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Anaesthesia News

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

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First open meeting of the Scottish Standing Committee

By Dr Ian G Johnston

Stirling which sits on the River Forth, in a natural gap between the Campsie and Ochil Hills, is the administrative capital of Scotland's Central Region. The castle, a former royal residence, looks down upon the site of Stirling Bridge where Mel Gibson, in his alter ego, won a famous victory against the southern invaders in 1297. It was in this historic setting that the Scottish Standing Committee of the Association held its first Open Day in February this year.

The Standing Committee was formed in 2001 as a response to the changes in the NHS in Scotland following devolution and the creation of the Scottish Parliament. Its constitution states that one Open Meeting will be held each calendar year. The Education and Conference Centre at Stirling Royal Infirmary was chosen as the venue for the first meeting, on 22 February 2002, in recognition of its excellent facilities and central geographical location.

A meeting was held the previous day, to which the President, Professor Strunin, accompanied by Drs. Dick Birks, David Whittaker and Sean McDevitt (Association Council Members) and Miss Lesley Turpin (Association General Manager) were welcomed by the convenor, Jim Dougall. It had previously been agreed that the Open meeting should start with the first ever Scottish Linkman Meeting where relevant issues could be raised, followed, later in the afternoon, by an Open Forum for all delegates, allowing sufficient time for contemplation of the issues prior to discussion. Other sessions would include both topical political and clinical subjects presented by expert speakers.

The Linkman Meeting, chaired by Peter Wallace, was started by Mike Ward, the Linkman Co-ordinator, who discussed his proposals for redrafting the duties and election process of the linkman and plans for future benefits to members. Worries about lack of participation were soon dispelled with the lively debate which followed. Much of the discussion focused on the 'new contract' but other issues such as consultants resident on-call, out of hours ITU cover and its medicolegal implications and CEPD requirements for anaesthetists with sub-speciality interests were brought to the forum.

Leo Strunin, having been asked to speak on the future of the speciality, did so with some hesitation as twenty years previously his predictions in a similar talk had not come to fruition. He did, however, give food for thought on several topics such as the continuing saga of the 'nurse anaesthetist' in relation to comparative staffing levels between Copenhagen and the UK and also the threat which the Medical Education Standards Board poses to the duration and future standard of specialist training in the country. Dr Veronica Reid then pre-empted the BMA and answered many of the earlier queries from the Linkman meeting by giving an update on the

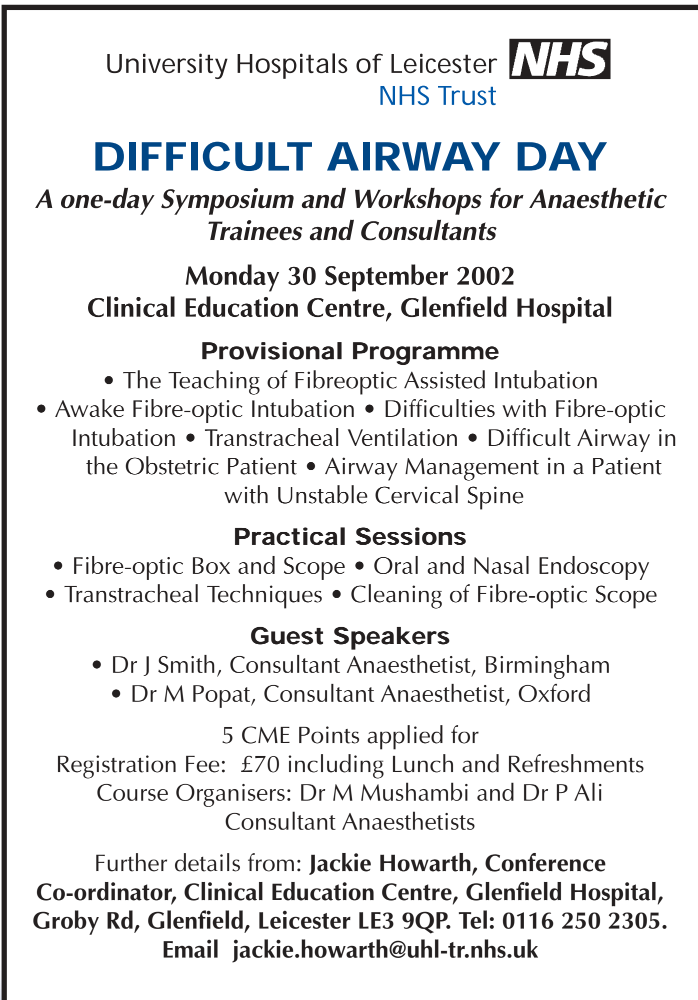
current Consultant Contract negotiations. She discussed the proposals for the core contract, the new Consultant Reward Scheme and the problems which continue to delay progress with the negotiations. One clear message which came across was that it is essential that we all have clear job plans in place now! The morning session was brought to an informative close by Dick Birks' talk on Circuits, Prions and Filters, in which he explained the role and current interests of the Association's Safety Committee. The history of prion disease, including vCJD, recent problems with breathing circuits and the responses of the manufacturers and government to the 'single use' issue were clearly illustrated.

Following the Open Forum, the Chairman welcomed Past President Morrell Lyons to present his views and bring us up to date on Portfolios. Despite our speciality leading the way with the Good Practice Guide, recent high profile medical disasters and increasing knowledge and expectation of patients have made it necessary for us to provide evidence to prove our competency. This and the recognised difficulties, for an individual, of working in a badly run department have led to the Personal and Departmental Portfolios. Dr. Lyons highlighted the problems which have been encountered in compiling a cross-speciality document which is suitable for all grades of staff but the delegates were encouraged by his enthusiasm for the process and the lead which the College and Association have taken.

The final session of the day was taken by Nikki Maran of the Scottish Clinical Simulation Centre on her topic entitled The Weakest Link in which she discussed the responses of trainees to 'real situation' mishaps in the operating theatre, crisis avoidance and errors observed in the simulator. It is a credit to her reputation as a speaker that the vast majority of the delegates remained in their seats until the close of the meeting, despite a blizzard raging outside.

All in all, the meeting was a tremendous success due, not least, to the outstanding efforts put in by the organiser, Heather Hosie and the response by the Scottish Members. You are all welcome back for the sequel in 2003.

Do you have an article for possible publication in Anaesthesia News?
See page 14 for more details.



PANG
Pain & Nociception Group
Principles and practice of sedation
Thursday 17 October 2002
Postgraduate Medical Centre
Charing Cross Hospital
Fulham Palace Road
London W6 8RF

This meeting aims to provide an understanding of the principles involved in providing sedation for patient interventions that may either be painful or distressing. It is intended for those who undertake investigative or operative procedures and for anaesthetists as part of basic training. It will focus on the issues of risk management and patient safety and should provide sufficient background information for a practitioner to undertake the technique with confidence, particularly if supervised in the first instance.

Principles
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CEPD (Royal College of Anaesthetists) and CPD (Royal College of Physicians) approved

Attendees limited to 100

Editorial

Dr Ruxton

Our new correspondent writes as Dr Ruxton. But why Dr Ruxton? Because he is a pre-eminent example of a good doctor, turned bad by his situation.

A GP in an age when GPs gave anaesthetics, delivered babies at home and operated, he murdered his wife and, because she was a witness, her maid. The case was a forensic sensation, body parts were found scattered around the Borders of Scotland and England and identification was largely by superimposition of a photograph of Mrs Ruxton on a skull. This, with circumstantial evidence of jealousy over another man and blood stains in his house, found him guilty and he was condemned to hang. But this did not matter to his patients, to whom he was a caring and diligent doctor. Within four days of the verdict, 2,500 people had petitioned the Home Secretary for mercy.

There was none and he hung but, whatever his crimes, he should be remembered as a good doctor rather than as a murderer. Indeed, he is still remembered today. I have anaesthetised two people who were in his hands, one a man whom he delivered by forceps and whose mother, he said, had great respect and gratitude for her care. The other was a lady who told me that her previous anaesthetic was given to her for delivery of her child, by “that nice Dr Ruxton”!

The image of medicine that we like to reflect rests on stories of self-sacrifice and devotion beyond the call of duty but, for every such story, there is another showing that doctors are human and will bend or break when pushed too hard. We do not have to look into history. The sectarian rioting in India has meant that doctors of one faith are too afraid to go to work in the other part of town (‘Muslim patients suffer as Hindu doctors fear for their safety’, BMJ, 18 May 2002). Recent events in Zimbabwe (‘We’re drowning’, *Anaesthesia News*, May 2002) have been marked by a more self-centred attitude to providing medical services that, to some, may echo current attitudes in the NHS.

For the NHS is under pressure as never before. Our fathers and grandfathers founded it in a fervour of social zeal. This great experiment for the public good was not so much bought from doctors by filling their mouths with gold as carried off by an army of medical revolutionaries in love with the beautiful bride of social medicine. Their dedication made the NHS possible but, at the same time, endangered the marriage as their love and devotion was not reciprocated. Spouses fall out of love if they are not appreciated. Generations who have seen inadequate investment, poor funding and pay that does not compare with similar jobs have felt unloved and the marriage is failing. The gold wedding ring was pawned long ago and must be redeemed if the marriage is to continue.

We have a new offer of mouthfuls of gold, millions to be spent on the NHS over the next few years. The Government has professed its love for the staff that runs the NHS and its intention to refurnish the home but, at the same time, demands more housework and aims to impose fidelity by a contractual chastity belt for the first seven years. The Government should remember the example of Dr Ruxton, the good doctor driven beyond endurance by a marriage that was, for him, loveless.

Most doctors and nurses are in love with medicine and many in this country are wedded to the concept of the NHS. But, unless the Government demonstrates its love and appreciation, by larger salaries and wages, starting with the lowest and most hard pressed, then the marriage of service and devotion that is the NHS will continue to fail.

John R Davies

Advertising in Anaesthesia News

Anaesthesia News reaches over 8,000 anaesthetists every month and is a great way of advertising your course, meeting or seminar.

Advertisements are accepted from anaesthetic societies and organisations, courses run by recognised ‘anaesthetic bodies’ and those judged to be of interest to members of the Association of Anaesthetists of Great Britain and Ireland and without obvious commercial intent.

Details of events and meetings will also be listed, free of charge, in the Calendar of Events which is sent out to all members four times per year, enclosed with *Anaesthesia* and *Anaesthesia News*. Display advertising is accepted in camera ready form, by email or on disk. Potential advertisers are invited to discuss their requirements with the Editorial Assistant, Nicola Heard, at the Association of Anaesthetists. Copy deadline is four weeks prior to the date of issue.

	1 month	2 months	3 months
Full Page	£485	£650	£810
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Contact Nicola Heard on 020 7631 8805, by fax on 020 7631 4352 or e-mail nicolaheard@aagbi.org

Letters *to the Editor*

Nay, nay and thrice nay!

There is never 'no problem' with double negatives. Officionados of MCQs know the mayhem they can cause and the not inconsiderable efforts over the years of Examinations Committees in eliminating these from College Exams. Meeting Organisers and their Scientific Committees still have to learn this hard lesson as evidenced by the otherwise excellent programme for the forthcoming AAGBI Annual Scientific Meeting in Bournemouth. The debate on Friday is to consider the motion "This house believes district general hospitals can no longer be expected to provide a full range of emergency services." When you vote for the motion, you are voting for a negative and when you vote against the motion, you are voting against a negative. This is confusing both for voters but most of all for the chairman announcing the results of the vote!

And this scenario is not untypical! At the Association of Paediatric Anaesthetists' (APA) Annual Scientific Meeting in Sheffield in March, the motion was not unreasonably entitled "Epidural analgesia should not be used routinely after laparotomy in a neonate" and the chairman did not just get the result of the vote incorrect but also sowed the seed of doubt that many in the audience had not in fact voted the right way unintentionally!

Having learned this lesson, the Scientific Committee of the APA has just spent a not unenjoyable day in Manchester designing the programme for next year's meeting in Dublin, not an unpleasant venue (members and non-members will not be unwelcome). A not inconsiderable time was spent designing debate motions with no negatives.

So, Scientific Committees, if you want to avoid confusion, give your debate motions a positive spin. If you must have negatives, make sure there isn't an uneven number of them... oh, bugger!

Neil S Morton, *Glasgow*

Cutting edge

I wonder how many other readers share my sense of humour? I was amused to read ('Intra-operative failure of capnography' *Anaesthesia News*, May 2002) of the patient "undergoing surgery for circumcision with a laryngeal mask size four". This must surely be a surgical first!!! Although, perhaps relevant, I will refrain from alluding to the colloquial name often used when referring to this particular item of anaesthetic equipment.

John Francis

SEND YOUR LETTERS TO
The Editor, *Anaesthesia News*, AAGBI,9 Bedford Square, London WC1B 3RE or email anaenews@aagbi.org

Omnia Vanitas

Oh, for goodness sake! For how much longer are anaesthetists going to fixate on the entirely trivial matter of 'dress sense'? We are, after all, one of the few professions that has clear evidence our manner of dress is irrelevant to patients' perceptions of us[1,2]. And in the last twenty years, while standards of dress have declined appallingly (if I am to judge solely from the pages of *Anaesthesia News*), patients' perceptions of our status have actually risen.

It is transcendentally patronising for us to imagine that people are so dim they will put their trust in the best-dressed doctor they see – particularly at a time when the word 'suit' has taken on the pejorative sense of "an uncreative, authoritarian person"[3]. If you don't believe me, look to the evidence of popular TV hospital dramas. Who are the only people who wear suits? – the incompetent, the uncaring and the unapproachable. And it is jaw-droppingly ageist to suggest (as has been done in these pages) that we must dress up to inspire confidence in our elderly patients. On the contrary; the older we get, the more experience we accumulate of well-dressed rogues and buffoons and the more distrustful those of us with any common sense become. By way of anecdotal evidence, I cite the eighty-year-old woman who recently nudged me and said: "I'm glad you're here. I can't talk to them ..." (nod to the departing surgical ward-round) "... in their suits and white coats."

So, if not for our patients, why should we dress up? Editorial comment in May's *Anaesthesia News* seems to offer the following answer: we must dress to improve our self-esteem. Now, I (the most mild-mannered of men) can manage a quite satisfactory level of self-esteem in any item of clothing from a t-shirt to a dinner-jacket. To be frank, any other state of mind seems to me to be more in need of psychotherapy than commendation and I would fight long and hard against the appointment of a consultant who had to wear a suit in order to present his or her opinion effectively.

We should of course avoid being dirty; we should eschew smelliness; our clothing should not display parts of our anatomy liable to cause alarm or despondency in onlookers – all this is mere courtesy. But, beyond that, William Hazlitt's phrase is as valid today as it was two hundred years ago: "Those who make their dress a principal part of themselves, will, in general, become of no more value than their dress."[4]

Grant Hutchison, *Dundee*

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1. Hennessy N, Harrison DA, Aitkenhead AR. The effect of the anaesthetist's attire on patient attitudes: the influence of dress on patient perception of the anaesthetist's prestige. *Anaesthesia* 1993; **48:** 219-22.

2. Sanders LD, Gildersleve CD, Rees LT, White M. The impact of the appearance of the anaesthetist on the patient's perception of the preoperative visit. *Anaesthesia* 1991; **46:** 1056-8.

3. Green J, ed. *The Cassell Dictionary of Slang*. London: Cassell, 1998.

4. Hazlitt W. On the Clerical Character. *Political Essays*. Oxford: Woodstock Books, 1994. (Read the whole, delightfully corrosive piece on-line at: www.blupete.com/Literature/Essays/Hazlitt/ClericalCharacter.htm

Letters *to the Editor*

Athletics Anonymous

These days, with all the emphasis on one's physical fitness, a new organisation has sprung up called 'Athletics Anonymous.' When you get the urge to play golf, tennis, go power-walking or bicycle riding (or anything else involving a type of physical activity), they send someone over to drink with you until the urge passes.

David Wilkinson, *London*

Whose fault?

I suggest that Dr Geoff Watson (letter *Anaesthesia News*, May 2002), rather than blame his ageing predecessors for the predicament in which he finds himself, should consider whether the reduction in the useful work by the so-called training grades, of which no doubt he was in favour at the time, might be a major cause of his problems.

Dr LVH Martin, *Edinburgh*

Cool

Regarding the Editor's request for equal pay for equal image, I am happy to report that the West Suffolk Hospital not only has anaesthetists heading up the expected departments of Anaesthesia, Critical Care, Pain and Day Surgery but the Medical Director is an anaesthetist and the Chairman of the Surgical Directorate is the Association's own historian, Neil Adams!

Our images range from chic to scruffy (that's me) and the hospital is none the worse for that. As a trainee, I recall a theatre sister begging a distinguished but rather laissez-faire senior consultant to "dress properly for theatre as there would be a TV crew filming". He performed an immaculate spinal clad in full DJ and dicky-bow. I don't think he ever suffered lack of confidence / public trust / poor efficacy of treatment, to paraphrase!

Anaesthetists may never have acquired the image but, fortunately, we still have style.

Pam Chrispin, *Consultant anaesthetist (dressed by Oxfam)*

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Further Information and application form from:
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email Tina.Craig@uhl-tr.nhs.uk

BRITISH SOCIETY OF ORTHOPAEDIC ANAESTHETISTS

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Tel: 01642 310022, Fax: 01642 324827

GAT *Page*

Yet more training reforms on the way

Over the last six months, both the government and our leading UK training authorities have once again taken the first significant steps to radically reform postgraduate education and training. The key points within two documents released for consultation and discussion are presented below, with the response forwarded by the GAT Committee on behalf of the trainee membership. Further details of both documents are available on the referenced websites. I would urge you all to read and consider their contents.

The Medical Education Standards Board [1]

At the end of 2001, the Department of Health published a consultation document 'Postgraduate Medical Education and Training' which outlined its intention to establish a new standards body, 'The Medical Education Standards Board' (MESB). Although it is implied that the establishment of this single body is just a logical step to combine the activities of the current governing authorities of the Specialist Training Authority (STA) and the Joint Committee on Postgraduate Training for General Practice, there is no doubt that the main objectives are clearly more than just the implementation of administration change. The overriding theme is that the needs of the NHS must come first, rather than the delivery of quality training to achieve 'specialist' trained doctors to a professional level we currently recognise as a Consultant in the UK.

The document contains repeated references to 'the training of doctors must be driven by the needs of the service' and the 'tension between training requirements and service needs', emphasising that the service element in posts should take precedence over training in the future. Similarly, training standards should be tailored to meet NHS requirements at any time. Whilst it is important to acknowledge that training numbers in each speciality must be linked to appropriate workforce planning, there can be no justification for changing the training requirements, namely their content, duration, quality or commitment to service, specifically to suit the number of 'specialists' required at any particular time.

With the establishment and extension of the role of the MESB, what is the future role of the Medical Royal Colleges? It is proposed that they would be responsible to the MESB in an advisory and supportive capacity. However, their autonomy for controlling postgraduate training on behalf of the STA would be removed and they could be forced to accept potentially inferior training standards to meet NHS needs. We recognise the threat posed towards anaesthetic departments by an impending 'College visit', even though the RCA has not removed training recognition from a hospital for over six years. Certainly, the interests of trainees would not necessarily be the priority of future competent authorities.

Worryingly so, this documents heralds the government's attempts to take control of postgraduate medical training, suggesting that the MESB should be accountable to the Secretary of State for Health, rather than an All-Party Select Committee on Health or the GMC which was the clear recommendation of Professor Kennedy in the Bristol Inquiry Report.

The proposed constitution of the MESB is 50% 'lay' representation, with the possibility of a 'lay' chairman. Although we recognise the importance of 'patient' representation, a composition of 50% 'lay' is considered curiously high. We have highlighted in our response the importance of trainee representation, commensurate with present trainee representation on the RCA Council.

No mention is made within the document of 'competency-based training' or 'competence assessment' – it is difficult to ascertain how training will be quality assured by the MESB.

The GAT Committee could find little evidence base to support the drive for change, other than a determined effort to replace the STA, the current competent authority which insists on 'higher standards' than the government believes are required.

The UK CCST: An appropriate level or not?

The STA recently issued a document to promote discussion about the level at which the UK CCST should be awarded for all specialities. The document, with the RCA response, is published on the RCA website [2]. The underlying intention of this paper appears to be to set the ball rolling to reduce the length of specialist training in the UK and introduce the concept of a 'specialist' or 'sub-consultant' grade. A number of Medical Royal Colleges have already started the process of reducing training time.

So what's the driver? To deliver the NHS Plan, the government requires trained medical staff, not necessarily of consultant status, to provide specialist medical care to patients. An additional 7,500 specialists need to be recruited to hit the target date, now less than two years away. Therefore, the idea of a 'sub-consultant' grade is an ideal quick fix for the politicians. It also potentially avoids the thorny issue of the suggested private practice ban for new consultants. The 'ban' would naturally be imposed on the 'sub-consultant' grade instead.

It is true that, after six years of 'Calman-style' training and the introduction of the unified training grade in the UK, the training of specialists to achieve their CCST continues to be considerably longer than anywhere else in Europe. Despite improvements in training delivery, few trainees complete their training within seven years post full registration. This is largely due to the fact that UK trainees continue to make a significant contribution to service work and, in particular, are the main providers of 'out-of-hours' service. Furthermore, the legislation to reduce junior doctors hours has reduced training

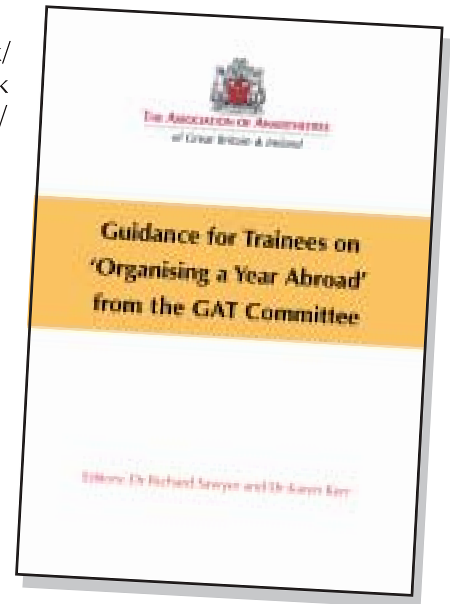
opportunities. I am constantly being told by consultants that current trainees in anaesthesia are nothing like the quality they used to be. Therefore, how can we consider reducing the training time in anaesthesia, without compromising our current standards or the quality of care we provide to our patients?

Your views on these topics are welcome. Contact the GAT Committee on gat@aagbi.org

Dr Sarah Harries, *Chairman, GAT*

References

(1) www.doh.gov.uk/medicaltrainingintheuk
(2) www.rcoa.ac.uk/newsflash



Important news about the Data Protection Act

Following the recent statement published by Dr Michael Ward in *Anaesthesia News*, June 2002, further information from the Information Commissioner's Office would suggest that, even if patient data on a computerised logbook are limited to the date, type and place of the operation, this is sufficient to render a patient identifiable. Therefore, there would be requirement for a doctor to notify under the Data Protection Act. The notification cost is an annual statutory fee of £35. Further information is available from: www.dataprotection.gov.uk

Tuesday 24 Sep 2002

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MS Carnival Destiny – Diary of a Ship's Physician

Six weeks had passed since I had first arrived at the quayside and the *Ms Carnival Destiny* had met my gaze. A magnificent white passenger liner emblazoned with her finest regalia. At the time she was the biggest passenger cruise liner in the world, weighing in at a little over 101,000 tonnes of steel. In fact she was so big that she could not physically make passage through the Panama Canal. Her overall length was 893 feet and was 116 feet across. She was also 14 storeys high and had a cruising speed of 21 knots. When fully occupied, she carried 3500 passengers and 1100 crew.

I had applied for the position as ship's physician on the recommendation of a friend and gladly accepted the appointment, albeit with a little trepidation. Arriving at Miami airport on a Thursday afternoon, I was greeted with a familiar humidity and warmth not often experienced in the UK. I had however grown up in this climate in South Africa and was therefore excited about spending six months in this fine weather again, instead of an English winter.

The next day was taken up with signing formal contracts at head office, followed by being driven downtown to be measured up and issued with several uniforms. Saturday was a day of relaxation spent visiting Miami Beach and Ocean Drive, before being taken to Miami harbour on Sunday morning to begin my six month contract on board the *Ms Carnival Destiny*.

Four more than able nurses of American, Canadian and British origin staffed the medical infirmary on board, with myself as the Head of Department. This was situated on Deck 4, the main deck above sea level and the main artery of the ship. I had a consulting room with two waiting rooms, one for crew and the other for passengers and a large procedures room at my disposal. There were also four 'side rooms', each with a bed and full monitoring equipment. We had our own pharmacy too but no X-ray facilities and, more importantly, no anaesthetic equipment. My only comfort as a doctor with four years of anaesthetic training under the belt was the availability of ketamine!

It is Sunday today and a big day for all the crew as it was turnaround day in Miami Harbour. We docked a little after 6am and I was woken by the familiar sound of the winches at the bow of the ship groaning away tethering us to the dock. This was supposed to be my only day to 'sleep in' as there was no clinic in the morning. It was not much later that the public announcement system sprang into action asking those lost passengers (of which there were many despite having been on board for seven days!) to attend US immigration in the huge auditorium prior to disembarking. Never mind, time to get up and have a leisurely breakfast before picking up the long anticipated weekly mail from friends and family.

After a relaxing stroll around the shops in Miami, I am back on board and scanning the referral letters from the General Practitioners of some of the more intrepid travellers who have boarded. Good news for me, only one passenger wheelchair bound with domiciliary oxygen this week. A bonus is that he has arranged to bring his own spare oxygen cylinders with him for the week so our precious supply is safe.

It is now 5pm, the start of the hour-long crew clinic and it is time to review the replies from the crew referrals to specialists that day – usually dermatologists and gynaecologists. Invariably, the odd passenger has already located the infirmary by now and we haven't even sailed yet! One cannot have a cold whilst on holiday and, of course, antibiotics are seen as the only cure and demanded by the majority of passengers (I am sure you can guess the nationality of these patients!). The hour passes without event and I am now free to exercise on the running track up on deck whilst admiring the view of Miami harbour receding into the distance as we sail into another perfect sunset. This week we are off to Cozumel, Mexico, which is a day and a half of sailing, followed by a stop off in Grand Cayman and Ocho Rios, Jamaica later.

After dinner in the crew mess (the officers mess being commandeered by the Italian officers and resembling a scene from *The Godfather*), it is time to move to the crew bar to make acquaintances with all the new crew who had signed on in the morning. The new dancers attracted particular interest from the predominantly male crew. Drinks in the crew bar are cheap, a dollar a beer to be exact. Wouldn't it have been nice to have been able to lose the pager, relax and spend a 10-dollar bill? So much for being on call 24 hours a day for virtually all of the seven days of the week!

The routine daily clinic hours started again on the Monday with crew hours from 8–9am and 5–6pm, whilst passenger hours were from 9–11am and 3–5pm. Today is an 'at sea' day which meant a full day and night of sailing without any ports to visit. These days tended to be fairly busy for me and even worse if the sea was rough. The consultations over the day for both passengers and crew would average between 40 and 50. This would be a typically normal day and, as my Spanish was not up to much, some consultations were rather drawn out. This even with a bilingual crew member who just happened to innocently walk past the infirmary at the time and who had been roped in to translate for me. Today, an elderly passenger has slipped on the wet decking alongside the swimming pool, sprained her ankle and sustained a Colles fracture of her right wrist. The fracture is reduced under mild sedation with midazolam and a haematoma block with local anaesthetic and placed in Plaster of Paris. The ankle is bandaged and an intramuscular injection of diclofenac goes a long way to help ease the discomfort. That was the easy part of the consultation. Now for the medicolegal paperwork that goes with it and the Incident Report, to be completed by myself and submitted to the Captain and Safety Officer. In such a litigious climate no chances are taken and I learnt very quickly how best to approach such difficult passengers who appeared determined to obtain a future free cruise as settlement.

And so Monday rolls into Tuesday when there is a formal night and a chance for the ladies to wear their shiny sequined dresses whilst

adorned with designer jewellery. For the senior officers it meant being introduced on stage in our formal evening dress aptly named 'penguin suits'. Then it was off to the main dining room and time for me to take my place at the Captain's table to rub shoulders and make polite conversation with those guests honoured to be invited. I use the word 'polite' as some of the guests were oblivious to the fact that South Africa was in Southern Africa!

Before I realise, Friday morning is heralded in by another spectacular sunrise. Usually a day to look forward to as I can escape from the ship for four hours to fit in a round of golf with some fellow crew at the Sandals Resort near Ocho Rios, Jamaica. This is a very entertaining 18 holes with the local caddies who have a sense of humour second to none and who can play golf better than I. A couple of beers around the course ensure that our minds are miles away from the duties and responsibilities of ship life. The journey back to the ship in a local taxi turns out to be an experience preferably missed as I see my life flash in front of my eyes, with a driver rather partial to smoking the much abundant locally grown weed for medicinal purposes, or so we were led to believe!

On my return to the ship, a rather anxious looking nurse greets me on the gangway. What now? A passenger has presented to the infirmary in my absence. Apparently she had been on a 'booze cruise and made a concerted effort to try finish the free rum punch, following which she had collapsed in the afternoon heat of 34 degrees Celsius and was, not surprisingly, unrousable. The local ambulance had been called and the paramedics had kindly decided to deposit this lady at the end of the gangway instead of taking her to the local hospital. Nice one chaps! I was greeted by a lady in her twentys who must have weighed more than 120kg, had a Glasgow Coma Score of 6 and was incontinent in more than one way. The recovery position, IV access, a dextrose saline infusion with vitamin B complex added and a sleep overnight in the infirmary did the trick. Fortunately, the rest of the night passed without any major drama.

It is 11am on Saturday morning and time for the weekly Captain's meeting. As the third highest ranked officer on board, a position shared with the Chief Engineer, I take my seat at the table. Each department head takes his/her turn to present the week's activities/events to the Captain. I get a little stick from fellow officers for it has now been four weeks in a row that the captain has not had to alter course in order to rendezvous with the US Coastguard helicopter on account of a medical emergency. We are on track for a new record.

I vividly recall trying to celebrate my 30th birthday in the crew bar. I had been presented with a cake by one of the dancers and the party was just getting into full swing when my pager summoned me to the infirmary. An elderly gentleman had presented with central chest pain not relieved by whisky or sublingual nitrates. A 12-lead ECG revealed an inferior myocardial infarction. We did not have the capabilities of administering thrombolytic therapy and we had a full day and a half of sailing ahead, before reaching Miami. What am I to do? It was too much of a gamble to keep him on board that long so the arduous process of a medical evacuation was set in motion. On this occasion we were sufficiently close to the port of Nassau in the Bahamas, so the bridge altered our course. At 5am that morning I found myself, together with a nurse and the patient (plus defibrillator of course!), on one of the lifeboats, coincidentally also designed to tender healthy passengers ashore in ports where the ship was unable to dock. I found myself gazing at the golden arches of the McDonald's outlet on the waterfront in Nassau which is where the ambulance was waiting for us.

One week blended into the next and, inevitably, there were more medical emergencies which required airlifting from the stern of the ship by US Coastguard helicopter. One such emergency was a passenger who presented with haematemesis and was actively bleeding from a gastric ulcer. His haemoglobin had dropped dangerously low to 5.1g.dl^{-1}. With no blood products on board, this was a particularly close call. Fortunately, there were no deaths whilst I was on board. This, however, was a fairly common occurrence going by the stories from the doctors on the other ships in the Carnival fleet.

Soon my six month contract had passed and, try as I did to justify another contract, this time to Hawaii and Alaska, I felt compelled to head back to the rain saturated shores of the UK to continue my training in anaesthesia. The experience and genuine friends gained made it all worthwhile, not least for the management experience and, dare I say, the experience practising in such a litigious population. What else did I gain? Naturally, a fantastic suntan. Oh, and last but by no means least, a wife-a former purser on board the *Carnival Destiny*!

Andrew Cook

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of Great Britain and Ireland

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History *Page*

Dr Herbert Harvey Pinkerton (1901–1982) and the Group of Anaesthetists in Training

Dr H H Pinkerton

This month marks the twentieth anniversary of the death of Dr Herbert Harvey Pinkerton, President of the Association of Anaesthetists, 1965–1967. During his presidency the body now known as the Group of Anaesthetists in Training (GAT) was established.

Dr Pinkerton, known as Tony, was born on 8 October 1901. His father, Peter, was a teacher and perhaps his commitment to education helps explain Pinkerton's later interest in the structured training of anaesthetists.

In 1920, Pinkerton went to Glasgow University to study engineering but switched to medicine in 1921, graduating in 1926 having excelled in his studies.

His first appointment was Resident Assistant at the Western Infirmary, Glasgow where he became a clinical tutor at the age of 26. He then spent seven years in general practice before specialising in anaesthesia. In 1936, he undertook post-graduate training and spent two months with Dr John Challis of the London Hospital before moving back to Glasgow, where he was appointed visiting anaesthetist to the Western Infirmary. In 1938, he received the DA.

Both Spencer and Raffan attest to Pinkerton's interest in the training of anaesthetists. Dr Spencer (Chairman of GAT, 1990-1993) remarks on his strong, genuine interest in younger people, in training and his teaching ability, organising tutorials long before it was considered essential. Dr Raffan (the Scottish Society of Anaesthetists) too, describes him as '…a natural teacher, …a man of infinite charm, and quietly persuasive'.

Pinkerton served on the Council of the AAGBI twice. His first term was 1949–52 and, following his re-election in 1960, he became President in 1965.

Associate membership of the Association began in the 1950s and, by the 1960s, an annual registrars' meeting had been established. Pinkerton (together with others) then developed the idea of setting up a formal trainee group with a committee. This resulted in the first organised meeting for all anaesthetic trainees in 1967, in Leeds, arranged by Professor J Nunn. This group was first known as the Associates in Training Group but was renamed Junior Anaesthetists Group in 1971 and Group of Anaesthetists in Training in 1991.

Evidence that Pinkerton's interest in GAT endured can be found in the GAT minutes of 18 November 1982 where it is recorded that he had expressed a wish to attend the Leeds Junior meeting of that year. Also, Professor Spence states "As President of the Association of Anaesthetists his greatest pleasure was in establishing the Associates in Training Group for trainee anaesthetists". Professor Spence describes him as, "…one of a distinguished group of anaesthetists whose ability and determination brought anaesthesia out of the darkness".

Following his death on 21 July 1982, the guest lecture at the Juniors' Annual Scientific Meeting, inaugurated by Dr J Alfred Lee, became known as the Pinkerton Lecture.

The records of GAT can be found in the archives of the Association of Anaesthetists. They are currently being catalogued and, whilst many survive, the archivist would be interested in hearing from anyone willing to donate further items relating to GAT and Pinkerton. Only by ensuring the survival of our records will we be able to demonstrate the contribution of people like Pinkerton and thereby to acknowledge the very great debt we owe them.

Trish Willis, *Archivist, AAGBI*
Tel: 020 7631 8806, email TrishWillis@aagbi.org

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Association of Anaesthetists Group of Anaesthetists in Training Committee Minutes, 1982.

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Mersey School Anaesthesia and Peri-operative Medicine

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A five-day course of intensive MCQ analysis intended only for candidates within weeks of sitting the Primary FRCA Examination.

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2002 December 2–6
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Two weeks of SAQ Practice and Analysis, MCQ Practice and Analysis and Lectures/Tutorials.

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2002 October 7–11
2002 October 14–18
2003 April 28–2 May
2003 May 5–9

For details, please contact (BY EMAIL ONLY PLEASE):

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Friday 13 September 2002
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Costs include lunch and use of extensive leisure facilities

For registration details contact the Conference Secretary, Liz Mason, Tel. 01803 654311, Email elizabeth.mason@sdevonhc-tr.swest.nhs.uk

5th South West Thames Anaesthesia Forum

7-10 October, 2002
Da Balaia, The Algarve, Portugal

Open to all Anaesthetists

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6th Oxford Difficult Airway Workshop

St Catherine's College, Oxford University
Wednesday 16 October 2002

7th Oxford Difficult Airway Workshop

St Catherine's College, Oxford University
Wednesday 12 March 2003

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The workshops cover a wide range of fibre-optic assisted techniques, ILMA and trans-tracheal access. There is a high faculty to delegate ratio (1:3) to allow maximum opportunity to interact and interrogate the faculty.

Included in the registration fee are refreshments, a course manual, and lunch at St Catherine's college in the heart of historic Oxford.

Course organisers:
Dr Mansukh T Popat and Dr Stuart W Benham
Registration fee: £150 Recognised for 6 CEPD points

All enquiries: **Mrs Scott, Nuffield Department of Anaesthetics, John Radcliffe Hospital, Oxford OX3 9DU**
marguerite.scott@orh.nhs.uk Telephone 01865 221590
Cheques to be made payable to 'Oxford Difficult Airway Group'

DO YOU HAVE AN ARTICLE FOR POSSIBLE FUTURE PUBLICATION?

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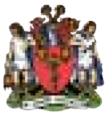

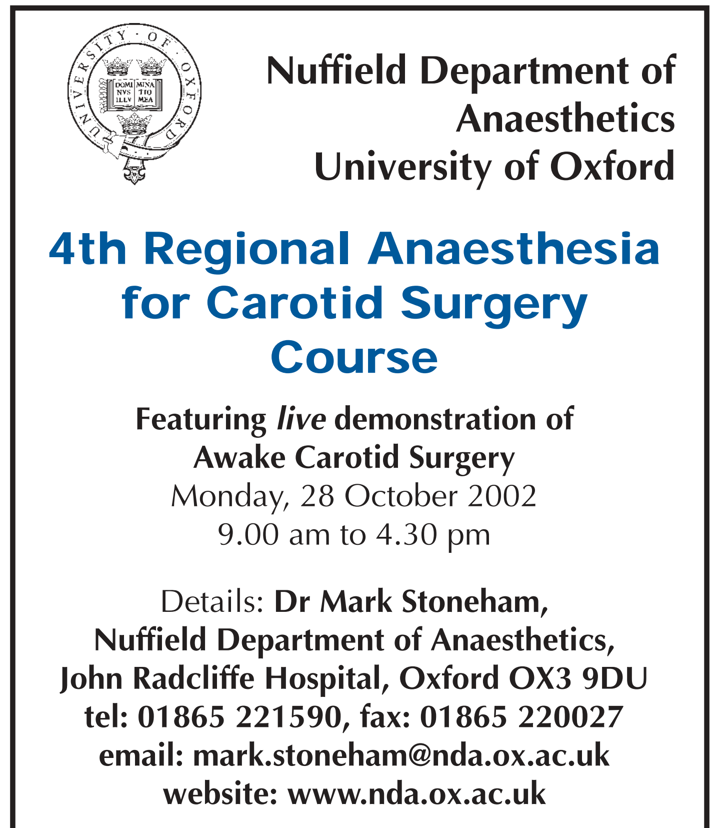

The 8th South Thames Acute Pain Conference

Worthing and Southlands NHS Trust
7 and 8 November 2002

Programme

• Pre-Emptive Analgesia – **S. Schug** (Perth, Australia) • Can Acute Pain Services Help Prevent Phantom Limb Pain? – **C. Stannard** (Bristol) • Can ITU Outreach Teams and Acute Pain Teams Work Together? – **D. Counsell** (Wrexham) • The Acute Back Pain Service – **P. Mortimer** (Sutton) • Cost of Acute Pain Services – **C. Phillips** (Swansea) • Regional Analgesia – Before or After General Anaesthesia – **B. Fischer** (Redditch) • Risk Management for Acute Pain Services – **L. Strunin** (London) • Continuous Regional Analgesia – **W. Harrop-Griffiths** (London) • Pain Management in Patients with HIV – **S. Cox** (London) • Pain Services – The Experience Down Under – **S. Schug** (Perth, Australia) • Plus a number of seminars and controversies • Conference Dinner at Avisford Park Hotel, Arundel, Thursday 8 (places limited)

Registration:	**Before 1/10/02**	**After 1/10/02**
Doctors:	£175	£230
Nurses/Pharmacists:	£95	£125

For application forms and further information contact:
Kathleen Durick, Anaesthetic Department, Worthing Hospital, Worthing and Southlands NHS Trust, Lyndhurst Road, Worthing,West Sussex BN11 2DH
Tel: 01903 205111, Ext. 5942, Fax: 01903 285151
Email: Kathleen.Durick@wash.nhs.uk

This meeting has been approved for 9 CME points

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The Bristol Crammer

Monday 16 September – Friday 20 September 2002

This five day course will include sessions on examination technique,intensive therapy, new drugs, current topics and practical subjects (viz. ECGs, X-rays and equipment) conducted by national and local experts. It will include mock examinations, performance analyses and will be held at Burwalls Conference Centre, Bristol.

For further details, please contact:
Jane McLean, Department of Anaesthesia, Bristol Royal Infirmary, Marlborough Street, Bristol BS2 8HW

Telephone: 0117 928 3801 (Direct Line)
email: jane.mclean@ubht.swest.nhs.uk

Course Director: Dr S Underwood FRCA
Some accommodation available

Course Fee £400 includes coffee, lunch and tea

Northern Final FRCA Crammer Course

Cleveland School of Anaesthesia

The James Cook University Hospital
(Formerly South Cleveland Hospital)

Marton Rd, Middlesbrough, TS4 3BW

23rd to 27th September, 2002

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(Course Limited to 12 Candidates)

Course Organiser:
Dr F. Clarke, Consultant Anaesthetist, James Cook University Hospital
Email: FionaL.Clarke@stees.nhs.uk

Application Forms from
Mrs. P.A. McSorley
Course Administrator
School of Anaesthesia
Cheriton House
James Cook University Hospital
Marton Road
Middlesbrough, TS4 3BW
Tel: 01642 854601
Email: p.mcsorley@stees.nhs.uk

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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'.

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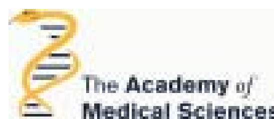

Notice of Research Fellowships in Anaesthesia

The Academy and The PPP Foundation are jointly inviting applications for fellowships in the field of academic anaesthesia and related specialities: intensive care medicine, pain management, and peri-operative medicine.

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Further information, application forms and instructions are available on the website: www.acmedsci.ac.uk

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Registered charity number: 1070618

The *Naked Gasman*

After appraisal comes the reckoning; usually in the form of 'counselling'. I recently received a letter from our local community liaison officer offering me counselling as I had been the victim of a crime. The crime was probably my own fault as I had left £10 in loose change in my trouser pocket in the theatre changing room believing it to be relatively safe as a new combination door lock had recently been fitted to keep thieves out. Unfortunately, this was an inside job and it is unpleasant to think that it may be someone who is part of the theatre team. I know one of our surgeons does not agree that we should all be paid the same amount for NHS waiting list initiative work that takes place at our local private hospitals but I doubt if even he would try to redress the balance that way. It reminded me of two of our plastic surgeons, one rich and one poor, who were walking along the hospital corridor when they spotted a £10 note on the floor. Which one of them do you think picked it up and pocketed it? The rich one of course – a poor plastic surgeon is just a figment of the imagination!

Would counselling have helped me? I could have done with being offered counselling on another occasion recently when an adolescent with a history of congenital heart disease died on our ITU following an elective max-fax procedure; a death made particularly harrowing as the parents were present during our increasingly futile resuscitation attempts: But then every week on Intensive Care has its moments of pathos which are papered over at the time by brief exchanges with other staff members over a hurried cup of coffee before moving on. How many of us reopen or tend to these wounds in a quieter moment perhaps with one's partner or colleagues?

I recently attended a workshop at a conference in Colorado which managed to combine five hours of lectures each day with seven hours of skiing in between, on top of jet-lag and trying to acclimatise to altitude. Incidentally, did you know that I have now entered the group known as 'Skiers'? Apparently, this stands for 'Spending the Kids' Inheritance and Early Retirement Seekers'. Anyway, the workshop was entitled 'How to cope with a bad outcome' and I fully expected to participate in the American way of breaking bad news to relatives and patients or perhaps counselling trainees and colleagues. I thought it was time to re-appraise my own counselling technique which was based on the 'curtain' method, as in "Pull yourself together."

This workshop, however, was nothing to do with counselling. It should have been called 'How to avoid being sued'. A case used to illustrate the problems was very reminiscent of the recent ones with blocked anaesthetic circuits in the UK and centred around the use of a co-axial circuit which had an imperforate transparent membrane at the patient end which had not been detected on the standard machine check. Following intubation, the patient was impossible to ventilate and the presumed diagnosis of severe bronchospasm made (after all, the machine had just been checked – it could not be that!). There was no response to bronchodilators and, by the time an Ambu bag was obtained and ventilation achieved for the first time, the patient, an overweight attorney, had suffered hypoxic brain damage. A number of interesting points emerged – first, the anaesthetic chart had been completed with some degree of confabulation as there were recorded values for non existent end-tidal CO_2 and, secondly, although an attempt had been made to pre-oxygenate the patient, the mask had not been closely applied to his face. If it had been it would have been obvious that no gas was being delivered. Whatever happened to the old practice of sniffing the gases being delivered from the circuit before giving them to the patient? Oh yes, it stopped when our erstwhile senior colleagues started to be reported for suspected drug abuse. Now, of course, we have a 'blame-free' adverse incident reporting system so, perhaps, we could safely go back to this practice… somehow I don't think so!

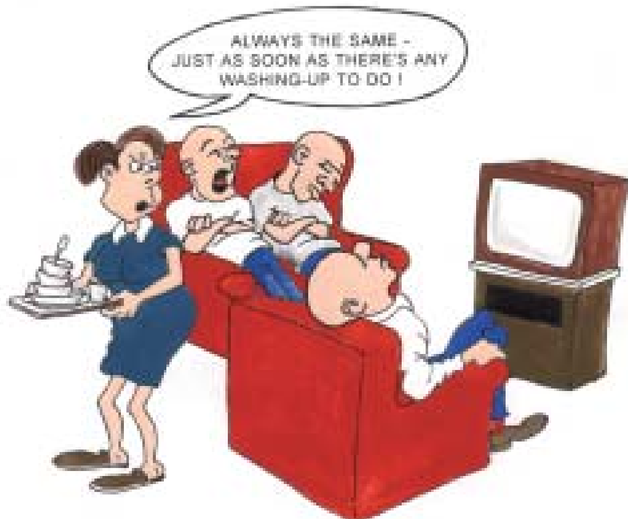
Thirdly, most of the audience was surprised when one of the Brits present asked why the anaesthetist concerned had not disconnected the circuit and blown down the tube. Shock, horror! The risk of HIV, Hep C etc was the US response. But, finally and most surprisingly, the equipment manufacturer, not the anaesthetist, was held to blame!

Maybe it was just a coincidence but, when we got back to our hotel room and switched on the TV, 'The Simpsons' were on with the episode in which Bart and Lisa get a nanny called Sherry Bobbins (aka Mary Poppins) who shows them how to tidy up their messy rooms by sweeping everything under the carpet whilst singing, to the tune "a spoonful of sugar makes the medicine go down", the refrain "It's the American Way!"

Keep up to date

Selective exhaustion affecting an entire household. What is it?

Answer on page 16



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Letter from Zimbabwe

The Stoke – Harare link

Anaesthetics specialist training in Zimbabwe has benefited hugely from a link with Stoke-on-Trent. For the last 10 or so years, registrars from the University of Zimbabwe Medical School have spent six months of their Masters programme at the North Staffordshire NHS Trust, getting first hand experience of anaesthetics in Britain.

Ever since the University of Zimbabwe Medical School was founded in 1963, we have needed specialist training. The need for it grew as most graduates from the school were going abroad for specialisation. Few were returning. In the early eighties, an estimated 60% of UZ graduates had left Zimbabwe. One way of retaining them was by having high quality local postgraduate courses. The medical school in Zimbabwe had originally been a college of the University of Birmingham and offered MBChB degrees until 1970. North Staffs (Stoke), then in the Birmingham rotation, took it up… and the rest is history, as the saying goes.

In the fifteen years of the Masters programme (started 1986) the anaesthetics scene in Zimbabwe has changed. Now, instead of coming from Britain and the west, most specialist anaesthetists have been through the local programme. 31 candidates have successfully completed the four years of the MMed (Anaesthesia). Most of these (20) have been to Stoke. Department staff are predominantly local graduates and most Stoke 'babies'. Of course, there have been ups and downs. The staff at Stoke have been supportive and patient as we have gone through our growth, always believing in the benefit of the programme. For us there has been teaching and exposure to good practice; for them a series of practical, experienced, registrars, mainly enthusiastic to learn! There have been attachments in other countries but they have not been as enduring.

For most of us, Stoke is our window to the outside world of anaesthesia. Local trainees often have an inferiority complex because they are training in a resource-poor country. With the attachment, they spend six months mixing with other trainees, attending meetings and exam courses and, of course, experiencing anaesthetic practice in a leading country. They learn how teamwork and discipline function in well developed health structures and how to respond to patients who are more assertive than they would find at home. They are not skilled in giving information and reassurance to patients and have to learn quickly how to function in the NHS!

Although the trainees are not there long enough to get extensive hands-on experience in many subspecialities, there are many benefits. They gain self-esteem through realising that their own home training has actually given them a good grounding of practical knowledge and skills. They have often carried greater responsibility than comparable graduates from Britain. They return home with a greater sense of what is possible, feeling that the potential for the speciality in Zimbabwe is limited mainly by our (collective) imagination. Anaesthesia developed in a context of limited resources and, with inspiration, we can find ways to work around being poor. Well-trained human resources are our greatest asset, of course.

But our department needs sub-specialists to teach, to provide a service and to provide an alternative viewpoint into problems. At the same time they would see how things work in our context. A mixed and varied international anaesthetic community is also good for development.

We have been fortunate in the support and good will we have had from Stoke over the years. It has made a huge difference to our training programme. This is a good example of a mature and mutually beneficial partnership. I think other programmes in developing countries could benefit similarly from this kind of link with a large department elsewhere. Despite all the hardships we are determined to make a success of it.

Farai Madzimbamuto
Sunanda@africaonline.co.zw

Keep up to date

What is the condition illustrated on page 15?

Familial periodic paralysis