Gas, gasmen, and grievances galore

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These last few months have been a bit of a break for me. I did an Out Of Program Experience in Intensive Care Medicine. A little unusual you may think, and I would agree with you. But in this day of the generic registrar (by that I mean that as Calman registrars we have all had the same basic training and have all done both DGH and teaching hospital posts) there has to be something extra on your CV at the end of the day to get you noticed when it come to that all important consultant interview. It may be your astounding ability to do the cha-cha, or your prowess on scaling the heights of K2 in record time or even your claim to have built the largest matchstick model of the Taj Mahal in Europe that catches the eye of a prospective employer, but whatever it is, it has to make you more attractive than your fellow interviewees. My trip into Intensive Care medicine included a six month break as the lowest of the low – a very junior SHO in anaesthetics. It wasn't a bad experience at all, and I am glad that I am now confident enough to be able to handle a bag and mask without the patient desaturating too quickly and be able to put a tube down should I have to (any anaesthetists reading this will no doubt be worrying about those Mallampati 3 and 4's that come my way, rest assured, one of the other good things I learnt from the anaesthetists is they know when to call for help early and that they work as a team without rancour in the most part). Having said that, though, one of the most demoralising episodes during that time about half way through the job was to be

asked what I'd learnt so far and when I replied that I was more confident with an airway etc… I was categorically told that I must NEVER think that I am able to handle an airway and that IN NO WAY was I competent enough to transfer a sick patient. This from an academic consultant, someone who, in theory was supposed to be a 'teacher'. I walked away thinking – that's not how I'd like to be remembered by a junior. I learnt a lot of practical things but that was a lesson in how *not* to talk to someone. It was also one of those times where my practical skills improved greatly in some areas (I can intubate) but in some areas I seemed to de skill rapidly (my CVP line inserting skills left me for a while) and I was made to feel a bit inferior as the 'medical registrar who cannulates carotid arteries'. It soon made me realise that I can't take for granted skills that I've acquired over the years and they need to be kept up to date. This has showed itself up in the job I have come back to as not having to run a cardiac arrest (the SHO's do all the work) but if I happen to stumble on one then they all defer to the medical registrar as the 'team leader' even though I may not have run one for several months. I recall an article asking consultants what they were prepared to do should the newly introduce Calman regime mean that they have to be resident on call and asking how many had put in a CVP line, or a temporary transvenous pacing wire in. The results showed that of those that replied to the questionnaire, 77% indicated that they would not resume emergency residential duties, and 71% indicated that they would probably withdraw from general medical duties under these circumstances. 70% and 77% had not inserted a central venous line or temporary pacemaker, respectively, within the previous five years [1]. When I was the 'artery cannuliser' that's the article that came to mind.

There were, however a vast number of good things I took away from my time as a gasman, one of the best was their commitment to a better understanding of fundamental, basic physiology and pharmacology. It is a shame that we as physicians do not get taught more formally (or, more to the point, do not get formally examined) on aspects of our work that is fundamental – being a physician is, after all, largely about pharmacological manipulation. I had to read a few textbooks and attended a primary FRCA course and was forced to renew a lot of my basic pharmacology and physiology. It is not as easy as it sounds and having not been taught these subjects formally since medical school (I seem to remember part 1 MRCP questions and courses being mainly about obscure things usually not relevant to everyday life) it made a change to the way I looked at things. I began to think of how we could change our own practice to be a little more reflective – why do we do the things we do? What is the rational for the decisions that we take? How can I bring that questioning into my everyday practice. It may be straightforward but when teaching students or juniors it makes that extra bit of difference to have that knowledge on board. Maybe the MRCP or even the MSc / MD / PhD should have some sort of module that reflects basic pharmacology and physiology. Many of us enjoy teaching and like me, feel that it would be folly to keep what we have learnt over the years to ourselves – and enjoy the challenge of trying to enthuse a bunch of (usually jaded and apathetic) students to the joys (!) of medicine. In acknowledgement of this I know of at least one deanery that is about to embark on a formal course leading to a ‘certificate in teaching medical students’. I hope that it is a success.

Another thing that I was surprised and a little shocked to hear was that to progress from year 3 to year 4 the anaesthetic trainees had to have something in print. Without some form of publication – a case report, an audit, a paper, etc., they could not easily pass their third year RITA. This, of course was a cause of great upset to most of the anaesthetic trainees that I encountered, most of whom wanted nothing more than a quiet DGH job with the local BUPA nearby who never wanted to read another journal again if they could help it. Maybe we should count ourselves lucky, by virtue of keeping our noses clean and our heads down we can get through to the end without having done anything formally. I know that we are strongly encouraged to have something in print, but will they fail us if we don't?

I have had some correspondence! I thank all of you who replied to my email about what I should write about, and not just spout off about subjects close to me personally. If you do think of anything that you feel should be for general consumption then do let me know. Many of the replies were in the same vein – RITA placements being unpredictable and very late (although this may be being sorted out a little earlier this year), the problem of the seemingly impossible task of achieving everything that is set out by the 'big grey book' and at the same time doing the service commitment aspect, the training aspect, the teaching the self education and the management. It all gets a bit much and there seems to be a variable amount of support from the top – e.g. attending the MSc or the sub-speciality or GIM training days – no cover is provided. It may be that only a certain number have to be attended over the 5 years, but it may be difficult even then. GIM RITA's also seem to be a bit haphazard. I seem to remember having had only 1 or 2 in my 5 years as a registrar. With only a few weeks to go as I write this before I'm due my GIM chitty –

the JCHMT keep sending me pieces of paper telling me my time is up - I haven't heard from the deanery. I'm not sure that the actual process of accreditation or of RITA's and what we are to expect of them has ever been explained to us? Maybe this is something deanery's need to explore.

Staffing levels seem to be an issue that also raises steam! Covering others in the department, or the lack of provision for clinics etc. I'm not sure what can be done, and neither do I wish to provide answers, but it is a common theme and maybe the people who go about assessing the jobs should think seriously at a way of anonymously assessing the jobs and asking questions that the trainees want to be asked to be able to give a meaningful answer. If you have had similar situations in your departments and have found solutions to these areas, then please let me know so that they can be shared.

One of the subjects that has come up recently, and may do so more and more now that the first years of Calman are coming to an end is the subject of removal expenses. In total we are allocated about £8000 to last the 5 years to cover either mileage or removal expenses. In my own case I have done only one central placement and was placed for my final year in a hospital that is as far away from where I live as it is possible to go in my region. Mileage is worked out as the distance that you travel to work minus the distance to your base (i.e. main teaching hospital). Earlier on in the rotation I was working about 10 miles further away from my base hospital and so claimed the 20 or so miles per day I was travelling extra. I now travel some 150 miles a day extra and claim most of this in mileage. But as I am coming to the end of my allowance I have been told that I will no longer get any money to

compensate me as I am close to having used up my money by month 5 of my 1 year contract. I feel aggrieved. Not only did I not choose to work where I am at present, but it is very far away from my home (and believe it or not I have a family I wish to live with) and I am spending hundreds of pounds a month in petrol. I am facing the fact that I may not be able to afford to go to work. If I can't afford to go to work, who takes the responsibility? I feel that in the next couple of years more and more people may face this situation. If you have any experience please let me know. I'll keep you updated.

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[1] Mather HM. Elkeles RS. Attitudes of consultant physicians to the Calman proposals: a questionnaire survey. North West Thames Diabetes and Endocrinology Specialist Group. BMJ. 311(7012):1060-2, 1995