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Welcome to the new edition of the Committee of Anaesthesia Trainees (CAT) newsletter. CAT News will function as the main instrument of communication between the CAT and the Irish Anaesthetic community. This is the first of four newsletters planned for the coming year. Our aim will be to publish any news that is of interest to Irish Anaesthetic trainees.

In this edition, David Moore outlines recent developments in the proposed introduction of a new payscale for Anaesthetic trainees. Aoife Quinn provides us with an update on the changes to the College exams, and we have a sample question from both the MCAI OSCE and the FCAI examinations. Janette Brohan gives us a brief history of the European Working Time Directive, the current plans to perform a nationwide audit of departmental compliance, and its overall impact on the quality of Anaesthesia training in Ireland. Rachel Jooste outlines the main findings of the NAP5 report.

We encourage our readers to get in contact with us regarding the content of the current or future editions of the newsletter. All submissions are welcome to cat@coa.ie.

Timothy Switzer
A Message from the President

I am delighted to introduce this excellent CAT Newsletter and would like to congratulate Timothy Switzer and all the CAT committee on this initiative. The CAT Committee, as many of you know, has been working very effectively by representing your views in these quite challenging medico-political times.

CAT has worked very hard to increase communication and feedback from trainees since its inception and this has benefited us enormously in making informed and effective decisions when considering changes that impact our trainees & fellows.

In September 2014 we were very pleased to welcome Dr David Moore to the College Council as the new Chairperson of CAT. David has attended two Council meetings now and has been an active participant in conversations around a number of current educational and training issues that have been raised.

On behalf of Council, I would also like to thank Dr Mort Kelleher for his input during 2013/14. The role is time consuming and often demanding. However it provides a great insight into the aims and objectives of the College Committees and, in turn, aids the College in identifying areas for improvement and a better understanding of the challenges faced by our trainees.

It is crucial that this increasingly active collaboration with you, the trainees, is maintained and developed as it aids and supports the College in its endeavours to becoming a more forward thinking and interactive educational training body keeping our focus always on our trainee needs.

I commend the new members of the Committee for their excellent start to the new academic year and having seen the proposed plan for 2014-15 projects, I look forward to working with you all and observing the progress and evolution of the Committee over the coming year. Can I wish CAT news every success!!
A New CAT

The CAT team last year, under the guidance of Mort Kelleher, achieved a great deal. He built on the solid foundations put in place by Roseita Carroll and her original committee.

It is a great challenge, and an honour, to be the new CAT Chair. I have difficult acts to follow, but I am privileged to be working with such a strong group of SATs on the committee this year. Our first official meeting as a new committee took place on the 30th September. However, a significant volume of work has been accomplished over the summer months.

One of our first projects was the compilation of the “CAT Plan 2014-2015”. We have set targets for the committee for the coming year. I would like to share some of these with you.

Our main objective this year is to improve our representation of trainees on the College committees. Each member of CAT sits on a committee within the CAI, and offers a trainees perspective.

We want to improve our communication with those we represent. We have used emails and the Newsletter over the last 3 years.

We recently introduced the CAT Facebook page.

We plan to develop these communication methods, and we will introduce new projects to built links between SATs and CAT.

We are improving the structure and organisation of CAT. Newly elected members will now serve a 2 year term. We will also elect a Vice-Chair - to help me!

We will develop our links with Anaesthesia trainees in the UK (GAT) and Northern Ireland. CAT will also continue to engage with students and interns interested in a career in Anaesthesia. We also have some exciting projects planned.

We’ve established sub-committees to investigate the viability of a national SAT audit group, and the future of pre-hospital emergency medicine in Ireland. We also continue with our individual committee projects, and we will continue to update you via Facebook and CAT News during the year.

We look forward to representing you in the CAI this year, and CAT would love to hear from you during the year - post a comment on Facebook or email cat@coa.ie.

Dr David Moore
Chair CAT

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**CAT 2014-2015**

**Chair**
David Moore

**Secretary/NCPA**
Aislinn Sherwin

**Editor CAT News/Treasurer**
Timothy Switzer

**Education Committee**
Rachel Jooste

**Training Committee**
Janette Brohan

**Forum Trainee Committee**
Hugh O’Callaghan

**Pain Committee**
David Moore

**Examinations Committee**
Aoife Quinn

**JFICMI Representative**
Aisling McMahon

**GAT Representative**
Colm Keane

**NCP for Critical Care**
Bilal Ahmed
The European Working Time Directive (EWTD) was initially introduced to guarantee health and safety in manufacturing and service sectors. EWTD entered into Irish law in 1997, but activities of doctors were excluded until 2004, when a European directive amended the EWTD to limit working hours of doctors.

The implications of EWTD include a limit of a 48-hour working week and 11 consecutive hours rest every 24 hours. Last year the IMO campaign, “24 No More – Enough is Enough”, highlighted the dissatisfaction among NCHDs at the lack of progress towards implementation of EWTD, particularly in relation to shift length. Following this, there have been increased efforts by some hospitals to reduce NCHD working hours.

The degree of implementation of EWTD varies from hospital to hospital. As of 31st July, the IMO reports that 16 hospitals are 100% compliant with limiting shifts to 24 hours. In the same report, only 5 hospitals were 100% compliant with limiting working weeks to 48 hours.

These figures relate to hospitals as a whole and not specifically to SATs. It has not yet been established what the state of play is with working hours for SATs. In an effort to achieve EWTD compliance, shift work has been introduced for some SATs. As work patterns change, it is vital to ensure that training is not compromised. It is not known how this change in work practices will affect training in Anaesthesia.

Potential issues in relation to this include more emphasis on service provision with less pre-anesthetic reviews, less departmental teaching and more night-time shifts with less elective surgical case exposure.

To further establish the level of EWTD compliance, and the impact this will have on training in Anaesthesia, CAT will distribute a questionnaire to SATs.

In the current environment, this is an important survey and all SATs are encouraged to respond. The results of this will be included in the next CAT News.
Well-being of the SAT

Well-being in the medical professional is a hot topic at the moment. The RCPI study on hospital doctor well-being has brought a new focus on this important area. In addition, recent reports on retention and training programme structures (MacCraith and Imrie reports) have identified deficiencies in our health system that may adversely impact on our doctors well-being, and may be contributing to the exodus of young Irish doctors.

What is well-being?
The National Economic and Social Council (NESC) published a report in 2009 entitled “Well-being Matters: A Social Report for Ireland”. It defined the term well-being as your physical, social and mental state. According to NESC our well-being depends on six main domains (figure). A sense of well-being is entirely subjective, and each domain may play a greater or lesser role depending on your personal values.

“Well-being requires that basic needs are met, that you have a sense of purpose, and that you feel able to achieve important goals, to participate in society and to live the life you value and have reason to value.” NESC 2009

Work and Participation
There are episodes during an on-call shift that push you to your limits. While many specialties will encounter this level of stress, often the Anaesthetist will be the last port of call in a disastrous situation, and that carries a unique level of stress.

This burden can have a detrimental effect on your physical and mental well-being.

While this stress is expected and unavoidable, our work practices (working long hours, 24-hour on-call shifts, and onerous rotas) can exacerbate the problem.

The CAI have significantly improved the working lives of SATs by introducing the “streamlined” scheme in 2012. We have a well defined career path, and clear targets.

Rewarding work that is valued by society is crucial to an individuals well-being. The HSE have been guilty in the past of not valuing the contribution of well trained specialists. Hopefully, they will recognise that this is a mistake, and establish an employment strategy for post-CST Anaesthetists. We are currently losing these highly qualified specialists because other health systems are paying more attention to their general well-being.

Health
Crucial elements of our wellbeing like healthy eating, exercise, recreation, and good sleep patterns are frequently neglected by the busy SAT.
The implementation of the EWTD next year, coupled with a more organised approach to exercise and healthy eating practices, could improve the general health of SATs. Employers could also help us by providing healthy meal options for on-call staff, and exercise incentives (subsidised gym memberships).

Worryingly, international statistics would suggest that 10-15% of medical professionals develop substance misuse problems. Considering there are over 20 NCHDs in many of our departments, 2-3 of your colleagues may have a problem with substance misuse. Anaesthetists are more likely to abuse opioids than other substances like alcohol. Fentanyl is the drug of choice in many cases and it tends to be highly addictive. It is not clear whether this is a problem for SATs in Ireland as no data exists.

Dr. Ide Delargy, director of the Sick Doctor Scheme, currently manages 40 doctors with substance abuse problems. Most of them are GPs, and she fears that hospital doctors, like SATs, are not presenting early enough.

**Democracy and Values**
The attempted alteration in pay-scales for SATs, and the the 30% pay-cut for new entrant Consultants has induced feelings of distrust in the average SAT. The HSE have introduced financial inequity at many different levels in our speciality, and this has resulted in recruitment problems and low moral. Our Consultant colleagues are also stretched to their limits, and departmental communication and camaraderie may suffer. This can result in bullying, failure of peer-support networks, and isolation.

Also, individual and societal values shape your well-being. Mental illness is under-diagnosed and poorly managed in doctors. There is a stigma associated with mental illness.

This may lead to concealment and collusion, shame, and late presentation for treatment. A modern approach to mental health, and a tendency towards treatment and rehabilitation rather than prosecution, will encourage doctors to look for help early. This would be good for both doctors and patients.

**Community and Environment**
The nature of the SAT scheme requires frequent rotations through hospitals to acquire all relevant competencies. In the past, this required moving residence on a 6-monthly basis which is extremely disruptive, and prevents integration into your community.

With the establishment of the hospital groups, and an increasing awareness of the negative impact of frequent moves, the CAI endeavour to deliver training in a specific region for a prolonged period of time. The HSE are also promoting the idea of “family-friendly” training that will hopefully improve trainee well-being.

**Relationships and Care**
Healthy relationships are crucial to an individual’s well-being. We must nurture these relationships, and recognise their role as a vital support, especially during periods of adversity.
However, many of my colleagues will admit to neglecting their social lives in favour of career advancement.

Generally, our family and friends recognise the significant professional commitment required during the SAT scheme, but we must be conscious to commit a reasonable proportion of our time to family and friends.

The Medical Council and the HSE are encouraging training bodies to offer “less than full-time” training to their trainees. At the moment there are 3 SATs availing of this option. While most SATs wish to complete their training promptly, this option may be attractive for some.

**Economic Resources**

SATs, similar to most groups in Irish society, have experienced significant reductions in income. Unfortunately, even in the face of economic recovery, the SAT salary is under review. Hospital payroll departments are notoriously reluctant to pay unrostered overtime hours, and significant time is spent by the average SAT in chasing up unpaid hours.

However, the financial burden of registration fees, exam and course fees, rent, and general living expenses continue to increase. Financial assistance from training grants is very difficult to access, and unreliable.

This disparity produces significant economic pressures for SATs, and we have a very uncertain economic future.

However, the HSE are transferring control of the discretionary fund to the CAI, which will improve trainees access to training funds. Also, CAT will encourage the IMO to represent the interests of SATs at future discussions with the HSE if further pay-cuts are suggested.

Ignoring one of the 6 domains above may result in a decline of your physical or mental well-being. If this occurs, we must be aware that we have a responsibility under “The Medical Council’s 8 Domains of Good Practice” to self-management and to the quality of patient care we provide. In this regard, we should be aware of the supports in place, and access help and treatment early.

As a caring professional, we should also be conscious of our colleagues who may be struggling to cope with life as an SAT. It can be a tough job, and a simple question like, “how are you doing?”, “is everything ok?”, or “can I help you with anything?”, may be enough to show support to a colleague under pressure.

**Supports**

Every SAT should be encouraged to maintain a healthy family and social life, and not succumb to unreasonable work demands. You never know when you’ll need that support.

Sometimes you may require professional help. Seek advise and help early. This may avoid serious consequences for you or your patients.

All guidelines in this area stress the importance of registering with a competent GP. Self-diagnosis and self-prescription are notoriously unreliable and unhelpful. It may delay the institution of an appropriate management plan. The Health in Practice (HiP) Network has a list of GPs experienced in the management of other health professionals. For those with substance misuse issues, the Sick Doctor Scheme (SDS) provides support.

**Occupational health specialists** are particularly skilled in the management of doctors with mental health problems.
Self-help strategies and groups are popular amongst doctors who generally feel a need to maintain some control over their management. However, this should be facilitated in collaboration with another health professional with an objective perspective.

Such strategies may include bibliotherapy (reading to relax), stress reduction techniques (mindfulness, counselling, etc.), and self-help groups (Aware, AA, Pieta House, Samaritans, etc.).

If an SATs issues are deemed serious enough that they may impair their clinical judgement and harm patients, they should be referred or reported to the medical councils health committee.

This is generally the result of a series of missed opportunities to fix things, and early management and treatment cannot be emphasised enough.

The Future
The RCPI study will give an insight into the issues facing Irish hospital doctors, and the potential threats to their well-being. Hopefully, this will guide the development of government funded strategies to care for physicians with mental health issues, like the Practitioner Health Programme in the UK.

The HSE and the CAI should continue to identify areas of our training and working lives that could be improved.

Finally, as a health professional, your own well-being must be your number one priority.

Self Assessment
You may complete a self-assessment tool on the following survey monkey link. It is a useful reflection exercise, and may help you re-evaluate your current lifestyle.

http://www.surveymonkey.com/s/1843531/Occupational-Stress-Assessment
Exams Update

For all those preparing for exams, it's important to note that 2015 is going to bring some changes with regards to the exam regulations. There will be a maximum of six attempts at all college examinations; previous attempts under the old regulations will not be included.

In relation to the FCAI there will be an increase in the number of MCQs from 40 to 60, to be taken within the two hours. A pass in the written component will be valid for three years towards taking the clinical component.

To help people with their preparations we have got two sample questions, and suggested marking schemes, from the exams office. The first is a communications OSCE for primary candidates. The second question is an FCAI sample.

Good luck!

MCAI OSCE

The scenario lasts 5 minutes. To pass the candidate must score 12 or more marks.

Information for Roleplayer

Background
6-year-old Jake requires a general anaesthetic for dental extraction of 6 baby teeth. You were given a booklet in the dental clinic detailing the procedure and general anaesthesia. Jake had a drink of water at 6am this morning (a cup full). It said in the booklet that was okay.

Concerns
Can I stay with him?
Does he have to have a needle? He hates them.
Will he be very sore when he wakes up?
What will I give him for pain?
When can I take him home?

Candidate Instructions
Jake requires dental extraction of 6 deciduous teeth under general anaesthesia. You meet Jake and his mother in the day ward.

Please take informed consent for general anaesthesia.

Examiners Information
The examiner has a copy of the candidate and roleplayer’s information.

Below is the examiners marking scheme.

This is an OSCE communication station.
FCAI Written

Discuss the likely diagnosis and the initial management of an 12 month old infant who presents to the Emergency Medicine Department of a non-specialist hospital with a 24 hour history of fever and choryzal symptoms. The infant was irritable but now appears lethargic and is noted to be developing a petechial rash.

Discussion
The most likely diagnosis is meningococcal disease caused by the bacterium Neisseria meningitidis (meningococcus) [type B - following the success of type C vaccine. Include for 4].
Meningococcal disease most commonly presents as bacterial meningitis (15% of cases) or septicaemia (25% of cases), or as a combination of the two syndromes (60% of cases). Include for 4].

It is important that the candidate recognises the urgency of the situation and should proceed with rapid assessment, initial treatment and stabilisation before transfer to a tertiary centre.

Initial assessment should follow ABCDE principles paying particular attention to development of shock. It is important to note the extent and development of the non-blanching petechial rash that may become purpuric and confluent. Base line monitoring, SaO2, ECG, NIBP, should be established.

Airway & breathing assessment may reveal tachypnoea. Signs of developing shock include increasing lightheartedness and decreased responsiveness, tachycardia, delayed capillary refill (>3secs), cold peripheries (skin/core temperature difference) and hypotension. Baseline neurological status should be assessed and recorded.

Initial Management
The infant should be given 100% oxygen 15 l/min via a facemask. Intravenous access MUST be established, ideally two peripheral cannulae sited. If IV access cannot be established then an intraosseous needle should be inserted (usually inserted into the proximal tibia) and secured. At the time of IV insertion bloods should be taken for PCR for N. meningitidis (to confirm the diagnosis), venous blood gas, FBC, coagulation studies, U&E, blood glucose, CRP, blood cultures.

An initial fluid bolus of isotonic crystalloid solution @ 20mls/kg (estimated wt approx 10kg) either N saline or Hartman’s Solution should be given to the infant.

Administration of antibiotics, cefotaxime 50mg/kg or ceftriaxone 80 mg/kg, should not be delayed and should be given IV or IO after initial fluid resuscitation has commenced. [N.B. ceftriaxone cannot be administered with Ca2+ containing solutions because of concerns about chelation. Administration of antibiotics can result in release of bacterial endotoxins that may be cardiotoxic resulting in cardiac dysfunction and hypotension. Include these points for 4].
The infant should be reassessed and if not haemodynamically stable a further fluid bolus 20mls/kg should be given. This may be crystalloid as above or colloid, 4.5% human albumin 20mls/kg. A third fluid bolus may be required (N.B. risk of developing pulmonary oedema). A lumbar puncture should not be undertaken at this time. (Candidates recommending LP at this point should be marked down).

The infant should be frequently reassessed using ABC protocol. An infant who continues to be unstable, with altered level of consciousness or risk of developing pulmonary oedema will require intubation. Ketamine (2mg/kg) is the induction agent of choice. Ett size 4.5.

Continuing haemodynamic instability will require inotropic support. When stable the patient should be transferred to a tertiary PICU.

Suggested Marking Scheme
1 - Outright Fail
Incorrect diagnosis, failure to recognise the deteriorating condition of the infant. Inadequate or inappropriate treatment and stabilisation prior to transfer to a tertiary centre.

2 - Borderline Fail
Inadequate or inappropriate treatment and stabilisation prior to transfer to a tertiary centre.

3 - Pass
A solid answer that correctly identifies the diagnosis, the deteriorating condition of the infant and the need for urgent treatment and stabilisation prior to transfer to a tertiary centre.

4 - Excellent
As 3 below but also includes a discussion of meningococcal disease, concerns with ceftriaxone and calcium containing solutions and possible effects of endotoxin release.
AAGBI Cycle for Guy

What do you get when you cross 30 Anaesthetists, 1 Critical Care Physio, 326 bananas, 47 liters of sudocreme, a champagne-less Indian restaurant, 6 sat-navs (each one completely operator dependent, obviously), several ice-baths, many flat tires and a horse box? But of course, The AAGBI’s Cycle for Guy.

This is the third year that cyclists have departed from AAGBI’s headquarters, 21 Portland Place, ahead of the Annual Congress, with destinations being Bournemouth in 2012, Dublin in 2013 and this year, Harrogate, a town famous for its floral decorations, tea shops, being host to the spectacular 1982 Eurovision Song Contest and the finishing line for Stage One of the 2014 Tour de France.

AAGBI’s annual cycle has gone from strength to strength over the last 3 years, and so far this year has raised £10,922 for two very worthy charities.

Firstly, Cyclists’ Touring Club’s (CTC) Cycle Safety Campaign. Cycling safety is of utmost importance to all cyclists, whether a daily commuter or an avid racer. However, it is a topic close to many Anaesthetists hearts, both in the UK and beyond for a very special reason. Dr Guy Jordan, a Consultant Anaesthetist at Frenchay Hospital Bristol and experienced cyclist, unfortunately died in a road traffic accident while cycling with colleagues in November 2013. Millions of pounds has been pledged by the UK and Irish governments to promote safe cycling, and donations from this cycle, as well as the publicity created on the AAGBI’s many media fora during it, will undoubtedly aid its cause.

Secondly, the Lifebox Foundation. Lifebox is an initiative co-founded by the AAGBI, and is an independent global health charity working to fund and install pulse oximetry, and establish surgical safety training programs, into every operating theatre worldwide.

Twenty-two enthusiastic cyclists set off on a bright Saturday morning. Once the team car/horse box was loaded up, and after many, many photographs with Guy’s Parents, Ann and Donald, we set off for Market Harborough.

The first coffee pit stop was 17 miles into our 105 mile cycle, which unfortunately the leading group of three cyclists had to sacrifice secondary to some very poor navigational skills!
Day two saw 4 Anaesthetists from Nottingham join us as we traversed the Vale of Belvoir. Our natural instincts led us all to a Costa Café in Melton Mowbray, and as with any top-rated international cycle, from then on in various groups of cyclists took several different yet scenic routes, some intentional, most unintentional, to eventually end up in Retford.

Day three was the third and final leg of our 260-mile journey. Navigational skills climaxed as the cycle was edging towards the home straight, with Rob’s Rolls in Wetherby providing some final calories. After almost 20 hours of cycling, we set our eyes on Betty’s Tea Shop and the Convention Center, Harrogate. Happiness, immense thirst, and jubilance were many of the feelings experienced as the cyclists sprinted into town.

Meanwhile, and in complete parallel, a group of 9 cyclists navigated from Bristol towards Harrogate, arriving also on the Monday afternoon.

Next year’s cycle route has yet to be decided upon. Will it be an epic and grueling 450-mile adventure from 21 Portland Place, or perhaps a more malleable 200-mile route from Harrogate, to Annual Congress 2015 in Edinburgh? Either way, going on this year’s event, a thoroughly enjoyable experience is guaranteed with ample amounts of laughter, limited amounts of tears and endless amounts of entertainment, while most importantly keeping cycle safety in the forefront of all our minds. With Dublin on the cards again for AAGBI’s Annual Congress in 2016/2017, the Annual Cycle is sure to come our way in the near future.

Special thanks also goes to the hours and hours of hard work put in by the AAGBI and Lifebox Fundraising Team, and to the team leader throughout, Karen Mackinnon.

So whether you simply cycle to and from work each day, or are a dab hand at clocking up the kilometers on a weekly basis, the AAGBI’s 2015 Cycle to Annual Congress in Edinburgh is for you!!

Some concluding words from Guy’s brother Ben; “On behalf of the whole Jordan family I would like to thank the AAGBI cyclists for their incredible commitment to raising funds in Guy’s memory. The funds raised by this bike ride will help CTC to campaign for the rights of cyclists to use the roads safely.”

If you wish to contribute to these very deserving cases, you can do so by following the link below:

www.aagbi.org/about-us/aagbi-fundraising/
**NAP5 in Ireland**

Accidental Awareness during General Anaesthesia (AAGA) is one of the most common concerns for patients to discuss before surgery. After death, ‘awareness with pain’ is ranked as the outcome anaesthetists most wish to avoid. The NAP5 Report focuses on failure of general anaesthesia and is the largest ever study of AAGA in the world. Data were captured from every public hospital in the UK and Ireland. The launch of NAP5 Ireland took place in the College on Thursday 11th September.

**Introduction**

The study involved detailed prospectively acquired reports from patients’ based entirely on their experiences. The content and themes outlined in the patient reports were analysed by a multidisciplinary panel.

There were three phases to NAP5:

a) A Baseline Survey conducted in early 2012, relating to the calendar year 2011, to ascertain anaesthetists knowledge of reports of AAGA, and certain baseline data related to anaesthetic practice (monitoring) and staffing.

b) The core project ran from 1 June 2012 to 31 May 2013.

c) An Activity Survey to provide denominator data for the key findings of interest, conducted between 26 November and 3 December 2012 in Ireland. (9-16 Sept 2013 UK)

Forty-one Local Co-ordinators (LCs) in Ireland volunteered to provide the link between the NAP5 team and all the 46 public hospitals. The LCs submitted patient reports of AAGA anonymously to a central secure online database over a calendar year.

Reports were then categorised by a multidisciplinary panel into the following main categories: Certain/Probable (Class A), Possible (B), Sedation (C), ICU (D), Unassessable (E), Unlikely (F), Drug errors (G) and Statement Only (SO).

**Incidence of AAGA in Ireland**

The NAP5-Ireland baseline survey (Jonker et al., 2014) elicited eight new reports of AAGA in 2011. The estimated number of General Anaesthetics in Ireland from an Irish Activity Survey (Jonker et al., 2014) was ~187 000. This yielded an annual incidence of AAGA of ~1:23000 general anaesthetics. This was comparable to the ~1:15000 estimated incidence during the UK Baseline survey (Pandit et al., 2013).

**Awareness cases in Ireland**

The 11 cases of AAGA reported in Ireland included the following:

- Five in Class A (Certain/probable)
- One in Class B (Possible)
- Two cases involving drug errors (Class G)
- One case of Sedation (Class C)
- Two Statement Only (SO)
Six reports were classed as Certain/probable or Possible AAGA:
- Two cases occurred during or soon after induction.
  - One after rapid sequence induction with thiopental for an elective C/S.
  - One due to failure to turn on the vaporiser to maintain anaesthesia.
- Four reports were of patient experiences of AAGA after surgery had commenced.
- Neuromuscular blockade was administered to five of the six patients (83%).
- None of the AAGA cases involved TIVA.
- Human factors contributed to AAGA in four of the cases.

**Risk Factors**
The following were identified as risk factors for AAGA:
- Drug factors: neuromuscular blockade, thiopental, TIVA techniques.
- Patient factors: female gender, younger adults (not children), obesity, previous AAGA, difficult airway management.
- Type of surgery: obstetric, cardiac, thoracic, neurosurgical.
- Organisational: emergencies, out of hours operating, junior anaesthetists.

**Recommendations to Avoid AAGA**
Chapter 4 in the NAP5 report is an executive summary and list 64 recommendations in an attempt to limit the risk of AAGA. The recommendations are divided broadly into national, institutional and personal levels.

There are numerous recommendations regarding the use of neuromuscular blockade (NMB) and are summarised below:
- Include nerve stimulators as ‘essential’ in monitoring whenever neuromuscular blocking drugs are used.
- Patients should be informed of the possibility of brief experience of feeling weak or unable to move when NMB is used (interpreted by patients as AAGA).
- During routine induction, loss of consciousness after induction should be verified by loss of response to verbal command and simple airway manipulation before administering NMB.
- Use of a specific form of DOA monitor is recommended to reduce risk of AAGA in individual patients deemed to be at high risk of AAGA for other reasons and in whom NMB is then used.
Obstetric patients undergoing caesarean section are at increased risk for AAGA. Consideration should be given to reducing the risk of AAGA in healthy parturients by:

- The use of increased doses of induction agents.
- Rapidly attaining adequate end-tidal volatile levels after induction without delay.
- Use of nitrous oxide in adequate concentrations.
- Appropriate use of opiates.
- Maintaining uterine tone with uterotonic agents to allow adequate concentrations of volatile agents to be used.

**Practice of anaesthesia in Ireland vs. UK**

One notable feature is the very large difference in size of the anaesthetic communities to which the Activity surveys were directed:

- The number of senior anaesthetists in Irish public hospitals per head of population is half that for the UK (1:13415 vs 1:7287).

  - The anaesthetic consultant to anaesthetic NCHD ratio in public hospitals in Ireland of 1.26 and consultant to 100,000 population ratio of 7.45 fall well short of recommendations set in the Report of the National Taskforce on Medical Staffing (Department of Health, 2003) of 0.61 and 11 respectively.

**Future research recommendations**

Relevant anaesthetic organisations in Ireland should develop an ongoing national database of AAGA reports.

This manpower data provides opportunity for more detailed analysis of anaesthetic service issues.

The chapters relating to the Irish data are available on the CAI website ([www.anaesthesia.ie/index.php/news-list/495-the-launch-of-nap-5-ireland](http://www.anaesthesia.ie/index.php/news-list/495-the-launch-of-nap-5-ireland)).
Revised Pay-scales for SATs

On 14th July 2014, the HSE directed hospitals to revise the pay scale for SATs, and all those trainees on streamlined programmes. This unilateral move was met with criticism from the postgraduate training bodies (PGTBs), trainees, and the IMO. While it would appear that the HSE have postponed the introduction of these scales, some hospitals continue to apply the reduced salary, and it is unclear what pay-scales will be implemented from January 2015.

Background
Previously, trainees progressing directly from a 2nd year BST position to HST benefited from a €20,000 rise in basic salary. This was seen as a reward and an incentive for trainees to progress rapidly and avoid “gap” years. However, with the introduction of streamlined training programmes in Anaesthesia, and more recently in Surgery, the majority of BSTs will progress directly to HST.

The HSE have expressed concerns that this could have major financial implications if the old BST/HST pay-scales applied to these trainees.

What are the new pay-scales?
Figure 1 represents the pay-scales introduced on 14th July, compared with the previous scale. Following discussions with the IMO, a revised pay-scale was released in August (Figure 2). This clarifies the entry levels to HST for those trainees with previous experience.

Why have the HSE amended the pay-scales?
The HSE argue that the expansion of these streamlined schemes could have significant financial implications for the Department of Health (DoH) and the Department for Public Expenditure and Reform (DPER). On the original scale, a BST 2 (SAT 2) progressing to SpR 1 (SAT 3) could expect a €20,000 increase in basic salary. The new scale would see this increment spread over a 2 year period.

While the HSE acknowledge that they will save money by introducing this scale, they claim that individual trainees will not be disadvantaged.

The HSE support this statement by claiming that trainees will progress through training quicker, be appointed as a Consultant at an earlier stage (with a significant increase in salary), and their salary over this time period will not be reduced in any meaningful way.
### Training Pay during first 9 years

<table>
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<tr>
<th>Year</th>
<th>Training designation</th>
<th>Grade</th>
<th>Salary point</th>
<th>Salary</th>
<th>Training designation</th>
<th>Grade</th>
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<tr>
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<td>Intern</td>
<td>Intern</td>
<td>1</td>
<td>€31,938</td>
<td>Intern</td>
<td>Intern</td>
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<tr>
<td>2</td>
<td>BST 1</td>
<td>SHO</td>
<td>1</td>
<td>€38,839</td>
<td>Specialist Training Year 1</td>
<td>SHO 1</td>
<td>€38,839</td>
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<td>3</td>
<td>BST 2</td>
<td>SHO</td>
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<td>SHO 2</td>
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<td>4</td>
<td>Gap - out of training</td>
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<td></td>
<td></td>
<td>Specialist Training Year 3</td>
<td>Special Trainee 1</td>
<td>Registrar 1</td>
<td>€50,578</td>
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<tr>
<td>5</td>
<td>HST 1</td>
<td>SpR</td>
<td>1</td>
<td>€60,404</td>
<td>Specialist Training Year 4</td>
<td>Special Trainee 4</td>
<td>Registrar 2</td>
<td>€52,687</td>
</tr>
<tr>
<td>6</td>
<td>HST 2</td>
<td>SpR</td>
<td>2</td>
<td>€61,855</td>
<td>Specialist Training Year 5</td>
<td>Special Trainee 5</td>
<td>SpR 1</td>
<td>€60,404</td>
</tr>
<tr>
<td>7</td>
<td>HST 3</td>
<td>SpR</td>
<td>3</td>
<td>€63,953</td>
<td>Specialist Training Year 6</td>
<td>Special Trainee 6</td>
<td>SpR 3</td>
<td>€63,953</td>
</tr>
<tr>
<td>8</td>
<td>HST 4</td>
<td>SpR</td>
<td>4</td>
<td>€65,000</td>
<td>Specialist Training Year 7</td>
<td>Special Trainee 7</td>
<td>SpR 4</td>
<td>€65,000</td>
</tr>
<tr>
<td>9</td>
<td>HST 5</td>
<td>SpR</td>
<td>5</td>
<td>€66,070</td>
<td>Specialist Training Year 8</td>
<td>Special Trainee 8</td>
<td>SpR 6</td>
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<td><strong>Total Cost</strong></td>
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<td><strong>€429,057</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Figure 1**

The HSE support this statement by claiming that trainees will progress through training quicker, be appointed as a Consultant at an earlier stage (with a significant increase in salary), and their salary over this time period will not be reduced in any meaningful way.

The HSE also point to an inequity in the remuneration of trainees on different training paths. SAT 3 trainees may earn substantially more money than an NCHD in their 3rd year post-internship as a Registrar or SHO in another speciality. With the eventual stream-lining of all training programmes, they envisage that this new scale will guarantee equality amongst all trainees.

The HSE claim the new scale will address the current difficulties retaining doctors. A new post-CST salary point (€71,388) is a significant increase on the top point of the registrar scale, which was traditionally paid for those undertaking fellowships after completion of training.

In a letter to the IMO (26th August 2014), Andrew Condon (General Manager, HSE) reiterated their commitment to NCHDs:
- NCHDs will not experience a reduction in the income they would have received over the course of specialist training.
- NCHDs are treated equitably and are not financially disadvantaged arising from their choice of one particular specialist training scheme over another.
- NCHDs who have completed specialist training are incentivised to remain in the health service.

**CATs Response**

The CAI have received well deserved praise from the HSE for establishing the SAT programme. Streamlined training is the target now for all PGTBs in Ireland, and to date, the success of the SAT programme has inspired this change. However, in spite of these positive developments in Irish medical training, large numbers of NCHDs continue to exit the system. Recent commentary in the medical media has focused on further possible incentives to improve retention, including tax breaks for NCHDs.
Trainees who have completed two years or less as SHO and move directly to HST1 or those progressing from ST2 to ST3:

<table>
<thead>
<tr>
<th>Years</th>
<th>Training Designation</th>
<th>Point</th>
<th>Annual Salary</th>
<th>Equivalent to</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>HST1/SAT3</td>
<td>3</td>
<td>€52,687</td>
<td>REG 2</td>
</tr>
</tbody>
</table>

Trainees who have completed at least one but not more than three years as Registrar prior to moving to HST1 will progress to ST5 as follows:

<table>
<thead>
<tr>
<th>Years</th>
<th>Training Designation</th>
<th>Point</th>
<th>Annual Salary</th>
<th>Equivalent to</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>HST2/ST4</td>
<td>4</td>
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<td>REG 2</td>
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<tr>
<td>5</td>
<td>HST3/ST5</td>
<td>5</td>
<td>€60,404</td>
<td>SpR 1</td>
</tr>
</tbody>
</table>

Trainees who have completed four or more years at Registrar prior to moving to HST1 will progress to ST6 as follows:

<table>
<thead>
<tr>
<th>Years</th>
<th>Training Designation</th>
<th>Point</th>
<th>Annual Salary</th>
<th>Equivalent to</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>HST2/ST4</td>
<td>4</td>
<td>€52,687</td>
<td>REG 2</td>
</tr>
<tr>
<td>5</td>
<td>HST3/ST5</td>
<td>5</td>
<td>€60,404</td>
<td>SpR 1</td>
</tr>
<tr>
<td>6</td>
<td>HST4/ST6</td>
<td>6</td>
<td>€63,953</td>
<td>SpR 3</td>
</tr>
</tbody>
</table>

**Figure 2**

However, the HSE have opted to introduce a revised pay-scale for streamlined schemes that reduces the earning potential of trainees. It is difficult to see how this will enhance the retention of NCHDs.

Despite the HSEs statement, NCHDs will experience a reduction in income. Our example (figure 3) shows that a typical SAT - on a 1:6 rota in theatre, working 60 hours/week - may have a reduced income of €14,000 over a 6 year period. This NCHD would have to work an extra year as a post-CST fellow/registrar to recover these earnings losses - they may be €3,000 better off over the 7 year period. However, a stated goal of the streamlined programme is to discourage a prolonged training period.

The HSEs ambition to treat all NCHDs equitably is appropriate. However, the vast majority of NCHDs will not be on a streamlined training programme in the foreseeable future. Therefore, CAT believes that it is inappropriate and inequitable to apply these scales to a small group of Anaesthesia trainees. A better strategy may be to wait, and apply them when all trainees are enrolled in streamlined programmes.

The CAT believes that the best way to “incentivise” the retention of post-CST doctors is to offer them an appropriate Consultant contract. They have completed their training. They should not be encouraged to spend an extra year working as a registrar on a slightly enhanced salary to recover the money lost over the preceding 6 years.

**The Anaesthesia Trainee Perspective**

The CAT and CAI have received correspondence from a number of concerned trainees. They have committed to the SAT scheme, and the Irish health system, for at least 6 years. The interview process for the SAT scheme is highly competitive, and attracts exceptional young doctors. These trainees are a valuable resource to the Irish health system - the same trainees the HSE refers to in the “Retaining Medical Talent Initiative”.

**Figure 2**

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**Figure 2**
The MacCraith report identified a number of barriers to the retention of doctors in Ireland. “Improving communication” and “Certainty/predictability of rotations” were two areas where the HSE had room to improve.

Unfortunately, there was limited communication between the HSE, and the IMO and the PGTBs on the new pay scales. Also, their rapid introduction introduces a huge degree of uncertainty into the lives of recently appointed SATs who must now re-evaluate their potential earnings in the next few years. We must remember that a significant cohort of the “Graduate Entry” doctors are entering the training schemes, and are attracted to streamlined programmes. These doctors, in particular, have large debits to repay.

Recent Developments
The IMO have indicated that the introduction of these pay-scales is in breach of the Haddington Road Agreement. The HSE have issued a statement to all hospitals to postpone the implementation of the new pay-scales, pending further discussions. However, some hospitals have continued to pay the reduced salary to SAT 3s.

CAT Recommendations
CAT have asked the IMO to address the following points with the HSE during any further negotiations.
- The CAT recognises the SAT scheme as a significant improvement in the delivery of Anaesthetic training in Ireland. The HSE should continue to support and promote the SAT scheme as a template for the other PGTB to follow.
- The HSE should postpone the introduction of new pay-scales for streamlined programmes until all PGTBs are engaged in streamlined training. This would be an equitable approach.
- When introducing the payscales, the HSE should avoid any reduction in NCHD earnings. This will further exacerbate the problems in retaining medical personnel, and may damage the good reputation of current streamlined programmes.
- New pay-scales should not apply to current SATs.

We would also encourage all SATs to write to the IMO encouraging a strong response to any further efforts from the HSE to introduce these pay cuts.

<table>
<thead>
<tr>
<th>SAT</th>
<th>Pay (New Scales)</th>
<th>Pay (Original Scale)</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>€58,378</td>
<td>€58,378</td>
<td>€0</td>
</tr>
<tr>
<td>2</td>
<td>€61,623</td>
<td>€61,623</td>
<td>€0</td>
</tr>
<tr>
<td>3</td>
<td>€79,193</td>
<td>€90,792</td>
<td>-€11,599</td>
</tr>
<tr>
<td>4</td>
<td>€90,792</td>
<td>€92,973</td>
<td>-€2,181</td>
</tr>
<tr>
<td>5</td>
<td>€96,126</td>
<td>€96,126</td>
<td>€0</td>
</tr>
<tr>
<td>6</td>
<td>€97,700</td>
<td>€97,700</td>
<td>€0</td>
</tr>
<tr>
<td>Post-CST</td>
<td>€107,301</td>
<td>€90,643</td>
<td>€16,659</td>
</tr>
</tbody>
</table>

Figure 3
Medical Careers Day 2014: Building Your Future

The Forum of Postgraduate Medical Training Bodies (PGTBs), in collaboration with HSE-MET, hosted a Careers Day for medical students and Interns in Dublin Castle on the 20th September 2014. The training bodies delivered presentations about their training schemes, and their specialty. Each PGTB had a stand at the event, and the CAI had a simulation station on display.

Presentations from Prof. Eilis McGovern (HSE-MET), Prof. John Crowe (RCPI and Forum), Dr. Ellen O’Sullivan (CAI and Forum), and Prof. Freddie Wood (Irish Medical Council) highlighted the recent advances in medical training in Ireland. All the speakers addressed the importance of retaining medical talent.

The Anaesthesia stand and simulation area was very popular with the delegates. A mixture of college staff, SATs and Consultants were on hand to answer questions the students had about the SAT scheme. Everybody was impressed with the level of interest and enthusiasm these young people displayed for our specialty.
One of the core responsibilities of CAT members is to represent SATs on CAI and external committees. In this section, we will update you on recent developments, or future plans, from the individual committees.

**Faculty of Pain Medicine**
The Faculty ran their annual exams on the 9th and 10th June. This year was the first year candidates sat the Fellowship exam. A trainee must have passed the Diploma exam and completed one year of full-time Pain Medicine (PM) training to be eligible to sit this exam. Six sat the Fellowship (4 passed) and 12 sat the Diploma (10 passed).

*It is appropriate that the first Pain Fellowship candidates will be conferred in the same year that PM receives specialty status from the Irish Medical Council - this was confirmed May 2014. The Faculty continue to improve the quality of PM training in Ireland, and 3 Special Interest Year posts (for SAT 6s) are expected to start July 2015.*

The HSE-MET have yet to include the PM exams on the list of exams and courses that they will reimburse. Considering PM is now a specialty, and the exams are essential for recognition as a Pain Specialist in Ireland, they should be included on this list. CAT have communicated this to HSE-MET and we await a response.

**Education**
The Consultant interview workshop will be held on the 13th April 2015. The majority of the course will be run by *Inspire Change.*

The Irish Congress of Anaesthesia will be held on the 21st and 22nd May 2015. A CAT organised ‘fun-run’ from outside the convention centre will be held on the morning of the 22nd.

**Examinations**
No meeting yet.

**Training**
The last Training Committee meeting took place on 30th September. The committee were briefed on the payscale issue facing SATs.

The IMC have asked all PGTBs to make flexible training options available to their trainees.

There is a poor response rate from trainees on the 6-monthly hospital assessment forms. These can be accessed in the Assessments section of the members area on the CAI website. The committee have emphasised the importance of completing these forms to ensure a high standard of training in all departments.

**JFICMI**
Intensive care medicine is continuing to develop its own identity as a distinct speciality in Ireland. In keeping with this, the JFICMI are developing a dedicated logbook, along with specific competencies. Once these have been completed, the CAT will make trainees aware of any requirements that are necessary to complete certification in Intensive Care Medicine.

**NCPA**
The Productive Operating Theatre (TPOT) training is ongoing. Two positions on this training course were offered free of charge to senior trainees. However no trainee expressed an interest in attending this course and the deadline for applications has now passed.
Committee Updates

ISC/GAT
The Irish Standing Committee enquired into the possibility of the introduction of a quarterly/monthly division of the payment of the annual Medical Council retention fee. The CAT would welcome any views that trainees have on this proposal.

There will be a joint GAT/CAT meeting in Dublin on the 28th and 29th November. Issues of interest to both Irish and UK trainees will be discussed at this meeting.

Critical Care Programme
The ‘Model of Care for Adult Critical Care’ launch will take place in the CAI on Thursday 16th October. It will highlight a ‘hub-and-spoke’ delivery for the Acute Hospital System, so that critically ill adult patients can access an appropriate level of critical care in a safe, effective, efficient and timely manner.

Forum Trainee Sub-Committee
Recent discussions between the IMO and the HSE at the LRC has led to the development of a new Consultant contract proposal. The IMO will soon put these proposals to a vote amongst its members. The current proposal, along with a debate on the possible acceptance/rejection of these proposals, is available on the CAT Facebook page. The CAT would encourage all trainees to voice their opinion and to take part in the forthcoming vote.

The ongoing discussions regarding the introduction of the new pay scale for SATs was outlined by David Moore earlier in this issue. The issue has been discussed at the forum, and the ongoing discussions will continue to be monitored carefully.

The MacCraith and Buttimer Reports highlighted the importance of flexible ‘family-friendly’ working hours in the retention of trainees and the recruitment of new Consultants. Funding has been available by the Department of Health and Children for 20 posts throughout the 13 postgraduate training bodies for less than full time training. The nature of these posts require them to be of a supernumerary nature, thus requiring additional funding. Currently there has not been a large degree of interest in the uptake of these posts. The CAT wishes to highlight the availability of these posts to anaesthetic trainees.
Pre-Hospital Care Update

New principles in pre-hospital care (PHC) are emerging from the experience of military anaesthetists in conflict, especially in Iraq and Afghanistan. Many countries, including the UK, are transferring this skill set to the management of civilian trauma victims in the pre-hospital setting. In May 2014, CAT invited expressions of interest in PHC from SATs. We received a great response, and in the following piece Hugh and Aislinn update us on the recent developments.

In Ireland the critical pre-hospital period is managed largely by paramedic staff. In the UK there have been large developments in pre-hospital training programmes, and trauma networks have been established. Indeed, Pre-Hospital Emergency Medicine (PHEM) has achieved recognition as a subspecialty of Anaesthesia in the UK. This upsurge in interest in PHC is reflected in the recent BJA supplement on trauma care.

The CAT are happy to report some recent positive developments regarding PHC and Anaesthesia training.

A consensus trainee document on PHC was considered by the CAI Training Committee on Thursday 30th September. It was subsequently decided to establish a ‘working group’ to explore the viability of including PHC as an optional part of training in the SAT scheme. The Training Committee recognised the lack of training opportunities for SATs in PHC compared to the UK, and the restrictions imposed on SATs by the Medical Practitioners Act 2007. The ‘working party’ will be Chaired by Dr Padraig Sheeran, who is a CAI Council member, and the Dean of the Faculty of Sports and Exercise Medicine. He also has a history of involvement in PHC activities and training.

The CAT are looking forward to contributing to the evolution of this aspect of Anaesthesia training in Ireland. We invite all SATs interested in PHC training, or those working with relevant organisations (RNLI, Red Cross, Order of Malta, Mountain Rescue, Reserve Defence Forces, Sporting bodies, etc.), to contact the CAT at cat@coa.ie and declare your interest in accessing PHC training opportunities.

We wish to thank all those trainees who have helped with this process so far.
I would like to take the opportunity to mention some overseas initiatives that the CAI is involved in that trainees might like to get involved in.

**Malawi LIFEBOX project**

Last August myself and some other representatives of the College travelled to Blantyre in Malawi to distribute 100 oximeters and provide oximetry training to anaesthetic clinical officers (ACOs) working in hospitals which did not possess these monitors. The oximeters were provided by Lifebox and partial funding for them was raised through a piano recital by Dr Jenny Porter from St. James’ Hospital.

The Malawi project is one that is very close to my heart and for a number of years we have been supporting ACOs and the training of a small number of anaesthetists in Malawi on the MMed programme which is based in Blantyre. The first three have qualified and are the future Anaesthesia Leaders in Malawi. Please let us know if you have an interest in lower income country teaching & training as there are ongoing projects planned.

**Facing Africa Airway Fellowship**

Recently we advertised The Facing Africa Anaesthetic Airway Fellowship. This is a new venture between the CAI and Facing Africa, a UK-based charity. The Fellowship is for senior trainees & fully funded by the CAI. It involves joining a team of 2 Consultant anaesthetists from Cork, 4 Consultant surgeons plus nurses.

The team provides free reconstructive facial surgery and care for Noma (cancrum oris) survivors over a 2 week period in a hospital in Addis Ababa, Ethiopia. There was great interest in this fellowship and, after interviews, Roseita Carroll, a former CAT chair was successful. This is a unique opportunity for the appointed Fellow to learn advanced airway techniques and experience working in a developing country. We look forward to receiving feedback from Roseita and remember that this Fellowship will be available each year so please apply.
GAT Visit: 28-29th November

The last weekend of November is an important one for CAT. The AAGBI’s Group of Anaesthetists in Training (GAT) are visiting Dublin.

GAT represent over 3,000 Anaesthetic trainees in the UK and Ireland, and have a wealth of experience and knowledge. The CAT is delighted to be able to learn from such an established organisation, and their visit is an important step in our development as a trainee committee.

The CAT and GAT will attend the KP Moore medal presentations followed by the Winter College Lecture on the Friday evening in the CAI (28th November). The next day (29th November) both committees will attend the Irish Standing Committee (AAGBI) meeting in the Conrad hotel. This will be followed by the first joint CAT/GAT meeting - the agenda will focus on training issues common to Irish and UK trainees.

CAT would like to welcome our Irish colleagues to attend both events, meet the committee members from GAT and contribute to the discussions.

<table>
<thead>
<tr>
<th>Upcoming College Events</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KP Moore Medal Competition</strong></td>
</tr>
<tr>
<td>Friday 28th November at the College of Anaesthetists of Ireland</td>
</tr>
<tr>
<td>Abstracts of clinical cases/research related to anaesthesia, intensive care and pain medicine considered</td>
</tr>
<tr>
<td>Closing date for abstract submission Friday 24th October</td>
</tr>
</tbody>
</table>

| **JFICMI Critical Care Refresher Series - Neurology** |
| Friday 12th December 5.30pm at the College of Anaesthetists Ireland |
| Applications can be downloaded from [www.icmed.com](http://www.icmed.com). |

| **Audit Study Day** |
| Thursday 11th December at the College of Anaesthetists of Ireland |
| Audit abstract submission date is Thursday 24th November |

| **Irish Society of Obstetric Anaesthesia AGM** |
| Friday 5th December at the College of Anaesthetists of Ireland |
| Closing date for abstract submission Friday 7th November |

| **Irish Orthopaedic Anaesthetists’ Association AGM** |
| Friday 5th December at O’Callaghan’s Davenport Hotel, Dublin 2 |
CAT Facebook Group

CAT established their Facebook page earlier this year. It is a “closed” group - only CAI trainees may join and view the pages content. As it grows, we hope it will serve as a valuable resource for its members. Over 30% of CAI trainees are now registered. Some of its current and future features are introduced below. To join, click: www.facebook.com/groups/47332529451334/

The CAT Facebook group will feature updates from committee meetings within the College, GAT and AAGBI ISC, Pain and ICU Faculty, and Forum Trainee Sub-Committee meetings. CAT will keep Irish Anaesthesia trainees updated on all issues and projects we are involved with via CAT News and the Facebook group page.

CAT will run polls, or post short surveys, on the Facebook group page. These are designed to gauge the general opinion of Anaesthesia trainees on certain subjects. We can use this information to provide a stronger trainee voice on our respective committees.

CAT will post upcoming events on Facebook. These events may include upcoming exams, conferences, courses, etc. Members may share information with their colleagues under these posts.

CAT will launch an accommodation post in the coming weeks. Please post your advertisement or request for a rental property. We hope this will make the January or July move easier for SATs.

The Swap post facilitates appropriate rotation swaps between SATs. This has been a popular addition to the page, and 2 swaps have been facilitated since July.
We’re here for you

MPS members have access to:
- Emergency telephone advice 24/7
- Complaints handling
- Report writing support
- Media and press relations support
- Support if you are the subject of a Garda investigation

- Specialist legal advice and representation for disciplinary hearings and IMC Fitness to Practise proceedings
  The financial implications of being subject to an IMC Fitness to Practise hearing will cost significantly more than your membership subscription

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