Our new Patron

“I am now able to give you the good news that The Duke of York would be delighted to become Patron of the Association.”

Lesley Murphy, Chief Executive of the Association, received this statement recently in a letter from HRH The Prince Andrew’s Private Secretary, confirming that the Prince will take over as Patron following the death of his aunt, HRH The Princess Margaret.

For many years, HRH The Princess Margaret was our Patron. She took an active interest in all the Association’s activities and opened the Sixth European Congress of Anaesthesiology, in London on 8 September 1982. She was kind enough to open the Association’s Bedford Square Headquarters, on 9 July 1987.

Her Royal Highness, The Princess Margaret, also officiated at the Diamond Jubilee, in January 1992, at which she was made an Honorary Member.

With our move to 21 Portland Place we have been awaiting news of our new Patron with anticipation, as there will be opportunities for us, over the coming years, to recognise the impact that a proactive Patron can have upon our Association.

In a statement from the Palace, The Duke of York said, “I am delighted to be taking on this patronage and I look forward to working with the Association and its members.”

As you are aware, at present, 21 Portland Place is undergoing some major construction work, as a Members Forum is developed. This will include not only our museum and archives, but a dining and socialising area where members can meet to discuss common issues, or where they can enjoy lunch whilst attending seminars.

Completion of the Forum is scheduled for the summer and following this an opening ceremony is planned. Indications are that this would be an ideal first event at which our new Patron would wish to be present.

Anaesthesia News joins with all members of the Association in welcoming His Royal Highness and we hope that a long and happy association will follow.
Vascular Anaesthesia Society of Great Britain and Ireland

Annual Scientific Meeting
Monday 8 and Tuesday 9 September
University of Leicester

CALL FOR ABSTRACTS

- CASE REPORTS
- AUDIT
- RESEARCH

Do you have any interesting case reports or have you performed any audit or research that you would be interested in presenting?

This would also be an ideal opportunity for your trainees to get involved.

There is a prize of £200 for the best presentation.

For further information please contact: Jane Heppenstall, Department of Anaesthesia, Royal Hallamshire Hospital, K Floor, Glossop Road, Sheffield S10 2JF.

Closing Date: 4 July 2003
I have a friend, a surgeon (really), who seems to appreciate what goes on before he gets the sharp instruments to work. What another colleague describes as OAFAT (Obligatory Anaesthetic Faffing Around Time), the time between the patient entering the anaesthetic room and being wheeled into the operating theatre, he appreciates as being a necessary part of the procedure which may make a difference to the outcome for the patient.

My friend is an ENT surgeon and he and I have been in some buttock-clenching scrapes together. In all of these he has been prepared to play second fiddle to the anaesthetic team which is struggling to prepare the patient for him, in difficult circumstances, and he has been known to assist during the OAFAT, in the knowledge that it is all for the good of the patient.

The Iraq crisis has had some strange repercussions. Not the least, for me anyway, is that I have been asked by my surgical colleague to work with him again, as his usual anaesthetist has gone off to war. This means that this ageing doctor, near Pipe and Slippers time as described by Bob Buckland recently, will be applying his dwindling skills in another location for the first time since he was a ‘narkosläkare’ in Sweden back in the 80s.

Is going to work in a strange place alarming? A little, but there is a competent team to back me up (I’ve checked), consisting of well trained SpRs, Associate Specialists and, very importantly, a properly qualified team of Operating Department Practitioners (ODP). I am fortunate enough to work with SpRs who have had adequate training over a suitable period. As outlined in the GAT page (6), will my successors be so fortunate if, in an effort to ‘get more patients through’, trainees are rushed through a shortened training period?

I know that I shall certainly be able to rely on the ODPs. Although trained in a different part of the world to those who normally assist me, I am confident that these colleagues will give of their best and, should any panic moments occur, be able to work alongside me for the benefit of the patient.

A sad occasion recently has brought into focus the reliance that many of us place on Associate Specialists and the like. We recently lost one of our Non-Consultant Career Grade doctors, a man who had survived the crisis in Iran after the fall of the Shah and had come to this country in difficult circumstances. The number of colleagues present at his funeral and memorial service, many of them surgeons, shows the respect in which Dr Shirazi was held. Countless numbers of patients in my locality will miss this man’s care.

Whatever our level of expertise, it is training that forms the basis of our competence. Training which is of adequate length, appropriate and ongoing. Only with this in place will we deserve the confidence of our compatriots and, most importantly, the patients.

John Ballance
SERVICE

I do not wish to prolong this correspondence but, with reference to the somewhat hysterical letter from Drs Spencer and Terry (Anaesthesia News, 187, February, 2003), in which they also refer to my previous letter (Anaesthesia News, in August 2002), I have two comments to make.

The letter from Spencer and Terry appeared two weeks before my wife and I celebrated our 50th wedding anniversary. We think we’ve managed quite well so far without their advice. The remark concerning my having full-time unpaid domestic help is, to my wife, both inaccurate and offensive. There is a great deal written about working women, usually by working women, and how marvellous they are at juggling (a favourite word) their priorities. In fact, my wife, although not a doctor, worked for the first 25 years of our marriage, including, for several years, running her own business. And then, for a further eight years, had a salaried post as secretary for WFSA.

I remain unashamed that my family took second place to my commitments as a doctor because I believe that, if one is to practise medicine, one’s profession and one’s patients should come first. Hence my dislike for today’s apparently endless clamour by doctors for less work and more money. If you can’t stand the heat, get out of the kitchen. I am certain the remark concerning my having full-time unpaid domestic help is, to my wife, both inaccurate and offensive. There is a great deal written about working women, usually by working women, and how marvellous they are at juggling (a favourite word) their priorities. In fact, my wife, although not a doctor, worked for the first 25 years of our marriage, including, for several years, running her own business. And then, for a further eight years, had a salaried post as secretary for WFSA.

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Two feminists who I once knew
had not one clue
who their priorities were
They’d heard of a louse
whose wife ran his house
And decided this simply won’t do.

I remain unashamed that my family took second place to my commitments as a doctor because I believe that, if one is to practise medicine, one’s profession and one’s patients should come first. Hence my dislike for today’s apparently endless clamour by doctors for less work and more money. If you can’t stand the heat, get out of the kitchen. I am certainly not alone in my views. Charles Lamb, an A&E doctor, wrote recently, “One 25 year old single SHO... suggested to me recently that he couldn’t live on a band 1a salary (about £38,000 a year!)” Lamb also agrees that doctors who are obsessed with time are in the wrong job. Maybe Edward Lear could have said it better thus:

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Dr John S. M. Zorab
Consultant Anaesthetist Emeritus

Nothing but the best

The comments on anaesthetic charts by The Naked Gasman brought back memories. As a registrar in London in the mid 80s I remember one consultant always writing nothing but USA in large letters across the chart. “Usual superb anaesthetic”.

David Gaylard, Consultant anaesthetist, Royal Perth Hospital, Western Australia
Not a bad job

I have observed the correspondence about John Zorab’s views with interest and now feel that I have to join the debate. First of all, some facts. In the last tax year, less than 4% of taxpayers earned more than £50,000 a year and less than 350,000 people in England and Wales earned more than £100,000. Doctors of all grades can hardly claim to be poorly paid. Yes, the work can be hard and stressful and the hours can be long and antisocial but there is, I believe, no more rewarding and enjoyable career. If you add in the job security and pension, the package looks pretty good and I know that it is envied by many, including those in the new industries, some of whom now form a significant group of mature graduates applying to study medicine.

I certainly recognise the views expressed by Diana Terry and Ruth Spencer and agree that the world has changed in terms of home life, partnerships, leisure and, perhaps most importantly, expectation but the prevailing negativity about a medical career and consultant lifestyle grieves me.

Perhaps, I am kidding myself or just getting old but I have never felt some of the pressures described by colleagues. My views have always been treated with respect, my concerns taken seriously and my workload recognised to my satisfaction. Like John, I have never felt the need for private practice, although this reflects my personal political views and this has allowed me to undertake other activities which are professionally rewarding. I do not think my family life has suffered and I play a full role in it.

For the record, I am comfortably into my fifties, have been a consultant for more than 20 years and do have a distinction award (B) but would like to see the system changed so that the majority rather than a minority get some sort of recognition of their contribution to the NHS.

Guy Routh, Consultant in Anaesthesia and Intensive Care, Medical Director, Gloucestershire

The March of Progress

Following the revised guidelines on monitoring handed down to us by the great and the good in anaesthesia, much effort was invested in convincing our finance director to replace all the anaesthetic machines and monitoring before the deadline. Dodging tricky questions about how many patients I had asphyxiated last year or how often I had failed to see that the tube was in the trachea, we persuaded him to part with the best part of £1M. The old ‘lethal’ machines were carted off to see service in far away lands and rows of shiny new ones were assembled, tested and installed. All the staff from the Clinical Director to the lowest ODP trainee were then given lessons in monitoring and the anaesthetic machine, finally marching off to their station with a CE mark stamped on their forehead.

Since then, in the last year I have experienced as many faults and failures as in the previous 12 years with the old kit, not surprising considering the additional complexity. On the whole, however, most of us are happy with knowing every aspect of the patient’s cardiorespiratory physiology.

Last Wednesday, the added value of the new technology was revealed to me in exquisite detail. I was performing a rapid sequence induction in a patient with hiatus hernia and regurgitation. The preoxygenation was complete, the cricoid pressure applied, the induction agent and the relaxant given, I was poised to intubate……and…. The monitor squeaked, the CO2 trace disappeared and signalled “calibrating gases, please wait”. Excuse me!

Douglas EF Newton FRCA

Syringe mislabelling

What a colourful back cover to your last issue, with the crest of both the Association and the College prominently displayed, indicating that all the great minds have been focusing on the matter of colour coding of syringe labels, supported by the Devices of two other bodies. This is a subject which, when Secretary of the WFSA, I urged all member National Societies to get a grip on – in 1996, I think it was.

But what is this buff label illustrating an induction agent? For the benefit of more junior members I should explain that ‘thiopentone’ is the (superseded) name used in the last century for ‘thiopenal’. Obviously the relevant working party has been taking its time.

But to get down to the serious stuff. The recommendation is to adopt the International Colour Coding System which is used in some four (admittedly large) countries. This might have been correct in 1996 but, as Iain Christie reported in Anaesthesia last September, 93% of those who use colour coded labels in the UK actually currently use a different system.

I am distinctly un-reassured to know that the purveyors of these labels have been “notified of this proposed standardisation in the hope that it can be implemented on or after 1 May, 2003” (my italics). What happens if the existing suppliers carry on as at present and a rival firm comes in with the new colours? One would have thought it essential to have already been assured of the full co-operation of the existing label sellers.

I hope all the members of all four bodies will keep their fingers crossed and their eyes firmly focused when the changeover actually comes – if it does. I shall advise my friends and relations not to have a general anaesthetic on 1 May (or after), if at all possible.

Michael Vickers, FRCA, Cardiff, Retired
In 1997, after the introduction of the Calman training scheme and the beginning of the reduction of junior doctors hours of work, the GAT committee carried out a survey of anaesthetic trainees. The result of that survey was that a large proportion of trainees considered the four-year programme to be too short, and this provided the impetus to extend the length of training.

Competency-based Training
The concept of competency-based training in anaesthesia was agreed between the Royal College of Anaesthetists (RCA) and the STA, when the decision was taken to extend the period of SpR training from four to five years. As a result, we have had the CBT documents published by the RCA in the form of CCST in anaesthesia I-IV (the provisional edition of CCST IV having just recently been published). These documents have had enormous input from many interested parties, as is evidenced upon reading them. From the trainee perspective they are superb, if somewhat daunting, with clear objectives for each period of training. There have been some teething problems with the implementation of the SpR1-2 document but, by the time you are reading this, the revised implementation date will have been reached and the process will be in full swing - or will it?

Implementation of the New Deal
The single most influential obstacle preventing trainees from availing of training opportunities in the current political climate is the implementation of the ‘New Deal’. Clearly, at twelve years of age, this is not such a new deal, but we are all still struggling to accommodate the intricacies of the number of hours permitted to be worked for each pattern of shift, and the exact numbers of minutes rest the individual trainees must have within a given period of time etc., in order to achieve compliance.

We are all aware of the financial penalties that many trusts are paying as a result of non-compliance, not to mention the influence on consultant-trainee relationships of the inequitable financial situation that has arisen.

Regional Task Forces
New Deal Regional Task Forces (RTFs)-Implementation Support Groups (ISGs) in NI and Scotland - are supporting the implementation of the New Deal by helping trusts to construct compliant rotas. The effect of implementation of the new deal on training opportunities is absolutely outwith their remit. The blinkered advice given to trainees is astounding.

We have clear evidence of instances where trainees have been advised to forego essential educational pursuits e.g. lunchtime journal clubs, teaching and viva practice, by RTFs or ISGs, to ensure that natural breaks occur in their compliant rotas. Trainees have been advised that it is fraudulent not to include these activities as hours of work when returning monitoring papers.

The proposed solution: reconstruct a completely new rota (usually impossible due to numbers constraints) or sit in the coffee room for the duration of the natural break, whilst the educational pursuit may be happening in an adjacent room!

And, if that isn’t enough... The Show Must Go On! The result of efforts to construct compliant rotas has been the emergence of rolling four or six-week rotas composed of varying weeks – some with heavy service commitment and some with heavy daytime commitment. Training opportunities are mainly available in the latter type of week and, all things being equal, training should proceed as outlined in the CBT documents during these ‘training’ weeks.

One small snag has emerged. In order to maintain the service, trainees may only take leave – annual or study - during these training weeks. If they wish to have leave during a designated ‘service’ week they must swap with another trainee. Hence they lose valuable training time.

The crucial difference between this situation and previous prospective-cover rotas, in the pre-New Deal era, is that trainees are no longer in theatre during the day before a night on call. Incredible as it seems, this point is not universally appreciated.

Expectations
Anaesthetic trainees want to be trained to gain enough experience to become competent career grade anaesthetists. The junior doctors who voted for the New Deal all those years ago voted for better working conditions and safer working practices. Perhaps naively, most did not envisage the destructive impact on training that would accompany the wish to work less than 100 hours per week, at a time when 80-hour weekends were the norm.

One might ask: which is better - a tired but experienced/competent doctor, or a well-rested inexperienced/incompetent one? Until recently, we have not had medical errors resulting from the latter group, although we have had many, over the years, from the former. The strength of argument in support of the new deal has been the citation of mistakes made by tired doctors.

High profile cases from last year should focus all of our
minds on the potential increase in the number of errors resulting from inexperienced trainees. It may become the case that the headlines do not differ, but the word ‘tired’ may be replaced by ‘inexperienced’.

Clearly, the ideal is a well-rested experienced/competent doctor. With the current system of working patterns, it is difficult to be certain that the CBT programmes will allow trainees to pass through the goalposts at the expected times. It is even more difficult to see how the shortened overall training period mooted in the joint statement from the Academy and the Department of Health (at the time of going to print) can be realised within the current constraints.

The ideal would, at present, appear to be unattainable. A touch of realism in the discussions may help facilitate the balancing act of preserving training time within the confines of compliant rotas.

Have your say!
The GAT committee will be conducting a survey over the coming months to determine the impact on your training of your compliant /almost-compliant rotas. The strength of our voice relies on the number of survey papers/e-mail responses returned. This is your opportunity to allow us to speak on your behalf. Please take advantage of it.

You can also contact us, at gat@aagbi.org, on this or any other training issues on which you would like us to represent you, at any time. Most importantly - don’t forget to respond to the survey!

Catriona Connolly, Vice-Chairman, GAT Committee

Advice from the CCSC and GAT for newly appointed consultants offered a contract based on the recently rejected framework document:
Where possible, SpRs should contact their local BMA office for advice from their Industrial Relations Officer and their local negotiating committee, Regional Consultants and Specialist Committee and Regional Junior Doctors Committee for the latest position.

The closing date for nominations for the GAT elections is 11 April
So you want to be an Associate Specialist?

Since regrading from Staff Grade to Associate Specialist grade last year, I have had several enquiries asking how it can be achieved, as there are no guidelines available for reference at the present time.

Well, it’s not an easy process and will take at least six months, if you are lucky and all goes well. The process involves a personal regrading which is usually without an external advertisement. You have to get the ball rolling yourself and start by persuading a number of people that you are worth regrading.

First, there are a few criteria to fulfil which are outlined in the BMA guidelines on the appointment of Associate Specialists. There should be ten years of continuous or aggregated employment since registration, with at least four years as a registrar or Staff Grade. It will be difficult to regrade without the FRCA or equivalent as this is a College recommendation for appointment.

This first stage is the easy bit. The most useful person to get the ball rolling in your support is the lead consultant anaesthetist in your department. He will ask - are you worth it? Are you a nine to five person, or do you contribute in other ways? Organising the Journal Club, teaching, supporting the trainees when ‘on call’, running a special, having a special skill such as fibreoptic intubation or pain work all help to demonstrate that you are. If he is convinced then your case will be put to the anaesthetic division for approval.

If successful, a recommendation to the Personnel Manager and the Medical Director will follow. The Personnel Manager will then contact the Royal College for the current criteria for an Associate Specialist. There may also be a funding issue to address. Watch out here, as there is potential for a drop in pay. You may be on a thirteen session Staff Grade contract, which will be difficult to match on the Associate Specialist scales. The problem arises because a full time Staff Grade contract is ten sessions (each being four hours) and a full time Associate Specialist contract is eleven notional half days (one NHD being 3.5 hours).

A letter seeking approval will go to the regional postgraduate tutor who may well ask your lead clinician some of his own questions. Why are you wanting an Associate Specialist and not seeking an additional consultant? What advantage is this appointment to your department? The reply was ‘It involves a resident night on call.’

No contest; the application is approved.

The next task for the personnel department is to arrange for an interview to take place. Not an easy one to fix, and it takes more time. Four people are necessary, a representative from your department, a representative from the Trust, a College representative, and, of course, you. The interview is to make sure a certain standard is met and it may be useful to brush up on current topics such as governance, proposed changes to the NCCG grades and national medical and anaesthetic politics. Actually, it can turn out to be quite a friendly interview, as you may well know some of the interviewers personally and they may be keen to support you.

There are definitely a lot of hurdles to cross during the journey and it takes constant chasing to keep up the momentum. However, it is worth the effort once you are there. Also, you never know, there is talk of facilitating further progression for SAS doctors so it may be a useful practice exercise for future events.

Rex Yetton
Associate Specialist,
Royal Sussex County Hospital, Brighton

3 April, Medical Emergencies Course, for SpRs and consultants in Emergency Medicine, ITU and Anaesthesia (£200)
24 April, Mature Consultants Course, for mature consultants in Anaesthesia (£150)
29 April, Paediatric Anaesthesia Critical Incident Day (SJM), for occasional paediatric anaesthetists (£160)
1 May, Low-Flow Anaesthesia Course, for anaesthetists (£150)
7 May, NCCG Critical Incidents Day, for non-consultant career grade anaesthetists (£150)
14 and 15 May, Obstetrics and Gynaec Course, for obstetric anaesthetists
19 May, Simulated Airway and Ventilation Emergency Course (PY), for SpRs and consultants in Emergency Med, ITU and Anaesthesia (£150)
20 and 21 May, 2 Day Paediatric Anaesthesia Critical Incident Day (GRL), for occasional paediatric anaesthetists (£275)
18 and 19 June, Team Training for Critical Incidents, for nurses and clinicians (£270)
8 and 9 July, 2 Day Paediatric Anaesthesia Critical Incident Day (GRL), for occasional paediatric anaesthetists (£275)
5 September, Medical Emergencies Course, for SpRs and consultants in Emergency Medicine, ITU and Anaesthesia (£200)
9 October Low-Flow Anaesthesia Course, for anaesthetists (£150)

Specific departmental courses can be arranged upon request (fee negotiable)

Includes coffee, tea, biscuits and lunch. CEPD points approved; five points (for one day) and eight points (for two day courses)

For bookings please contact Jane Southway, Secretary on Tel (0117) 927 7120 or Alan Jones, Centre Manager, The Bristol Medical Simulation Centre, UBHT Education Centre, Level 5, Upper Maudlin Street, Bristol BS2 8AE. Tel (0117) 342 0108, email alan@simulationuk.com; and/or visit the website at http://simulationuk.com (this contains course details).
Difficult Airway Society Annual Meeting 2003: Preliminary Notice

Wednesday 3 December
Full day of workshops at Anatomy Department and Hunter Halls, University of Glasgow

Thursday 4 and Friday 5 December
Scottish Exhibition and Conference Centre and Moat House Hotel, Glasgow

Invited Papers
Free Papers
Debates:
Tracheal intubation in suspected cervical spinal injury;
Management of “Can’t Intubate, Can’t Ventilate” situation;
Airway problems in thoracic anaesthesia;

Social programme includes dinner and ceilidh on Thursday 4 December

Full details will be available shortly at: www.das2003.com

Difficult Airway Society Annual Meeting 2003: Preliminary Notice

University Hospital of Leicester
NHS Trust

Difficult Airway Day
A one-day Symposium and Workshops for Anaesthetic Trainees and Consultants
Thursday 12 June 2003
Leicester City Football Stadium

Provisional Programme
- The Teaching of Fibreoptic Assisted Intubation
- Awake Fibreoptic Intubation • Difficulties with Fibreoptic Intubation • Difficult Airway Scenarios

Practical Sessions:
- Fibre-optic Box and Scope • Oral and Nasal Endoscopy
- Tracheal Techniques • Intubating LMA
- Cleaning of Fibre-optic Scope

Guest Speaker: Dr J Smith, Consultant Anaesthetist, Birmingham

5 CME Points Applied for
Registration fee £100 including lunch and refreshments
Course Organisers: Dr M Mushambi and Dr P Ali, Consultant Anaesthetists.

Further details from Jackie Howarth, Conference Co-ordinator,
Clinical Education Centre, Glenfield Hospital, Groby Rd,
Glenfield, Leicester LE3 9QP
Tel: 0116 250 2305, Email jackie.howarth@uhl-tr.nhs.uk

AN INTRODUCTION TO RESEARCH
University of Wales
College of Medicine, Cardiff
2 - 3 July 2003

A two day intensive course consisting of:
Tutorials
Small group work (Ratio 1:4)
Hands on computer work and statistics using SPSS

10 CPD points. Places limited to 20
Cost: £250 including lunch

Application form from:
Mrs Maria Gundy
Department of Anaesthetics
University of Wales
College of Medicine
Heath Park CARDIFF
CF14 4XN
Tel: 0292 074 4349
e-mail: gundyma@cf.ac.uk

Annual Scientific Meeting (Joint Meeting with EuroSIVA)
30th & 31st May 2003
The Glasgow Marriott Hotel
Scientific Sessions all Friday & Saturday Morning

8 CEPD points
New Drug Applications
Free Papers - the Graseby Prize
Ketamine - revival of an anaesthetic agent
TIVA trainer Workshops (2 CEPD points)
Registration Fee £199 (£150 for Trainees)
(Reduced Registration Fee for those registering via the website before 15th April)
Registration forms from Departmental Secretaries, or telephone 0141 201 1658
Full details, workshop availability & registration at:
http://www.glasgow2003.org
In the previous article I proposed an inhalation anaesthesia machine suitable for any country in the world, whether rich or poor. Many people – including all those who work in the International Development Departments of every Government in the EU – will say that in an epidemic of famine, AIDS, war and corrupt government, who needs anaesthesia? I say: we should carry on supporting the services of surgery and anaesthesia, regardless of the chaos we may find in any particular place. Indeed, during such bad times, they are needed more than ever. Clinical services can function after their own fashion and can be provided at a fraction of the cost of an EU or DFID health development report. It is largely to protect the interests of the latter organisations that no one has ever done a comparative cost-benefit analysis.

The machine uses the novel concept of a circle system supplied by oxygen from a portable electric concentrator and a facility to allow ventilation with room air in case of oxygen supply failure for any reason. A nurse or paramedical anaesthetist should be able to use it as easily as a specialist, without necessarily having to understand how a circle system works.

Three modifications to the breathing system are needed to make it simpler to use and allow for oxygen failure:

- an inflating balloon valve located in the expiratory limb of the circle;
- an air inlet valve;
- a bellows to hand ventilate (Mk I) or an automatic ventilator (Mk II) that also allows manual ventilation.

Referring to the figure, during spontaneous breathing, the patient moves the gas around the system in the same manner as in a conventional circle breathing system. Fresh gas (oxygen from the concentrator [1] and volatile agent from the plenum vaporiser [2]) is added at 1–5 litres/minute. The day-glow coloured reservoir bag [3] is visible but out of reach on the back bar and moves with respiration as usual. The bellows [4] also moves a little as in a draw-over system.

As with draw-over, the anaesthetist operates the bellows to hand ventilate.

The ‘pop-off’ or positive pressure relief valve (PPRV [5]) which in a conventional circle system has to be partially closed to enable inflation of the chest is fixed wide open and out of reach in this system. The gas from the bellows would therefore tend to go on round and out, following the path of least resistance, and not go to the patient.

The occurrence of squeezing a bag or bellows and not feeling the elasticity, and seeing the inflation of the lungs can be likened to driving down a steep hill in a car with the brake pedal ineffectually pressed to the floor.

This alarming event does not happen because of the balloon inflating valve [6]. During a positive pressure inflation of the lungs, the same pressure is directed via a small pipe [7] from the bellows which inflates the balloon in the lumen of the expiratory limb. The balloon obstructs flow in this limb and gas is directed to the patient. Clearly, the pressure in the balloon is the same as outside in the lumen and so one might expect that some gas would get past it, even making a rude noise in the process, but the dome of the balloon abuts against an annular ring [8] and forms a seal. As one pushes harder on the bellows, the balloon abuts harder on the ring and the seal actually improves.

When the inflating pressure is released, the small amount of gas in the balloon is pushed back out by the higher pressure in the patient’s airway, it collapses and the patient’s exhaled gas passes the flattened balloon towards the soda lime canister [9] and reservoir bag. A light spring in the PPRV keeps the bag distended. Unlike all contemporary inflating valves, such as Ambu and Laerdal, which would jam if used in this way, the balloon cannot get jammed in the forward
In February, Abbott Laboratories UK was presented with a special award on behalf of the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland, recognising Abbott UK’s support of anaesthesia and the anaesthetic profession over the last 25 years.

During that time Abbott Laboratories has introduced three key inhalational anaesthetics, enflurane, isoflurane and, in 1995, sevoflurane. Sevoflurane is now the most commonly used inhalational anaesthetic in the UK. Alongside its commitment to improving the agents available to anaesthetists and their patients, Abbott has invested in a programme of continued education, providing ‘simulation training’ to almost 50% of practising consultants in specialist centres to help physicians prepare for unique events in the operating theatre.

This award coincides with the presentation of the Queen’s Award for Enterprise: International Trade 2002 at Buckingham Palace on 17 February 2003, in recognition of the company’s consistent growth in overseas trade.

Bill Dempsey, Senior Vice-President, International Operations of Abbott Laboratories, said: “Abbott Laboratories is pleased to have made contributions to advancing the practice of anaesthesia through the discovery of sodium pentothal in the 1930s to the development of anaesthetic gases that are commonly used in surgical procedures today. Abbott appreciates the recognition by these organisations.”
Sulphuric ether, which was first prepared in Liverpool in 1765 by the chemist Matthew Turner, was used by local physicians. In 1836, Richard Formby, a Physician at the Infirmary, found that the impure chloric ether, which he had obtained from America, was beneficial in the treatment of hysteria. This triggered the search for a purer, more stable compound within the laboratories of Liverpool’s Apothecaries’ Hall and culminated in the separation and purification of the active constituent, chloroform, by James Walddie in the early 1840s. The superior quality of Walddie’s chloroform was highly acclaimed by many local Physicians for the treatment of a variety of neurological conditions. Walddie subsequently confirmed the anaesthetic properties of the drug when he addressed a meeting of the Liverpool Literary and Philosophical Society on 27 November 1847 on the topic ‘Chloroform: the new agent for producing insensibility to pain by inhalation.’

Despite the high quality of academic dissemination of scientific and medical knowledge within Liverpool throughout the 19th century, surgeons remained sceptical about the use of both chloroform and ether until well into the 20th century.

There was, however, one exception, Sir William Banks, Senior Surgeon to the Royal Infirmary. Concerned by the fact that surgically related deaths had doubled in England and Wales in the last decade of the 19th century, he chose his personal experience of the use of chloroform and ether in “thousands” of cases as the topic for a lengthy dissertation at the 14th Annual Meeting of the Liverpool Medical Institution in May 1901. Aware that any drug which has the potential to “take such a hold on the nervous system to produce insensibility to pain and abolish the power of movement must be so potent to, ipso facto, imply danger”, Sir William discussed how, he believed, the safety of anaesthesia with chloroform could be improved. Physiological research, particularly in animals, was not the answer while volumetric analysis in the clinical setting was not practicable. The greatest dangers with chloroform administration lay both in the occurrence of absolute overdosing and the failure to supply adequate air and oxygen during the process. For these very reasons fatalities most frequently occurred in the early stage of anaesthesia. The care required during this period cannot be over-estimated. During prolonged operations most patients will require only very small doses to maintain control. A good ‘chloroformist’ should be able to rapidly assess his patient’s ability to deal with the drug and consequently maintain a smooth plain of anaesthesia by ‘rule of thumb.’ He concluded that the most important factor in the safe administration of anaesthesia is the experience of the anaesthetist.

Predicting that anaesthesia would always be a source of dread, Sir William pictured a major operation as a kind of pitched battle between the surgeon and death in a situation where “the surgeon is General; the anaesthetist commands a Brigade.” If the battle is lost disgrace falls on the surgeon. Surgeons should, therefore, be masters over the management of the anaesthetic as well as every other aspect of the operation.

Have things really changed in the 21st century?

Anne M Florence

Writing for Anaesthesia News

Anaesthesia News is always happy to receive copy of articles, reports, travel stories and opinions. Most will be accepted although some editorial revision or abbreviation may be necessary. Letters to the Editor are particularly welcome. There are several ways of sending your work to your Newsletter and it should arrive at least four weeks before the intended publication date. A Word file, posted on a disk or sent attached to an email is best, although typescript may be scanned. Please send photographs, of reasonable size and in colour, either as a jpg file attached to an email, or as ‘hard copy’.

Our contact details are: 21 Portland Place, London W1B 1PY. Telephone 020 7631 1650. Fax 020 7631 4352. Email anaenews@aagbi.org
FIFTY YEARS AGO

Two of the characteristics of the British people are said to be taciturnity and a habit of understatement, and these may have contributed to the extraordinary ignorance of the responsibilities of the anaesthetist on the part of the general public. It may be argued that this is no concern of ours, but there are definite indications that such is not the case. For example, Sir Heneage Ogilvie has recently written: “It is easy to see how a ruthless Minister of Health, determined to reduce the cost of the service and to break the cartel of doctors, could set about to dilute labour... A nurse, given a course in the use of specula, could with the help of a welfare worker deal with two-thirds of the otolaryngological out-patients.”

If this is so, there is no doubt that attempts would be made to introduce the nurse-anaesthetist into this country, and the Chairman of one Regional Hospital Board has actually suggested that this should be done. It is easy to see the rapid deterioration in the speciality which would result from such action, and the only counter-measure at our disposal is the propagation of knowledge. At the present time, this is simply confined to an occasional broadcast in the Home and Overseas Service, but we might well copy our colleagues across the water in some of their methods.

During the past year, “Life” published an illustrated article describing the anaesthetic service of St. Vincent’s Hospital in New York City, and this must have reached an enormous public. Again, the American Society of Anesthesiologists have published a brochure entitled “The Story of Anaesthesia” for circulation among the lay public. This should do much towards disseminating accurate information about the services which modern anaesthetists render to their patients. A documentary film could be produced which would be extremely interesting and instructive without being morbid, and this might well prove useful provided that no suspicion of advertising could arise from any identification of individuals featured in it. The same remarks apply to a television programme. Our readers can doubtless think of many other activities which could be undertaken by a public relations service.

After all our speciality has nothing to be ashamed of, and many readers must have noticed the striking passage in Dr. C. E. M. Joad’s recent book, “The Recovery of Belief”... “There is a time-honoured controversy as to the most important single discovery in the history of the human race. Some opt for fire; some for the invention of the wheel; some for the growing of corn. For my part, I would give my vote to the invention of anaesthetics.”

Christopher Langton Hewer,
Anaesthesia 8, 73 (April, 1953)
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26th & 27th June 2003

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North Thames Introduction to Anaesthesia for SHO’s
1 day/week for 6 weeks at the Royal Free Hospital, London and 1 Simulator day
Proposed 2003 start dates:
7th March ~ 6th June
5th September ~ 5 December
Full details on our web site or contact:
Dr Pete Bishop:
docbish@hotmail.com

Provisional Announcement
Paediatric Sedation:
Developing Safe Practice
Institute of Electrical Engineers, London
16th & 17th October 2003
Meeting Chair: Dr Mike Sury, GOSH
Further details can be found at:
www.ucl.ac.uk/anaesthesia/meetings

Meetings & Conferences
Centre for Anaesthesia, University College London
Clinical Speciality Advisor in Patient Safety – Anaesthetics

Salary: Pro rata at current salary sessional rate
Location: Mainly operate from local clinical base

The Royal College of Anaesthetists in conjunction with the National Patient Safety Agency (NPSA) is looking for a Clinical Speciality Advisor (CSA) to advise on Patient Safety issues within anaesthesia, pain management and critical care. The NPSA is a Special Health Authority created to co-ordinate the efforts of all those involved in healthcare, and more importantly to learn from, adverse incidents occurring in the NHS.

The postholder will establish, develop and lead a range of multidisciplinary work in order to:

- identify key clinical risks;
- propose solutions to address these risks and others identified from analysis of reported clinical incidents;
- advise on appropriate research to inform actions to improve patient safety.

This will ultimately help to achieve NPSA goals and play a key role in bringing patient safety to a national level, enabling the entire NHS to learn from incidents and make itself safer and more stress free for patients.

You will select and convene an expert multidisciplinary Clinical Safety reference group of appropriate clinical, academic and voluntary sector colleagues to generate ideas for action to improve patient safety, comment on information and proposals from the NPSA and other agencies and advise on appropriate research. The reference group will meet at least four times per year, produce regular progress updates and an annual report. You must be active in clinical practice at the time of appointment. Applicants will be considered if they intend to retire during the proposed term of employment.

For the job description, person specification and any enquiries in relation to this post, please contact Marion Barritt, Directorate of Clinical Programmes, NPSA on tel. 020 7927 9352 or by email marion.barritt@npsa.nhs.uk

Please send a CV and supporting statement, including the names of two referees to Marion Barritt, Directorate of Clinical Programmes, National Patient Safety Agency, 4-8 Maple Street, London W1T 5HD.

The closing date for this position is 5 May 2003.

The Agency is an equal opportunities employer and all employees are actively encouraged to contribute to the promotion of diversity.
Courses offered in 2003 for consultant anaesthetists

ACRM (Anaesthesia Crisis Resource Management) The integration of technical training and non-technical skills (human behaviour) to facilitate teamwork and situation awareness. (£250) 13 June; 25 July; 10 Sept; 5 Nov.

ACRM and Obstetric Anaesthesia The principals of ACRM, as above, with an obstetric theme. (£250) 16 May; 11 July; 30 July; 8 Oct.

Instructors Course (two days) For multi-professional generic instructors concentrating on the logistics of running courses, and the art of debriefing (£400). 26 and 27 June; 30 and 31 Oct.

Paediatric Emergencies Aimed at consultants at DGH, dealing with children regularly or occasionally (£250). Dates to be announced.

Specific Departmental Courses can be arranged upon request. Includes coffee, tea, biscuits, and lunch. CEPD points applied for.

Contact Claire Elliott on 020 7631 8817, by fax on 020 7631 4352, or email claireelliott@aagbi.org

**Courses offered in 2003 for consultant anaesthetists**

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<th>Month 2 (5% discount)</th>
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All prices shown below are exclusive of VAT

The prices are exclusive of VAT which is charged at the standard rate unless a valid VAT Exemption Certificate can be submitted.

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**GAT ANNUAL SCIENTIFIC MEETING**

17–19 SEPTEMBER 2003
University of Bristol

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Mersey School of Anaesthesia and Peri-operative Medicine

“Lam Tee Dee Roi Uc Mah, Sam Tee Kye Moi Lee”*

The Mersey Selective Course
A five-day course of lectures and tutorials designed to cover the more esoteric aspects of the Primary Basic Sciences.
(Trainees are advised to consider this course two to three months ahead of the MCQ paper).
16 – 20 June
29 September – 3 October

Basic Obstetric Anaesthesia Course
A one day course on the practice and theory of obstetric anaesthesia specifically designed for SHOs as an introduction to Maternity Unit responsibilities.
Autumn date to be arranged

Primary Prep Course (MCQ)
A five-day course of intensive MCQ analysis intended only for candidates within weeks of sitting the Primary FRCA Examination.
19 (1pm) – 22 August
23 (1 pm) – 28 November

Primary Prep Course – (OSCE/Orals)
A five-day course of master classes, OSCE and viva practice, available only to trainees who have been successful in the preceding MCQ paper.
(Failure to ‘get a viva’ will lead to a reserved place on the next course).
2 (6 pm) – 9 May
19 (6 pm) – 26 September

Final FRCA (Booker) Course
Two weeks of SAQ practice and analysis, MCQ practice and analysis and lectures/tutorials.
(Candidates may register for either one or two weeks).
28 April – 2 May (Closed)
5 – 9 May (Closed)
6 – 10 October
13 – 17 October

For details WWW.MSOA.ORG.UK

For Application Form
BY EMAIL ONLY PLEASE
MSA@rlbuh-tr.nwest.nhs.uk

* “If you feed the children with a spoon, they will never learn to use the chopsticks”
Do something – anything!
(The civil service decision process)

Civil Service decision making is strange. We do not notice how strange it is until we compare it to our own decision making. We happily say to ourselves “Don’t know – wait and see” as often as we decide to do something. Not the Civil Service. There the motto is “Do something – anything”. No action is not an option.

Of course, they will tell us that their masters require it, though it often seems their master is a hostile press. And it must be remembered that their true masters, the politicos, will select from options presented to them. By the civil servants.

Of course, part of the attraction of the “Do anything” bit is it allows them to do something they’ve wanted to do for ages, even if it has nothing to do with the problem at hand. And when they need a scalp for their CV, which the ambitious administrator is always on the lookout for, they grab it with both hands. And no decision, once made, can be reversed.

Suppose you, a DOH employee, have a really daft idea. You will not know how daft it is, having no idea how the NHS works. Perhaps it’s reform of SHO training. Currently, meddling in training is fashionable – see the New Deal, Calman, PMETB. You don’t know what SHO training involves. You don’t know, except on the theoretical level achievable by a high court judge, what medical training involves. But you know there have been grumbles from some medical SHOs. Ah, you think, we’ll put that right. Being too distant to realise the grumblers are a tiny minority, or to be able to develop a workable solution, you rearrange the deckchairs on the Titanic.

So, you pinch a couple of good ideas (programme based, time capped training, courtesy Royal College of Anaesthetists), add on a maybe OK idea pinched from abroad, (two years as a houseman), stick in an obviously sorely needed (this is meant to be irony, by the way) piece of administrative neatness – unify the training grades! – add on another thing you’ve wanted to do for ages – shorten the CCST training to three years! – also administratively neat, though totally irrelevant (to SHO training), and potentially pleasing your political masters (more ‘specialists’, you think, and quicker). Give it a snappy title, and publish: Unfinished Business! (or Unfinished Training, as it is popularly known). The next step is ‘consultation’. Don’t be misled: this is not Consultation, whereby a proposal is discussed and debated, modified and perhaps rejected. This is ‘consultation’, where a proposal is cosmetically discussed and debated but never significantly modified, and absolutely never rejected. Partly this is achieved by two stage ‘consultation’, where the Great and Good take first look, and refine it a bit - they know better than to try to kick it out – and when they are committed, it goes to ‘public consultation’, even more of a sham. Never mind that this is probably the worst time ever to make another change to training and hours, in the run up to the implementation of the working time directive. Never mind that there is neither evidence nor logic to support most of it. Never mind that it could be the worst idea since sliced bread. Once it has been decided, no change is not an option. There used to be a saying, “Democracy is the worst system of government, apart from all the others.” It would be nice if the civil servants would consider that this might apply to some of the methods and systems developed painfully over the years to run medicine. (Perhaps someone has: It is rumoured, as I complete this, that they might allow the Colleges to decide whether to shorten training to three years! And there may even be some high level resistance to unified training grades!! Common sense? We must welcome it where we see it.)

Finally, an uplifting thought. There are more administrators than beds in the NHS. I have heard 160,000 beds and 200,000 administrators quoted, which feels about right. Accepting for the moment that some of these are necessary – ward clerks, secretaries, the odd hospital manager, because someone has to order the supplies, write the letters, arrange the car parking – shall we suppose that perhaps 75% are creating more problems than they are solving, by micro-management, national service frameworks, central planning and the rest.

There are thus 150,000 intelligent, caring, hard working quasi-professionals ready for re-allocation. Lets do it! It will release billions of pounds (actually, literally, billions!) for healthcare, and all these ace decision makers could be retrained as doctors and nurses. Think of that! Every trust in the land, of which there are about 300, would get about 500 extra doctors and nurses. Then all we’ll need will be 50% more beds, which we will easily afford as doctors and nurses are so much cheaper than NHS administrators. No chance? Well, you’re probably right.

Dr de Quincy

(Dr de Quincy is a consultant at a DGH near you)
Hospital Acquired Infections (H.A.I) are responsible for up to 5000 deaths a year and a huge financial burden to the NHS\(^{(1)}\).

Fight back with Anti-Microbial Breathing Systems

Silver Knight™ Range from Intersurgical

---

**Hospital Acquired Infections including MRSA, are responsible for up to 5,000 hospital deaths every year in the UK and the financial burden placed upon the NHS exceeds £930 million p.a.\(^{(1)}\). In a recent study over 40% of all hospital infections were found to be *Staphylococci species*\(^{(2)}\). One in ten hospital patients fall victim to infection\(^{(1)}\). Many antibiotics are not effective and some can even be toxic.

Silver Knight™ is an anti-microbial that uses silver ions to disrupt the enzyme activities of microbes preventing them from reproducing.

One of the major factors of MRSA proliferation in the hospital environment is a transmission of microorganisms.

Intersurgical has developed Silver Knight™, a unique method of patient protection against MRSA. Silver Knight™ is a silver ion solution that destroys MRSA and inhibits the proliferation of dangerous micro-organisms that spread MRSA.

---

### Sample Initial count Count after 24 hrs

<table>
<thead>
<tr>
<th>Sample</th>
<th>Initial count</th>
<th>Count after 24 hrs</th>
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<td>100</td>
</tr>
<tr>
<td>Flextube™</td>
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</tbody>
</table>

**Conclusion**

Use of Silver Knight™ reduces MRSA by 99.9%.

There are 4 systems currently available in the Silver Knight™ Range:

- 2000100 Basic Breathing System 1.6m
- 2001100 Basic Breathing System 2.4m
- 2010100 Basic Breathing System + Reservoir Bag, Limb and Elbow
- 2115100 Deluxe Bain

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\(^{(1)}\) PHLS - Report 1999
\(^{(2)}\) NINSS - Report 2002

Silver Knight™ does not destroy all micro-organisms which come into contact with Flextube™. It is essential that all infection control procedures are followed.

Silver Knight™ is only present in Flextube™ of Intersurgical Silver Knight™ Breathing Systems, it is not present in any other Breathing System Components, such as the reservoir bag or APL valve.

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Breakpoints

Fourteen years ago my recently widowed hairdresser decided to live with her daughter. “We have such a good gardener’, she said, “I suppose you would not like to have him when I move?” I had just had another burglary and was thinking about having someone living on the property. I interviewed him while sitting under the hairdryer and asked him if he would like to come and work for me. “Yes, Madam” he said, and that was it. So began the old colonial master/servant relationship of which till that time I had strongly disapproved. I had no idea how we should behave towards each other, but he taught me. At 6.30am on the dot he brought in the Rain Gauge for me to read and then began sweeping up. After a few days he asked if I would like him to draw the curtains and put on the lights, if I came home late, “not of course the bathroom”. I said “Thank you, Langton, I would like that very much, but not of course the bathroom”. I never discovered why not the bathroom as I could hardly be having a bath if I was out. Now I shall never discover, as he was killed in a road accident a few days ago.

We sometimes discuss what the endgame is going to be in our rapidly disintegrating country. Mugabe must have a breakpoint, as each of us does individually. Lots and lots of people have reached their breakpoints and left the country. I am luckier than most as I have somewhere to go and the funds to get there. I am quite aware that if I ever get arrested I shall run away at the first opportunity thereafter. Our gaols are filthy and terrible things are happening in them. But that apart I had felt I should cope all right as long as there is a water supply. I eat almost entirely from the garden, and can ride my bicycle when the fuel completely runs out.

A small incident before Christmas made me realise that I too am vulnerable. My hairdresser also bequeathed me her ginger cat, Kela. His real name is Akela, but Langton never managed to pronounce it so he became just Kela. Over the years he became much loved and spoilt. He decided he could only eat one sort of food, frozen chicken entrails called Suncrest. Everything else was refused. Then Suncrest disappeared from the market and it was rumoured that the farm had been taken over by War Vets. We tried everything, including expensive tins sent from England. He might have accepted liver, but there was none. For three days he sat at my feet crying and asking to be fed. I would hug him and then he would purr briefly, but still looking at me accusingly. I was ashamed that my cat’s hunger hit me more than that of people in the street. Then, Gideon, Langton’s son, found a packet of Suncrest in a supermarket on the other side of town. The farm was still functioning.

Losing Langton has been a stress of a quite different degree. He did everything for me, as well as producing the constant supply of fruit and vegetables. He did the painting; the flowers, the washing and ironing, and he fed Kela. The night we were struck by lightning, and water was pouring into the airing cupboard, he climbed on the roof in the storm and fixed a tarpaulin over the hole. I suppose he was not just a worker, and a guard, but a friend.

He was only once not there at exactly 6.30 am. It was a Monday morning in early February after he had been home for a weekend. At lunchtime there was a scrap of paper in the letterbox, which read, “Molly is sick. She cannot walk. She make baby”. Six weeks since Langton had been home for Christmas, could be a ruptured ectopic... I picked up one of Langton’s brothers, Johnny, and we drove straight out to Langton’s plot 220km away in the mountainous part of northeastern Zimbabwe. For the last kilometre you follow a footpath through the bush. I took a step off the Landover on a tree. When we reached Harare Hospital Molly’s Hb was 3.5 g/dl. She had two units of blood in theatre and did well.

Last week we made the same journey. A friend came to help with the driving. There were nine of us, and the coffin, in the Landover. It was very sad. Just before we set out from my house, I said that Europeans usually put flowers on the coffin. Gideon replied that it was the same in Shona culture, but he had no money. I gave him Langton’s secateurs and he cut a huge bunch of yellow and red flowers, Langton’s flowers. I wrapped the stems in a damp cloth and then a plastic bag. So we took him home.

Ruth Hutchinson
RHutchinson@healthnet.zw