Tales from the back line

The aid donors talk about sustainable development and cost recovery in health but who pays for actual health care? I was interested in a recent operation that took place at our hospital in Malawi.

A child of five months was scheduled for hernia repair. He was assisted by a Malawian government nurse who scrubbed, although there was no runner as there is a chronic shortage of nurses.

A clinical officer anaesthetist, partly paid by the Malawi Government, but also paid by a fund supported by the EU and local commercial benefactors, helped with the anaesthesia and moved the child out of the theatre.

The operating theatre was a Japanese donation. The anaesthesia machine came from Danida, the Danish aid organisation. The oxygen source was from a concentrator almost a decade ago.

The operating table was a Japanese donation. The laryngoscope and LMA for maintaining the airway were given by other forgotten wellwishers. The syringe and needle came from one of the many boxes we used, halothane and suxamethonium, both donations from one of the many boxes we used, halothane and suxamethonium, both donations from an organisation. The oxygen source was from a concentrator.

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‘Question Time’ which would have carried on all day were it not for the call for coffee!

The final session was on Emergency Medicine. Dr R J Evans had everyone taking notes with ‘hot of the press’ updates from the European Resuscitation Council guidelines, whilst Dr P J Hilton managed to make a talk on immediate burn management both funny and useful! Finally, Dr L R McNicol kept us on the edge of our seats with a talk on Paediatric Emergencies. He answered most of our dreaded questions such as ‘what do I do if I get called to casualty with a kid with...?’

A big thanks to all the speakers who informed and entertained us over the three days and a round of applause for the stamina of the audience who turned out in force night after night!

Workshops
This was a first! Four parallel workshops ran during the meeting. Dr M R Stacey ran a workshop on anaesthetic simulators which was a popular station as many people had had no previous experience of using a simulator. Drs Turley, Morris and Stacey from Cardiff ran a workshop on Difficult Airway Management. They had an array of equipment and highly desirable fibre-optic laryngoscopes, as well as some of the most adrenaline and sweat-inducing photographs of clinical scenarios. All in all, these sessions were incredibly popular and more workshops will be available next year.

Registrar’s Prize
Once again, Dr Morgan was pleased to announce that the overall standard of the research and presentation was high. Drs Bown, Harrison, Stacey and Stacey from Cardiff ran a workshop on Difficult Airway Management. They had an array of equipment and highly desirable fibre-optic laryngoscopes, as well as some of the most adrenaline and sweat-inducing photographs of clinical scenarios. All in all, these sessions were incredibly popular and more workshops will be available next year.

Abbott History Prize
Dr I Mackenzie from Oxford presented an extensively well-researched talk on the History of Septic Shock. It was surprising to learn for how long early septic shock has been researched, although thankfully some of the treatments have now changed!

Trainee Conference
Dr J Harrison chaired this session. The first talk was given by Dr M Wilkes, Chairman of the BMA Ethics Committee on ‘The Ethical Minerfield’. This was a thought provoking talk on a subject that is so poorly taught and yet so important. Ms H Scott, Deputy Health Service Ombudsman, gave a stimulating talk on ‘Beyond the Trusts’ complaints procedure. Delightful as she was, we were all left with the feeling that we should avoid any encounters with her on a professional basis!

Annual General Meeting
Dr M Nixon, Chairman of GAT, gave a whirlwind update on what the GAT Committee was about and what the individual members had been up to in the past year. In particular, she gave an account of the National Bodies, Committees and Working Parties attended, as well as the seminars and projects currently in progress. She announced that Drs Bowler, Harrison, Loughrey and Shinde had offered their resignations, having gracefully outgrown their trainee role! They thanked them for all their hard work and enthusiasm over the years. Dr M Nixon welcomed Drs St Hare (Cardiff), K Kerr (S Yorkshire), T Corcoran (Dublin) and Dr D Cameron (SE Scotland) onto the

A Tale of Everyday Folk in the North
Well, we all suspected it and now the World Health Organisation has confirmed that Britain is 18th in the world in terms of effective care delivered for every pound spent and only 26th in its responsiveness to patients and ability to treat them professionally and with dignity. The evidence is irrefutable, the NHS is failing in its purpose and the government seems bent on blaming the consultants, those lazy, incompetent, greedy moneybags interested only in increasing waiting lists so they can line their pockets with private work. We can be forgiven for feeling unfairly victimised. The unprecedented level of hostility currently being hurled at the profession in almost every newspaper and news programme is becoming intolerable. Both the health secretary and the media are going to have to learn that alienating senior doctors in the Health Service is unlikely to result in a culture of increasing excellence. This is likely to prove to be the last straw that breaks the back of many a consultant who is in a position to retire or emigrate. Moreover, incoming newly appointed consultants are likely to refuse to carry the burden of the extensive hours currently being worked by many in the provision of only a basic service.

Last week our local rag ran an aggressively ‘doctor bashing’ headline almost every day including ‘Stop Killer Doctors’ and ‘Warning System Will Trap Rogue Doctors’. This latter headed up an article about a newly appointed chief officer of a nearby Community Health Council who plans to stamp out ‘rogue doctors’ practising in this area by building up a database from patients’ complaints. ‘Three strikes and you’re out’, supposedly and let’s not worry about the complaints being genuine or upheld after investigation. It should not take him long to collect his data as complaints have apparently gone up from an average of one a week to three or four a day.

Complaints like this one, perhaps, which occurred in my hospital in the same week. A child of six arrived in theatre for grommets, completely hysterical, kicking, screaming and refusing treatment. Her mother was quite unable to control her and so my colleague suggested her operation be postponed to another day so that she could prepare her properly for the experience and give an opportunity for some premedication. The mother insisted the anaesthetic proceed. She was advised that restraint would certainly be necessary and was asked to help by holding the child herself. She refused point blank and stood in the corner of the anaesthetic room while a nurse held her gently but effectively and my colleague spoke firmly to her.

Unbelievably, the woman then left theatre, pausing only to lodge an official complaint against my colleague for holding her child down forcibly and frightening her. This complaint will probably get nowhere but, in the meantime, my poor colleague who has never had to answer a complaint will have to fill in piles of paperwork, attend a complaints hearing and, presumably, be logged into this database.

Undoubtedly, my colleague was very upset but, at the weekend, the Sunday Times brought him some hope. ‘Rogue patients may be hired to test suspect doctors’ read the headline of an article which outlined (wrongly of course) a new GMC system whereby actors will be recruited to display fake medical symptoms to... test the skills of Britain’s 190,000 doctors...’

Could it be that this mother was an actor sent to provoke us? We can only hope that this is the case and we are all in complete agreement that my worthy colleague was not found lacking!

Free to read....
A Tale of Everyday Folk in the North
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Evelyn Baker Medal
An award for clinical competence

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the ‘unsung heroes’ of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement and wisdom and skill in communicating with patients, their relatives and colleagues. The ability to train and encourage trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation. Dr John Cole of Sheffield was the first winner of the Evelyn Baker medal in 1998 and Dr Meena Choksi from Pontypridd will be presented with her award at the Annual Scientific Meeting in Birmingham in September this year.

Nominations are now invited for the award to be presented at the WSM in January 2001 and may be made by any member of the Association to any practising anaesthetist, who is a member of the Association. The nomination, accompanied by a citation of up to 1000 words should be sent to the Honorary Secretary by Friday 20 October 2000.

Further information is available on the website www.aagbi.org or can be obtained from Bedford Square.

Dr Leslie Baird presents the Evelyn Baker Medal to Dr John Cole in Glasgow, September 1998

Northern Anaesthetic Research Consortium Research in Medicine Course (2000)

A two-day symposium designed for all SpRs and interested Consultants looking at research methods, study design and statistical principles. The course will assume no previous knowledge of research and will concentrate on improving understanding and performing the research process from initiation to completion.

Invited Speakers:
Sir Miles Irving, Prof P Kelly, Dr C Dodds, Dr S Cruikshank, Dr D G Greaves, Dr I D Conacher, Dr P M C Wright, Dr E Kirkman

Venue:
Postgraduate Department, Freeman Hospital, Newcastle upon Tyne.

Dates:
25 and 26 September 2000. Fee: £200

Application forms, details and programme please contact:
Lisa Smith or Dr Chris Snowden, Anaesthetic Department, Freeman Hospital, Freeman Rd, Newcastle upon Tyne NE7 7DN, Tel: 0191 204 3111 ext 31049, Email: lisa.smith@nufh.northy.nhs.uk

Oxford Radcliffe Hospitals NHS Trust
John Radcliffe Hospital Oxford

Thursday 2 November 2000

3rd Oxford Difficult Airway Workshop

Dr M Popat FRCA Consultant Anaesthetist
Dr S W Benham MBChB FRCA Anaesthetics and Intensive Care

A full and vibrant day of lectures, interactive discussion and 3 hours of workshop to inoculate you with enthusiasm to approach the difficult airway patient. The morning will concentrate on fibroptic techniques with a variety of training models (mannequins and Oxford Fibreoptic Training Box). There will be interactive discussion on various topics, including anaesthetising the upper airway, but with an emphasis of hands on experience.

The afternoon will explore alternative techniques to secure the airway, including intubating LMA and cuffed fiberoptics. We will also be teaching the ID lines. There will be an intense practical session to cover the unexpected, the unbelievable and the unmentionable: ‘Can’t intubate, can’t ventilate’: to end the day.

Numbers are limited to give participants ample time at each practical workstation. Astonishingly cheap price for the day includes registration, lunch and refreshments and the undivided attention of faculty. We recommend early booking to avoid tears.

Course Fee
Consultants £100
Trainees £75

To secure a place contact: Mrs Scott, Anaesthetic Department, Level 1, John Radcliffe Hospital, Oxford OX3 9DU
Tel 01865 221985
Fax 01865 220817

Cheques should be made payable to Oxford Difficult Airway Group

Visa, Mastercard or AMEX accepted

And finally...

Many thanks to Dr R Vaughan, Professor M Harmer and Dr S W Benham of Oxford for their hard work in producing a scientific symposium of such high quality and to Drs Harries and Bowler on the GAT Committee who put in a huge amount of work as part of the local organising committee. Finally, a special thanks to Jo, Karen, Metin and James from the Association who parted, organised and kept the whole ASM together.

(Please see page 6 for photographs)

Personal Profile

Patricia Willis started work at the Association on 15 May 2000 as Archivist but with additional responsibility for the museum and library. The Editor asked Trish to describe herself and her new job.

I returned to full time education in 1990 as a mature, if not to say ancient student and read history at King’s College, London. Having decided that I really wanted to pursue a career that involved history, I went on to obtain a diploma and MA in Archives and Records Management from University College, London.

After two years in the Surrey Record Office, I joined the Corporation of London Records Office, the repository for the archives of the Corporation of London, in 1996. Before joining the Association I was employed by Baits and The London NHS Trust as Trust Records Officer. I looked after the modern archives and the unintubatable, entitled ‘Can’t intubate, can’t ventilate’, to end the day.

I believe that, at the Association, I have been fortunate enough to find a position that will enable me to develop my skills and take responsibility for an archive, museum and library. I would like to make these accessible and to develop the excellent work that has already begun on these collections. I will also be able to offer records management advice to my colleagues at the Association. It has been immediately apparent that the staff at the Association are welcoming and a great pleasure to work with.

When I am not being an archivist, I enjoy gardening and growing plants that the slugs and snails subsequently consume with evident pleasure.
Anaesthesia News reaches over 7000 anaesthetists every month and is a great way of advertising your course, meeting or seminar. Advertisements are accepted from anaesthetic societies and organisations, courses run by recognised ‘anaesthetic bodies’ and those judged to be of interest to members of the Association of Anaesthetists of Great Britain and Ireland and without obvious commercial intent. Events will also be listed, free of charge, in the calendar of events on the Association website (www.aagbi.org) and the calendar will also be sent to members four times per year, enclosed with Anaesthesia and Anaesthesia News.

Display advertising can be in two colours and is accepted in camera ready form, by email or on disk. Potential advertisers are invited to discuss their requirements with the Editorial Assistant, Jane Meakin, at the Association. Copy deadlines are six weeks prior to the date of issue. Contact Jane for a Rate Card on 020 7631 8810, by fax on 020 7531 4352 or email on anaenews@aagbi.org.

Visitors to the Association’s BOC Museum can see a colour photograph of a most interesting oil painting virtually unknown to anaesthetists. It depicts a young scientist and his assistant in a late eighteenth century chemical laboratory. A Nooth’s apparatus stands prominently on the right. The original is 24 inches by 18 inches, it is signed and dated LR, 1827 and the provenance suggests that the subject is the young Humphry Davy.

So here, fortuitously, are depicted early connections with the first two agents used to produce general anaesthesia: Davy and nitrous oxide and Nooth, whose apparatus for the domestic production of carbonated water was adapted as a vaporizer for ether by Robinson and Squire.

The original is in the Museum of the History of Science, Oxford. It was purchased for fifteen guineas in 1961. We are grateful to the Museum for supplying the photograph.

Copies of this colour photograph, A4 size, price £20, can be obtained from Giles Hudson, Department of Photography, Museum of the History of Science, Broad Street, Oxford OX1 3AZ. We are very grateful to Mr Hudson for his help.

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 six 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 jpeg file attached to an email, or as ‘hard copy’. Our contact details are – 9 Bedford Square, London WC1B 3RA, telephone 020 7631 8810, fax 020 7631 4352 or email at anaenews@aagbi.org.

Tuesday 23 October 2000

For further details and application forms please contact:
Miss Melanie Warwick, Nuffield Department of Anaesthetics, John Radcliffe Hospital, Oxford OX3 9DU
Tel: (01865) 221590, Fax: (01865) 220027

Application form available at: www.nda.ox.ac.uk
email: mark.stoneham@nda.ox.ac.uk

Places are limited to 60
**Letters to the Editor**

**NCCGs**

Oh, how I agree with Kate Bullen in her ‘Give us a chance’ comment in the June issue of *Anaesthesia News*. It seems quite illogical to me that, whereas a well known [BU] Provident Association would previously quite happily send me a cheque for a minor procedure, they now will not recognise me for a minor procedure on my regular NHS list.

Since the advice given to the Provident Societies, which was obviously so very much to their liking that they have so readily acted upon it, came from our speciality, we NCCGs can only jump to the most obvious conclusions.

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**Labelling of Anaesthetic Drugs**

I would like to bring two problems in labelling to wider attention. The first is the microscopic, barely visible, wording on glass ampoules. There is so much information to be presented in a small space that, even on a 2ml ampoule, it can be difficult to discern the identity of the contents among the general clutter and against the background of the other side of the ampoule. On a 1ml ampoule this becomes impossible, of course. It is a fact that the important bits, such as the batch number and expiry date, are given greater prominence. You may have thought that proprietary brands would be less of a problem. Not at all. The need to include the generic name results in even less available space.

The problem is particularly noticeable among emergency drugs; I defy any presbyopic of my age to read the name, let alone the strength, of a 1ml ampoule of atropine or adrenaline, even with reading glasses. Let alone in an emergency situation when the latter may not be to hand. Is the problem becoming more widespread, or is it just my getting older?

Presumably, my contemporaries in more conventional surroundings have eagle eyed trainees to transfer their drugs to syringes for them and apply nice distinctly coloured labels. Which brings me to my second point. Have you noticed that all drug labels appear to be the same colour and same typeface? To my knowledge this has led to a patient receiving succinylcholine in error for midazolam while undergoing awake surgery under regional block, with grave psychological results for the patient, not to mention the legal consequences.

The ten Commandments into the ten guidelines. “Life is short and the occasion fleeting; experience fallacious and judgment defective”, Hippocrates (460–360BC). Art long; the occasion fleeting; experience fallacious and judgement defective. Thus, when you go to such physicians you must always worry that a few doctors have committed suicide, despite being innocent. If they are proved innocent, they cannot demand compensation for the trauma they have been through. The trauma is so severe that a substantial trust in the trust which forced the medical profession to adopt the higher ethical and medical standards, not the imposed regulations and stigmatisation. The problem is particularly noticeable among emergency drugs; I defy any presbyopic of my age to read the name, let alone the strength, of a 1ml ampoule of atropine or adrenaline, even with reading glasses. Let alone in an emergency situation when the latter may not be to hand. Is the problem becoming more widespread, or is it just my getting older?

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**Dictatorship of the media**

Following the Bristol case, voices have been raised against the medical profession, demanding several changes in the way our profession is regulated. Before the media forgot, another serious case called Harold Shipman came to light. To dig another nail in the coffin of the trust of the medical profession. Inside the medical profession, like any other profession, there will be addicts, alcoholics, abusers, rapists, racists, thieves and even killers. The presence of such abnormal cases in society is inevitable and history can tell.

One of the greatest horrors of the Second World War was that the physicians of one of the most cultured nations of Europe not only did not protest against the eugenic and racist killings of the Nazis but also co-operated with them. The first gas chambers were designed by psychiatrists and the concentration camps maintained the fiction of ‘medical’ selection for the gas chambers by having physicians in charge of those selections. Thus, medicalised killings in Germany were due to change from oath to code.

Ancient and modern pre and post-Hippocratics physicians were and are willing to kill for a price, whether financial or ideological. There is, as Gerald Manley Hopkins put it, “a death dance in our veins”. Thus, when you go to such physicians you must always worry whether someone else has paid more for your death than your life.

We, the majority of doctors, removed this fear, generated a substantial trust and consequently became what we are today. It is this trust which forced the medical profession to adopt the higher ethical and medical standards, not the imposed regulations and stigmatisation.

In the eyes of the General Medical Council and, sadly, the public, we are guilty until proved otherwise. The Consumers Association welcomed the call for new power to suspend doctors. So, doctors are under suspicion until investigations take place, however long that may be. If they are proved innocent, they cannot demand compensation for the trauma they have been through. The trauma is so severe that a few doctors have committed suicide, despite being innocent.

Mistakes will happen even if the General Medical Council turned the ten Commandments into the ten guidelines. “Life is short and the occasion fleeting; experience fallacious and judgement defective”, Hippocrates (460–360BC).
When trauma patients are admitted to the Accident and Emergency Department of a British hospital, they are cared for by a team consisting of ‘casualty’ doctor, surgeon and anaesthetist. It is the performance of this team which will determine whether the patient survives the ‘golden hour’ of trauma management. Training improves the quality of medical care given at this critical time and, as most early deaths are caused by airway and breathing problems, well-trained anaesthetists are central to good trauma management in the Accident and Emergency Department.

Anaesthetists may also be called upon to provide ‘forward aid’ in the out-of-hospital environment and may be requested to attend an RTA if a victim cannot be rapidly extricated from an accident or if there is a major incident. They may also volunteer their expertise at motor racing circuits or other events where trauma may occur. These situations demand an understanding of the priorities of resuscitation, knowledge of basic and advanced resuscitation techniques and the aptitude to work as a team with other medical specialities and the other emergency services. This is the remit of the Anaesthetic Trauma and Critical Care Course (ATACC).

The next course will be held at the Wrexham Maelor Hospital, North Wales, from 27 to 29 September. If you would like to enrol, please contact the address below. We would be particularly interested in hearing from consultant anaesthetists wishing to bring ATACC to their area.

Contact: Tim Simper, Resuscitation Training Officer, Cardiothoracic Centre, Thomas Drive, Liverpool L14 3PE. 0151 228 1616 extension 2444 (am) or 2447 (pm). E-mail: Nmayne@ccl-tr.nwest.nhs.uk

David Southern, Wrexham

Council of the Association has recently awarded the following grants:

Dr Charles Hinds (London) has received a Departmental Project Grant of £19,468 for his project The in-vivo pharmacology of peripheral vascular and endothelial dysfunction in septic humans.

A Departmental Project Grant of £20,130 has been awarded to Dr Duncan Young (Oxford) for his research Exhaled hydrogen and methane as markers of colonic perfusion.

A Research Grant of £9,857.52 was awarded to Dr Alastair Chambers (Aberdeen) for his research The Development and Progression of Chronic Pain: follow up of a cohort of 4,441 patients.

The Association Travel Grant has recently been increased from £750 to £1,000. These can be applied for throughout the year. Council has approved the following Travel Grants:

- Dr Peter Cole (York) £1,000 to spend a three week study period in the acute pain management centre of the Hvidovre University Hospital, Copenhagen led by Professor Henrik Kohlet;
- Dr David Lockey (Bristol) £750 to study administration of anaesthesia in the pre-hospital environment at the Metrohealth Medical Centre, Case Western Reserve University, Cleveland, Ohio, USA;
- Dr Halia O’Shea (Edinburgh) £800 for a visit to Papua New Guinea to become involved with clinical anaesthesia and education and training of local health workers in Vunapope, East New Britain Province;

On 30 June, Miss Nina Lewis from the University of Nottingham received the first Wylie Medal for her winning Undergraduate Essay Prize entry Salt, sugar or boiled cow – whether the future of intravenous fluid replacement? The President presented Nina with her medal and a cheque over lunch with Council members at Bedford Square. Nina has just qualified at the University of Nottingham and the President wished her well with her future career in medicine and hoped she would show continued interest in anaesthesia.

Irish Mace awarded

The President presented Dr Bill Blunnie, President of the Irish College of Anaesthetists, with a mace commissioned by the Association for the Irish College.

Dr Blunnie thanked the Association for its support during his presidency and, in turn, presented the Association with a Waterford crystal bowl.
Witnesses believe that it is not possible to abstain from blood. Christians to abstain... from blood (Acts 15:20). Jehovah's correct and which goes on to state; “The Bible commands... from blood (Acts 15:20). Jehovah's Witnesses (Watch Tower Bible and Tract Society of Britain) applicable. The UK governing body of the Jehovah's general guidance given in the AAGBI's guidelines was still Bedford Square, the President issued a statement that the worldwide, that blood transfusion is now acceptable in a story about a change in the views of Jehovah's Witnesses. On 14 June this year, most UK National newspapers carried representative body in the UK and elsewhere. by most anaesthetists and the Jehovah's Witnesses' repre- tional project either by the purchase of equip- ment or the part funding of a salary for medical or technical help or other support. Further information and application forms are available from the Association website: www.aagbi.org or the Honorary Secretary, Association of Anaesthetists of Great Britain and Ireland, 9 Bedford Square, London WC1B 3RA. Closing date for applications: 17 November 2000. Association Educational Awards are only open to members of the Association of Anaesthetists of Great Britain and Ireland.

Statement on Management of Jehovah’s Witnesses

The Association of Anaesthetists published a ‘glossy’ entitled The Anaesthetic Management of Jehovah’s Witnesses, in June 1999, which received considerable publicity in the national press and which was well received by most anaesthetists and the Jehovah’s Witnesses’ representative body in the UK and elsewhere.

On 14 June this year, most UK National newspapers carried a story about a change in the views of Jehovah’s Witnesses worldwide, that blood transfusion is now acceptable in certain circumstances. In response to press enquiries to Bedford Square, the President issued a statement that the general guidance given in the AAGBI’s guidelines was still applicable. The UK governing body of the Jehovah’s Witnesses (Watch Tower Bible and Tract Society of Britain) has now issued a press release which confirms this view as correct and which goes on to state: “The Bible commands Christians to abstain... from blood (Acts 15:20). Jehovah's Witnesses believe that it is not possible to abstain from blood and accept blood transfusions. This position has not changed.” By accepting a blood transfusion, a Jehovah's Witness “revokes his own membership by his own actions, rather than the congregation initiating this step. This represents a procedural change... however, the end result is the same.”

The information and guidance given in the AAGBI’s document remains correct. Any competent patient is entitled to express wishes regarding acceptable treatment modalities that must be adhered to, provided the consequences of such action have been fully explained to the patient, however much that conflicts with the views held by the anaesthetist.

Dr Michael Ward
Chairman, Anaesthetic Management of Jehovah’s Witnesses Working Party

WFSA World Congress Report

The Association was among a strong delegation from the British Isles at the 12th World Congress of the World Federation of Societies of Anesthesiologists (WFSA), in Montréal, from 4 to 9 June. The Palais des Congrès housed a sizeable exhibition of stands, including our own and this was manned by Jane Meakin, Metin Enver and a team of willing ‘volunteers’.

As well as advertising the benefits of joining the Association, staff present recruited new and ‘lapsed’ members, as the picture shows (top right). Also seen is the suave Dr David Bogod, persuading a delegate from Germany to model a T-shirt which she was then allowed to take away. The stand was visited on one of the days by the Consul General, Mr Marcus Hope who was accompanied by a colourful escort in the form of a member of the Royal Cana- dian Mounted Police and the Commercial Officer, Ms Stephanie Murphy.

Among the many other exhibition stands was one display- ing the Laryngeal Mask Airway. The company had the good sense to invite Dr Archie Brann to demonstrate the airway and he is seen doing just this, surrounded by an interested crowd (below).

The meeting itself consisted of an excellent scientific pro- gramme, supported by well organised workshops. The large international attendance allowed the President and Honorary Secretary of the Association to meet opposite numbers from the United States, Canada and Australia, to discuss items of mutual interest.

UK leadership of several of the WFSA’s committees was assured when Professor Harmer and Drs Wilkinson, Bogod, Eltringham, Wilson, Casey and Ballance were elected.

Finally, the Association hosted a reception attended by the heads of more than 20 national societies and local dignitaries.
Magill Symposium & Re-union Dinner
Wednesday 11 October 2000 at 2pm
Chelsea and Westminster Hospital, London

Anaesthesia – The Simulator and the Future

Speakers
Dr Mark Bloch, Director, Simulator Centre, Chelsea and Westminster Hospital, London
Dr Frances Forrest, Simulator Centre, Bristol
Virgin Airlines
Sir Donald Irvine, President – GMC
Magill Speaker: Professor David Hatch, Great Ormond Street Hospital

Followed by dinner in the evening at the Meriden Hotel, Piccadilly, London.

Cost £50 per head to attend symposium, £60 per head to attend dinner or £100 per head to attend both

Places are limited to 200, so early booking is essential. If you would like to attend, please contact Maureen Fortier, Anaesthetic Secretary, Magill Department of Anaesthesia, Chelsea and Westminster Hospital. Tel 020 8746 8026 or Fax 020 8746 8801. Email maureen.fortier@chelwest.org

MSc in Evidence Based Anaesthesia
Teesside University and the Cleveland School of Anaesthesia

Course Starts in Sept-Oct 2000
The Aim of the Course is to provide a detailed understanding of the process of evidence based reviewing and to learn how to do a major systematic review within a specialised area of your interest.

Two Years Part time Evening and Weekend Classes
First Year Course involves Practical Teaching on Research Methodology, Statistics including Systematic review and Meta-analysis techniques and Clinical Audit.
Second Year involves an Evidence Based Research Project at your own work place to publishable standard.

For further information please contact
Mrs Pat McSorley, Cleveland School of Anaesthesia
South Cleveland Hospital
Middlesbrough TS4 3BW
Tel 01642 854601, Fax 01642 854246.
Email: ChrisDodds@ea-cdodds.freeserve.co.uk

National Final FRCA Crammer Course
25-29 September 2000
South Cleveland Hospital
Marton Road
Middlesbrough TS4 3BW

Course Fee: £350
Application form and details available from:
Mrs P.A. McSorley, Course Administrator,
Cleveland School of Anaesthesia, Cheriton House, Middlesbrough TS4 3BW
Tel: 01642 854601

DIFFICULT AIRWAY SOCIETY ANNUAL SCIENTIFIC MEETING
23-24 November 2000
Manchester
Details of meeting and submission of abstracts and posters from -
Mrs Anne Norbury
Dept of Anaesthesia
Manchester Royal Infirmary
Tel: 0161 276 4552
Fax: 0161 276 8027
e-mail: anorbury@fe3.cmht.nwest.nhs.uk

University of Leicester
FINAL FRCA REVISION COURSE
An intensive revision course for the Final FRCA based on small group tutorials and including written and oral examination practice

DATE: 3-6 OCTOBER 2000
VENUE: LEICESTER ROYAL INFIRMARY

FEES: £275 Non-residential (including lunch & refreshments)
£375 Residential at local hotel (including lunch & refreshments)

Course Director - Dr. Jonathan Thompson

Places are strictly limited so please apply early to
Christine Gethins on 0116 258 5291
Department of Anaesthesia & Pain Management
Leicester Royal Infirmary

www.anaesthesiupdates.com
In association with Club Med Corporate

3rd South West Thames Anaesthesia Forum
23-26 October, 2000
(revised dates)
Da Baliaia, The Algarve
Portugal

Open to all Anaesthetists - limited to 100 participants

The Scientific Programme will include lectures, and discussions on:
• Acute and Chronic Pain
• Paediatric Update
• Day Case Anaesthesia
• Obstetric Anaesthesia
• Neurology and Anaesthesia
• ITU and Relevant Medical Topics
• Cardiothoracic topics

Guest Speakers
Video on New Equipment, Drugs and Techniques
Anaesthetists in training presenting papers are eligible for prizes
Deadline for abstracts: August 13th 2000

This Meeting is approved for CME purposes

For further details, please contact:
Fax: 020 8725 3135
Tel: 020 8725 0018
Dr J.B. Liban
Department of Anaesthesia
St George’s Hospital
Blackshaw Road
London SW17 0QT

email: liban@mailbox.co.uk

Book Now!
Association of Anaesthetists of Great Britain & Ireland
Royal College of Anaesthetists
CONTINUING MEDICAL EDUCATION DAY
7 October 2000
at the Hilton London Metropole

For further details telephone 020 7631 8803/2 or email meetings@aagbi.org
Magill Symposium & Re-union Dinner
Wednesday 11 October 2000 at 2pm
Chelsea and Westminster Hospital, London

Anaesthesia – The Simulator and the Future

Speakers
Dr Mark Bloch, Director, Simulator Centre, Chelsea and Westminster Hospital, London
Dr Frances Forrest, Simulator Centre, Bristol
Virgin Airlines
Sir Donald Irvine, President – GMC
Magill Speaker: Professor David Hatch, Great Ormond Street Hospital
Followed by dinner in the evening at the Meriden Hotel, Piccadilly, London.
Cost £50 per head to attend symposium, £60 per head to attend dinner or £100 per head to attend both

Places are limited to 200, so early booking is essential. If you would like to attend, please contact Maureen Fortier, Anaesthetic Secretary, Magill Department of Anaesthesia, Chelsea and Westminster Hospital. Tel 020 8746 8026 or Fax 020 8746 8801. Email maureen.fortier@chelwest.org

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• Radiology for Anaesthetist
• New Drugs Update
• Training & Education
• Anaesthetic Audit
• Free papers
• Panel Discussions
• Workshops

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CONTINUING MEDICAL EDUCATION DAY
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Witnesses believe that it is not possible to abstain from blood. Christians to abstain… from blood (Acts 15:20). Jehovah’s Witnesses, in June 1999, which received considerable publicity in the national press and which was well received by most anaesthetists and the Jehovah’s Witnesses’ representative body in the UK and elsewhere.

On 14 June this year, most UK National newspapers carried a story about a change in the views of Jehovah’s Witnesses worldwide, that blood transfusion is now acceptable in certain circumstances. In response to press enquiries to Bedford Square, the President issued a statement that the general guidance given in the AAGBI’s guidelines was still applicable. The UK governing body of the Jehovah’s Witnesses (Watch Tower Bible and Tract Society of Britain) has now issued a press release which confirms this view as correct and which goes on to state: “The Bible commands Christians to abstain… from blood (Acts 15:20). Jehovah’s Witnesses believe that it is not possible to abstain from blood and accept blood transfusions. This position has not changed.” By accepting a blood transfusion, a Jehovah’s Witness “revokes his own membership by his own actions, rather than the congregation initiating this step. This represents a procedural change… however, the end result is the same.”

The information and guidance given in the AAGBI’s document remains correct. Any competent patient is entitled to express wishes regarding acceptable treatment modalities that must be adhered to, provided the consequences of such action have been fully explained to the patient, however much that conflicts with the views held by the anaesthetist.

Dr Michael Ward
Chairman, Anaesthetic Management of Jehovah’s Witnesses Working Party

The Association was among a strong delegation from the British Isles at the 12th World Congress of the World Federation of Societies of Anesthesiologists (WFSA), in Montréal, from 4 to 9 June. The Palais des Congrès housed a sizeable exhibition of stands, including our own and this was manned by Jane Meakin, Metin Enver and a team of willing ‘volunteers’.

As well as advertising the benefits of joining the Association, stall present recruited new and ‘lapsed’ members, as the picture shows (top right). Also seen is the suave Dr David Bogod, persuading a delegate from Germany to model a T-shirt which she was then allowed to take away.

The stand was visited on one of the days by the Consul General, Mr Marcus Hope who was accompanied by a colourful escort in the form of a member of the Royal Canadian Mounted Police and the Commercial Officer, Ms Stephanie Murphy.

Among the many other exhibition stands was one displaying the Laryngeal Mask Airway. The company had the good sense to invite Dr Archie Brain to demonstrate the airway and he is seen doing just this, surrounded by an interested crowd (below).

The meeting itself consisted of an excellent scientific programme, supported by well organised workshops. The large international attendance allowed the President and Honorary Secretary of the Association to meet opposite numbers from the United States, Canada and Australia, to discuss items of mutual interest.

UK leadership of several of the WFSA’s committees was assured when Professor Harmer and Drs Wilkinson, Bogod, Eltringham, Wilson, Casey and Ballance were elected.

Finally, the Association hosted a reception attended by the heads of more than 20 national societies and local dignitaries.
Major trauma is an infrequent occurrence in Britain as British citizens do not readily shoot or stab each other. Most trauma results from road traffic accidents (RTA) and industrial accidents and this generates a different pattern of trauma from that seen in the United States. When trauma patients are admitted to the Accident and Emergency Department of a British hospital, they are cared for by a team consisting of ‘casualty’ doctor, surgeon and anaesthetist. It is the performance of this team which will determine whether the patient survives the ‘golden hour’ of trauma management. Training improves the quality of medical care given at this critical time and, as most early deaths are caused by airway and breathing problems, well-trained anaesthetists are central to good trauma management in the Accident and Emergency Department. Anaesthetists may also be called upon to provide ‘forward aid’ in the out-of-hospital environment and may be requested to attend an RTA if a victim cannot be rapidly extricated from an accident or if there is a major incident. They may also volunteer their expertise at motor racing circuits or other events where trauma may occur. These situations demand an understanding of the priorities of resuscitation, knowledge of basic and advanced resuscitation techniques and the aptitude to work as a team with other medical specialties and the other emergency services. This is the remit of the Anaesthetic Trauma and Critical Care Course (ATACC).

The next course will be held at the Wrexham Maelor Hospital, North Wales, from 27 to 29 September. If you would like to enrol, please contact the address below. We would be particularly interested in hearing from consultant anaesthetists wishing to bring ATACC to their area.

Contact: Tim Simper, Resuscitation Training Officer, Cardiothoracic Centre, Thomas Drive, Liverpool L14 3PE. 0151 228 1616 extension 2444 (am) or 2447 (pm).
E-mail: Nmayne@ccl-tr.nwest.nhs.uk

David Southern, Wrexham

EDUCATION AND RESEARCH TRUST GRANTS

Council of the Association has recently awarded the following grants:

Dr Charles Hinds (London) has received a Departmental Project Grant of £19,468 for his project The in-vivo pharmacology of peripheral vascular and endothelial dysfunction in septic humans.

A Departmental Project Grant of £20,130 has been awarded to Dr Duncan Young (Oxford) for his research Exhaled hydrogen and methane as markers of colonic perfusion.

A Research Grant of £9,857.52 was awarded to Dr Alastair Chambers (Aberdeen) for his research The Development and Progression of Chronic Pain: follow up of a cohort of 4,441 patients.

The Association Travel Grant has recently been increased from £750 to £1,000. These can be applied for throughout the year. Council has approved the following Travel Grants:

• Dr Peter Cole (York) £1,000 to spend a three week study period in the acute pain management centre of the Hvidovre University Hospital, Copenhagen led by Professor Henrik Kohlet;

• Dr David Lockey (Bristol) £750 to study administration of anaesthesia in the pre-hospital environment at the Metrohealth Medical Centre, Case Western Reserve University, Cleveland, Ohio, USA;

• Dr Halia O’Shea (Edinburgh) £800 for a visit to Papua New Guinea to become involved with clinical anaesthesia and education and training of local health workers in Vunapope, East New Britain Province;

On 30 June, Miss Nina Lewis from the University of Nottingham received the first Wylie Medal for her winning Undergraduate Essay Prize entry Salt, sugar or boiled cow – whether the future of intravenous fluid replacement? The President presented Nina with her medal and a cheque over lunch with Council members at Bedford Square. Nina has just qualified at the University of Nottingham and the President wished her well with her future career in medicine and hoped she would show continued interest in anaesthesia.

Irish Mace awarded

The President presented Dr Bill Blunnie, President of the Irish College of Anaesthetists, with a mace commissioned by the Association for the Irish College.

Dr Blunnie thanked the Association for its support during his presidency and, in turn, presented the Association with a Waterford crystal bowl.
Dictatorship of the media

F
ollowing the Bristol case, voices have been raised against the medical profession, demanding several changes in the way our profession is regulated. Before the media forgot, another serious case called Harold Shipman came to light to dig another nail in the coffin of the trust of the medical profession. Inside the medical profession, like any other profession, there will be addicts, alcoholics, abusers, rapists, racists, thieves and even killers. The presence of such abnormal cases in society is inevitable and history can tell.

One of the greatest horrors of the Second World War was that the physicians of one of the most cultured nations of Europe not only did not protest against the egotistic and racist killings of the Nazis but also co-operated with them. The first gas chambers were designed by psychiatrists and the concentration camps maintained the fiction of ‘medical’ selection for the gas chambers by having physicians in charge of those selections. Thus, medicalised killings in Germany were due to change from oath to code.

Ancient and modern pre and post-Hippocratic physicians were and are willing to kill for a price, whether financial or ideological. There is, as Gerald Manley Hopkins put it, “a death dance in our veins”. Thus, when you go to such physicians you must always worry whether someone else has paid more for your death than for your life.

We, the majority of doctors, removed this fear, generated a substantial trust and consequently became what we are today. It is this trust which forced the medical profession to adopt the higher ethical and medical standards, not the imposed regulations and stigmatisation.

In the eyes of the General Medical Council and, sadly, the public, we are guilty until proved innocent, whereas a well known saying states that a few doctors have committed suicide, despite being innocent. If they are proved innocent, they cannot demand compensation. We, the majority of doctors, removed this fear, generated a substantial trust and consequently became what we are today. It is this trust which forced the medical profession to adopt the higher ethical and medical standards, not the imposed regulations and stigmatisation.

The problem is particularly noticeable among emergency drugs; I defy any preshrype of my age to read the name, let alone the strength, of a 1ml ampule of ketamine or fentanyl, even with reading glasses, let alone in an emergency situation when the latter may not be to hand. Is the problem becoming more widespread, or is it just my getting older? Is the problem becoming more widespread, or is it just my getting older?

Presumably, my contemporaries in more conventional surroundings will have eagle eyed trainees to transfer their drugs to syringes for them and apply nice distinctively coloured labels.

Which brings me to my second point. Have you noticed that all syringe labels when viewed from the back are white? To my knowledge, the problem is particularly noticeable among emergency drugs; I defy any preshrype of my age to read the name, let alone the strength, of a 1ml ampule of ketamine or fentanyl, even with reading glasses, let alone in an emergency situation when the latter may not be to hand. Is the problem becoming more widespread, or is it just my getting older? Is the problem becoming more widespread, or is it just my getting older?

I would like to bring two problems in labelling to wider attention. The first is the microscopic, lettering being used on glass ampoules. There is so much information to be presented in a small space that, even on a 1ml ampoule, it can be difficult to decipher the identity of the contents among the general clutter and against the background of the other side of the ampoule. On a 1ml ampoule this become impossible, though of course the important bits, like the batch number and expiry dates, are given greater prominence.

You may have thought that proprietary brands would be less of a problem. Not at all. The need to include the generic name results in even less available space. The problem is particularly noticeable among emergency drugs; I defy any preshrype of my age to read the name, let alone the strength, of a 1ml ampule of ketamine or fentanyl, even with reading glasses, let alone in an emergency situation when the latter may not be to hand. Is the problem becoming more widespread, or is it just my getting older? Is the problem becoming more widespread, or is it just my getting older?

The second point is that a number of controversies debates

• Obstetric Pain Relief – G Marshall (Carshalton)
• Hospital formulary and limited prescribing lists – J. Collier (London)
• Patients’ perception of PCA – G. Chumbley (London)
• Opioid systems and analgesia; new developments from gene knockouts – C. Bountra
• New developments in the treatment of PONV – C. Bountra
• Anaesthesia /analgesia through the ages – J. Nunn (Harrow)
• Acute Pain Management: Scientific Evidence? – I. Power (Sydney)
• The 6th South Thames Acute Pain Conference

The 6th South Thames Acute Pain Conference

St. George’s Hospital NHS Trust
9 and 10 November 2000

Programme

• Acute Pain Management: Scientific Evidence? – I. Power (Sydney)
• Anaesthesia analgesia through the ages – J. Nunn (Harrow)
• Assessing the quality of postoperative analgesia; why do epidurals fail? – G. McLeod (Dundee)
• Analgesic efficacy of cannabinoids – A. Holdcroft (London)
• New developments in the treatment of PONV – C. Bountra
• Opioid systems and analgesia; new developments from gene knockouts – J. Nunn (Harrow)
• Ten years of Acute Pain Services – J. Chasen, Ward (London)
• Obstetric Pain Relief – G. Marshall (Cochrane)
• Plus a number of controversies debates
• Conference Dinner at Le Gourmet, Thursday 9 (places limited)

Registration: Before 1/10/00

Nurses/Pharmacists

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For further information contact
Joanne Barnes or Karen Grigg on 020 7631 8802/3
Advertising in Anaesthesia News

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

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Display advertising can be in two colours and is accepted in camera ready form, by email or on disk. Potential advertisers are invited to discuss their requirements with the Editorial Assistant, Jane Meakin, at the Association.

Copy deadline is six weeks prior to the date of issue. Please send photographs, of reasonable size and in colour, either as a jpg file attached to an email, or as ‘hard copy’.

Our contact details are – 9 Bedford Square, London WC1B 3RA, telephone 020 7631 8810, fax 020 7631 4352 or email at anaenews@aagbi.org

V

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So here, fortuitously, are depicted early connections with the first two agents used to produce general anaesthesia: Davy and nitrous oxide and Nooth, whose apparatus for the domestic production of carbonated water was adapted as a vaporizer for ether by Robinson and Squire.

The original is in the Museum of the History of Science, Oxford. It was purchased for fifteen guineas in 1961. We are grateful to the Museum for supplying the photograph.

Copies of this colour photograph, A4 size, price £20, can be obtained from Giles Hudson, Department of Photography, Museum of the History of Science, Broad Street, Oxford OX1 3AZ. We are very grateful to Mr Hudson for his help.

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 six 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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Nuffield Department of Anaesthetics, University of Oxford

SECOND REGIONAL ANAESTHESIA FOR CAROTID SURGERY COURSE (course organiser Dr Mark Stoneham)

- Lectures from invited speakers
- Video presentation
- Workshops – including surface anatomy and protected anatomy specimens
- 5 CME points awarded
- Registration fee £75

Monday 23 October 2000

For further details and application forms please contact:
Miss Melanie Warwick, Nuffield Department of Anaesthetics, John Radcliffe Hospital, Oxford OX3 9DU
Tel: (01865) 221590, Fax: (01865) 220827
Application form available at: www.nda.ox.ac.uk
email: mark.stoneham@nda.ox.ac.uk
Places are limited to 60

Conference Organiser: Dr Chanda Banerjee, Consultant Anaesthetics, South Cleveland Hospital, Middlesbrough

Conference Faculty:
Dr Mark Stoneham, Consultant Anaesthetics, St James Hospital, Leeds
Dr Richard Castle, Consultant Anaesthetics, York Teaching Hospitals Trust
Dr Neil D’Sa, Consultant Anaesthetics, St James University Hospital, Leeds
Dr Andrew Charalambous, Consultant Anaesthetics, Leeds Teaching Hospitals Trust
Dr Andrew Robotham, Consultant Anaesthetics, North Staffordshire Hospital Trust
Dr William Cartlidge, Consultant Anaesthetics, Wrightington Hospital Trust
Dr Lewis Main, Consultant Anaesthetics, York Teaching Hospitals Trust
Dr Sean McCandless, Consultant Anaesthetics, York Teaching Hospitals Trust
Dr Nigel Webster, Consultant Anaesthetics, St James University Hospital, Leeds
Dr Paul Oldham, Consultant Anaesthetics, Sheffield Teaching Hospitals Trust
Dr Mark Stoneham, Consultant Anaesthetics, John Radcliffe Hospital, Oxford

Nuffield Department of Anaesthetics, University of Oxford

Annual National Conference
Thursday 16th & Friday 17th November 2000
Tall Trees Hotel, Yarn, Middlesbrough, UK

Future Imaging of Anaesthesia for Education and Training: an Update
Professor Stephen Williams, University of Oxford

Perioperative Training: Problems and Solutions
Professor Andrew McDonald, University of Oxford

Teaching, Education & Training in Anaesthesia: Sub-specialty Workshops
Dr Chanda Banerjee, Consultant Anaesthetics, South Cleveland Hospital, Middlesbrough

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The Evelyn Baker Medal
An award for clinical competence

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the ‘unsung heroes’ of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement and wisdom and skill in communicating with patients, their relatives and colleagues. The award is intended to encourage trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation.

Dr John Cole of Sheffield was the first winner of the Evelyn Baker medal in 1998 and Dr Meena Choksi from Pontypridd will be presented with her award at the Annual Scientific Meeting in Birmingham in September this year.

Nominations are now invited for the award to be presented at the WSM in January 2001 and may be made by any member of the Association to any practising anaesthetist who is a member of the Association. The nomination, accompanied by a citation of up to 1000 words should be sent to the Honorary Secretary by Friday 20 October 2000.

Further information is available on the website www.aagbi.org or can be obtained from Bedford Square.

Evelyn Baker Medal

Oxford Radcliffe Hospitals NHS Trust
John Radcliffe Hospital Oxford

Thursday 2 November 2000
3rd Oxford Difficult Airway Workshop

Dr M Popat FRCA Consultant Anaesthetist

Dr S W Benham MRCP FRCA Anaesthetics and Intensive Care

A full and vibrant day of lectures, interactive discussion and 3 hours of workshop to inoculate with an enthusiasm to approach the difficult airway patient. The morning will concentrate on fibreoptic techniques with a variety of training models (mannequins and Oxford Fibreoptic Training Box). There will be interactive discussion on various topics, including anaesthetising the upper airway, but with an emphasis on hands on experience.

The afternoon will explore alternative techniques to secure the airway, including Intubating LMA and cricothyrotomy and video-assisted intubation. There will be an extremely practical session to cover the unexpected, the unbelieveable and the unmentionable entitled: ‘Can’t intubate, can’t ventilate’, to end the day.

Numbers are limited to give participants ample time at each practical workation. Astonishingly cheap price for the day includes registration, lunch and refreshments and the undivided attention of faculty. We recommend early booking to avoid tears.

Course Fee
Consultants £100 Trainees £75

To secure a place please contact: Mrs Scott, Anaesthetic Department, Level 1, John Radcliffe Hospital, Oxford OX3 9DU Tel: 01865 221963 Fax: 01865 220827

Cheques should be made payable to: Oxford Difficult Airway Group

Dr Leslie Baard presents the Evelyn Baker Medal to Dr John Cole in Glasgow, September 1998

Personal Profile
Patricia Willis started work at the Association on 15 May 2000 as Archivist but with additional responsibility for the museum and library. The Editor asked Trish to describe herself and her new job.

I returned to full time education in 1990 as a mature, if not ancient student and read history at King’s College, London. Having decided that I really wanted to pursue a career that involved history, I went on to obtain a diploma and MA in Archives and Records Management from University College, London.

After two years in the Surrey Record Office, I joined the Corporation of London Records Office, the repository for the archives of the Corporation of London, in 1996. Before joining the Association I was employed by Baits and The London NHS Trust as Trust Records Officer. I looked after the modern records created by departments of the Trust and ensured that records created by departments of the Trust and ensured that retention schedules were drawn up and that records were either transferred to the archives or destroyed.

I believe that, at the Association, I have been fortunate enough to find a position that will enable me to develop my skills and take responsibility for an archive, museum and library. I would like to make these accessible and to develop the excellent work that has already begun on these collections. I will also be able to offer records management advice to my colleagues at the Association. It has been immediately apparent that the staff at the Association are welcoming and a great pleasure to work with.

When I am not being an archivist, I enjoy gardening and growing plants that the slugs and snails subsequently consume with evident pleasure.

Dr David Whittaker receives the Pinkerton Lecture Medal from Dr Marie Nixon.

And finally...
Many thanks to Dr R Vaughan, Professor M Harmer and Dr F Clayburn for their hard work in producing a scientific meeting of such high quality and to Drs Harries and Bowler on the GAT Committee who put in a huge amount of work as part of the local organising committee. Finally, a special thanks to Jo, Karen, Metin and James from the Association who parted organised and kept the whole ASM together.

(More photographs on page 6)
Gas Flo
Notes from a Small Hospital
A Tale of Everyday Folk in the North

Well, we all suspected it and now the World Health Organisation has confirmed that Britain is 18th in the world in terms of effective care delivered for every pound spent and only 26th in its responsiveness to patients and ability to treat them professionally and with dignity. The evidence is irrefutable, the NHS is failing in its purpose and the government seems bent on blaming the consultants, those lazy, incompetent, greedy moneybags interested only in increasing waiting lists so they can line their pockets with private work. We can be forgiven for feeling unfairly victimised. The unprecedented level of hostility currently being harled at the profession in almost every newspaper and news programme is becoming intolerable. Both the health secretary and the media are going to have to learn that alienating senior doctors in the Health Service is unlikely to result in a culture of increasing excellence. This is likely to prove to be the last straw that breaks the back of many a consultant who is in a position to retire or emigrate. Moreover, incoming newly appointed consultants are likely to refuse to carry the burden of the extensive hours currently being worked by many in the provision of only a basic service.

Last week our local rag ran an aggressively ‘doctor bashing’ headline almost every day including ‘Stop Killer Doctors’ and ‘Warning System Will Trap Rogue Doctors’. This latter headed up an article about a newly appointed chief officer of a nearby Community Health Council who plans to stamp out ‘rogue doctors’ practising in this area by building up a database from patients’ complaints. ‘Three strikes and you’re out’, supposedly and let’s not worry about the complaints being genuine or upheld after investigation. It should not take him long to collect his data as complaints have apparently gone up from an average of one a week to three or four a day.

Complaints like this one, perhaps, which occurred in my hospital in the same week. A child of six arrived in theatre for grommets, an average of one a week to three or four a day.

Dr J Harrison chaired this session. The first talk was given by Dr M Wilkes, Chairman of the BMA’s Ethics Committee on ‘The Ethical Minefield’. This was a thought provoking talk on a subject that is so poorly taught and yet so important. Ms H Scott, Deputy Health Service Ombudsman, gave a stimulating talk on ‘Beyond the Trusts’ complaints procedure. Delightful as she was, we were all left with the feeling that we should avoid any encounters with her on a professional basis!

Dr M Nixon, Chairman of GAT, gave a whirlwind update on what the GAT Committee was about and what the individual members had been up to in the past year. In particular, she gave an account of the National Bodies, Committees and Working Parties attended, as well as the seminars and projects currently in progress. She announced that Drs Bowler, Harrison, Loughtrey and Shinde had offered their resignations, having graciously outgrown their trainee role! She thanked them for all their hard work and enthusiasm over the years. Dr Nixon welcomed Drs S Harries (Cardiff), R Kerr (S Yorkshire), T Corcoran (Dublin) and Dr D Cameron (SE Scotland) onto the Appointed Consultants Working Party. Dr Nixon also outlined (wrongly of course) a new GMC system whereby actors will be hired to test suspect doctors’ read the headline of an article which outlined (wrongly of course) a new GMC system whereby actors will be hired to test suspect doctors’ reading and, presumably, be logged into this database.

Understandably, my colleague was very upset but, at the week-end, the Sunday Times brought him some hope. ‘Rogue patients may be tested to hit suspect doctors’ read the headline of an article which outlined (wrongly of course) a new GMC system whereby actors will be recruited to display fake medical symptoms to ‘test the skills of Britain’s 190,000 doctors…’ Could it be that this mother was an actor sent to provoke us? We can only hope that this is the case and we are all in complete agreement that my worthy colleague was not found lacking!
The aid donors talk about sustainable development and cost recovery in health but who pays for actual health care? I was interested in a recent operation that took place at our hospital in Malawi.

A child of five months was scheduled for hernia repair. I gave the anaesthetic, paid by the Dutch aid organisation DGIS. My surgical colleague, also paid by DGIS, did the surgery. He was assisted by a Malawian government nurse who scrubbed, although there was no runner as there is a chronic shortage of nurses.

A clinical officer anaesthetist, partly paid by the Malawi Government, but also paid by a fund supported by the EU, who still had a soft spot for his old home. The used anaesthesia machine came from Danida, the Danish aid organisation, almost a decade ago.

The operating theatre was planned by a British surgeon and local commercial benefactors, helped with the anaesthesia from the Government, but also paid by a fund supported by the EU. The surgical instruments were part of a donation from Rotary International, the autoclave also.

There was one piece of paper relating to this case, the total amount of notes or pre-op work up for the child. Having the consistency of thin ‘Brisco’ paper, it measured 3 x 3 inches and had the patient’s name and ‘for RH repair’ written on it. The surgeon added the word ‘done’ and the job was, indeed, done. The pen was his own.

The piece of paper, the scrub nurse and part of the ACO’s book were donated by someone who scrubbed, although there was no runner as there is a chronic shortage of nurses.

There was one piece of paper written on it. The surgeon added the word ‘done’ and the job was, indeed, done. The pen was his own.

The copy deadline for the October 2000 edition of Anaesthesia News is 18 August

Paul Fenton was born in 1947 and medically educated at Guys Hospital. After house jobs and tropical medicine courses, he first learnt anaesthesia in Zambia, consolidating this experience and passing the FRACR while working at King’s College Hospital. He went to Malawi in 1986 as Senior Lecturer and, since 1991, has been the Associate Professor at the Malawi College of Medicine.

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Anaesthesia News
Editor: John Ballance
Advertising: Jane Meakin
Design: Eyekon Design
Telephone 021 350 2435.
Printing: Rotadex Print
Telephone 021 783 7411.

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Annual meeting of the Group of Anaesthetists in Training (GAT), Cardiff, 2000

This was my last GAT ASM in an official capacity and what a way to go! Not only was the scientific programme excellent and the social events riotous but nearly 400 trainees made it to the conference. This was over 100 more than last year and this, I am sure, not only reflects the quality of the speakers and the attraction of Cardiff, but the goodwill of rota monitors in allowing us to slope off to the one and only national anaesthetic meeting for trainees. Thanks to you all!

Scientific Meeting

The meeting began with a hilarious double act from Professor M Harmer and Dr R Vaughan who gave a theatrical glimpse of the past and possible future of anaesthesia. This was followed by an informative session on blood transfusion in the UK and all we needed to know about autologous blood transfusion. The afternoon began with a session on critical care of the surgical patient. Dr G Findlay encouraged teamwork in the ‘one hour’ before surgery and Dr N Stalford stressed organisation and communication in the CCEP course, whilst Dr S Ridley woke everyone up with the words ‘empire building!’ He was, of course, referring to the fact that every hospital should have a High Dependency Unit… and not for all the obvious reasons!

The day concluded with a session on thoracic anaesthesia. Entertaining as ever, Dr A Pearce gave a great lecture on bronchoscopy, whilst Dr R Vaughan urged that, if we remember nothing else, we should be prepared for the dramatic complications of a mediastinoscopy. Finally, Dr J Jothard summarised one lung anaesthesia in 20 minutes!

The second day opened up with a session on ‘equipment evaluation and standards’, chaired by Professor WW Mapleson. This stressed the importance of maintaining high clinical standards and of raising international standards for safety and compatibility.

The third day began with an ‘Open to Debate’ session, chaired by Professor M Harmer. Three contentious issues were argued by three excellent speakers, Dr E Major supporting percutaneous tracheostomies, Dr R Collis advocating Combined Spinal/Epidural (CSE) for all caesarean sections and Dr R A Mason putting forward the merits of fibre-optic intubation. This was followed by...