



# Anaesthesia News

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

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## Travels with the President

*By Leo Strunin*

First to Middlesbrough for the launch of the Department of Anaesthesia, University of Teeside, School of Health and Social Care. In these troubled university times when the research assessment exercise (RAE) has cut a swathe through academic departments in all disciplines, it was heartening to witness a university opening a new academic Department of Anaesthesia. Professor Chris Dodds will lead the department that will have a base covering most of the North East. On behalf of the Association, I wished the new department well.

Next to Stirling to attend the first Open Meeting of the Scottish Standing

Committee of the AAGBI. A full report of this meeting will follow in a future Newsletter. Suffice to say, the meeting was well organised and attended and included a Linkman meeting and open forum, updates on 'progress' on the new contract, revalidation, circuits, filters and prions and interesting observations from the Scottish Simulator Centre on doctors' behaviour in emergencies.

Speaking at both venues, I used the following quotation which I have always thought was attributed to Petronius Arbiter but recent correspondence in the press seems to suggest he was not the author. Nevertheless, it does seem apt at present in the NHS.



*Professor Cunningham, Doctor Ellen O'Sullivan and the President with the AAGBI's gift*



'We trained hard but every time we began to form up teams we would be reorganised. I was to learn later in life that we tend to meet any new situation by reorganising and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation.'

Finally, to Dublin for the College of Anaesthetists, RCSI and the President's Dinner. This was an opportunity to view the new premises of the College at 22 Merrion Square North, Dublin 2 and to take a picture of the mace presented by the AAGBI to the College of Anaesthetists to mark its progress as a separate institution. The picture shows Professor Anthony Cunningham, President of the College of Anaesthetists RCSI on the left, Dr Ellen O'Sullivan, AAGBI Council Member and myself. In case you are not sure, the mace is across all of us.

**DO YOU HAVE AN ARTICLE FOR POSSIBLE FUTURE PUBLICATION?**

The Editor, Anaesthesia News, AAGBI,  
9 Bedford Square, London WC1B 3RE or  
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## Advertising in Anaesthesia News

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## Editorial

### Elementary

I am taken to task this month, by Dr Geoff Watson on page five, for the use of the term 'ageing consultant population', when he thinks I should note that the average age is, in fact, falling. He implies that this influx of new blood is 'carrying the can for the failings' of the older consultants. We are to blame, it seems, for his future career spent resident on call and receiving 'an ever diminishing salary'.

Roddie McNicol, not such an old CROC as I, agrees, on page eight, at least about resident on call but I feel bound to point out that, in those trusts where negotiated resident on call occurs, the financial rewards for a night spent in a bare hospital room, with cleaners banging on the doors in the morning, are huge. Or is money not what motivates our younger colleagues?

Why does Dr Watson think that we (or rather he and his contemporaries) are being blamed for all the ills of the NHS? As a speciality, we are well known for attempting to uphold standards, refusing to be fobbed off with inappropriate

assistance and, unlike some colleagues in other disciplines, upholding standards against all the odds.

One of the ills of the NHS is that it insists on rolling huge numbers of patients through the surgical process (apologies for manager-speak), to reduce waiting lists irrespective of the compromise in patient safety. How many Association members work in trusts where they have been asked to undertake Waiting List Initiative (WLI) lists when there are routine operating sessions lying idle because the surgeons cannot get their act together? How many work with surgeons who will only undertake WLIs when on call so as not to spoil another weekend? Woe betide the anaesthetist who tries to do the same thing!

A senior Association member has an apt expression for the way WLIs are organised and the means by which the unequal divide between surgeons and anaesthetists is perpetuated. It is called the Fido Principle. A manager holds out an inadequate sum of money, says "here, good dog" and somebody comes running. We are letting ourselves and our patients down if we accept this inequality which implies that the service we give is in some way inferior. If we continue to do this, it should be no surprise to us if the ills of the NHS are visited upon us.

Forgive a member of the ageing consultant population but there does seem to be a drive across the NHS to lower, not raise standards. A colleague was recently asked to undertake a list with an assistant who was a nurse anaesthetist in his own country but over here on holiday and wanted a bit of spare cash. Good grief! Are we not getting through to managers, driven by other, higher, forces in the NHS, that anaesthesia is a speciality undertaken by qualified doctors with appropriately trained assistants present at all times?

Perhaps we do need a National Anaesthetists Day, as hinted at on page four, where smartly dressed anaesthetists, of all ages, demonstrate that we do care about our profession, are not prepared to see it downgraded, will work hard both on and off call and would like to be fairly recompensed for our efforts.

It's all quite simple really.

**John Ballance**

## Journals and Textbooks Wanted

*One of the commonest complaints from anaesthetists working in the developing world is their inability to obtain anaesthetic literature. This is particularly important to them as many are practising alone in isolated hospitals without colleagues to whom they can refer.*

Following an appeal in a previous issue, over 130 readers have responded by donating their own journals, once they have read them, on a regular basis, direct to colleagues in the developing world.

This generous gesture has been greatly appreciated by the recipients, many of whom have no access to any other literature. More donors are now required and it is hoped that other readers will wish to do the same. Textbooks that are surplus to requirements are also badly needed and would be greatly appreciated.

The WFSA maintains a list of those anaesthetists in the developing world who have requested literature. If you feel able to help, please contact **Dr RJ Eltringham, Literature Distribution Committee, World Federation of Societies of Anaesthesiologists, Floor 8, Imperial Square, 15-19 Kingsway, London WC2B 6TH.**

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



## Letters to the Editor

### Equal Pay for Equal Image?

As I read the article by Dr John Wedley (Waiting List Initiatives – Equal Pay for Equal Work, *Anaesthesia News* No. 176, March 2002), I could not agree more with him that our work is no less important or requires less effort than our surgical colleagues and that we should be entitled to equal remuneration. This has, however, reminded me of an incident where a consultant anaesthetist was introducing himself to a surgeon. After mentioning his own name, he proceeded in an almost apologetic tone in saying, “As you can see from the way that I am dressed, I am an anaesthetist.”

As I see it, one of the main aims of National Anaesthesia Day is to raise the profile of anaesthetists as doctors and to educate the public and indeed our non-anaesthetist medical colleagues in what we do and hopefully also what we are worth to the health service and to them personally. This should also perhaps extend to the hospital managers in both the NHS and private sectors.

A well-known Audit Commission survey showed that sixty per cent of patients admitted to hospital see an anaesthetist at sometime during their stay. This is contrasted by the fact that our speciality only accounts for two per cent of trust resources. In commercial terms, this represents an extremely high ‘return on capital employed’ ratio in our speciality. It is one thing to acknowledge this fact consciously and another for this fact to permeate into the subconscious realms of ourselves and indeed of others that interact with us professionally and socially. How is it that after about ten years after we crawled out of the shadows of the Royal College of Surgeons and formed our own Royal College that we are still suffering from such poor self-image? From my own personal experience, I have observed that quite often the Clinical Director of the Anaesthetic Directorate is a surgeon. I have yet to see the opposite! I find this anomaly almost tragic.

In the Good Medical Practice guide published by the General Medical Council, we are told that we are to maintain a professional conduct and trust of our patients. Does the shabby way that we dress ourselves influence our behaviour and language in our professional capacity? Does the image that we project jeopardise the trust of our patients and in turn the efficacy of our treatments? Are we liable to accusations of professional misconduct? It is a pity that despite our great advancements in anaesthesia, intensive care and pain management, that we seek to undervalue ourselves by such a simple act.

I believe that image plays an important part when we are negotiating for better pay and work conditions. If we are to expect parity in pay and treatments with the surgeons, then we have to act and speak the part. If we don't make this effort to improve our personal image while expecting the public and our colleagues to give us the due respect, it would be at best ignorant, and at worst arrogant.

Perhaps, instead of having a National Anaesthesia Day this year, we can have a National Anaesthetists Day instead. We can then all troop up to the mountains of Snowdonia for a spot of confidence and image building. Come on guys, take some pride!

### Innovations in the NHS

Anyone who has an idea will hope that it is useful. If it really is useful, then others will take it up and use it. Some may feel that their colleagues' appreciation is sufficient reward for their innovation and enterprise. Others may wish to market their idea, expand the number of grateful users and earn something from their originality. Those in the second group should know that they are most unlikely to be able to do so, if they work in the NHS.

It is generally accepted in law that an innovation ‘made in the course of the normal duties of the employee’ is the property of the employer. Not unreasonable if your job is to research and develop new drugs or processes. Your employer makes a large investment in you and the facilities you need to do that work.

But the NHS has decided, ‘... this would cover an innovation arising from these normal duties *irrespective of the time of day* when the idea actually struck’<sup>1</sup> (my italics). Moreover, they have also decided that this applies to NHS employees who are whole time, part time, trainees not paid by the Trust or Trust employees who are seconded somewhere else.

If your idea is ‘unconnected with the normal course of NHS duties’, then you are allowed to keep it. So you can write *War or Peace*, invent a water-powered radio or the first perpetual motion machine and keep your intellectual property. If you receive any form of wage or salary from the Trust and your idea is to improve nursing, medical, paramedical, administrative or hotel services, that idea belongs to the Trust. No matter that you used your own training, literature research and experiments. It belongs to the Trust.

The NHS recognises that inventors deserve some recompense for their originality. It will share with the inventor half of any proceeds of the innovation. This appears so worthwhile to the NHS that my own Trust has appointed a Research and Development Manager who, no doubt, will be expected to generate their own salary and has joined ‘TrusTech’, a Regional collaboration that will “identify, protect and exploit” ideas<sup>2</sup>.

I have news for the NHS. In my experience, no manufacturer will agree to make the investment in money and time that a new idea requires under these conditions. Their payback must come from the 50% that is allowed to the inventor, after the Trust has recovered its own expenses. In the usual circumstances, that will not be enough to justify their investment. There appears to be no NHS recognition that varying levels of investment exist between Trust as employer, the inventor and any investors in the idea and no opportunity for negotiation.

Your only alternative is to resign and leave the employ of the NHS, as soon as you have a useful idea. Even then, you will have been employed when you had it so it probably still belongs to the Trust. Not the best way to encourage the innovative NHS that we are told is so desperately required.

#### References

1. **Management of Intellectual Property and related matters**; NHS Executive 1998 p.18.1.73.
2. **Policy on Intellectual Property**; Morecambe Bay Hospitals NHS Trust, 2001.

John R. Davies, Lancaster

(Written on my own PC, in my own time. Research via the Internet, via my own ‘phone line and using my own subscription to an ISP. A copy of “Policy on Intellectual Property”, was provided for me by the MBHNSHST.)



## Letters to the Editor

### A better way

I was interested in Dr da Silva's comments regarding the risk that exhausted doctors take when driving home (Letters, March 2002). He states that the only two solutions to this problem are either provision of a room for uninterrupted sleep before the doctor leaves or offering them a taxi service home. I disagree.

The only solution to this problem is to reduce hours of continuous duty to within safe and sensible limits. If a doctor is so tired that they cannot drive home safely then they haven't actually been fit to work in the last few hours either. If you're not competent to drive, you're not competent to have been giving an anaesthetic!

### Whose fault?

As a recently appointed consultant anaesthetist I can sympathise with the concerns of the many about rest periods and time off. However, I would question the phrase 'ageing consultant population' used in your March editorial. The consultant body has grown massively over the past decade, which must surely mean that the average age is falling steadily. This means that an increasing number of 'young' consultants will be carrying the can for the failings of our 'ageing' predecessors. Whilst I sympathise with your fate, I cannot help but to wonder whose fault it is that I find myself facing the prospect of a whole career spent resident on-call, receiving an ever diminishing salary and being blamed for the ills of the NHS to boot.

*Geoff Watson, Winchester*

### Intra-operative failure of capnography

While recently anaesthetising a spontaneously breathing adult patient in supine position undergoing day surgery for circumcision with a laryngeal mask size four, the capnography trace on the Datex-Ohmeda AS/3 went flat with a carbon dioxide reading of 0.0 for the remaining eight minutes of the operation. It had worked fine all morning.

I had checked the machine pre-operatively, manually as well as automatically: no abnormalities detected. All efforts to try and identify and eliminate the source of the problem failed. The gas sampling line was correctly placed facing upright, did not leak, was not kinked or in any form damaged and clear of bubbles or fluid. The water trap was not showing any signs of damage either and taking it out and putting back in again did not help. All other monitoring including volatile, nitrous oxide and oxygen sampling worked reliably, the readings were those of a fit and well anaesthetised young man. Fresh gas flow consisted of 1.21 of nitrous oxide and 0.81 of oxygen. The patient was indeed cardiovascularly and respiratorily stable and there was no change whatsoever in the circumstances of the operation suggesting any explanation of the sudden failure of the capnography. The patient kept shifting reasonable tidal volumes, the chest sounded clear, limbs and face were warm with good pulses; the position of the table, the patient himself, his head or tubing was not altered. The patient woke up shortly afterwards and was feeling fine and went home as planned.

After having seen the patient through arousal in recovery, I returned to theatre and carefully checked the machine again. This time there was a minimal leak on high bag pressure and I could locate it at the patient end of the Y-piece close to the

sampling ports of the monitoring piece mounted next. A 4mm long hair-fine fissure was revealed (see photo) which could hardly be seen in the frontal plane, only on close oblique inspection. The capnography recovered instantly after replacing the Y-piece.

I conclude that the leak was responsible for the isolated capnography failure. It had occurred or at least significantly deteriorated while not being manipulated other than by the patient's respiration. Possible reasons for the increase of the leak could be seen in mechanical friction or pressure due to repeated connection and disconnection, hitting hard surfaces while disconnected or heat and moisture further eroding an existing very fine crack. The case highlighted yet again the importance of visual inspection of the corrugated tubing and its connections, not only to detect blockage but also to confirm integrity of the apparatus itself, in order to prevent unexpected dangers which may compromise patient safety.

*P. Bauer*



**EDITOR'S NOTE: This case illustrates the importance of checking circuitry and of patient observation.**



## Spec Soc Page

# ALFA – The Association for Low Flow Anaesthesia

**The aim of the Association is to promote interest, development and intellectual exchange in the practice of low flow anaesthesia.**

The origins of ALFA go back to Manchester in 1994 when Nigel Harper organised a symposium on Low Flow Anaesthesia. The success of this meeting led to a second symposium in 1995. Mike Logan organised a meeting in Edinburgh the following year at which it was announced that we were all members of ALFA and that Professor Alistair Spence had accepted the Presidency of the Association.

ALFA currently has 600 members from as far afield as Vietnam and Brazil. Most, however, are from Europe with 47% based in the UK. Membership is open to anyone with an interest in anaesthesia with reduced fresh gas flows. ALFA's main activity remains the annual symposium with speakers from the forefront of research and development in all areas relating to gaseous anaesthesia, as well as coverage of the more fundamental aspects of low flow techniques. Having our roots in the UK and an international membership, we aim to alternate our annual meetings between UK and overseas venues. In 1997, we met in Belfast with subsequent meetings in Gent, York and Ulm.

Administrative problems lead to the cancellation of ALFA2001 and, as a result, we have brought our 2002 meeting forward from the autumn to the spring. Professor Francesco Giunta will be entertaining us in Pisa on 26 and 27 April. Anyone who attended the CENSA meeting in Florence last June will know that Tuscan food, wine, architecture and hospitality make for a very enjoyable meeting.

We have a website which features abstracts from our meetings, details of future meetings and most of the things you expect to find on a website.

ALFA has excellent relationships with several major companies and their enthusiastic support of our meetings means that, at present, we charge no membership subscription. Membership is by application to the Membership Secretary and remains valid for five years after the last attendance at our Annual Symposium.

If you have an interest in Low Flow Anaesthesia, or if you think that you should find out more about its benefits and intricacies and, in particular, if you have an interest in Italian food and good head for heights, why not contact us?

**Either, visit our website and sign the guestbook with a request for membership or contact Dr Michael Logan at The Department of Anaesthesia, Edinburgh Royal Infirmary, Lauriston Place, Edinburgh EH3 9YW or via email at [mikel@srv1.med.ed.ac.uk](mailto:mikel@srv1.med.ed.ac.uk) Our website can be found at [www.alfanaes.freeserve.co.uk/alfa-1.htm](http://www.alfanaes.freeserve.co.uk/alfa-1.htm)**

*Geoff Nunn, Secretary, ALFA*



### 5th South West Thames Anaesthesia Forum

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

#### Open to all Anaesthetists

The Scientific Programme will include lectures, and discussions on:

- Acute and Chronic Pain
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**Deadlines for abstracts: August 17th 2002**

**This meeting is approved for CME purposes**

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## From the *Museum*

### *This year's exhibition features Anaesthesia for Laryngeal Surgery from 1870 to 1900*

It is startling to discover that John Snow anaesthetised a number of patients for major operations on the jaws, such as would be daunting even today. The problems can be imagined and his solution was to anaesthetise so lightly as to maintain the cough reflex, using posture to drain blood out of the mouth. But in other hands there was a high incidence of peri- and postoperative complications, so often fatal that it became the practice to perform all such operations without anaesthesia at all.

The invention of the indirect laryngoscope by a singing teacher, Manuel Garcia (1805–1906), in 1854, made the diagnosis of disease and even the per-oral approach to the larynx, possible. General anaesthesia and the antiseptic regime introduced by Lister during the 1860s made surgery of the larynx a feasible undertaking, providing a further challenge.

#### Trendelenburg's Tube

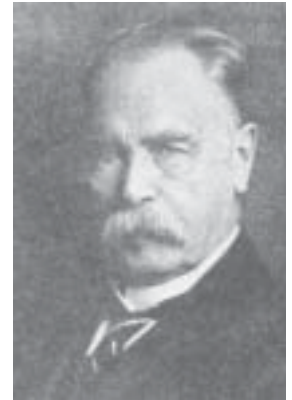
In 1869, the German surgeon Friedrich Trendelenburg (1844–1924), then a trainee attached to von Langenbeck, wrote that one did not need to be very sensitive to feel horror at such a cruel process. Trying to find a means of preventing blood from running down the trachea, so as to allow an inhalation anaesthetic to be administered during major operations on the jaws or mouth, the idea of plugging the trachea came to him. After trials on dogs he devised a cuffed tube, to be inserted through a tracheotomy, the so-called tampon-cannula. The cuff was inflated by a rubber bulb which was left attached to allow for topping up in case of leakage. The anaesthetic agent, ether or chloroform, was dripped onto layers of gauze covering the wide end of a funnel, the spout of which was connected to the tracheotomy tube by a length of rubber tubing. Langenbeck used it immediately for an upper jaw resection and found it very satisfactory. Junker published a description in the *Medical Times* after visiting Langenbeck's clinic in 1871. The tube became of even greater importance when Billroth, in 1873, introduced the operation of extirpation of the larynx but a major problem was the unreliability of the inflatable cuff.

#### Michael's (Hahn's) Tube

In 1882, the Hamburg ENT surgeon Isaak Michael (1848–1897), to prevent aspiration in diphtheritic paralysis of the cords, devised a tube with a dry sponge-rubber cuff which would swell as it absorbed moisture and seal off the trachea. He described it at a surgical congress and published an account; but it was never his purpose that the tube should be used during general anaesthesia. This use of Michael's tube, for surgery of the larynx, was suggested by Eugen Hahn, (not, as has been pointed out by Dr. Michael Goerig, by Wilhelm Friedrich Hahn (1796–1874), who was credited with it by K. Bryn Thomas in

his 'The Development of Anaesthetic Apparatus').

Eugen Hahn (1841–1902) qualified in Berlin in 1866 and served as an army surgeon during the Austrian and Franco-Prussian Wars. In 1880, he was appointed director of the surgical department of the Friedrichshain Municipal Hospital. As an authority on laryngeal surgery, he was called to London in 1886 by Felix Semon to perform the celebrated operation on the barrister and London police magistrate



*Friedrich Trendelenburg*

Montague Williams. While he merits credit for introducing the use of Michael's tube into general anaesthesia, it is unfair that his name has become exclusively attached to it. As Goerig has indicated, only von Esmarch's surgical textbook of 1892, by labelling it the Michael-Hahn tube, has indicated its real origin.

**Management of the Anaesthetic and Operation**  
By 1900, there were broadly two surgical approaches to carcinoma of the larynx; either total laryngectomy, or the more conservative operation of entering the larynx by thyrotomy, dividing the cartilage down the midline, opening the larynx like a book and excising the growth. The patient would be anaesthetised and a tracheotomy performed. The Michael-Hahn tube, wrapped tightly with tape to collapse the sponge, was introduced and the tape removed. The surgeon waited some ten minutes for the sponge to absorb moisture and swell up sufficiently to completely seal the trachea, while the anaesthetic was continued with Trendelenburg's cone. Postoperatively, some surgeons left the Michael-Hahn tube in place for two or more days, while others replaced it more quickly with an ordinary tracheotomy tube, Durham's being the popular choice.

Although thyrotomy, pioneered by Semon, Hahn, and Butlin, had become the favoured operation in Great Britain, total laryngectomy was the choice of the German school and, by 1898, a reviewer was able to collect 188 fully documented cases. After this operation it was usual to pack the wound with iodoform gauze and allow it to heal by granulation but the Philadelphia pioneer ENT surgeon Jacob Solis Cohen (1838–1927), father of the physician who elaborated Richardson's idea of the oesophageal stethoscope (*Anaesthesia News*, April 2001), brought the trachea forward and stitched it to the skin of the neck, closing the tissues above and behind it. This was reported to have the advantage of quicker healing and that the patient could swallow much more easily.

Acknowledgements to Dr Michael Goerig of Hamburg and Mr John Booth FRCS.

*David Zuck*



## Thoughts from *Abroad*

*(Read on, this is not a travelogue)*

Dear Ed.,

I'll let you guess where I am. They speak English with a Cockney/West Countryish/Irish kind of drawl and drive on the left-hand side of the road. Got it? They have three national drinks, one from a blue can (they call it a "tin"), another from a green tin and the third from a yellow tin covered in XXs. In theory you shouldn't need any more hints but the fact that they drive large 4x4s with lethal 'roo bars on the bonnet should help. **(I think I've got it, but one more would help, Ed.)**. OK, they live in a country where the sun shines all day but they're all as pale as sheets because of a morbid fear of malignant melanoma. **(That'll be Australia, Ed.)**.

Yes, here I am in the land of Oz with the other Dr. McNicol for the marriage of our firstborn, Yet Another Dr. McNicol (YA) and his beloved Naomi. YA has followed many trainees in the SHO/SpR grade to sunny Queensland, a state full of promise, if not doctors. The population is increasing at 100,000 per annum and I am certain that YA will not be the last of our young colleagues to be seduced by working conditions superior to our own (at time of writing), in a land with a classless society, where people succeed on merit while enjoying a lifestyle that is debatably better than Manchester and Glasgow, the only workplaces the McNicols have for comparison.

It all started when YA was in his penultimate year at Manchester and followed in his parents' footsteps by spending an elective abroad. In our case, in 1967, it was North America but the next generation seem to be bewitched by Australia. It, and the lovely bride to be, certainly worked their magic on YA, this despite his father's warning not to get too involved with the local Sheilas. The other Dr. McNicol and I can still remember one of our classmates being prised from the clutches of what can only be described as a 'Madison Avenue Model' as he embarked on the flight back home from Toronto to Prestwick. We assumed then and have since that he had a lucky escape. Bearing this warning in mind, YA nevertheless met a girl in Sydney within a few days of landing and the rest is history.

Toowoomba – what could be a more Australian sounding name Ed.? – **(I thought Toowoomba was something to do with wombats passing wind underwater, Ed. No, Ed., that's "Vrroomba")**, is a town the size of Paisley with a population of 90-100,000, situated in the Great Dividing Range at a height of 2,700 feet, which is just less than Ben Lomond. If your reader has ever walked up that mountain to be lost in freezing fog within 1,000 feet of the summit, he may express surprise that a community like Toowoomba, complete with its university, cathedrals and 150 parks and gardens should flourish at such an altitude. Queensland is not, and never will be, Scotland. The climate in Toowoomba is excellent, indeed the best in Queensland they say as they have to 'rug up' in winter and many houses are built with facilities for accommodating a fire. They also have pergolas and verandas to provide shade during the summer and for stopping the dreaded rays striking one's guests' whiter than white skin when they come for a barbie.

The local development agency's motto is "Four good seasons are four good reasons for visiting Toowoomba" and it seems to work as the town (they call it a "city" but then every little hamlet in Oz is a city) is expanding at a great rate, mainly with the recently retired who

come for the aforementioned cooler climate. If four seasons become too much for the inhabitants, they are ninety minutes from Brisbane, the beach and year round sun.

YA is the equivalent of an SHO 3 and was recruited by the well known locum agency responsible for most of the locum appointments in Queensland. He is working in emergency medicine **(we used to call that "casualty" when I was a boy, Ed.)** and plans to make a career in that speciality. Ed, at this stage I have to comment on the lifestyle that young docs of YA's age can afford in Australia and it may cause a mass exodus of trainees from the UK, will that be O.K? **(Carry on. Do they want consultants as well? Ed.)**

First, let me take you back to when the other Dr McNicol and I were students. Like every young couple we planned a future that could reasonably be claimed to be achievable. We based this on our consultant teachers' lifestyles. Even those who were young and recently appointed lived in beautiful detached houses. In the West of Scotland, specifically Glasgow, these are typified by elegant Victorian red sandstone buildings with large airy rooms, situated either in the west end or south side. It seemed not unreasonable to imagine ourselves living in one of these homes by the time we were in our mid to late thirties. It was not to be. By the early seventies the salary of NHS consultants had dropped in comparison to other professions. Estimates of amounts vary but somewhere in the order of 50% is a guesstimate. The profession's response to this was to make a reasoned case each year to the Review Body for a substantial increase. Evidence was produced to prove that we were falling behind and year after year our claims were disregarded. We received fractions of what we felt was a reasonable increase, eventually having to bite the bullet when part-implementation was introduced in the final years of the last government. Eventually, the other Dr McNicol and I had to accept that we were not going to aspire to our ambitions. Not that we haven't been able to bring the kids up in a style much better than most of the population, in a nice, modern (1960s), small detached house but, nevertheless, there is a certain feeling of having been sold short. We've now arrived at the point in our lives when we could afford that house but it's too late, we don't need it anymore. By contrast, see what a junior doctor and partner not involved in healthcare can achieve in Australia.

My son and the lovely Naomi have now bought their first home. At a similar stage in our careers we could afford a three roomed semi (two bedrooms) on our combined income and new SHOs nowadays would seem to be in the same position, at least before they received all that dosh in April! Not so in Australia, where YA and Naomi built their first home, a detached four bedroomed (master en-suite), with an open plan family area including modern kitchen with walk-in larder, dining and living area and a separate formal lounge. Needless to say, there are the usual external fittings to ensure shade etc. The other Dr McNicol reckons that such a house, costing around £72,000 there would cost £250,000 here and that's Glasgow prices. London would cost another 75-100% on top of that, indeed at time of going to press our middle child has made an offer of £70,000 for a two-roomed flat in Manchester. Although the cost of living in Oz is significantly less than here, not every young couple can afford such luxury so I imagine SHOs must make a reasonable living there. I know that a substantial part of YA's salary comes from overtime and that a week of night-shift can be quite lucrative so it may be that our own trainees will soon be in a similar position and living in nicer homes than their



young consultant colleagues.

You already know my thoughts on Consultant Resident On Call (CROC) Ed. (**Yes, that there's no evidence that it provides a better service than the present arrangements and that we're being forced into it by Calman and The New Deal, Ed.**) and this trip has reinforced one of my anxieties i.e. that working 24 hour stretches is a young person's game. We've been here for two nights now, so, including a two-night stopover in Hong Kong, it's four nights since we left home and I'm still totally knackered. To me jet lag is indistinguishable from that dreadful feeling following an all-nighter in theatre. I'm dizzy, nauseous, tired but unable to sleep and irritable. If I'm called out in the middle of the night, it takes at least two or three days for me to recover. It wasn't always like this and I can fondly remember long

lunches and rounds of golf with the President-elect following nights on call as registrars. So what's changed? Well, maybe I'm out of practice and could get used to it again, however I'm certain it's a function of my age. I know many departments retire their colleagues from night duty at varying ages and it will be interesting to see whether this is discussed and implemented in the new contract negotiations. It would be interesting to hear your reader's views on this, e.g. should we be contracted to do night duty and if not what is a suitable age to give it up?

I should add, Ed., that on our stopover in Hong Kong word got out that She Who Shops was back in town and the Hang Seng went up ten points. All the best to you and the present Mrs Ed.

**Roddie**

## AAGBI Website

**Like Dr Who, websites occasionally take on a completely new appearance and our site has recently undergone just such a transformation.**

The Association website was launched in April 1996, when it was the first of its kind in Great Britain and Ireland. Hosted by the Newcastle University server, with the snappy address of [www.ncl.ac.uk/~nassoca/](http://www.ncl.ac.uk/~nassoca/) and run by Roger Hayes from the university, it aimed to provide up-to-date information about the Association and its activities.<sup>1</sup>

In May 1999, the first complete makeover took place and the site was put on a more professional footing with its domain name [www.aagbi.org](http://www.aagbi.org) and hosted by a commercial service provider. The Association staff maintained the content but, unfortunately, the opportunities for doing this were limited to particular areas, for example seminars, events and publications. Any change to other pages turned out to be very costly which is why Mal Morgan remained as President on the site for a year after his term of office had finished!

Last year, a new developer, Yip Design, was engaged to create a new site that could be completely maintained by the Association and this incarnation made its debut in September last year. For those who have visited the site (hopefully all of you!) there are four main divisions accessible from the front page, for Members, Trainees, the Public and the next major meeting.

Short cuts to most pages are available from the drop down box on the home page or from the side navigation panels on other pages.

During the first few months, the daily hit rate has steadily been increasing and now stands at over 550 per day. One advantage of the new site is that detailed statistics are available which enable us to see which are the most popular features. The top 20 pages are shown in the table, with the number of hits during February 2002.

Clearly the 'glossies' are the most popular section, receiving more hits than the members page itself. The link to *Anaesthesia* remains popular, despite the fact that it is not currently available! This is due to the fact that it requires a secure link, not available to the general public. John Yip is currently working on providing this feature, together with a site search facility, so both of these should be available later in the year.

One feature that has been reinstated is the link to the Mailbase mailing list (see the links page). This was dropped in the previous version of the site, for reasons that are not entirely clear, so, hopefully, this will enable a wider audience to participate in the discussions.

If you visit the news page, you should find the latest information about the activities of the Association and here you will also find a link to a list of the pages most recently updated. So, please keep a regular eye on the site (now that we all have desktop access in the NHS, that should not be a problem!) and please let me know of any suggestions that you have to improve the site or if you spot any problems. I would be especially interested to know if you have visited the site trying to find some information that isn't there – let me know and I will see what I can do.

**Chris Barham**, Website Editor  
[chris\\_barham@compuserve.com](mailto:chris_barham@compuserve.com)

1. Charlton JE, Association Home Page, *Anaesthesia News*, July 1999, Page 9.

Page	Hits
guidelines	1048
members	906
seminars news	635
<i>Anaesthesia</i>	620
GAT	513
links	468
<i>Anaesthesia News</i>	377
ASM 2002	369
public	358
staff	307
spec societies	292
news	270
events	235
executive	206
grants/awards	188
trainee news	140
working parties	132
patient publications	124
international links	121
history	115





## GAT Page

# Representation and Communication

***The GAT Committee is elected by its members. Why is it elected? It is elected because the process of election endows authority. Why is authority required? Authority is primarily required to make power legitimate and power in this instance is the power to do and say things on behalf of the electorate.***

It is, after all, based on our political system of representational democracy. Nice pedigree, then, until you hear that many regard representational democracy as democracy's weakest variant. Why so? Well take your very own member of parliament... Oh, you've no idea who that is. Well there you go. Now name the elected members of the GAT Committee. Now tell me how you can get in touch with the GAT committee to let them know how you feel about some of the issues the Committee is currently engaged with... Oh, you don't know what issues...

It seems we've discovered one of the many problems with such a system, perhaps the biggest one, that of participation. Representation can only occur 'fairly' if all participate equally, allowing the representatives to get a clear view of opinion. In reality, only a minority takes part and thus the democratic ideal appears to fall flat on its face, the so-called tyranny of the minority. This is terrible. If only everyone took part, then perhaps we could have the much better tyranny of the majority. No, it would have to be a considered tyranny of the fully informed majority as gleaned by a tiny elected minority.

There seems to be a problem with participation. Here is another problem with participation: it is easier for some to participate than others. If you chat to your MP over the garden fence every weekend because they live next door others might accuse you of unfair influence and the MP of bias. Fortunately, only someone with enormous personal integrity would ever be elected to such a position of responsibility and thus our worries are easily quelled.

Our political system has evolved over hundreds of years and competed well with alternative systems in this time. And just look at the alternatives: either intuitively abhorrent or fundamentally impractical. Furthermore, the system generates a framework of rules both concrete and intangible that simply reek of virtue. If these aren't reason enough then there is always accountability and the next election.

The GAT Committee is elected and therefore has power to do things for its members. There's little point in a posteriori justification. What we're dealing with is a fait accompli. Our raison d'être is clear to anyone with commonsense. We must use our savoir-faire to get on with the jobs at hand. However, as with all unsatisfactory matters, the GAT Committee feels that representation and communication could be improved...

The Committee uses a variety of media to extend itself, as Marshall McLuhan would have it. In the past this was confined to print, the spoken word and through organised events. The first is good for conveying ideas from the Committee, assuming that all members receive the Newsletter and then read the GAT page. No doubt there were people who wrote to the Committee too... The spoken word has its problems, even if the Committee was to take verbal aperients.

Events allow a flurry of communication but are short-lived. They also tend to be fuelled by 'dutch enthusiasm' which, like common-room angst, burns itself out like fire in a tinderbox.

The Committee is keen to extend itself as far as possible. It is one of our unwritten duties. It would seem a great advance, therefore, to have the services of the information technology industry. With quiet confidence we planned the re-launch of the GAT website ([www.aagbi.org/trainee.html](http://www.aagbi.org/trainee.html)) and the GAT Linkman scheme.

The idea with the website was to start simple and build gradually according to needs that would become apparent. Great, providing everyone you want to communicate with visits the site regularly. Crushingly obvious now of course but this little caveat had been buried beneath our initial enthusiasm. Some recompense comes from the fact that the GAT pages are the second most hit-upon after 'publications' but it's very difficult to know what percentage of members are reached through this medium.

The other idea thrown up in the lava of our initial excitement was to generate a database of GAT members' email addresses. At the time I was involved in trying to achieve just that for my own region's Specialist Registrars. We must have managed about 95% of people at best but, whenever a group mailshot was sent, at least 5% were returned as undeliverable mail. Still, you're probably thinking that's still a reasonable hit rate. The trouble comes when considering the huge amount of work involved in trying to keep such a database up-to-date. In time it will happen but, in the meantime, there's always the Linkmen...

Now, there have been grown-up Linkmen for many years and the scheme works well. The problem for us is that everyone moves hospital every six to twelve months, making the one Linkman per hospital idea a non-starter. So, we had a cunning plan: Each region or school of anaesthesia will have a Speciality Training Committee (STC) or equivalent and these should have a trainee representative or two. Chances are they are members of the Association. Chances are they are well informed. Chances are they are a bit more motivated in matters political and practical. Chances are they'd make the best Linkmen. So, I began tracking down this promising species.

Having written to all 25 of the College's Regional Advisers asking for help, we now have 10 new Junior Linkmen. Rather than list them here I'm rather fiendishly going to tell you that their identities will soon appear on the GAT website ([www.aagbi.org/trainee.html](http://www.aagbi.org/trainee.html)). I'm still not sure who the others are. If you're one of them, then why not get in touch? If you know one of them, then why not shop them to the Committee? We're all reasonably reasonable people and, anyway, we've been elected...

In the meantime, I've no doubt that we'll be hard pushed to beat the reassuring tangibility of this Association Newsletter and its regular GAT Page!

You can contact the Committee about anything relevant to GAT, by post to the Association of Anaesthetists, 9 Bedford Square, London WC1B 3RE; by telephone on 020 7631 1650; by email at [gat@aagbi.org](mailto:gat@aagbi.org); by voice, providing a member of the Committee is within earshot.

*Dr Nevil Hutchinson, Trainee Linkman Co-ordinator*



# The Glostavent

## A New Anaesthetic Machine For Use In Difficult Situations

The various improvements that have occurred in recent years in the design and performance of anaesthetic machines have undoubtedly led to significantly increased patient safety. However, as these machines have become ever more sophisticated, so their cost has escalated. A new state of the art anaesthetic machine in the United Kingdom currently costs between £20–£40,000, a figure clearly beyond the range of most anaesthetic departments in the less affluent parts of the world.

These new machines function well when used in sophisticated environments, where maintenance and servicing facilities can be guaranteed. However, they rely heavily on computer technology and frequently require a degree of attention, beyond the skills of even the most competent local hospital technicians. Even a minor fault can be disastrous if no one knows how to correct it. Consequently, a service contract is essential, adding a further 10% of the purchase price per year.

Moreover, they are not designed for use in adverse environments or when the supply of electricity or oxygen may be interrupted without warning, rendering them unworkable with catastrophic results. Attempts to introduce these expensive modern anaesthetic machines into the developing world have repeatedly ended in failure and have been an expensive waste of resources. For this reason, a new purpose built anaesthetic machine known as the Glostavent has been specifically designed to overcome the difficulties frequently encountered by those practising under adverse conditions. At £7,500, the Glostavent is much less expensive to purchase, is more economical to run, easy to understand and operate and is robust, requiring minimum servicing. It can be used on both adults and children, either as an anaesthetic machine in the operating room, or as a ventilator in an intensive care unit or recovery room. Most important of all, it can continue to function even if the supplies of oxygen or electricity fail, situations which are not uncommon in remote locations and have been responsible for many avoidable tragedies.

It incorporates four components, each of which has, in its own right, already proved valuable to anaesthetists in the developing world. They are the draw-over anaesthesia system, the Manley Multivent ventilator, the oxygen concentrator and the air compressor.

### The draw-over anaesthesia system

In this system, atmospheric air is used as the carrier gas which is drawn over a low resistance vaporiser by the patient's own inspiratory efforts. It therefore does not depend on the supply of pressurised gases or cylinders.

### The Manley Multivent ventilator

This is a mechanical version of the Oxford Inflating Bellows which is powered by either oxygen or air, at a pressure of 140Kpa. It is very easy to operate, having just two controls, tidal volume and respiratory rate. Unlike other gas driven ventilators, it is extremely economical in the consumption of driving gas, requiring just 1/10 of the minute volume delivered to the patient. When oxygen is being used as the driving gas, even further savings are possible as, having powered the bellows, it is collected and returned to the patient circuit to supplement the inspired oxygen concentration. In other words, the same

oxygen can be used twice, first to drive the ventilator and then for the patient to breathe.

### The oxygen concentrator

This electrically driven device provides an unlimited supply of oxygen from the atmosphere, without the expense of purchasing or transporting heavy oxygen cylinders. Atmospheric air containing 20% oxygen is drawn into the concentrator and compressed to 140Kpa. Then, the nitrogen is absorbed by canisters containing zeolite, leaving residual oxygen for the patient. It can produce a concentration of 90% oxygen at a flow rate of up to five litres per minute, at a cost of only 2.5p per hour.



### The air compressor

This is used to provide an unlimited source of compressed air needed to drive the ventilator. In the Glostavent, a separate air compressor is not required, as the oxygen concentrator has been modified to enable some of the compressed air generated to be diverted to drive the ventilator. In this way, a continuous supply of compressed air is available at no extra charge.

The four components are interconnected and mounted on a trolley with two oxygen cylinders which are kept in reserve in case a failure of electricity prevents the oxygen concentrator from functioning. Under normal circumstances, when electricity is available, it is more economical to use the oxygen concentrator both as source of oxygen for the patient to breathe and of compressed air to drive the ventilator. Should the electricity supply fail, the reserve oxygen cylinders are turned on, one to drive the ventilator and the other to supply oxygen. In this way, the anaesthetic can be continued without interruption,

The Glostavent has now been thoroughly tested and has proved reliable in providing anaesthesia over a wide range of patients of all ages. It has also been used successfully as a ventilator in an intensive care setting. Its development has been supported by grants from the Department For International Development (DfID), the World Federation of Societies of Anaesthesiology (WFSA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI), as well as many other charities and it is already in use in a number of countries, including Zambia, Mozambique, Ukraine and Vietnam.

It is hoped that it will soon be made available to anaesthetists in many more countries and will bring about a significant step forward in the provision of safer anaesthesia throughout the world.

*Drs Roger Eltringham and Wilson Thomas  
Gloucester*



## THE ASSOCIATION OF ANAESTHETISTS

*of Great Britain and Ireland*

### Seminars at Bedford Square

## THE HISTORY OF ANAESTHESIA

Thursday 30 May 2002

Organisers: Dr Geoff Hall Davies and Dr Neil Adams

#### Topics include:

Liver Transplantation at King's College Hospital, Denmark Hill (1972–1980) • Anaesthesia for the First UK Liver Transplant • History of Anaesthesia for Liver Transplantation • Anaesthesia for the first UK Heart Transplant • Anaesthesia's First 'Home' Sam Gamgee of Tolkien • The Association of Anaesthetists of Great Britain and Ireland – change and progress • Antiques Roadshow\*

\* Delegates are invited to bring with them interesting or 'mystery' pieces of apparatus or artefacts together with a brief resumé of any available information. These should be handed to Dr Adams or Dr Zuck at the beginning of the seminar to enable him to identify them during the afternoon. They will then be presented for open discussion.

For further information please contact Nicola Heard on 020 7631 8805 or email [seminars@aagbi.org](mailto:seminars@aagbi.org)

## THE ASSOCIATION OF DENTAL ANAESTHETISTS 25th ANNIVERSARY SUMMER SCIENTIFIC MEETING

Newcastle upon Tyne June 21/22 2002

#### FRIDAY 21 JUNE

- Session I** Pharmacological Topics:  
Synergy, Professor J G Whitwam  
Opioids, Professor C J Hull  
Non Opioid Analgesia, Professor R Seymour
- Session II** Free Papers, Lunch
- Session III** Orofacial Signs of Child Physical Abuse, Professor R R Welbury  
Free Papers
- Session IV** The ADA 25 Anniversary Guest Lecture  
Professor Sir M J Rawlins, Chairman, National Institute for Clinical Excellence

#### SATURDAY 22 JUNE

Annual General Meeting  
Award of Honorary Life Memberships to Dr Penelope Hewitt and Dr Adrian Padfield

- Session V** The ADA Prize Essay for Postgraduates in Training  
Free Papers  
Open Forum  
Meeting Closes at 1300

Enquiries and Registration forms from: Department of Anaesthesia, Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne NE1 4LP. Tel +44 (0) 191 282 4386. Email: [s.a.hargrave@ncl.ac.uk](mailto:s.a.hargrave@ncl.ac.uk)



## UNIVERSITY OF CAMBRIDGE

Division of Anaesthesia

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Email: [dww21@cam.ac.uk](mailto:dww21@cam.ac.uk)

[www.medschl.cam.ac.uk/anaesthetics/smart.htm](http://www.medschl.cam.ac.uk/anaesthetics/smart.htm)



## Nuffield Department of Anaesthetics University of Oxford

### 4th Regional Anaesthesia for Carotid Surgery Course

Featuring *live* demonstration of  
**Awake Carotid Surgery**

Monday, 28 October 2002

9.00 am to 4.30 pm

Details: Dr Mark Stoneham,  
Nuffield Department of Anaesthetics,  
John Radcliffe Hospital, Oxford OX3 9DU  
tel: 01865 221590, fax: 01865 220027  
email: [mark.stoneham@nda.ox.ac.uk](mailto:mark.stoneham@nda.ox.ac.uk)  
website: [www.nda.ox.ac.uk](http://www.nda.ox.ac.uk)



# Final F.R.C.A. Examination Intensive Preparation Course

## 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

### PAIN INTERVENTION INTEREST GROUP

OFFICIAL SPECIAL INTEREST GROUP OF THE PAIN SOCIETY OF GREAT BRITAIN AND IRELAND

## ANNUAL SCIENTIFIC MEETING

**Friday 21 June 2002**

**The Gleeson Lecture Theatre, Lift Bank C, Lower Ground Floor Chelsea and Westminster Hospital, London SW10 9NH**

- 09.00 Registration / Coffee / Trade Exhibition
- 09.55 **Welcome** – Dr Andrew Lawson, Chelsea and Westminster
- 10.00 **Update on Epidural Steroids** – Dr J Van Zundert, Maastricht
- 10.45 **The Dorsal Root Ganglion in Radicular Pain** – Dr Charles Gauci, Whipp's Cross
- 11.15 Coffee / Trade Exhibition
- 11.30 **Spinal Cord Stimulation in Radicular Pain** – Dr Simon Thompson, Colchester
- 12.15 **Disc Related Pain – Where's the Evidence?** – Dr Andrew Lawson, Chelsea and Westminster
- 12.45 Lunch / Trade Exhibition
- 14.0 **MRI of the Lumbar Spine** – Dr J Healy, Chelsea and Westminster
- 14.45 **Discography and RF Annuloplasty** – Dr Simon Dolin, Chichester
- 15.15 Coffee / Trade Exhibition
- 15.45 **Failed Back Surgery Syndrome** – Dr Jon Richardson, Bradford Royal Infirmary
- 16.15 **Introducing New Interventional Treatments** – The View from NICE – TO BE CONFIRMED.
- 16.45 **Pathology of RF Lesioning** – Dr Sherif, Guy's Hospital
- 17.15 **General Evaluation and Discussion**
- 17.30 Close

\*\* Please note that the order of the programme may be subject to change\*\* CME Applied for.



I would like to register for the **PAIN INTERVENTION INTEREST GROUP MEETING £100**

Name: ..... Address: .....

Cheque enclosed (£100) £..... (made payable to: Westminster Medical School Research Trust).

**Please send to: Simone Seychell, Anaesthetic Dept, Chelsea and Westminster Hospital, Fulham Road, London SW10 9NH**



# PANG

Pain and Nociception Group

ICSM - Charing Cross Hospital  
Fulham, London W6 8RP

Monday 13 & Tuesday 14 May 2002

## London chronic pain symposium

- |   |  |
|---|--|
| Neurophysiology of chronic pain               | Palliative medicine & lessons for chronic pain |
| Chronic regional pain syndromes               | Chronic visceral pain                          |
| The human effect in pain management           | Central - post stroke pain                     |
| The psychological cost of pain                | Management of spasticity                       |
| Motivating and empowering patients            | Opiates for chronic pain                       |
| Occupational aspects of back pain             | Chronic pain in children                       |
| "Botox" and other therapies for back pain     | Chronic pelvic pain                            |
| Practical approaches to assist return to work | Spinal drug delivery systems                   |
|   | Micro-discectomy                               |

Registration £250 Trainees £180 (inc. VAT)

Further information:

Mrs S Welham  
PANG Administrator  
7 Dover Road  
Sandwich, Kent CT13 0BL

Tel/fax: 01304 612520

Mobile: 07801 930370

(Approved for CPEP)  
(Cancellation rates available)

Thursday 6<sup>th</sup>  
Friday 7<sup>th</sup>  
June 2002

3rd PLYMOUTH  
Symposium of  
Paediatric  
Anaesthesia

Plymouth Medical Centre  
Derriford Hospital, Plymouth

International Faculty including

Dr David Baines - Professor David Hatch - Dr Helen Holtby  
Dr Jerry Lerman - Professor Robert Sneyd - Dr Andy Wolf

Organised by  
Dr AS Carr  
Dr A Johnson

### Lectures

- Uniformed Drugs in Paediatric Anaesthesia
- Cystic Fibrosis
- Cerebral Palsy
- Propofol and the child
- Recent Advances in treatment of PONV

### Workshops

- Fiberoptic Intubation
- Paed Anaesthesia in Remote Locations
- Tips for Teaching
- Regional Analgesia

Case Scenarios - Controversies in Paediatric Anaesthesia

### Course Dinner Thursday 6th June

For details please contact

Ms Carol Friend, Anaesthetic Dept,  
Derriford Hospital, Plymouth PL6 8DH  
T 01752 792692 F 01752 763287  
E carol.friend@pghnt.swest.nhs.uk

Celebrate the Queen's Golden Jubilee in  
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5 CME Points  
25<sup>th</sup> April, 23<sup>rd</sup> May,  
20<sup>th</sup> June, 18<sup>th</sup> July  
Sept onwards dates TBA

- Lectures and Practical Sessions on:-
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  - Physiology of cardiac output
  - Waveform interpretation
  - Critical review of the literature
  - Cost effectiveness and outcomes
  - Clinical applications

For further details contact:  
Dr Mark Hamilton  
mark.hamilton@ucl.ac.uk

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OPERATIVE MEDICINE



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acceptable provided it has not been  
published in peer reviewed journal by the  
abstract deadline, 31<sup>st</sup> May 2002.

Abstracts to: [dennylevett@hotmail.com](mailto:dennylevett@hotmail.com)

### Invited Speakers Include:

Jan Bakker (NL); John Kellum (USA);  
Lew Kaplan (USA); Andy Shaw (USA);  
Max Jonas (UK); Jonathan Wilson (UK)

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  - Myocardial Ischaemia
  - Fluid Optimisation
  - Post-Operative Analgesia
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For further details contact:  
Dr Sarah Chieveley-Williams

[sarah.chieveley-williams@uclh.org](mailto:sarah.chieveley-williams@uclh.org)



MEETINGS & CONFERENCES FROM THE CENTRE FOR ANAESTHESIA, UCL

Fax: 020 7580 6423 / Tel: 020 7323 9911 / [ucl.acru@btinternet.com](mailto:ucl.acru@btinternet.com)

Professor Monty Mythen: [www.ucl.ac.uk/anaesthesia/meetings](http://www.ucl.ac.uk/anaesthesia/meetings)





## Dr Ruxton *Writes...*

### You're never alone as a (trainee) anaesthetist

Many consultant anaesthetists, like me in their fifties, look back at our training and snort into our coffee cups. "These young trainees don't know they're born: when I was a trainee, now that was tough". Today, six months of direct supervision by a fully trained anaesthetist, close support thereafter, no trainee to work alone without a consultant in the next theatre. Lists cancelled if consultant anaesthetists are on leave but consultant resident-on-call if there is no cover for the inexperienced SHO.

These changes have been hard fought and hard won and we sometimes wonder if the sacrifice was worth it. When my first solo Caesarean section was a month after starting anaesthesia, an extended introduction to giving anaesthetics seems superfluous.

But then you are reminded of how it really used to be, and apparently still is, in some places and specialities. An article on the loss of SHOs from psychiatry ('Why are SHOs giving up on psychiatry?' *Hospital Doctor*, 7/3/02 p26,) may have been answered a week earlier, by an article in the Guardian (Bedside Stories, *Guardian* 28/2/02, p15). In the latter, Dr Michael Foxton describes his plight.

He is a new SHO, left to conduct his first schizophrenia clinic. He is alone, "the only psychiatrist in town." A patient is aggressive, threatening and walks out of the clinic, leaving Dr Foxton frightened for himself and others, ashamed that he could not handle the patient or cope with the situation and distressed by his lack of anyone to turn to for advice. If you are reading this, Dr Foxton, report your consultant to the Regional Educational Adviser, resign your post and look for a job in anaesthesia.

My first section patient survived, well and with a happy baby, no thanks to me or my trainers. Dr Foxton can have no idea if his patient harmed themselves or anyone else. Certainly, he gained nothing from this 'training opportunity' and his trainers have probably lost him as a potential consultant psychiatrist. Perhaps we have achieved something in anaesthesia.

## Keep up to date

An embarrassing pecuniary shortfall, sufficient to provoke audible complaints, is known as...? *Answer on page 16*



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## We're Drowning

In Zimbabwe the deterioration in civil society is frightening. In general this is unrecognised. Behaviour considered unacceptable two years ago is now the norm. Corruption, the black market, bad manners on the road and declining levels of service are all acceptable; and above all the knowledge that the police will not come to the victim's aid if the aggression is in any way 'political'. Police and the law enforcement agencies condone illegal activity and the judicial system has been emasculated.

My concern is that this change in behaviour is eroding the attitudes and conduct of health professionals and is affecting patient care. This is unmistakable in most large referral and teaching hospitals, much less so in the mission hospitals. Unfortunately, it is spreading as new doctors and nurses leave the training institutions. Often the individual wishes of the doctor are considered more important than the needs of the patient. The response to emergency calls is tardy despite functioning bleeps and mobile 'phones and in spite of the risk of litigation. The medical students are watching and learning this new conduct, after all medicine is an apprenticeship and students emulate their tutors.

There are fine young doctors coming through. They are highly intelligent and well taught academically. But their standard of medical practice, their diligence, their commitment to patient care, their clinical acumen and their ability to work on the ward with other medical staff, nurses, laboratory technologists and radiographers is lacking. As the system is unfolding, the laboratories and radiology

departments no longer provide a 24-hour service; even Casualty may be shut. At 4pm they go home as there are not enough trained staff to cover the night. We senior doctors trained to international standards in patient care are impotent without the full medical team and in a situation where often the cupboard is bare of essential drugs and equipment.



Of course, the patient suffers but it's not our fault. It is the fault of the lab.tech., the nurses, the Hospital Superintendent, the Minister of Health or anyone else. But not me. "I am not the one" is the cry.

This is a commitment to mediocrity now and will lead to an ever deteriorating Health Service in the future. The privileged, the famous and the affluent don't care, they go private! If they are sick and they judge the private hospital care to be unsatisfactory, they get on a plane and go abroad. They are a tiny minority. The majority, young and old, have no such option. For the poor, when the hospital runs out of drugs, relatives are sent to buy from where ever they can. They go 'round the family begging and days later produce the drug, sometimes too late. No one cares. No one feels any responsibility. This lack of recognition of the problem is a failure to see the obvious. How do we make the point, especially to these young health care professionals of the future, that we all are "the one"?

**Laurie Marks**

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## Keep up to date

What is the condition illustrated on page 15?

Hormone deficiency

*The copy deadline for the July 2002 edition of Anaesthesia News is 18 May*

## 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'.

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