



# Anaesthesia News

The Newsletter of the Association of Anaesthetists of Great Britain and Ireland

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## 35th Annual Scientific Meeting of GAT, Keele, 12-14 June 2002



By Dr Elis Owain Hughes

As a member of the organising committee for this year's GAT Annual Scientific Meeting, whilst attending last year's meeting in St Andrews I had one over-riding concern. I was not worried about us matching their excellent scientific programme, nor was I worried about having to organise two great social events or even having to live up to their magnificent setting. No, my greatest worry was that nobody I spoke to seemed to have any concept of where Keele was!

Keele is situated about three miles from Stoke-on-Trent, home to Wedgwood pottery, Sir Stanley Matthews, Robbie Williams, Nick Hancock and soon to be remembered for its GAT meeting. It is just off the M6, about half way between Manchester and Birmingham and is easily accessible by road and by rail.

For those wishing to fly, it is within an hour of Liverpool, Manchester and Birmingham airports. It is a relatively new university campus with excellent facilities, all within close proximity.

The scientific programme should appeal to all grades of

trainee and covers topics such as:

- current trends in ITU;
- Starling was a star, but did Ringer have the solution?
- types of monitoring you don't see every day;
- hot topics in Obstetric Anaesthesia – why are we doing so many sections?
- a debate on whether or not there is a need for anaesthetists in A&E!
- transfer of the critically ill patient;
- Pinkerton Lecture – Professor Phillip Routledge, Professor of Clinical Pharmacology at Cardiff University – 'Drug safety; a titanic struggle'.

As always, there will also be the Registrar's Prize and the Linkman conference. In addition, GAT is launching its new





audit prize at this year's meeting. This is to be contested in the form of a poster presentation, so for all of you out there who've had to do some form of audit this is a chance for you to get something more out of it (£££) other than just a mention on your CV!

Equally important at any GAT meeting is the social programme. The informal function planned for the first night is to be held at the four star Moat House Hotel in Stoke-on-Trent and promises to be the usual mix of good location, good food and good music. The formal dinner will take place at the spectacular Keele Hall, located on the university campus itself and only a few minutes walk from the residences.

For those with stamina or a wish to clear away a few cobwebs at the end of the meeting, Alton Towers is within 30 minutes drive and could be easily visited on the Friday afternoon. I hope that this has whetted your appetite and look forward to seeing you all at Keele in June. Book your study leave now!

## Paediatric Anaesthesia Research Fund



The Association of Paediatric Anaesthetists provides a maximum of £5,000 per annum in one or several grants to support projects that serve scientific development in basic or clinical research in the field of paediatric anaesthesia.

The closing date for submission is 30 June 2002.

Copies of the Statutes and application forms can be obtained from:

**Dr GH Meakin, Honorary Secretary,  
APA University Department of Anaesthesia,  
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## Forthcoming courses for 2002 at The Bristol Medical Simulation Centre

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12 March	Paediatric Course, for occasional paediatric anaesthetists (£150)
26 March	Low-Flow Anaesthesia Course, for anaesthetists (£150)
27 and 28 March	Transport for the Critically Ill Course, for all grades (£275)
24 April	NCCG Critical Incidents Day, for non-consultant career grade anaesthetists (£150)
11 June	Paediatric Course, for occasional paediatric anaesthetists (£150)
19 and 20 June	Team Training for Critical Incidents, for nurses and clinicians (£270)
17 July	NCCG Critical Incidents Day, for non-consultant career grade anaesthetists (£150)
16 October	NCCG Critical Incidents Day, for non-consultant career grade anaesthetists (£150)
22 October	Low-Flow Anaesthesia Course, for anaesthetists (£150)
23 and 24 October	Team Training for Critical Incidents, for nurses and clinicians (£270)
30 October	Paediatric Anaesthesia Critical Incident Day, for occasional paediatric anaesthetists (£150)
18 December	Paediatric Anaesthesia Critical Incident Day, for occasional paediatric anaesthetists (£150)

Specific Departmental Courses can be arranged upon request (fee negotiable)

Don't miss out **BOOK NOW!** Includes coffee, tea, biscuits and lunch. CEPD points approved; 5 points (for 1 day) and 8 points (for 2 day courses).

For bookings please contact:

Jane Southway, Secretary on Tel (0117) 9277120 or Alan Jones, Centre Manager, The Bristol Medical Simulation Centre, UBHT Education Centre, Level 5, Upper Maudlin Street, Bristol BS2 8AE  
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Application forms from:

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# Editorial

## How much are you worth?

Something all consultants will be looking forward to, as a new year begins, is the new consultant contract, currently being negotiated on our behalf by the BMA. Peter Hawker and Derek Machin have played their cards very close to their chests so far and have been widely criticised for not consulting sufficiently with the profession. They have, however, a very tricky juggling act to perform.

We are promised a significant rise in basic pay and payment for the work that we do. Given that there will be a limited amount of cash on the negotiating table, this produces a dilemma. To favour basic pay, which benefits all, or to back out of hours and heavy workload which favours only some.

Not everyone will want differential pay for consultants and yet those of us in hard pressed specialities, of which Anaesthesia is one, will probably support it. One compelling reason is

that it is fair. I will never forget a certain Saturday evening dinner party where a fellow guest, a consultant physician, refused wine because he was on call. He went on to relate how exciting the Premiership football match had been that he had attended in the afternoon. Clearly, one man's on call is another man's relaxing day off! Why should consultants who never or rarely work unsociable hours get the same reward, either in pay or compensatory time off, as those who do?

Another argument is that of potential recruitment problems. Trainees have already shown their unwillingness to work long and unsociable hours without adequate compensation. How else can they be attracted into hard pressed specialities? Moreover, the principal of differential pay for consultants will be attractive to the Department of Health which seems to regard consultants as a lot of idle fat cats (regrettably true in a very few cases) and would seek to encourage us to work harder. Anaesthetists can only gain from the concept.


As Chairman of the CCSC Anaesthetic Subcommittee, I have tried strenuously to put this point of view to our negotiators. I have also pointed out that anaesthetists make up a very significant proportion of the consultant body. Let us hope that they have listened. In the meantime, can I urge you all to write to Derek Machin with your views, even if they are at variance with mine?

This is probably the last chance for many years for the consultant body to get a fair deal on our contract. Let us not waste it through apathy.



*Stephanie Greenwell*  
Deputy Editor

*Sitting the Primary in 2002? . . . .*



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## Letters to the Editor

### Vanishingly small risks

I anaesthetised a list of tonsillectomies the other day and immediately thought of Gas Flo's delightful article, full of wit and wisdom, in the August 2001 edition of your Organ. In the course of four cases, two snares snapped off at the handle before the tonsil had been half garotted and three disposable Boyle-Davis gags 'slipped out', a total of six times, removing two teeth in the process. Luckily, they were milk teeth of wobbly standing and the Tooth Fairy was fully on hand to compensate loss and mitigate distress but one wonders how much more danger and morbidity is going to be caused by this rotten equipment.

Now, I read in *Anaesthesia* that items of re-usable anaesthetic equipment which have been 'cleaned and autoclaved' still have protein deposits on them. So now, I suppose, we will be told to throw away all anaesthetic equipment after use. Although this will contribute to the 400 million tons of rubbish, the disposal of which is currently excercising Mrs Beckett and the Government so much and, although it will cost the NHS dear, it must be done in order to reduce the risk of transferring the nvCJD prion.

But will it? The numerator of the risk factor is about 110 (cases of nvCJD so far diagnosed) but the denominator is somewhat larger. Assuming that about 50 million people in the UK are not vegetarian and had the temerity to ingest beef products such as hamburgers, steak or mince at least once a week between 1980 and 1988 – when the Ruminant Feed Ban became law – that makes 50x52x8 million (= 20.8 billion) exposures. So, the risk of contracting this horrible disease from eating beef is 1 in 189,090,900. This doesn't include those who have had surgery or an anaesthetic within the same period, of which there must be about 24 million.

So, even though several means of catching the disease have been found, such as cannibalism, hormone injections and eating contaminated brains, re-using surgical and anaesthetic equipment and eating beef almost certainly are not among them. The fact is that 85% of all CJD cases are sporadic – meaning their occurrence can only be explained by chance. It may be that the length of the incubation

period is uncertain but, if it gets much longer, it won't matter because we'll all have died of something else.

When Gas Flo said this was a VSR (Vanishingly Small Risk), she was dead right, wasn't she? And when we have to throw everything away after one use, it's not risk management, it's panic.

*Dr D M Jackson,  
Swindon*

### Are you equipped?

In preparation for this Trust's response to the RCA's edict on anaesthesia machines, I have been conducting a brief telephone survey of the position and activities of other anaesthetic departments similar to ours. Apart from realising that we are woefully behind everyone else in terms of becoming 'compliant', I have also realised that it was extremely useful talking to other 'Equipment Officers'.

Of the ten or so other consultants I spoke to almost all agreed that some kind of gathering to discuss problems and exchange ideas would be extremely useful. Might I be so bold as to suggest that the AAGBI represents the perfect umbrella organisation under whose auspices such a group might be convened. We could meet two or three times a year, perhaps once each year together with representatives from BAREMA and the MDA. With luck, foresight and careful planning this group might allow anaesthetists to guide developments in all aspects of equipment design, manufacture and use, rather than reacting to problems only as and when they are brought to our attention by yet another disaster reported in the news.

It might also allow those who opine on these matters on behalf of the AAGBI to be informed by grass-roots opinion and practice.

*Iain Mackenzie  
Cambridge*



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## Anaesthetist or Doctor?

Whatever they felt about National Anaesthesia Day, anaesthetists were not surprised to learn from last year's NAD poll that 40% of the public did not know that anaesthetists are doctors. However, they may be more surprised to learn that at least one 'world-class' pharmaceutical company appears to suffer from the same ignorance.

All drugs today must include a 'Patient Information Leaflet' (PIL) with the packaging. At first, these were written without clinical knowledge or insight, so that many were unintentionally funny. PILs have now been in existence long enough to be have been edited into the real world. Except one.

Imagine you are a patient about to undergo anaesthesia. What would you think if you read the PIL for an anaesthetic agent whose first paragraph ends "If you have any other questions... ask your anaesthetist or doctor."? Would this make you think of your anaesthetist as a doctor? It gets worse. "Before receiving your anaesthetic, the anaesthetist, surgeon (sic) or intensive care doctor will assess your medical condition..."

Altogether, this misleading document contains similar references to "anaesthetist or doctor" three times, "anaesthetist or intensive care doctor" six times, "anaesthetist, surgeon or intensive care doctor" once, "anaesthetist" once and "anaesthetist or hospital pharmacist" once.

The reference to the anaesthetist alone appears among details of technique, as if this was the anaesthetist's sole responsibility. That to the anaesthetist and pharmacist is in a section on storage of the drug, to which I could not complain if it did not say that the pharmacist is responsible for the use of the drug.

Altogether, I feel that this leaflet, intended for patients but probably never read by one, betrays ignorance, not only of the qualifications of the anaesthetist but of their role and responsibility. How very sad, when the pharmaceutical company once promoted itself as 'world class' and has been closely associated with the development of several anaesthetic agents. How much sadder that it was over a year ago that I pointed this out to the company, was assured that my fears could not be further from the truth and that the leaflet would be shortly rewritten. The leaflet has not been revised.

I keep you in suspense no longer. The drug is Diprivan, made by a firm called Zeneca or something. Never heard of them.

*John Davies, Lancaster*

## Funding for LMAs

Following a recent telephone survey of anaesthetic departments, it has become apparent that a number of anaesthetists who routinely used LMAs for tonsillectomy have reverted to using tracheal tubes as a result of the cost implication of disposing of an expensive item after single use. However, it has come to my attention that a letter has been circulated by the Department of Health to Chief Executives of NHS Trusts and Health Authorities which clearly states that there is central funding for all airway equipment, INCLUDING LMAs.

This was obviously news to me. I wonder how many other consultant anaesthetists are unaware of this fact. More information from [tonsils@doh.gsi.gov.uk](mailto:tonsils@doh.gsi.gov.uk)

*Rhys M Jones, Cardiff*

PLEASE SEND YOUR LETTERS TO

The Editor, *Anaesthesia News*, AAGBI, 9 Bedford Square, London WC1B 3RE or email [anaenews@aagbi.org](mailto:anaenews@aagbi.org)

## Changing things

Dr Alladi's letter on stress at work (*Anaesthesia News*, October 2001) makes several good points and quite rightly identifies a number of known stressors for anaesthetists. These include lack of control and unpredictability in our work. He is right in stating that stress management strategies should be adopted by the whole organisation. Nevertheless, as the Deputy Editor points out, we cannot necessarily expect any assistance from management as they themselves have their own agendas and have often already committed themselves and their systems to unrealistic performance goals.

I am concerned, however, that there is a note of helplessness in Dr Alladi's letter. This echoes the feelings of helplessness often expressed to me at our stress seminars and at meetings around the country. I don't think that we are helpless. However, we can easily come to believe that we are! I think that we can, in fact, escape from this helplessness by questioning some of our beliefs and then by being assertive.

One of the reasons that we may allow our activities to be compromised in such a way as Dr Alladi describes is because we are not being assertive. Another reason may be that we may have developed distorted beliefs about the correct actions. We may have come to believe that we do have to do whatever the surgeon asks. We may believe that our obligation to ensure that the trust reaches its performance targets overrides our obligation to optimise patient care.

Is it true that we have to anaesthetise any patient who is presented to us on an operating list, without preparation? What would happen if we refused? Would we be viewed as obstructive – or as wise clinicians? Why do some of us feel unable to do what we know is best for the patient? What do we fear? Is it loss of face, or loss of private practice? Do we have to allow operating lists to be unmanageably long? What would happen if, after previously warning that we were going to do this, we cancelled some of the cases to make the list a manageable length? Would we be accused of being lazy – or sensible? Could we suggest that the surgeons look at requesting a further operating list. That would be constructive.

The action of refusing to anaesthetise a patient until their clinical condition has been optimised is a positive and assertive action. It is undertaken in the patient's best interests. We have to understand that our first obligation is to the individual patient and clinical governance demands that we recognise that obligation. Neither managers nor surgeons should make performance commitments which compromise patients' care. We need to question our beliefs when it appears that we are being asked to act, or are indeed acting against our better judgement.

I can see some of you saying "That's all very well for her" - but we all have to start somewhere. I did – I wasn't born assertive! Try it! Look at your beliefs! If necessary, revise them. Then be true to them! This does involve being assertive - but it is easier if you believe in what you are doing.

*Di Dickson*

*dianadickson@aol.com*



# History Page

## Vignettes of Anaesthetic History

### Ether

1846, 19 December – most probably the first use of ether anaesthesia for surgery in the Old World took place at the Dumfries and Galloway Royal Infirmary, Scotland. The news about ether was brought from Boston to Dumfries by William Fraser, ship’s surgeon aboard the Cunard paddle steamer *Acadia*. Having docked at Liverpool, he hurried to his home in Dumfries for Christmas and wasted no time in informing his surgical colleagues about Morton’s demonstration of etherisation. As a result, surgeon William Scott administered ether and proceeded to operate – seemingly an amputation. However, Scott did not publish this until 1872, when he wrote to *The Lancet*. As mentioned in the October issue of *Anaesthesia News*, ether was used on the same day (19 December 1846) in London for dentistry. The news was brought to London by a letter carried across the Atlantic by the same vessel, *Acadia*.



Dumfries and Galloway Royal Infirmary c. 1840

1846, 21 December – most importantly, however, it was the enormous publicity given to the painless amputation in London under ether by Liston which triggered the march of ether through Great Britain and Europe.

### Birthdays

1908, 25 December - Geoffrey Stephen William Organe was born in Madras. He studied medicine at Christ’s College, Cambridge and the Westminster Hospital Medical School. After taking the DA in 1937 he became House Anaesthetist at Westminster Hospital under Ivan Magill. In 1938 he was the first to describe (with RJB Broad) the use of intermittent thiopentone with nitrous oxide and oxygen. In 1948 he was a founder member of the Faculty of Anaesthetists at the Royal College of Surgeons of England.

### Sir Geoffrey Organe

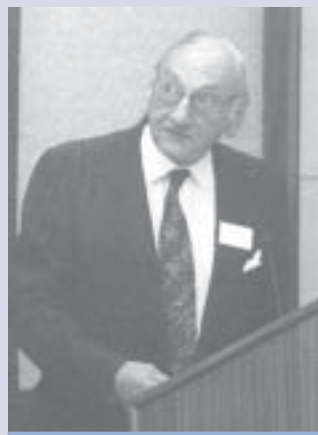
President of the AAGBI 1953–56 and in 1955 became the first Secretary and Treasurer of the newly formed WFSA. Appointed Professor of Anaesthesia at Westminster Hospital Medical School in 1966 and

Knighthood in 1968 when Britain hosted the 5th World Congress of Anaesthesia in London. He died in 1989.

1918, 8 December – Gordon Jackson Rees was born in Owestry, Shropshire. He studied medicine at the University of Liverpool. After serving in the RAF Medical Branch, he studied anaesthesia in Oxford under Professor Robert Macintosh and William Mushin, obtaining the DA in 1946. Appointed Consultant Anaesthetist at the Royal Liverpool Hospitals in 1949; the following year he and Professor T Cecil Gray introduced the concept of “a balanced anaesthetic when a relaxant is used to complete the triad of relaxation, narcosis and analgesia”. Jackson Rees is best remembered for another achievement in 1950: the introduction of “a double ended bag to the exhaust limb of the Ayre’s T-piece” for controlled ventilation in neonates – the Jackson Rees modification. A founder member and later President of the Association of Paediatric Anaesthetists of Great Britain and Ireland, he became the first President of the Federation of European Associations of Paediatric Anaesthesia. An enthusiastic member of the History of Anaesthesia Society, he died in January 2001.



Sir Geoffrey Organe



Dr Jackson Rees


### Nobel Prizes

10 December, date of the award of Nobel Prizes in Stockholm every year since 1901.


- 1902 Emil Fischer – synthesised the first barbiturate.
- 1908 Paul Ehrlich – receptor concept, blood-brain barrier.
- 1930 Karl Landsteiner – discovery of human blood groups.
- 1936 Henry Hallett Dale and Otto Loewi – elucidated the chemical transmission of nerve impulses.
- 1944 J Erlanger and HS Gasser – classified mammalian nerve fibres into A, B and C groups.
- 1957 Daniel Bovet – synthesised gallamine and introduced suxamethonium.
- 1970 B Katz, J Axelrod, U von Euler – details of neuromuscular transmission.
- 1998 R Furchgott, L Ignarro, F Murad – work on nitric oxide.

Alistair McKenzie





University Hospitals of Leicester   
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## Writing for Anaesthesia News

Anaesthesia News is always happy to receive copy of articles, reports, travel stories and opinions. Most will be accepted although some editorial revision or abbreviation may be necessary. Letters to the Editor are particularly welcome. There are several ways of sending your work to your Newsletter and it should arrive at least four weeks before the intended publication date. A Word file, posted on a disk or sent attached to an email is best, although typescript may be scanned. Please send photographs, of reasonable size and in colour, either as a jpg file attached to an email, or as 'hard copy'. Our contact details are: 9 Bedford Square, London WC1B 3RE. Telephone 020 7631 1650. Fax 020 7631 4352. Email [anaenews@aagbi.org](mailto:anaenews@aagbi.org)

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## A taxonomy for Sodde and his Successors

In his haste to deflate my presumed pretensions and demonstrate his greater erudition, Professor Norman (*Anaesthesia News* No: 170, September, 2001) rushes to take up the cudgels but misses the point. I admit that it is one of some subtlety and I suppose it's partly my fault for leaking out a major philosophical development as a throwaway in the introduction to a much slighter piece on how good the UK anaesthesia system is when compared with some others (*Anaesthesia News* No: 169, August, 2001).

As he rightly points out, there are several apparently similar formulations of the same idea. However, the similarity is actually superficial and it is clearly time for a proper taxonomy of the various branches of the generic Sodde's law. (I acknowledge here my debt to Philip Keep who first revealed that the misnamed 'sod's law' was promulgated by Hippolyte Malchance, Comte de Sodde, Physician-in-Adversity to Louis XVI (Today's Anaesthetist, 1995; 10:110 and 132).

### Physics first

The first sub-class of Sodde's law is related to a well established principle of physics – Le Chatelier's Law, also known as the Law of Pure Cussedness. In essence this says that, when one tries to induce a physical change in a system, the system reacts in a way which attempts to resist the change. A simple example is the compression of a gas. When one does this its temperature rises, thus causing it to try to expand.

### Just your luck

The second sub-class is based on the so-called Laws of Chance. Sodde's Law and Murphy's law attribute a malign influence to the random workings of chance. Why does the toast always fall butter side down? "If something can go wrong, it will." All these formulations arise from the fact that we are more prone to notice, remember and use as conversational gambits chance events which were unfavourable rather than the ones which were favourable. Not much cocktail party mileage in reporting that egg yolk did not break getting it out of the frying pan, despite being dropped. If a Landrover had driven off a motorway onto a railway line just after a train had passed it would never have made the national news, even though it happened by chance.

### The biter bit

The third sub-class is exemplified by Edward Tenner, to whom Professor Norman refers, whose book 'Why things bite back' has chapters explaining why, in a variety of concrete examples, the intended result was not achieved and, indeed, even the opposite result followed. The examples all followed the introduction of technology or innovation and the problem is what to call this effect. I had overlooked the fact that, inside, on the frontispiece, (not the title page) Tenner adds a rider to

his title which then reads: 'Why things bite back – Technology and the Revenge of Unintended Consequences.' This I regard as incorrect terminology. It should have been 'unexpected' rather than 'unintended' because they are effects which were not necessarily related to any intention, one way or another. But, once a new technology is available, its introduction is very difficult to control and the consequences are never all favourable. Think of mobile phones, genetically modified foods and cloning, to take but three recent examples. But even the prediction of an adverse effect cannot put the genie back in the bottle.

Even 'unexpected' is unsatisfactory as, in many cases, they may be expected but assumed to be of no importance. Tenner cites the use of air conditioners as actually heating up the ambient atmosphere, making the city outside the air conditioned offices even more uncomfortable and thus creating pressure for even more air conditioners. Unwanted Outcomes would possibly be better.

### The fourth protocol

Vickers' Law of Unintended Consequences, however, is about humans whose behaviour, in the mass, tends to take a course of action which those who hoped to change their behaviour did not want (or even expect). It exists because the instigators are politicians (with or without a capital P) who see the world and its people as they would like them to be, rather than how they are. They become convinced of the reality of their inner construct. Enoch Powell was certainly aware of this phenomenon when he enigmatically asserted that, if you want to damage your neighbour, give him a subsidy.

These unintended outcomes are generally anything but unexpected to a cynical realist. Let me take a topical example. Today's Sunday paper reviews a book by the Home Secretary in which he floats the idea of increasing the turnout at elections by entering all those who vote in a lottery for substantial cash prizes. Assuming that the secrecy of the ballot is preserved, I predict that there will be two consequences: there will be a lot more spoilt ballot papers and more votes for fringe parties with attractive or misleading names. There may be a third: voting for any party other than the one which cynically tried to manipulate them. "You have a civic duty and I am going to bribe you to do it."

So, despite Professor Norman's charge that it has all been said before, I remain convinced that there is a fourth category of Sodde-type events, namely where an attempt to change behaviour by law or instruction produces an unintended (though not necessarily unexpected) reaction. At all events, even if he denies me the accolade of Vickers' Law of Unintended Consequences, Professor Norman must surely at least grant me Vickers' Sodding Taxonomy.

Michael Vickers



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**10th Video-Conference Meeting**

**LOCAL ANAESTHESIA FOR OPHTHALMIC SURGERY**

*Friday, 8 February 2002, Middlesbrough*

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in North Riding Infirmary, Middlesbrough on 8 February 2002. The meeting will include lectures and live demonstration of orbital blocks. Attendance is limited to 50 participants. Application form and information from Mrs Pat McSorley (Course Administrator 01642 854601). Registration fee is £225 (BOAS Members £200) inclusive of catering. Cheque payable to Cleveland School of Anaesthesia.

**PROGRAMME**

09.00-9.25 **Registration and Coffee** (Staff Restaurant), Lecture in Day Centre Ward 56  
9.25 **Welcome** – Dr Chris Dodds.  
*Chairman: Dr Robert Johnson, Bristol*  
9.30-10.15 **Anatomy Relevant to Orbital Blocks** Prof Jonathan Dutton, North Carolina, USA  
  
10.15-11.00 **The evolution of an effective regional anaesthesia blocking technique for intra-ocular surgery.** Dr Roy Hamilton, Calgary, Canada  
11.15-11.45 **Coffee Break** (Staff Restaurant)  
*Chairman: Dr A P Rubin, London*  
11.45-12.15 **Sub-Tenon's Block: What's New?** Prof Chris Dodds, Middlesbrough  
12.20-12.45 **Local Anaesthesia for Posterior Segment Surgery.** Mr Bartley McNeela, Middlesbrough  
12.50-13.45 **Lunch**, East Ocean, Chinese Restaurant  
13.45-17.00 **Live Demonstration of Orbital Blocks**  
Demonstration Co-ordinators: Dr Anthony Rubin, Dr Chandra Kumar, Mr Tim Dowd, Mr Mamdouh El-Naggar and Mr David Smerdon  
  
**Needle Block**  
Retro/peribulbar Dr Chandra Kumar, Middlesbrough  
Hamilton's Technique Dr Roy Hamilton, Calgary, Canada  
Dr Sean Williamson, Middlesbrough  
Other Needle Blocks Dr Anthony Rubin, London  
Dr Sean Tighe, Chester  
  
**Sub-Tenon**  
Metal Cannula Dr Caroline Carr, London  
Kumar-Dodds Cannula Dr Chris Dodds, Middlesbrough  
Short Cannula Mr Barley McNeela, Middlesbrough  
Greenbaum's Technique, Dr Chandra Kumar, Middlesbrough  
17.00 **Closing remarks**, Prof. Chris Dodds, Middlesbrough

Meeting Organiser: **Dr Chandra Kumar, Consultant Anaesthetist, Cleveland School of Anaesthesia, James Cook University Hospital, Middlesbrough TS4 3BW**  
Tel: 01642 854601, email: cmkumar@globalnet.co.uk

**Royal Orthopaedic Hospital, Birmingham**



**Regional Anaesthesia  
Study Day**

*Thursday 28 February 2002*

This one day course will be held at the research and teaching centre of the Royal Orthopaedic Hospital in Birmingham. The course is aimed at all grades of anaesthetists who would like to further their knowledge of regional anaesthetic techniques. Areas covered include:

- Local anaesthetic drugs
- Complications
- Equipment
- Advantages and disadvantages of regional anaesthesia
- Catheter techniques
- Upper and lower limb blocks

For details please contact the course organiser Dr Guy Shinner FRCA, c/o Anaesthetic Department, The Royal Orthopaedic Hospital NHS Trust, Bristol Road West, Northfield, Birmingham B31 2AP or email guyshinner@barclays.net or tel: 0121 685 4000 ext 55570.

Course details will be available at [www.msa.org.uk](http://www.msa.org.uk)  
Cost £60

CME approval applied for.



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## Thoughts from abroad (Read on, this is not a travelogue)

### *Bonjour Ed.,*

*Here I am sitting on a beach staring at the Med, cloudless blue sky above, with the Albères, the easternmost foothills of the Pyrenees to my right, so you'll no doubt know exactly where I am (O.K. it's somewhere in Spain. Ed.). Close, Ed., but no coconuts. There are a few clues that should make it easy for you, such as the lack of expressions such as "hola" and "buenos dias" (Ah! En France, Ed.).*

The other Dr. McNicol and I are here in the Pyrenees Orientale district of Roussillon in the third last French town before passing over the mighty Pyrenees into Spain. Argelès is a complex of three villages; the port, where we are renting an appartement, the beach resort and the old town, two kilometres inland. We have the perfect combination of sun, sand and mountains, enabling us to choose between long walks along the promenade or into the hills that rise up to about 2,000 feet. In Scotland we call these "mountains". Needless to say, we are in search of a healthy holiday and have been swayed by the television advertisements for the olive oil spread that will keep us frisky into our old age. The other Dr McNicol, being a pathologist, knows about these things and she has assured me that the secret of a healthy holiday is to travel to a Mediterranean resort, eat as much food fried in olive oil as possible, consume as many anchovies as possible and drink at least two bottles of red wine per day (does she not mean 'units'? Ed). Ed., she knows what she means. I trust the other Dr McNicol on this one. It can only be in France that a steak frites washed down with a bottle of Cotes de Roussillon is the healthy option. What a marvellous country!

As usual I've brought a few of my friends with me. This year there's Wilbur, Bernard and Gerald (Smith, Cornwell and Seymour). Patrick (O'Brian) failed to make the cut as I still don't know the difference between starboard and larboard and what does it mean to 'wear' a ship? To be honest I have tried, even looking for websites that would describe the bits and bobs of old sailing ships but have been singularly unsuccessful. Nevertheless, my three other mates have provided me with hours of excellent reading, although for the first time I thought a 'Sharpe' novel might not be up to the usual standard (that'll be 'Sharpe's Prey', Ed.). However, Bernard is not losing the plot as his other book (Harlequin) is a brilliant read, if you're into action and suspense, medieval style. The other Dr McNicol is more into the structure of the novel and most nominations for the Booker Prize accompany us on our holidays. This year I was persuaded by her to read 'Super Cannes' by JG Ballard as she thought I would like it and, having enjoyed the movie *The Empire of the Sun*, I thought I'd give it a try. Well, talk about

racy! I think I'll have to read some more of the other Dr McNicol's arty farty books!

You'll remember that the other Dr McNicol is also into shopping and I had naively imagined that, apart from the odd bowl or two made by the local artisans, the holiday would be reasonably stress free shoppingwise. Doh! The next town, to the south,

just happens to be one of France's oldest and most highly regarded artistic centres. Collioure (see photograph), unfortunately only 55 minutes walk by a coastal path, was made famous by Matisse and his followers and is now packed with artists' workshops, galleries and markets. No doubt some of the paintings on display are reasonably priced, however I have yet to find them. The other Dr McNicol has a nose for the better known artists and fame does not come cheaply. The normal event of things will be that in a few days she will have narrowed down the choice of paintings to two and after a SWOT analysis she'll buy them both. Unfortunately, as I'm colour blind it's difficult to argue when she describes the artist's genius with colour and light, so she's always onto a winner.

Part of the appeal about this part of France is its proximity to Spain and the opportunity to partake of the odd tapas lunch (exceptionally healthy, according to the above criteria) and so it was that yesterday found us heading south. There are two routes to Spain, one by the A-road running parallel to and in combination with the motorway and the other by the corniche. The former sounded rather boring so we opted for the latter, more scenic route. In my ignorance I thought that 'corniche' was French for 'coast' as in 'the coastal road' but, as you are without the hindrance of an education at Allan Glen's School, you will no doubt know that it means 'cliff' as in "Thank God that the upholstery of this brand new hired car is brown with a diced carrot coloured motif"! I suppose such a misinterpretation is only to be expected coming from someone who, on the first evening of the holiday, entered a local restaurant and having greeted the waiter with "au revoir" then asked for a grilled rope sandal and salad as the main course (Ed. a little





knowledge of French is required to see where that mistake came from).

It is at this point Ed. that my medical metaphor comes to mind. Imagine, if you will, a cliff face 100 feet high to your right and the road twisting past it in a series of hairpin bends, totally blind to the oncoming traffic. To your left there is a void, blue sky with the occasional glimpse of the Mediterranean, regularly obscured by semi-articulated lorries full of various brands of yoghurt coming down the middle of the road in the opposite direction (I've noticed that too, why is it always yoghurt? Ed.). You are driving your first ever diesel and are still coming to grips with the finer points of acceleration and traction. The present Mrs Ed. is desperately reciting the Litany of Irish Saints in the off chance of finding the patron saint of white knuckles and looking up you realise there is another 1,000 feet to go before the top of the road, without any turning points, so that there is no chance of reverting to Plan B and going down the motorway (Very descriptive but where's the metaphor, Ed?).

For the car think hospital consultants, driven by their Joint Negotiating Committee against the vagaries of the road that is the government. To one side the inflexible, resistant demands for junior consultants with no independent practice (or, it seems, loyalty payments), plus the uncharted waters of revalidation and appraisal. On the other side if we fail to agree to the government's demands we risk spinning over the precipice towards a health service run by an administration that will remain anti-doctor for not only our medical lifetimes but for

those of our younger and newer colleagues. The present government is not too fussy how the service is manned, or by whom and a negotiating committee that holds out for too much already has the threat of non-consultants being employed to fill the gaps created by dissatisfied consultants leaving the service.

How to play it then Ed.? I'm glad I'm not driving the metaphorical car I have to say. The public utterances of the great and good on the negotiating committee have been quite reassuring. There is a certain amount of steel tempered by a quiet pragmatism and a definite awareness that medical history is being made. I think the committee driving the car will have to steer as close to the centre of the road as possible and accept some conditions that can only be described as impositions whilst making some gains eg on working conditions and salaries. Having said that I have not taken account of the fickle nature of government and it could be that even if our boys (and girls) do get the balance right there is always the risk of a fast one being pulled on them in the form of the unexpected. We could yet find them at the bottom of a metaphorical cliff covered in metaphorical strawberry Yoplait.

I'm off to Oz in December, Ed., to see our first-born, yet another Dr. McNicol, marry his Oz sweetheart and, if I find the time, I'll put paper to pen and send you some more thoughts from abroad. Take care.

*Roddie*

## Infection and Anaesthesia

In recent months, this topic has given rise to many guidance enquiries at the Association on issues such as CJD and acceptable practice in the context of anaesthetic breathing systems. Though disposable tubing is in widespread use, legal interpretation of the semantics of terms such as 'single use', 'once only use' and 'dispose after use' has caused confusion.

Other relevant concerns in our clinical practice include automatic ventilator acquired infection, blood borne infection, hospital acquired (nosocomial) infection and occupationally acquired infection, all of which are under review and will be detailed in Guidelines to be published in the Spring as a new Association 'glossy' booklet.

An oversubscribed Association seminar, generously sponsored by Pall Medical, has already been devoted to Infection and the Anaesthetist and is scheduled to take place again in February. The CJD story continues to unfold and we have been fortunate to have had first hand accounts from leading names in pathology and microbiology on its nature and infectivity. The current position of CJD and anaesthesia has been published in the Bulletin of the Royal College of Anaesthetists by its Vice President, as well as in a previous edition of *Anaesthesia News*.

Topics to be covered in the Infection and Anaesthesia seminar are: prion disease; infectivity and protection from prions; CJD and anaesthesia; ventilator associated pneumonia; breathing system filters and microbiological barrier protection.

*Iain Levack*  
Council Member



FROM LEFT TO RIGHT: Dr Geoffrey L Ridgway, Professor James W Ironside, Professor Graham Smith, Dr Iain D Levack, speakers at the seminar.



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Wednesday, 6 February 2002

A menu of provocative discourse and discussion, 09.30 to 16.30, The Liverpool Maritime Museum

Hosts: Professor Anthony P Adams, President, Section of Anaesthesia, RSM

Professor Martin Leuwer, Head of School, MSAPM

Chairmen: Professor J P H Fee, Professor J M Hunter, Dr S Ingram, Professor B J Pollard

### THE PROPOSED PROGRAMME

#### Hanging Offences

*Professor P Hutton, President,  
The Royal College of Anaesthetists.*

- what is a hanging offence?
- who is the judge?
- what should be the sentence?
- how long need be the parole?

#### Learning to Live with a Hanging Offence

*Dr J McKenzie, Consultant Anaesthetist,  
Royal Berkshire Hospital, Reading.*

- the personal consequences;
- the professional consequences;
- the private consequences.

#### Identifying and Remediating Poor Performance

*Dr K Judkins, Medical Director, Clinical Governance, Lead and Consultant in Anaesthesia, Pinderfields and Pontefract NHS Trust*

- what to do when things go wrong;
- when to take action: when do mistakes become poor performance?
- tackling performance issues in a no blame culture: our approach in Pinderfields and Pontefract.

#### Clinical Risk Management in Anaesthesia

*Dr Mark Hitchcock, Consultant Anaesthetist, West Dorset General Hospitals NHS Trust*

- how to undertake a risk assessment: the key risk areas in anaesthesia;
- developing effective risk management in anaesthesia;
- how we tackle risk management in West Dorset.

#### Improving Clinical Performance in Anaesthesia under Clinical Governance

*Dr R Hopkinson, Medical Director, Lead for Clinical Governance, Chairman of Risk Management and Consultant Anaesthetist, Birmingham Heartlands Hospital NHS Trust*

- the key components of clinical performance;
- a no blame culture is essential to improve clinical practice: key steps to initiate change;
- how we are developing a clinical performance in Birmingham.

#### Demonstrating Good Practice in Anaesthesia

*Dr S M Lyons, Chairman, The Joint Committee on Good Practice (RCA and AAGBI)*

- an overview of the work of the joint committee;
- developing a template for anaesthetists in order to demonstrate good practice in preparation for revalidation: guidance for Portfolios and Appraisals.

#### Revalidation

*Mr D Skinner, Head of Regulation Policy, General Medical Council*

- an overview of the system for revalidation;
- developing local systems and practice: what you need to do.

#### Appraisal in Practice

*Dr J Leigh, Consultant Anaesthetist, North Bristol NHS Trust*

- how we are developing a system for consultant peer appraisal in the Anaesthetists' Directorate at North Bristol;
- how this system may support revalidation and clinical governance;
- an overview of the system and how it is working.

**£95 including lunch and refreshment  
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For further information, please contact:

The Secretary, Mersey School of Anaesthesia and Peri-operative Medicine, Postgraduate Centre, Broadgreen Hospital, Liverpool L14 3LB. Tel 0151 282 6609, fax 0151 282 6935, email msa@rlbuh-tr.nwest.nhs.uk



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Dr M Tremlett, Consultant Anaesthetist, James Cook University  
Hospital. Email: mtremlett@anaesthetics.org.uk

Application forms from:

Mrs PA McSorley, Course Administrator,  
School of Anaesthesia

Cheriton House, James Cook University Hospital,  
Marton Road Middlesbrough TS4 3BW.

Tel: 01642 854601.

Email: Pat.McSorley@email.stahnst.northy.nhs.uk

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Deadline of abstract submission: 15 March 2002

#### Abstract, registration and other details from

Dr Chandra M Kumar,  
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Meeting Organiser,  
James Cook University Hospital  
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Middlesbrough TS4 3BW.  
Email: [cmkumar@globalnet.co.uk](mailto:cmkumar@globalnet.co.uk)  
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#### Organising Faculty

Prof. Chris Dodds, Middlesbrough  
Dr. B Fischer, Redditch  
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# PANG

Pain and Nociception Group

ICSM - Charing Cross Hospital  
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## Forthcoming symposia

Thursday 29 November 2001

### A refresher day in pain management

Wednesday 23 January 2002

### Low back pain - finding solutions

Tuesday 12 March 2002

### Regional anaesthesia - update

Monday - Tuesday, 13 - 14 May 2002

### London chronic pain symposium

Thursday 20 June 2002

### London acute pain symposium

Further information: Mrs S Welham  
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7 Dover Road  
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(Approved for CME)  
(Concessory rates available)



## 13th South West Thames Anaesthesia Update

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- Acute and Chronic Pain
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email: liban@mailbox.co.uk

[www.anaesthesiaupdates.com](http://www.anaesthesiaupdates.com)

## AIM: Anaesthetists In Management

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- Chairman: Peter Wallace, President-elect AAGBI

More information from:

Gretl McHugh, Dept of Anaesthesia, Manchester Royal  
Infirmary, Oxford Road, Manchester M13 9WL.

Fax 0161 273 5685. Email [gretl.mchugh@man.ac.uk](mailto:gretl.mchugh@man.ac.uk)

(Conference commences 1pm on 25th, finishes 4pm on 26th)



## The Pain Society

The British Chapter of the  
International Association for the Study of Pain

### Annual Scientific Meeting 9-12 April 2002 Bournemouth International Centre

#### Plenary sessions include:

- Phantom Limb Pain – Dr TS Jensen
- Dysfunctional Pain: A Challenge to Taxonomy and Treatment – Prof BH Sjölund
- Acute Pain Teams: Past, Present and Future – Prof B Ready
- Pain in Children and Adolescents – Prof PJ McGrath

#### Parallel sessions include:

- Safe Practice in Acute Pain Management
- TENS
- Debate "This House Believes that Acute and Chronic Pain Teams Should Merge"
- Epiduroscopy: Its Role in Radiculopathic Pain
- Debate: "The Place of Intrathecal Drug Delivery Systems"
- Medico-legal Workshop: Quantifying Disability

In addition, there will be a total of 32 parallel mini-symposia and workshops catering for all interests. The meeting is open to doctors and other health care professionals with an interest in pain management. Full details are available from:

The Pain Society, 9 Bedford Square, London WC1B 3RE  
Tel (020) 7631 8870, Fax (020) 7323 2015  
email [painsociety.org](mailto:painsociety.org) meetings@painsociety.org



## Gas Flo

### Notes from a Small Hospital A Tale of Everyday Folk in the North

A funny thing happened in our ITU recently. A patient, who had been admitted postoperatively three days previously, woke up in a very agitated state with eyes starting out of his head, clutched at my colleague's sleeve and whispered, "Have they gone?" He would not elaborate on who 'They' were but spent the rest of the day clearly terrified and demanding to see what lay beyond the dividers on either side of his bed.

Eventually, he admitted to us that 'They' were the Nazis. Now we have a few senior staff who would fit this description but, to the best of our knowledge, this patient had not been in contact with any of them, so the mystery continued until the evening when his daughter came to visit. Apparently, her father had spent some time during the Second World War as a prisoner-of-war. What, however, could have triggered such memories?

Further investigation revealed that, before going to theatre, he had been admitted to A&E, very poorly and semiconscious. The attending SHO was German and, by some coincidence, so were the surgical registrar and the anaesthetic registrar. Each time the nurses left them during the resuscitation to go and get something, they quite understandably spoke to each other in their native language. The mystery was solved.

When we told the surgical registrar this little tale, he promised to go and apologise to the patient. "Don't worry," he said, with a twinkle in his eye. "I'll completely reassure him that there is nothing to fear. The war is over. We let you win!" Communication problems are certainly not confined to those from foreign parts. One of our receptionists recently sent for a patient called Mirena Coil for the gynae list and we have had a similar search for a Mr Denis Brown in general surgery.

Then there are the surgeons who have a language all their own, seem only to understand what they want to understand and are completely incapable of cutting and listening at the same time, let alone responding appropriately. Here's a good example. "The light is terrible." (I can see quite well but I haven't the faintest idea what I'm doing in here.) Moreover, when you attempt to move the light, they will say nothing if it's OK and merely complain if it is not, so it is impossible to know when to stop. Same with the height of the table and the temperature in theatre. Another example. "What's the blood pressure?" (The patient is bleeding like stink. It's probably my fault but I'll try to blame it on you.) And "I'm nearly finished here. You can think about sending for the next one." (Actually, I'm miles off finishing but sending for the next patient will keep you off my back for a few minutes while I think about what to do next.)

Which brings me to a really amusing communication error which occurred some weeks ago. I was working in orthopaedic theatre with an anaesthetic nurse who hails from an area close by famous for the particularly broad accent of the inhabitants. We were to be accompanied by a young male nurse, newly arrived from the Philippines and undergoing an induction period in theatre. To the great annoyance of the anaesthetic nurse, the patient arrived in the anaesthetic room minus underpants. (Why is it that all gynae and urology patients have their pants on and all others do not?) Anyway, tutting with irritation, our nurse asked the Filipino to go quickly to Recovery and get some, as it was a long list and time was of the essence. He dashed off and to the complete consternation of the recovery staff and all vaguely conscious patients, cannoned through the double doors in the manner of a gunfighter entering a wild-west saloon crying "KNIKKAS!" Of course the poor boy had absolutely no idea of what he had been sent for and the effect it would have on the staff but it gave us all a good laugh, including him when he got over the embarrassment. All of which illustrates a number of points:

1. The workforce in the NHS is becoming increasingly cosmopolitan.
2. This is not always the cause of communication problems but it can be.
3. Misunderstandings can be potentially serious for the patient but are more often a source of amusement.
4. Laughter is a universal language.
5. Even Germans can have a sense of humour.

A funny thing happened to me on the way to the theatre...

## Keep up to date

Tone-deaf people are said to suffer from this skin infection – what is it? *Answer on page 16*



Gas Flo



## Letter from Zimbabwe

### Taking risks

It is a well-publicised fact now that HIV prevalence rates in Southern Africa are in the range of 30% and lead the world. Of course, the debate rages about the causes and whether behaviour change is taking place or not. A parallel can be drawn between the responses in the UK to eating beef, the BSE crisis and vCJD. The issue is people's understanding of risk and risk taking behaviour.

Can one spot a non-condom user on the streets of Harare? My wife, a Public Health specialist, thinks she can. Condom use is one of the factors that have had a major impact on HIV prevalence in other countries such as Uganda and Thailand. A recent incident demonstrated this. While attempting to turn right at an intersection recently during the busy rush hour, the lights in my favour, a driver from the opposite direction bared down on the red lights with all the cars hooting for him to stop. He wouldn't. Quite clearly he knew that a collision was likely but took the high risk. Would he wear a condom, if he had the opportunity?

Several 'Knowledge, Attitude and Practice' studies have shown that most people have the knowledge and know the recommended practice but the attitude of some people is still that it will not happen to them. Of course, all groups have their line of defence. Many anaesthetists do not wear gloves (even here). If they survived the hated colonialists, what is HIV in comparison?

Factors that lead to behaviour change are complex and individual. It is felt that our societies' response to the epidemic in Africa has been less than acceptable. The intense discussion that has been developing around these issues is now being superseded by the debate about Anti-Retro Viral Drugs. Are entrenched individual and societal habits going to change when you can take pills? The people in many countries hoped that their leaders would seize this moment of catastrophe to transform the society. For the leaders,

however, the apparent risk of not being in power is much greater.

One thing I have always wondered of colleagues and myself is whether we know the risk we take when it is our turn to be patients in our own health system. Would awareness of such risks introduce a self-interest factor? I guess we all say "it will not happen to me." It did happen to some high profile people but nothing changed.

People have turned to religion on such a scale and passion they no longer feel they can determine events in their lives. It is all God's will. A description of missionaries in Africa goes like this: they came and asked us to close our eyes so we could pray. When we opened our eyes, the country was theirs. This time we have closed our eyes, denying the HIV / AIDS epidemic. There is prayer but no change in the risk taking behaviour.



Dr FD Madzimbamuto

**WEST OF SCOTLAND DEANERY**

**SUB-COMMITTEE IN ANAESTHESIA**

**STUDY DAY ON ANAESTHESIA**  
**Tuesday 19 March 2002**  
 Kelvin Conference Centre,  
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**REGIONAL ANAESTHESIA**

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**TOPICS WILL INCLUDE :-**

- Upper limb blocks
- Lower limb blocks
- Head and neck blocks
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- Update on obstetric regional anaesthesia
- Thoracic epidurals
- Do regional techniques improve outcome?
- Regional anaesthesia and chronic pain

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**SCPMDE**

## Keep up to date

What is the condition illustrated on page 15?

Tinea

The copy deadline for the March 2002 edition of Anaesthesia News is 18 January