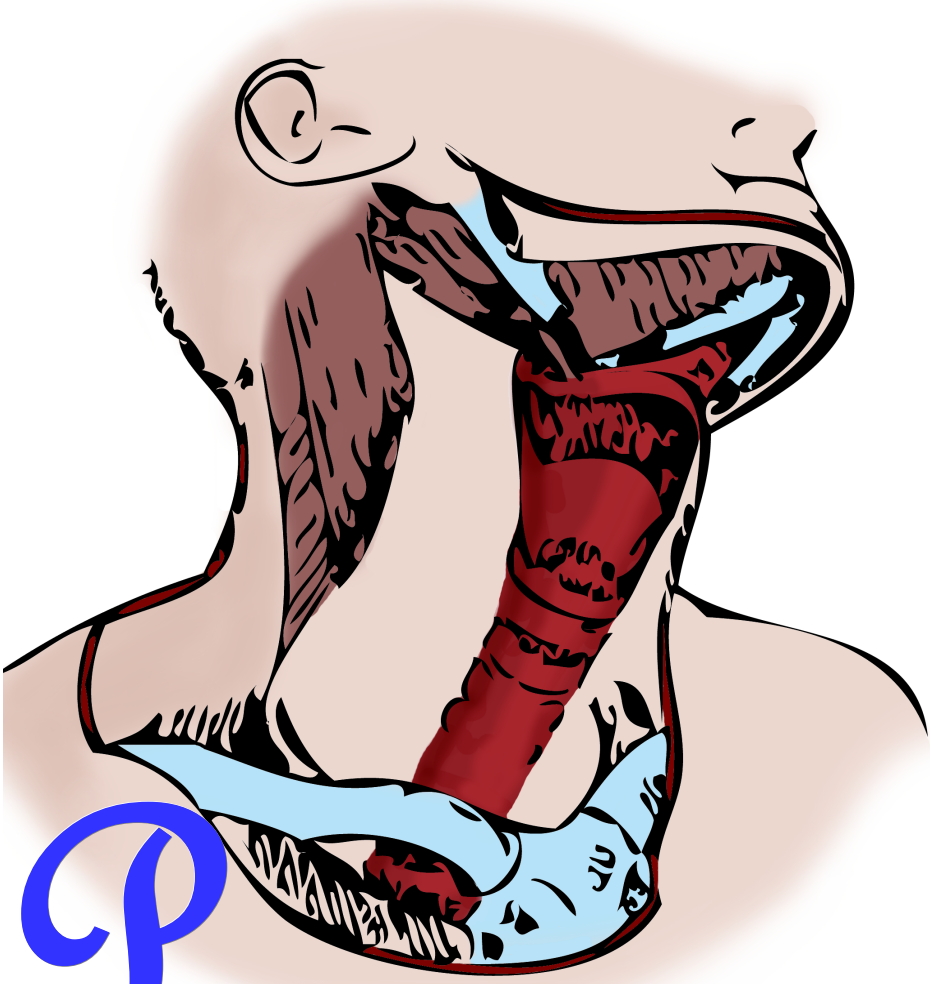
The Difficult Airway Society

Newsletter November 2012



Projects Edition

www.das.uk.com

From the editors

This edition doesn't need much from us. It is an attempt to gather all of the Society's activities into one place and keep you, the members informed…

Even then by the time you read this it will actually be out of date– that's despite the fact that the Cardiff ASM is less than two weeks away as we write!

In between times DAS Council will have met and considered more new projects and reviewed others. Similarly other projects (such as ADEPT) are preparing to move forward but have nothing new to report since they featured in the Autumn Newsletter.

However the spare column inches allows us to do two things– i) to thank all of the contributors who provide us with copy for the Newsletter and ii) to encourage you, DAS Members, to write for the Newsletter. We will take anything from Course Reports to Opinion Pieces although we generally encourage people to submit case reports to the Annual Scientific Meeting– next year its DAS Ascot.

We hope to see you in Cardiff– do come and talk to us and tell us what you think of the Newsletter. Should it be in A4 format, should it be entirely online, is the font too small? We want to know what you think about your Newsletter– we will even try and implement the changes.

RB *AMcN*
London *Edinburgh*

newsletter@das.uk.com

Contents

From the President

Although this is only the second ever projects edition of the Newsletter, it is one of my favourites. DAS is an ever growing, ever evolving society and this newsletter gives just a small flavour of that.

The DAS Professors initiative shows just how much the Society has evolved and I should thank Jaideep Pandit and all those involved in the process– all of the applications were of the highest standard and it is reassuring to know that there is such a pool of talent interested in promoting the Society both now an din the future.

The DAS RCoA Airway Leads project is another sign of just how the Society is growing up. The College will now be keeping a record of Hospital Airway Leads and I imagine that this will be a job that DAS members will be keen to fill in their hospitals. DAS is planning to support Airway Leads with training and educational resources and we hope to have more information on that at Cardiff .

Mentioning Cardiff gives me the chance to thank the work of Mark Price and his team for what promises to be an excellent meeting. The Society's annual scientific meeting has also grown in stature over time and I am sure that this one will continue to impress the delegates and progress the science of airway management.

An important feature of the annual scientific meeting is the annual members meeting at the end of Thursday afternoon This year sees the committee bring forward a constitutional change to allow DAS to elect officers by electronic voting.

This is important because of the number of members we now have and it brings us into line with other major anaesthetic and critical care societys- although for it to work members must have a valid email address registered with das@aagbi.org.

With this newsletter you should also have received a copy of the extubation guidelines flowcharts– the successful completion of a DAS Project of which you will hear more during the meeting, My thanks must go to all of those who worked on the guidelines and to all those involved in guidelines groups rewriting the intubation guidelines, collaborating with the OAA on obstetric guidelines, the work of the Society is never ending!

I will close by saying that I hope you enjoy DAS Cardiff– and that if you are reading this online you will consider joining us next year at DAS Ascot.

My thanks again to the members of the Local Organising Committee who have put such a lot of work into making this meeting a success and to the ever hard-working DAS Committee who ensure that the Society remains relevant to its members improving science, practice, safety and innovation in the field of airway management.

EO'S

DAS Professors

Following his presentation in Nottingham, Jaideep Pandit brings us up to date with this exciting DAS initiative.

Last year, DAS resolved to create DAS-sponsored Professorships of Anaesthesia & Airway Management', to be held for one calendar year (the successful candidates undertaking roles within the society that furthered our subspecialty). We have run this process to a successful conclusion.

There were 8 expressions of interest but only 4 went on to full applications; thus this was a very competitive process from the very start. Applications were scored by an international panel of 10 experts in the field (from UK, Europe, USA, Canada and Japan), including 8 professors of anaesthesia, 2 leaders of national anaesthetic organisations/societies, and 3 editors of mainstream anaesthesia journals.

The DAS Committee reviewed the scoring process and there was further external quality assurance from a lay member and a retired university vice-chancellor. The scores justified two awards being made, which having been ratified by the DAS Committee in November will be announced at the DAS session

The application process for the awards to be made for 2014 will open in January 2013. Potentially interested individuals are invited to discuss their application informally with Professor Pandit jaideep.pandit@dpag.ox.ac.uk

JJP

Revision of the Intubation Guidelines

When these guidelines were first published in 2004 I'm sure Drs Henderson, Popat, Latto and Pearce did not realise that it would become the most cited airway algorithm in the world. Local guidelines were in existence across the country in some guise or another but they were not unified, or necessarily supported by .the available evidence.

The idea of a guideline was conceived at a DAS annual society meeting in 1999 and draft flow-charts were presented almost annually at the ASM to garner appraisal from the society members. Medline was the medical search engine of the day and was extensively used along with personal knowledge and advice, evidence, experience and consensus. The DAS committee honed the guidelines and a small group of experts then reviewed the final version before publication 5 years later.

Nearly a decade later DAS has determined that the guidelines need a revision. The degree to which this should occur are still being debated but there is much to consider.

Firstly the available references alluding to difficult intubation run into the tens of thousands - much can be cast aside but this must be done manually.
Airway management has also naturally moved on. Older accepted techniques are not often if rarely used despite their usefulness, for instance the oesophageal detector. Also 2nd generation supraglottic devices are now readily available and recommended in specific circumstances whereas the iLMA was the most sophisticated LMA available at the time. Do we include these devices and practices and if not where is the evidence against?

Newer technology such as videolaryngoscopy is now commonplace, modern pharmacology has given us sugammadex, available in most theatre suites and we have had NAP4. This audit has had a profound aspect change for many of us in anaesthesia and rightly so. How do we include these changes in a revised guideline?

Rather than revising the guidelines for unanticipated intubation should we be considering including protocols and advice for managing the expected difficult airway?

A committee to address all of this has been set-up and we have had several meetings calling on the combined knowledge of our airway community glitterati as well as some hard graft. Hopefully we'll have something before 5 years is up.

RB

DEPARTMENTAL AIRWAY LEADS

The article we reproduce below was published in the College's November Bulletin (http://www.rcoa.ac.uk/document-store/bulletin-76-november-2012) by kind permission of the Bulletin Editor (Dr Anne Thornberry) and the Council of the Royal College of Anaesthetists.

The RCoA-DAS Departmental Airway Lead and NAP4 follow-up surveys: an announcement

The fourth National Audit Project of the RCoA and Difficult Airway Society (NAP4) was launched in March 2011. The project identified more than 180 cases in one year where complications of airway management in anaesthesia, intensive care or the emergency department led to major patient harm including 48 events resulting in death or brain damage. Analysis of the reporting patterns indicated that only one in four of events occurring may have been captured by the project. In the detailed report more than 150 recommendations were made with the aim of improving national, institutional and individual professional practice to reduce the risk of such events.

The RCoA-DAS Airway Lead

One of the key recommendations of the NAP4 report was that each department of anaesthesia should have a 'Departmental Airway Lead'. This has been a long-standing recommendation of the Difficult Airway Society (DAS) and some hospitals already have such posts. Following discussion between representatives of the Difficult Airway Society and the RCoA, the College Council has endorsed a strong recommendation that all departments should conform with this NAP4 recommendation.

The responsibilities of the Airway Lead should include:

➢ Overseeing local airway training for anaesthetists and assisting in airway training more widely.

➢ Ensuring local policies exist and are disseminated for predictable airway emergencies.

➢ Ensuring that difficult airway equipment is appropriate to the local guidelines and standardised within the organisation.

➢ Liaising specifically with the intensive care unit and emergency department to ensure consistency.

Clearly, the roles of the Airway Lead would not be limited to this list and the person should provide leadership and practical support in all relevant matters. Local flexibility in the exact roles of the Airway Lead is assumed but further responsibilities might include: actively engaging in airway device procurement; ensuring consistency of airway assessment and planning; ensuring best practice in management of patients at risk of aspiration and the obese; and overseeing audit of airway assessment, guideline adherence and complications.

Much of this work is probably already performed in an ad hoc manner in hospitals that do not have an Airway Lead: this decision and its announcement aims to improve the uptake and reliability of this role. The formal recommendation for this post to be adopted in all hospitals emphasises the importance of safe airway management and also the important leadership role the anaesthetic department can take in airway management across the hospital. While the RCoA cannot impose the allocation of SPA activity on hospitals, the formal recognition of this role by the RCoA should help those seeking local recognition of this work in job and SPA planning. The RCoA plans to maintain a database of Departmental Airway Leads.

The appointment of an RCoA-DAS Departmental Airway Lead is now recommended by DAS, in the NAP4 report and strongly recommended by the RCoA.

NAP4 Follow-up Surveys

In addition to the above strong recommendation, two surveys are planned to study the impact of NAP4 and re-visit airway management practice after NAP4.

1 National survey of institutional responses to NAP4

While widely quoted and cited, it is uncertain how much the NAP4 report has impacted on organisation and practice and to what extent its recommendations have been implemented. This is important for a number of reasons including understanding the impact of this and future NAPs. A high quality detailed online survey is planned for autumn 2012. This one-off survey will be circulated via the new network of Quality Audit and Research Co-ordinators (QuARCs) and RCoA-DAS Departmental Airway Lead as necessary. We hope this survey will be welcomed and completed in all hospitals.

2 National 'sprint audit' of airway management practices

The Health Service Research Centre of the National Institute of Academic Anaesthesia has proposed that 'sprint audits' might form a useful mechanism to collect national data on anaesthesia practice and activity over short periods. A sprint audit is planned over a period of a few days intending to collect data from all patients anaesthetised on the given days to examine the impact of NAP4 on everyday airway assessment and management. This is likely to occur early in 2013.

We hope the announcement of the RCoA-DAS Departmental Airway Lead and these follow-up projects are welcomed as we strive to learn from and act on the findings of NAP4.

Tim Cook	*College Advisor on Airway Management and NAP4 Editor*
Nick Woodall	*Editor NAP4*
Chris Frerk	*Editor NAP4*
Ellen O'Sullivan	*President DAS*
Alistair McNarry	*DAS*
Sharon Drake	*Director of Education and Research, RCoA*
Professor Mike Grocott	*Director Health Services Research Centre, NIAA*

The Videolaryngoscopy Project

Being a member of DAS is all about believing it's important to improve airway management for the benefit of our patients. About 5 or 6 years ago we got our first video laryngoscope at Northampton General Hospital and conversations with DAS colleagues at the time set us thinking - "Would these devices help us look after patients more safely?"

The questions we needed to answer included:
1) Can videoscopes help us secure an airway with a tracheal tube when the Macintosh laryngoscope fails?
2) Are some videoscopes better than others at showing us the larynx?
3) Is it easier to place a tracheal tube using some videoscopes compared to others?
4) What are the learning curves for using the various videoscopes?
5) What are the pitfalls and how can we overcome them?

Out of these questions the videolaryngoscopy project was born.

There have been many peer reviewed publications on the subject; manikin studies, case series studies, evaluations by experts in selected populations such as the obese patient and the "predicted difficult" patient and a few with small numbers comparing a particular device with the Macintosh, but none answering the question as to how these new tools perform in our real world day to day practice.

After alpha and beta testing, a new way of assessing videolaryngoscopes was launched www.videoscope.das.uk.com Any anaesthetist using videolaryngoscopy as a tool for intubation is welcome to submit data to the study and many have signed up. The dataset collected is small to encourage participation while hopefully providing information that will be useful to the profession as a whole. Those who sign up and upload data automatically have access to their own "logbook" of video-intubations whilst simultaneously adding to the bigger picture. Combined data is presented, available to any and all who visit the site, updated manually at present (at intervals depending on webmaster workload)!

What's the news so far?
Information gleaned from the project has led to the construction of a user guide (available to all via the weblink) with top tips from regular users to short cut some of the learning curves, acting as a sort of virtual training guide.

There's been initial interest from a journal editor in the data collection technique as a

model for future studies in airway management *(must get round to writing that paper sometime)*

We've had a discussion with one of the videoscope manufacturers about the project. They are highlighting it in their internal communications & encouraging their "reps" to bring it to the attention of their anaesthetists as they can see the value of real world evaluations of their product being available to existing and future customers.

I've had several calls on the back of the project asking me "which videoscope would you recommend based on the project to date?" I'm always happy to give an opinion!

So, the long and the short….. (*aka the results, ed.)*
Nearly all the videoscopes on the market have been used on occasion to "rescue" a failed Macintosh intubation.

Videointubation is a new skill and needs training and practice (the ability to intubate using a Macintosh does not prepare you to intubate using a videoscope). Your left hand needs to learn a new skill (exposing the larynx) and your right hand needs to learn a new skill (passing a tube) – for details see the user guide!

Videoscopes are not a homogenous group – the skills are not directly transferable from one device to another.

The various scopes have advantages and disadvantages, in the first instance pick just one device and practice with it until you become competent or ideally (as a DAS member) expert in its use.

What next?
At DAS Cardiff I need to track down the new ADEPT officer to talk studies that will help anaesthetists involved in procurement to decide which devices we can support for purchase around the UK for routine use while more focussed studies will give us more detailed information about the many new videoscopes that continue to come to market.

I believe all anaesthetists should be familiar with the use of at least one videolaryngoscope and be using it regularly as part of their routine practice. It's not acceptable as airway experts to have only one technique for placing a tracheal tube.

Chris Frerk

The editors would like to thank Dr Frerk for his willingness to engage in potentially dangerous sports, just to provide pictures for the newsletter

Treasurer's Statement

I am pleased to report that the Society is on a much stronger financial footing now our new revenue streams have bedded in. This is welcome, as we can no longer rely upon our Annual Scientific Meeting (ASM) to generate profits large enough to fund DAS's charitable aspirations and, at the same time, maintain a £100k cash reserve to guarantee future local orgainising committees of ASM's against loss.

The most important new revenue stream has undoubtedly been the increase in member's subscription fees from £10 to £25, conferring upon DAS a significant and dependable source of income. We are extremely grateful for the generosity of our members: it has allowed us to comfortably fund the DAS Extubation Guidelines, award two significant airway research grants via the NIAA, continue our sponsorship of Ugandan trainee anaesthetists plus maintain the iDAS smart phone app. Along with charges for newsletter adverts, a DAS PAYPAL account has given overseas members a quick and convenient way of paying their subscriptions as well as attracting companies from afar a field as the USA and Australia to the DAS equipment manufacturers directory page: all welcome sources of income.

We have also reduced our expenditure: DAS committee members, co-opted members and working party members have all endeavored to limit their expenses whilst on DAS business. Savings have been made regards the DAS newsletter's printing costs. The society was also the grateful recipient of £2.4k donation from Guys hospital (unused funds in a legacy account used to organize previous DAS meetings).

I am delighted to report that the £30k loan to Nottingham 2011 was repaid in full along with a modest profit (£2.6k). Loans have been raised by the local organizing committees of Cardiff 2013 (£10k) and Ascot 2013 (£8.9k).

DAS continues to administer accounts for the DAS 2007 ASM's local organizing committee (Portsmouth) and the recipients of our 2010 NIAA grant.

Dr. Pete Groom
DAS Treasurer
Peter will have a more detailed version of the accounts to present at the Annual Members Meeting.

DAS Surveys

Imran Ahmad writes

I would like to start off by thanking all of you who have taken the time to complete the various surveys we have distributed over the past year.

We set up the service in response to the increasing number of requests from DAS members asking if they could send out airway related surveys. We currently have close to 3000 members at DAS, so a huge amount of useful information can be obtained from these surveys, which enables us to target a large group of anaesthetists with an interest in airway management.

We have had a number of survey requests this year, those selected have been distributed to our members receiving between 350-900 responses. Most of these surveys have been submitted as abstracts to this year's meeting, as well as to other national meetings and journals.

The service was very useful when we were asked by the NIAA to complete the priority setting exercise for research in airway management. Over 350 of our members replied to the questionnaire, enabling us to inform the NIAA which areas of research should be prioritised in the field of airway management. Of all the sub-speciality groups involved in this exercise, we received the largest number of responses.

Below are the titles of the surveys distributed over the last year:

National survey of LMA size selection and cuff pressure monitoring in the operating theatres in the UK
Extubation practices in theatre
Bag mask ventilation in rapid sequence induction: to bag mask ventilate or not?
Videolaryngoscopy survey
DAS Priority Setting Exercise

I am fully aware that most of us are regularly bombarded with survey requests, this is why we have limited the number of surveys we distribute to our members and we only select clinically important and well designed surveys. We are currently creating a tab on the DAS website which will have a summary of all the DAS survey findings for you to view so please look out for this in the near future.

I hope you will continue to support our surveys by taking out a few moments of your time to complete them, we will soon all be able to benefit from the findings by accessing a summary of the results, which will represent the views of a large group of anaesthetists with an interest in airway management.

We already have a number of survey requests awaiting distribution next year, but if you would like to submit a survey to DAS please follow the guidelines on the DAS website, under the tab 'DAS Surveys' and email me on surveys-coordinator@das.uk.com

Imran Ahmad, DAS Surveys Coordinator

RESEARCH PRIORITY SETTING EXERCISE 2012:

As promised we list below the Specific Questions that ranked highly from the 330 responses (see the Autumn Newsletter)

Specific Questions

Can we predict patients whose lungs are difficult to mask ventilate?

Does preoxygenation matter?

Can we predict which patients will be difficult to intubate?

What is the best form of airway management in the obstructed patient?

Is gas induction indicated in the difficult airway?

Should we practice/teach needle or surgical tracheal emergency access?

What is the best airway management strategy for the morbidly obese?

Should we start doing routine awake fibreoptic intubations for all morbidly obese patients?

There is a trend towards ventilating on laryngeal masks. Is this is as safe as intubating is morbidity less or outcomes better with improved patient satisfaction?

What is the prevalence of sleep apnoea in surgical patient's and how are these patient's best managed perioperatively?

Do single use fibre scopes have any advantage over reusable scopes?

What are the minimum engineering design features for airway equipment?

Which video laryngoscope is best for difficult intubation?

Which of the new laryngoscope is most effective at facilitating tracheal intubation under vision?

Which sedation techniques pose the least risk to the airway?

Is cricoid pressure in a rapid sequence induction technique still necessary?

Is a classical rapid sequence induction still the safest anaesthetic for patients who have a low risk of regurgitation but are classed as an emergency cases, e.g. appendicectomy.
Is there place for rapid sequence induction with cricoid pressure in modern anaesthetic practice?
Does rapid sequence induction reduce overall risk of airway management problems at induction or does actually increase the risk?
Is intubation safer than supraglottic airway devices?
When, if at all, is a rapid sequence induction with cricoid pressure required?
Is there any evidence that cricoid pressure prevents serious morbidity or clinically significant aspiration?
RCT cricoid versus no cricoid for emergency cases.
Do antacids decrease aspiration pneumonitis?
Does suxamethonium have any influence on aspiration?
As the widespread use of the laryngeal mask resulted in an increase in the incidence of gastric aspiration?
Does the routine use of short acting opiates as part of a rapid sequence technique decreased morbidity by facilitating airway control?
Can we predict patients who have a high aspiration risk?

Will an 'airway team' with predesignated roles for its team members improve airway safety?

Does the use of the cuffed endotracheal tube in prepubertal children enhance safety and decreased overall morbidity?

In pediatric anaesthesia is awake extubation safer than extubation in deep anaesthesia?

Should the head tilt position replace the left lateral head down position for failed intubation/recovery on the basis of increased patients size impeding ventilation?

Management of the airway in the presence of c spine injury: Which intubating devices?

Dr Imran Ahmed
Survey Officer DAS

Professor Jaideep J Pandit
Scientific Officer DAS

ADAM– Ongoing Developments

AdamWiki (http://adamwiki.liv.ac.uk) –

sister website to ADAM (http://adam.liv.ac.uk)

When the ADAM website was first launched we realised it was not going to be quite the same for someone trying to use it if they had not been on an ADAM-based course.

The newly released AdamWiki serves two functions: as a manual for the ADAM website and as an airway wiki for users to access and hopefully even contribute to.

Because they have been designed to work together you are registered for AdamWiki immediately after registering for ADAM. The same password is used for both sites.

In ADAM your username is the email address you register with but the wiki needs to be different and is generally of the form "J.Smith". You can only change your password in ADAM (under the submenu "User Admin"). You will then get a mail to say when you password in AdamWiki has been updated to match it.

You can use either ADAM or AdamWiki alone but the two are designed to work in tandem and optimal use is to have both open in separate browser tags. Then when you click an AdamWiki logo in ADAM, this automatically updates the wiki tag to the appropriate wiki article.

Because it is a wiki you can add upload may different items: tutorials, projects, "how I manage …", "how I use …" with many file types. Some editorial control will inevitably be needed to keep a degree of order and to help folk find what it is they are looking for. You have to accept responsibility for copyright infringements and you do need to have written permission for videos. Ideally you should make your contributions in "wikitext". This is the wordprocessor used in "Mediawiki" and there is loads of information out there on how to use it.

Pete Charters (charters@liv.ac.uk)

Does your department have an AIRWAY LEAD?

The Council of the Royal College of Anaesthetists have now strongly endorsed the NAP4 recommendation that all hospitals should have an Airway Lead.

Tim Cook, the College's Advisor on Airway Management wrote to all Clinical Directors in October 2012 and invited them to register their hospital's Airway Lead onto the College Airway Lead Database.

This DAS RCoA Airway Lead could have many roles– see the Bulletin article reprint, but the first step is to have someone fill the post.

Please ask in you hospital– in some places that will mean you volunteering to take on the role .

Consider what you could do to improve teaching and training in airway management in your hospital.

Get your department to register their Airway Lead with the RCoA.

Look out for the Airway lead Training day!

Don't forget your details

Help DAS to stay in touch with you by keeping your details up to date. Members frequently forget to update their address and email details when they change leaving DAS unable to keep you informed of its activities.

Help us to avoid

Undelivered Mail Returned to Sender

in the DAS Inbox

The Specialist Societies Manager of the AAGBI Busola Adesanya-Yusuf dedicates a remarkable proportion of her working life to the Society and she will happily update your contact details.

Contact Busola

Busola Adesanya-Yusuf
Specialist Societies Manager
Association of Anaesthetists of Great Britain & Ireland
21 Portland Place
London
W1B 1PY

Or email DAS@aagbi.org

Lay Representation on DAS Council

In keeping with other Anaesthetic Societies and to comply with the requirements of the NIAA, DAS are seeking to appoint a Lay Representative.

A call for interested parties

Please note: DAS members are welcome to encourage potentially interested people to apply, however the application must come from the interested individual. This process does not allow for nominations by medical professionals.

DAS is looking for a Lay Representative to attend Council meetings which are presently held up to three times per year (a fourth business meeting is held during the Annual Scientific Meeting). The successful applicant would bring a lay perspective to DAS strategy and decisions, so that our policies are properly influenced by a lay (patient) perspective. We would expect the Lay Representative to serve for two years in the first instance.

The role would not attract any payment but the appointment would be allowed travel and subsistence expenses in line with the current DAS policy.

Interested parties should apply to the secretary@das.uk.com by way of a 1 page resume outlining any previous experience of involvement in healthcare, human factors, teaching and training and or their interest in anaesthesia or airway management. Two references should also be supplied.

As Lay Representatives are designed to increase the openness of the Society, potential applicants should also detail any association with the present members of DAS Council

Applicants may be interviewed by telephone and unfortunately it will not be possible to provide feedback to the unsuccessful applicants.

The deadline for applications is- **31st December 2012**

Specific queries about the post can also be addressed to the Secretary at the email address above.

DIFFICULT AIRWAY SOCIETY

Cardiff/Caerdydd 21st - 23rd November 2012

DAS Grants

DAS is delighted to report that through the NIAA it has been able to support a research project to the sum of £3,855.40,

.

"Bench study comparing three different emergency tracheal access devices in a porcine model."

Wendy King, Bhavesh Patel.

Royal Surrey County Hospital Guildford

Dr Patel summed up the study

"VBM has recently introduced the Surgicric-1 into the market place. This new device looks to provide a simple pre-prepared 'all-you-need' surgical cricothyroidotomy kit which may bridge the divide between needle cricothyroidotomy and a surgical technique.

We plan to conduct a bench study comparing 3 cricothyrotomy techniques (surgical cricothyroidotomy, Melker Emergency Cricothyrotomy, and the new VBM Surgicric -1) on a porcine airway.

We would like to congratulate them on their substantial award and look forward to hearing about their study as it progresses. Members are welcome to seek advice or funding for a potential airway investigations or projects . They are advised to contact the Scientific Officer in the first instance jaideep.pandit@dpag.ox.ac.uk.

DIFFICULT AIRWAY SOCIETY

Cardiff/Caerdydd 21st - 23rd November 2012

DAS 2012 Conference Notes

Wednesday 21st November 2012, 17:00 – 19:30
The Welcome Reception and opening of Trade Exhibition will be taking place at Cardiff City Hall following the workshops

Thursday 22nd November 2012
Registration from 0800, programme starts 0900
The day includes
The SAM Lecture (Prof Richard Cooper) and
The Macewen Medal Lecture (Prof William Mapleson)

1600 Special Meeting to consider constitutional changes
Followed immediately by the
Annual Members Meeting

1930-0100 Gala Dinner National Museum of Wales

Friday 23rd November 2012
Registration from 0800, programme starts 0900
The day includes
Modelling, Predicting and Extubating the airway
Pro Con Debate– Paralyse then Ventilate or Ventilate then Paralyse

Wednesday13th November 2013
DAS Ascot opens

Proposed Constitutional Changes

This article first appeared in the Autumn Newsletter. It is rproduced here to try and explain the thinking behind the constitutional changes that will be proposed at the special meeting preceding the Annual Members Meeting in Cardiff.

The Difficult Airway Society is approaching its twentieth birthday, and the constitution is showing how our lives have changed in the intervening years. In the original constitution there is no mention of email addresses or digital communication. Similarly voting for the elected posts on Council was to be done by votes cast at the Annual Members Meeting.

The Society has grown, and with well over 2000 members it is unreasonable to expect everyone to make it to the Annual Scientific Meeting to vote. The Society was faced with a dilemma– the constitution enshrines the principle of one member one vote but this was becoming harder to deliver.

One solution is to move to electronic voting– administered by a body such as the Electoral Reform Society– members would be emailed out a voter specific but confidential pin number to allow them to cast their votes for the candidates.

Unfortunately this means that certain sections of the constitution need to be updated – and while a root and branch review of the constitution is underway, the opportunity to make our voting processes more transparent seemed too good to miss– the actual wording of the changes can be found on Page 24, but in short

> *Voting will move away from the Annual Members Meeting and will be conducted electronically in February*
>
> *It allows the Society to function should an elected officer need to demit office during the year*
>
> *It formalises the positions of past President, Secretary and Treasurer to allow the smooth transition of activities*

And that's really it!

The changes proposed will probably require some further changes to each paragraph in due course, but the aim is to democratically move the society in line with the progress of technology– 'tho we don't have a voting app yet! *AMcN*

Full Text of the *proposed*

Constitutional Changes

Please see the article on the preceding page for an explanation of what the proposed changes mean in practice

The amendments and additions are in red.

3.02 Full Membership
Full Membership of the Society is open to all medical practitioners regardless of grade, who remain registered with the General Medical Council or a similar institution in their country of qualification and who share the common purposes of the Society.

Each Full Member shall be eligible to vote at the elections of the Society, and shall have one vote which may be recorded in person or electronically as decided by the Society, and by delivery to the Secretary of the Society.

4.02. Election of Officers
Written nominations for the posts of Officers shall be submitted to the Honorary Secretary by the start of the Annual Scientific Meeting. The nominee must be a Full Member of the Society in good standing, must have a seconder, and must give written notice of a wish to be nominated.

All Full Members with a valid email address held by the Society shall be informed of the nominations for the Officer posts either in writing or electronically
Voting shall be by a majority of votes cast by Full Members during the voting period.

Electronic voting for the vacant posts will commence not later than the 28th February for a period of not less than 2 weeks.
Members without access to a valid email address should identify themselves to the Honorary Secretary by the conclusion of the Annual Scientific Meeting
The results will be issued electronically following ratification by the Council of the Society

Officers may, upon retirement from office, be eligible for a further term of office.

4.03 Vacant posts arising out side the nomination period
Should any elected post fall unexpectedly vacant during the year, the committee have the right to appoint an appropriate individual to that post until proper elections

can be held as outlined.

4.04 Office bearers during an election
Post holders of posts declared vacant at the Annual Scientific Meeting will remain in office until the successful conclusion of the electoral process outlined. When they demit office they shall remain as immediate past president, secretary or treasurer as appropriate for 1 year.

4.05 Vacant posts without candidates
Should no nominations be received by the end of the annual scientific meeting for a post declared vacant, the committee reserve the right to appoint an individual to said post to allow the full and proper functioning of the Society until a further nomination announcement and election can be held the following year

Please note that if the constitutional changes are accepted then the Annual Members meeting which follows will be conducted under the new rather than the old constitution

Questions on the proposed constitutional changes can be addressed to the Honorary Secretary

In the Spring Edition

Meet the trainee rep

The Macewen Medallists

The abstract competition prize winners

Hear how it is across the pond, a report from SAM

November 2012

Dear Difficult Airway Society Member,

Nominations for the vacant posts (to be decided at the AMM or by electronic voting depending on the constitutional changes) are as follows Candidates are listed in alphabetical order

Nominated for DAS President:

Dr Atul Kapila

Dr Jairaj Rangasami

Dr Andew Norris

Nominated for DAS Hon. Secretary:

Dr Alistair McNarry

Dr Mark Alexander Price

Dr Subrahmanyam Radhakrishna

Dr. Atul Kapila
Difficult Airway Society Hon Secretary :
Department of Anaesthesia
Royal Berkshire Hospital
London Road, Reading
Berkshire RG1 5AN, U.K.
+44 (0)118 3227065

Difficult Airway Society Annual Members Meeting
22nd November 2012 16:00 Cardiff

Agenda

1. Constitutional changes – in Special Members Meeting
2. President's report — Dr Ellen O'Sullivan
3. Honorary Secretary's Report — Dr Atul Kapila
4. Honorary Treasurer's Report — Dr Peter Groom
5. DAS Project Reports — Dr Jaideep Pandit
6. DAS Newsletter — Dr Alistair McNarry & Dr Ravi Bhagrath
7. DAS medal
8. Trainee Rep
9. Future Meetings

2013: Ascot — *Drs Jairaj Rangasami/ Mridula Rai*

2014: Stratford upon Avon — *Dr Subrahmanyam Radhakrishna*

2015: DAS 20th Anniversary Meeting
World Airway Management Meeting (WAMM) DUBLIN
Drs Ellen O'Sullivan, Bernie Liban, Elizabeth Berhinger and the DAS/ SAM Team

10 Date of next meeting

I hope that you are able to attend.

Best wishes
Atul Kapila

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