway management in ICU. Clear communication is vital as well as adopting a critical care intubation checklist [2]

No matter how emergent it is, double-checking never takes time. A plan is worthless if it does not have a structure.

Mona Sallam
Specialty Doctor Anaesthetics, Queen’s Hospital Burton

References

Dear Editor

SAFE paediatric course in Masaka

At the end of January I had the privilege of being part of the faculty for a SAFE paediatric anaesthesia course in Masaka, Uganda. I know that a number of articles and letters have been written about these courses so why bother writing another one? Well, for a number of reasons:

1. This is an excellent course with well thought out, appropriate content with a helpful faculties’ manual enabling most qualified anaesthetists to deliver the course.
2. The course is dynamic. At the end of every day each session is discussed with all the facilitators to check if any improvements or changes are needed to improve delivery.
3. On this occasion the course was being run for physician anaesthetists, some with paediatric fellowships, from Kenya, Zambia, Malawi, Ethiopia and Uganda. Not only were these doctors participating in the course, they were also discussing what was appropriate to teach to their own clinical officers and anaesthetic nurses in their own environment.
4. The SAFE paediatric course was followed by a one day training of the trainers’ course and then became the faculty for 60 Ugandan anaesthetic officers the following week.
5. The course was exciting because not only was it being expanded across Africa but it was being organised and run by an African faculty assisted only by three anaesthetists from the UK and one from the USA.
6. The course ran to perfection. The sessions and lectures ran to schedule, there was time for questions and all the equipment was laid out and easy to access when preparing for a skills session.

Having lived in Uganda for a long time, I have attended and participated in a number of conferences, workshops and courses across Africa and often time can have quite a flexible fee to it, it is made to stretch to fit the speaker or the discussion. This course was remarkable, all facilitators were punctual, the sessions ran strictly to time and all equipment was available and functional. We never had to make do. The whole process was enjoyable and well executed.

I wanted to write this letter to reassure people who donate regularly to the International Relations Committee and wonder what happens to their money. This is money well spent for a useful, well written (by Dr Isabeau Walker and Dr Michelle White) course that has impact on anaesthetic officers’ performance but has now been handed over and run impeccably by a well- chosen Ugandan faculty. I would like to congratulate and express my gratitude to all those who made this happen and I appreciate the effect it has had on the anaesthetic officers I work with on a daily basis.

Yin Yong Choo
CT2, Basildon University Hospital

P Tamhane
Consultant Anaesthetist, Basildon University Hospital

References

Dear Editor

Patient positioning to perform popliteal fossa nerve block

Having an assistant to hold the leg, the Oxford position, and placing the leg on a chair are some of the techniques described in the literature to enable sciatic nerve block at the popliteal fossa in a supine patient [1,2]. If the block is performed with patient supine, sufficient space must be provided to accommodate the transducer beneath the knee and thigh. This can also be accomplished by resting the foot on an elevated footrest or by flexing the knee while an assistant stabilises the foot and ankle on the bed. Here we describe our practice of using Carter Braine limb support for positioning the leg in a supine patient. While the patient is supine, the leg is placed on the Carter Braine support with 60–900 flexion at the hip and knee to ensure there is no undue stretch on the nerves, muscles or tendons, and that the patient’s leg is comfortably positioned. This technique also allows room for the probe to be tilted caudally to bring the angle of incidence to 900 to the nerve. With this positioning technique, both in-plane in-axis and in-plane out-of-axis block can be performed with ease (Figure 1).

Figure 1. Leg positioned in Carter Braine support

We have been using this technique for the last few years with great success and it has proved popular with anaesthetic nurses.

Sudheer Jillella and Ramesh Sadasivan
University Hospital Coventry and Warwickshire NHS Trust

References
The three-day course focuses on small group teaching and maximises interaction between faculty and participants with training material that includes a manual, videos, protocols, a textbook and a drug dose and protocol pocket book of basic skills. The course aims to improve the practice of anaesthesia for pregnant women to a safe standard. It is clinically relevant and addresses the core and extended roles of the anaesthetist. The first three modules cover safe airway practice and spinal anaesthesia. The obstetric content is based on the clinical conditions causing 80% of maternal deaths, namely haemorrhage, sepsis, eclampsia, obstructed labour, the complications of abortion and early newborn care (including resuscitation). As a three-day course there is a lot to cover but it is designed in this way to avoid lengthy periods away from the workplace for the attendees. It allows two back to back courses to be run by travelling faculty and a ‘Training of the Trainers’ course can be conveniently delivered between the two courses.

It is a remarkable fact that every person delivering anaesthesia to pregnant women in Uganda has now completed the SAFE Obstetric course. Based on the success in Uganda, additional courses have been run in 16 countries including Bangladesh, Colombia, Ghana, Sierra Leone and Kenya. Since its inception, a total of 31 courses have taken place across Asia, Africa and South America, training a total of 899 people, both physician and non-physician anaesthesia providers (and 146 trained in TiT). Despite the course having been run in a wide range of settings, and delivered to anaesthetists with consultant status and non-physician anaesthetists in rural African settings, feedback has been uniformly positive: that the course is highly educational and relevant.

Following on from the success of SAFE Obstetrics, the AAGBI and the World Federation of Societies of Anaesthesiologists (WFSA) developed the SAFE Paediatric Anaesthesia course in 2014 to meet the challenge of providing safe anaesthesia care for children in developing world settings. The need is considerable in low-income countries where more than 50% of the population is under 14 years of age, and it has been estimated that 85% of children will require some sort of surgery before their 15th birthday. In many low-income countries there are few specialist surgeons and anaesthetists, and paediatric surgery and anaesthesia is of necessity the work of the general surgeon and non-physician anaesthetist.

The SAFE Paediatric Anaesthesia course is also run over three days and aims to provide refresher training for both physician and non-physician anaesthetists in the essentials of paediatric anaesthesia which emphasises the principles of safe care for children; in particular, assessment, vigilance and competence in essential skills. The course has been written by paediatric anaesthetists with relevant experience, and includes sessions on anaesthesia for common elective and emergency conditions in children, pain management, fluid resuscitation, newborn and paediatric life support and paediatric trauma management. The course consists of six short lectures and a series of modular breakout sessions including skill sessions, scenarios, demonstrations, discussions, workshops, DVDs, and interactive lectures. Course materials include the AAGBI/WFSA ‘SAFE Paediatric and Obstetric Pocket Handbook’ of drug doses and protocols, written by UK volunteers working in Uganda. Like the Obstetrics course, SAFE Paediatric Anaesthesia is supported by a ‘Training of the Trainers’ course to achieve independence and sustainability for the programme. Based on the success of the SAFE Paediatric courses in Uganda, nine courses, training 330 physician and non-physician anaesthesia providers in Uganda, Kenya, Ethiopia, Zambia, Madagascar and Malawi, have been delivered.

The success of the courses is always evaluated through pre-and post-course testing, but the most telling feedback is through the open comments:

‘Do this course every year.’

‘We would like the ‘Chief of Service’ to realise that we do not have enough of these types of courses.’

‘Very interesting – above all the practical side complimenting the theory.’

‘Please organise another conference for our colleagues who could not attend this one.’

‘We wish that God would help you to do more training to improve standards in anaesthesia.’

‘I really appreciate your kindly response for this conference. Very interesting and knowledgeable.’

‘Please continue with this kind of hearty support so that we can apply skills and knowledge to save more life in any situation we are in.’

Funding for the courses has been through the AAGBI Foundation grants administered through the International Relations Committee, the WFSA and THET who have funded a network of courses across East Africa. The true cost of the courses has also been heavily subsidised by UK volunteers who have given up their time and contributed significantly to their own travel expenses. Wherever SAFE has been delivered there have been requests for more and the AAGBI and the WFSA are committed to continuing their support. However, additional funding will be required in the future due to the demand these popular courses have generated.

Rachel Collis
Chair, AAGBI International Relations Committee

Isabeau Walker
Chair, AAGBI SAFE Steering Committee

*with thanks to Nick Boyd, Simulation Fellow, GOSH, for the photo
15th Anaesthesia, Pain and Critical Care Update
Friday 30th September & Saturday 1st October 2016
Royal Armouries, Armouries Drive, Leeds LS10 1LT

REGISTRATION
08:00 - 08:45: Registration, Coffee, Trade Stands
08:45 - 09:00: Welcome address - Dr Vinu Guruswamy, Leeds, Organising Secretary

SESSION 1       (Chairs – Prof Ravi Mahajan & Dr Mahesh Shah)
09:00 - 09:25:
Management of Critically unwell parturients
Dr Audrey Quinn, Middlesborough 2B06, 3B00

09:25 - 09:50:
Day to day challenges in Paediatric Anaesthesia
Dr Stephanie Bew, Leeds 2D02, 3D00

09:50 - 10:15:
Trauma Anaesthesia - lessons learnt & is there a fixed recipe
Dr Martin Drummer, Leeds 2A02, 3A10

10:15 - 10:30: Discussion
10:30 - 11:00: Coffee break, Trade Stands, Posters

SESSION 2       (Chairs – Prof Rajinder Mirakhur & Dr Ravi Marthi)
11:00 - 11:25:
Paediatric Anaesthesia in India - remembering ‘Taare Zameen Par’
Prof (Retd) Rebecca Jacob, India 3J00

11:25 - 11:50:
Patient safety first
Dr Liam Brennan, President RCoA 3I00

11:50 - 12:15:
Is Medical profession under threat in UK
Dr Anthea Mowat, Deputy Chair BMA, London 3J00

12:15 - 12:30: Discussion
12:30 - 13:30: Lunch , Posters, Trade Stands

SESSION 3A    (Chairs – Dr Roop Kishen & Dr Shivkumar Singh)
13:30 - 14:45: Free paper presentation

SESSION 3B     (Chairs – Dr Ranjit Verma & Dr Nalini Malarkkan)
13:30 - 13:55:
Acute Brain Injury - Optimum management from DGH to Tertiary Center
Dr Tonny Veenith, QEH, Birmingham 2F01, 3F00

13:55 - 14:20:
Acute pain in Chronic pain patients
Dr Harini Ganeshan, London 3E00

14:20 - 14:45:
Why people fail in Revalidation
Ms Tista Chakravarthy- Gannon, Lead Regional Advisor, GMC, London 3J00

14:45 - 15:00: Discussion
15:00 - 15:30: Coffee, Trade Stands and Posters

SESSION 4       (Chairs – Dr Abhiram Mallick & Dr Jayavanth Kini)
15:30 - 15:55:
Peri-operative Medicine
Dr Ramani Moonesinghe, London 2A06, 2A07

15:55 - 16:20:
Oxygen Insufflation in Difficult Airway
Dr Ali Ford, President, DAS 2F01, 3F00

16:20 - 16:30: Discussion

SESSION 5       (Chairs – Prof Monsukh Popat & Dr Pawan Gupta)
16:30 - 17:15:
Debate – This house believes consultants being resident on call is the way forward for the NHS
Supporting the notion - Dr Simon Tomlinson, Manchester, Against the notion - Dr Hamish McLure, Leeds

(RCoA Approved 6 CPD points)

Workshops on 1st October 2016

WS 1 - Airway workshop (AW)
Dr Samal Sinasvadas / Dr Heather Garton

Regional Anaesthesia (RA)
Dr Sameer Bhandari / Dr Vinay Shankar

WS 2 UL (UPPER LIMB / TRUNK)

WS 3 LL (LOWER LIMB / CNB)

WS 4 - Simulation workshop (SW)
Leeds - Theatre emergencies, training the trainers and debrief

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Each delegate can attend 2 of 4 workshops
(RCoA Approved 6 CPD points)

Further details and registration, visit www.baoia.co.uk

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Anna Rakhmeev, Newcastle, UK
George Collier, London, UK
Bri Dew, London, UK
Mark Hamilton, London, UK
Hussein Salilla, Chair, SIAA
Ewen Lowet, Southampton, UK
Mike Mangion, UK
Dar Martin, London, UK
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Ramu Maran, London, UK
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