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A day in the life of an anaesthetist who rather likes... Coldplay

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So I like Coldplay, it's not my fault I'm a 31 year old man who has been influenced by pop culture. If you had just started to take notice of music in the late 90's you may have caught the Chris Martin bug too. Is there anything wrong with a slight propensity for enjoying the exquisitely dark melodies of the aforementioned privileged Devonian? Do you remember fondly the distorted guitars and swishing percussion of 'Yellow'? But enough about Mr Martin and his excellent band and a bit about me - I am no musician or Devonian, I now count myself a Yorkshireman but I too am privileged, I am privileged to be an anaesthetist.

As an anaesthetist I am aware of my General Medical Council (GMC) obligations and as such I feel it is my duty to offer you, the reader, an informed consent. Don't worry you'll almost certainly be fine but you may suffer from implicit or explicit awareness of Coldplay references when reading this account. For example I will now refer to the track title ***'Don't Panic.'*** This, as any anaesthetist with any taste in music will know, was the first track of Coldplay's launch album but is also the first principle of anaesthesia.

08:05 Drone Drone Drone Drone - Trauma call to Emergency Department resuscitation estimated time of arrival 5 minutes (the droning was my bleep and no certainly not a Coldplay reference!). The paramedics wheel in a man at the higher reaches of any Body Mass Index (BMI) scale who has been crushed in an industrial accident. They are holding a mask to his face and squeezing an Ambu bag, not too much chest movement though... Transferred to our Emergency Department trolley (the brakes of which despite being on don't work too well) and the patient lurches across, with the experienced nurses using their ingenuity to control the NHS equipment. Collar, blocks and tape are on and the airway is a jowly blood and vomit strewn mess. How am I going to get an endotracheal tube down that? Ah there's no breathing and no carotid pulse. Now, as cardio pulmonary resuscitation (CPR) is commenced, the jelly like airway wobbles around slightly reminiscent of sound waves. The cacophony of alarms doesn't sound anything like the slow sweet sounds of 'Don't Panic'. Fortunately I am an anaesthetist and I have been well trained, I will not panic when

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faced with this standard Advanced Trauma Life Support (ATLS) scenario.

Anaesthetic training includes a superfluity of training for these acute scenarios. It is a minimum of seven years and we have spiral learning so key themes are repeated at basic, intermediate and higher levels. For example every anaesthetist does an airway module at least three times during their training. This repetition however is always at a higher level so whilst a junior anaesthetist's airway module may focus on rapid sequence intubation the senior trainee has rapid sequence, glidescope intubations, fibre optic intubations and other airway techniques in their expansive armoury. These highly practiced individuals are more concerned with the decision making on whether to just ask for an awake surgical tracheostomy than with risking a complex and perilous airway technique. Advanced airway skills have always been the hallmark of the anaesthetist but whilst airway situations often causes the largest surges of adrenalin these dexterously demanding techniques are not in my view the most compelling part of anaesthetics.

09:00 The trauma case needs scanning. The medical registrar needs help with a deteriorating asthmatic on the Acute Assessment Unit (AAU) and resuscitation has got someone in status epilepticus. Each of these situations requires an anaesthetist, all are urgent. What would you do in my place? Would you see the patient in status or would you see the asthmatic – it sound like the asthmatic is close to respiratory arrest, but surely you have a responsibility for the patient you are already with? A stressful situation - ***time for sparks to fly***, time to ***run around at the speed of sound***? Do not despair, everything is not lost. Time to call for some help. I am fortunate enough to work in a specialty where I rarely work alone, there are colleagues working on ICU, there is often an outstanding outreach nurse available and of course the ever-present consultant. Sure enough after a few phone calls, the cavalry arrives and I can continue to focus on giving excellent care to the patient I am with.

I try to avoid ***'a rush of blood to the head'*** after any little success for a patient – treating that life threatening bradycardia, securing the post-op ICU (Intensive Care Unit) bed, safely transferring that burns patient to Pinderfields. Coldplay didn't get carried away with their second album after its initial success and nor do I. There is too much to contend with, GMC obligations, National Institute for Health and

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Care Excellence (NICE) guidance, trust directives, fellowship exams, and seemingly endless training assessments not to mention the odd article to enhance the curriculum vitae (CV) for that elusive consultant post...

14:30 Rostered to a paediatric list with a consultant. I have seen the patients pre-operatively and we do a case-based discussion focusing on the differences in management of adult and child obstructive sleep apnoea. One of the major differences between anaesthetic training and other specialties is the huge amount of one to one time a trainee spends with experienced consultants. These accompanied lists give rise to countless opportunities in which to practice, learn, discuss and see different and perhaps slightly eccentric techniques. In the last few years paper assessment has disappeared, one of many changes I have been witness to. I now send assessments via my obligatory iPhone.

The integration of technology has been one of many positive changes in Hull. The NHS we work in is a government organisation and therefore is constantly changing driven by ***'Politik'*** winds. As you are aware the government introduced the controversial, and British Medical Association (BMA) opposed, Health and Social Care Act 2012[(1)] which abolished primary care trusts and set up GP commissioning groups to give community doctors more power in treatment funding decisions. At the secondary/ tertiary care level the Royal College of Physicians published the 'Future Hospital: Caring for medical patients[(2)]' in autumn 2013 which set out a vision for future acute medical care. It sees patients' needs at the centre and doctors taking lead roles to co-ordinate primary and secondary services in acute physical, mental and social care. Overall there is a decentralising tendency and an empowerment of local leaders. These are exciting times for doctors who are the group increasingly being expected to advance the NHS.

For those who have contact with anaesthetists you probably know that we get everywhere: ICU, Emergency Department, the wards, the radiology department, women and children's not to mention theatres. We are involved in pretty much every specialty and get to have a certain amount of knowledge of how things work. We also get to have front row seats of the best and worst aspects of NHS treatment. This brings me to a slightly sore point for the Trust - the Care Quality Commission's (CQC) recent visit to Hull and their comments. Good in parts but overall

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needs improvement. Anaesthetists witness the sharp, rigorous and safe care of labouring women, I have seen how immediately involved ICU consultants are in caring for the critically ill at all hours of the day and night. On the other hand I have also picked up patients from harassed and stretched staff. I have been involved in cancelling elective patients due to organisational issues. I have transferred the possibly c-spine injured patient to the moving brakeless Emergency Department trolley and am of course acutely aware of the constant 'bed pressure' which is the beating percussion on which every guitar rift of clinical decision is timed. Anaesthetists have a great position in the hospital from which to observe the running of the hospital, coupled with administration skills learnt from theatres and intensive care, it is no surprise that many anaesthetists go on to do well in the management and executive positions of hospitals.

19:00 Thank goodness, the spinal has gone in. The soon to be mother however is understandably a bit on the anxious side. She grabs my hand and tells me she can feel it. The midwife has only started sterilizing the abdomen. The next 15 minutes are spent explaining, reassuring, listening and persuading. Fortunately the mother summons courage from the confident calm dialogue and soon there is a waarrggghh. An X&Y is born. The mother is also crying but smiling, as I congratulate her I think I detect a soupcon of gratefulness in her exhausted and delighted face.

20:30 At home now, but the work is not over - exams are coming. I have organised to practice my oral 'viva' technique with a generous consultant over Skype. Tonight we discuss the estimated time of arrivals of how an osmometer works and colligative properties. Despite misgivings over the relevance or usefulness of these estimated time of arrivals they do appeal to the scientist in me and it is great that members of the department are so willing to give their time so benevolently. The use of video conferencing to do these kinds of sessions is also tremendous and becoming more common. There are even moves towards trialling our region wide teaching online. In a world where the word 'amazeballs' has found its way into the Oxford dictionary (online), it seems only right that we are moving with the times.

The purpose of this article was not to keep your vocabulary up to date or even make you suffer post-traumatic stress disorder (PTSD) style flash backs of a certain famous band. We all know the environment we work in is not perfect but in many ways it

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is improving, for example the uptake of technology in the anaesthetic department. Work can be challenging for us all. My days are often busy and demanding but they are also well supported and satisfying. I hope to have shown that we live in stimulating times for doctors in the NHS and that training in modern anaesthesia is not only high quality, exciting and varied but gives us the skills and the unique opportunity to become the medical leaders of the future.

Glossary

Amazeballs

Extremely good or impressive; amazing

http://www.oxforddictionaries.com/definition/english/amazeballs [accessed 4/10/2014]

Status epilepticus

Seizure activity lasting for 30 minutes or more is called status epilepticus.

https://www.epilepsy.org.uk/info/seizures-explained [accessed 4/10/2014]

Bradycardia

Bradycardia is strictly defined in adults as a pulse rate below 60 beats per minute (bpm)

http://www.patient.co.uk/doctor/bradycardia [accessed 4/10/2014]

References

1. Health and Social Care Act 2012 http://www.local.gov.uk/c/document_library/get_file?uuid=e0e0321b-49f1-4ec2-9e73-5ba379e0787b&groupId=10180 (accessed 6/10/2014)
2. Future Hospital: Caring for medical patients (Royal College of Physicians) https://www.rcplondon.ac.uk/sites/default/files/executive-summary_0.pdf (accessed 6/10/2014)

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