Farewell Bedford Square

At 1700 on Friday 7 June, Professor Leo Strunin, President of the Association, banged the gavel at the end of the last Council meeting to be held in Bedford Square. David Whitaker, the Assistant Honorary Secretary, lowered the flag for the last time and the move to Portland Place was under way.

This small ceremony brought to an end nearly seventeen years in Bedford Square although the premises were officially opened by our late Patron, HRH Princess Margaret, on 9 July 1987. As early as 1977, at the Annual General Meeting, a resolution was passed suggesting new premises for the Association which had outgrown its accommodation in BMA House, Tavistock Square. The Faculty of Anaesthetists approved separate status for the Association in 1980 and active house hunting began but it was not until Derek Wylie, then President, was walking through Bedford Square in 1983, after two premises had been rejected, that number 9 was considered.

The building was in a very dilapidated state but some soul searching by Presidents and Officers led to the signing of a contract in April 1984. Restoration work continued for more than a year, until the first Council meeting was held on 6 December 1985, the last in BMA House.
having been on 4 October of that year.

Improvements have continued to be made over the years and the building has been regularly refurbished. The expansion of the departments of the Association, the inclusion of other societies and the relentless increase in membership have meant that, for some time, 9 Bedford Square has seemed less and less adequate in size for the task intended. Perhaps the most important factor has been the increasing demand for the very high quality seminars. Putting some of these ‘back to back’ (having the same material presented on two subsequent days) initially helped but even these have been overwhelmed.

The future. 21 Portland Place has roughly twice the floor space and will accommodate the Association staff in greater comfort. There will be opportunities for greater numbers of members to participate in seminars and other meetings and catering for these will be much more efficient.

The next edition of Anaesthesia News will feature an article on the new premises. The information for this review of 9 Bedford Square has been gleaned from Tom Boulton’s excellent historical book, published in 1999. Copies are still available.

The flag comes down.
Cheers?

A flood of one letter (Frankie Dormon, page five) has arrived this month concerning the new contract. Clearly, Dr Dormon and her colleagues have thought about the proposed deal and have some concerns. Has nobody else? For some time now, we have been led to believe that the BMA was about to produce a magic rabbit out of the Government’s hat, one with which it would be foolish not to run. Well, now it’s out. It will be of no surprise to anyone, surely, that the proposals on which we must vote are a curate’s egg. But will the curate find more bad bits than good?

The Association is shortly to produce a response to the proposals but a sneak preview would suggest that the overall impression of the BMA’s efforts would be “could do better”. Consultants will view the proposals differently, depending on their age, seniority, retirement plans, academic work and private practice and, although would-be consultants will welcome the disappearance of the ‘seven year rule’, there are extra sessions to be worked.

The working week has been extended to 40 hours but we are expected to be grateful because, apparently, most consultants are working 48 hours at least. Pay progression has been handled and, once certain criteria are met, will be automatic. Fair, surely? Well, no. Progression will be more in the hands of management and anaesthetists, already disadvantaged by the Merit Award system, will find that differentials with surgical colleagues of equal seniority will be perpetuated.

On call duties and other out-of-hours work have been considered and progress made with the former but not with the latter where sense may prevail only after several more years. It will take 20 years for a new consultant to get a reasonable pay deal, if these figures are correct. Consultants resident on call at night (the CROCs) will attract a rate just greater than day time. The CROCs will snap at that, I’m sure. Although the good news is that trusts will no longer be able to offer (insist on) their own contracts, the bad is that local managers will still reign supreme. They will influence basic pay and higher awards and departments already viewed as the bad guys (stopping work getting done for the ridiculous reason of patient safety, for example) will be further put upon.

But, as Dr Dormon and her colleagues infer in her letter, the definition of the working week (0800 to 2200 in the week and 0900 to 1300 at weekends) is what really irritates. When we stagger in on a Sunday morning for yet another orthopaedic trauma list and some administrative muck-up occurs, will the Chief Executive be at his desk to deal with the problem? I think not.

When the Association’s document hits your doormat, please read it well and comment. Letters to Anaesthesia News will be welcome and, together, we will calculate the number of cheers (0, 1, 2 or 3) we can award the BMA.

John Ballance
**Letters to the Editor**

**True**

I read with interest the letter from Robin Weller (Anaesthesia News, June 2002). I must confess to not understanding about 86.3% of it, as I live and work approximately 106.3 and 98.5 miles (respectively) from Bristol.

One point I wish to take issue with is Dr Weller’s description of nitrous oxide as “the only true gas”. Unless it has recently become climatically much warmer in the West of England, or their hospital has over-enthusiastic heating, nitrous oxide will be below its critical temperature. It is therefore technically a vapour, until it has warmed to almost (normothermic) body temperature.

It is beyond question, however, that it is the least expensive volatile agent available, allowing one to use lower quantities of the more expensive ones in combination with it, to achieve the same effect. Yours, in thoroughly irritating pedantry.

*Jeremy Weinbren, London*

---

**I’ll drink to that!**


“The vomiting which is due to ether usually begins before consciousness has fully returned and lasts for hours or even days. Those cases which suffer from persistent vomiting are often relieved by having the stomach washed out with a warm, alkaline solution. They are usually intolerant of fluids by mouth but they will retain champagne or ginger ale.”

*Dr Anthony Kitsberg*

Consultant Anaesthetist, Chase Farm Hospital

---

**SERVICE**

The celebrations and reporting that surrounded Her Majesty’s Jubilee was widely appreciated. The words of the Archbishop of Canterbury at the Service of Celebration and Thanksgiving in St Paul’s Cathedral were, or should be, very applicable to the medical profession. Ours is a profession dedicated to service to others. The Archbishop said, “To contemporary ears, ‘service’ can sometimes sound a cold, teeth-gritting sort of word. Something better avoided if something less demanding, more self-serving is available”. He went on to say “... that real greatness finds its fullest expression in serving others”.

Medicine is undoubtedly a great profession and I count myself enormously fortunate to have had the opportunity throughout my professional life to serve others. Repayment, either in money or gratitude, has not always been munificent but the opportunity to serve has been constant and the reward of knowing that one was, hopefully, helping one’s fellow man has been more than sufficient reward.

I wonder sometimes, when I read of the endless demands made by today’s doctors for more leisure, less work and more money whether they ever pause to consider how tremendously fortunate they are to be part of a profession dedicated to serving others. If serving others cannot or does not provide them with the joy and satisfaction that I have always found, I fear they should never have become doctors in the first place.

*Dr John S M Zorab*

Consultant Anaesthetist Emeritus

---

**Lullaby**

As usual I enjoyed the June edition of Anaesthesia News although I was disappointed at your choice of correspondence. Dr Weller’s letter from Bristol may have been extremely funny to anyone who knew what he was on about but those outside that select band (i.e. most of your readership) would have been baffled by it. Please keep departmental teasing off your letters page and leave room for the weightier issues facing today’s anaesthetist.

Speaking of which, I believe I have identified another reason for the poor public image of anaesthetists which so frustrates National Anaesthesia Day organisers. Perhaps your readers (particularly those with a paediatric interest) are familiar with a children’s TV programme called Hilltop Hospital which is currently shown in the early afternoons. A sort of Doctor in the House for the under fives, this animated programme concerns events at a small DGH staffed by various loveable animals including Dr Matthews the dog (a keen trainee), Kitty the cat (a lovestruck nurse) and two teddy bears (the porters). The most dynamic character is Surgeon Sally, an overbearing but technically gifted hippopotamus who attracts admiration from all, particularly her canine trainee. All well so far.

Of particular concern to our speciality must be the portrayal of the anaesthetist, an elderly, myopic tortoise called Dr Atticus. He is shown in a very poor light: nodding off during operations unless he is regularly fed biscuits, accidentally inhaling his own vapour and, worst of all, obeying an instruction from Surgeon Sally to “pass the gas!”.

There is no mention of pre-operative assessment, audit, critical care, acute/chronic pain relief or resuscitation. Luckily, I was able to counteract this negative stereotyping by giving my three year old daughter an extended tutorial on the role of the anaesthetist in hospital practice today, during which she became much more contented and indeed fell asleep.

I leave it to my colleagues to decide what action we should take. Perhaps a rival cartoon series produced by our own speciality is required.

*Paul Edgar, SpR, Newcastle*
**Whose fault?**

It would be regrettable to start an age versus youth controversy at a time when all the profession needs to work together, but as one of Geoff Watson’s “ageing predecessors” I feel that at least a partial answer to his query could be given.

For years, long before the EU directives were mooted, improved training and shorter hours for junior doctors were being sought and in anaesthesia consultants and trainees worked together to achieve these aims. The Junior Anaesthetists Group (as it was originally called) has been constructive and responsible, unlike their more strident representatives in the BMA. What always surprised me though was that so many juniors took a very short-term view and failed to see that they were improving their own lot at the expense of the consultants. New consultants are now inheriting a situation they helped to create for, unlike trainees, consultants’ contracts are at present open-ended. It is not the fault of “ageing predecessors” that the EU directive has exacerbated the problems.

Doctors sometimes forget that medicine is not the only profession where young people gain experience by working long hours, sometimes for modest pay. Many accept this as an investment in their future careers and are prepared to do so for a limited number of years if they see their ultimate post as worthwhile. Dr Watson clearly thinks it is not, so perhaps instead of laying blame he should join the battle to improve things, lest he becomes one of the next generation’s “ageing predecessors”.

-- Aileen Adams
Cambridge

It has been customary for the chairman of the Primary FRCA examination to make a short speech to the successful candidates, after the results have been announced at the end of each day’s examining. Successive chairmen have sought to encourage career progression by these young doctors and have extolled the virtues of joining the AAGBI and GAT in particular. My task was made easier recently when the enclosed came into my possession. I take it that this is the new GAT handbook. If so, can I rejoin GAT?

-- Paul Cartwright, Derby

**Give us a break!**

Regarding the new contract, many of my colleagues are worried that the public will think that we are being churlish not to accept loads of money for just a little tightening up of our freedom. However, I have just one clear message. I cannot accept a contract that states that working from 9–1 on a Sunday is exactly the same as working from 9–1 on a Monday.

Of course, there are other issues, like I may be working in your hospital on that Sunday etc etc but it is easy to become bogged down in too much detail This is a simple fact!

-- Frankie Dormon, Poole

SEND YOUR LETTERS TO
The Editor, Anaesthesia News, AAGBI, 9 Bedford Square, London WC1B 3RE or email anaenews@aagbi.org
The GAT ASM 2002 Keele

To the accompaniment of Beckham’s boys brushing aside opposition in the World Cup, the 35th GAT ASM delivered a scientific and social programme of the highest quality. The meeting opened (following a nail biting 0-0 draw with Nigeria) with a session on intensive care. Dr Stenhouse began with an honest, concise and persuasive description of outreach intensive care medicine which tied in well with the third lecture of the morning by Dr O’Dea, who outlined how ITU had changed dramatically since the 1970s and would continue to evolve in the future. Sandwiched between these two was Professor Mythen’s highly amusing tales of frozen baboons being sent to Mars and scrapes with the tabloid press. He also managed to squeeze in enough evidence to convert even the most stern of cynics to the advantages of using balanced intravenous fluids instead of saline based fluids.

This was followed by an extremely informative and relevant obstetrics session. Mr Young put the rise in caesarean section rate under the microscope. Dr Howell gave a superb evidence-based account of the effects of epidurals on obstetric outcome. Dr Bogod gave us the benefit of his wide medicolegal experience. Unfortunately, despite the excellent standard of all the lectures, none came up with a sound, evidence-based argument enabling us to refuse to site epidurals at 3 am — a huge personal disappointment.

The final session of the first day dealt with trauma and transfers. Dr Jeganath highlighted the need for more formal training in transfer of the critically ill patient. We had a superb account of experiences with the Sydney Aeromedical Rescue Team by Dr Thwaites, which served to highlight just how important teamwork, planning, communication and leadership skills are in the successful, safe running of a rescue team. It was also rather nice to discover from Dr Jones and Ms Dormaz that there is a perfectly good (arguably better) British alternative to ATLS for trauma management.

The following morning, the President of the Royal College of Anaesthetists addressed a packed auditorium as the first speaker in the Examinations and Education session. Professor Hutton provided a unique insight into dramatic potential changes to our training and the political motivations that lie behind them. He outlined the background and content of some of the recent documents that have come from the Department of Health and the Specialist Training Authority: in particular the Medical Education Standards Board document and the shortened CCST document, respectively. He encouraged delegates to visit the RCA website, www.rcoa.co.uk, on a regular basis, since all new documents affecting training and the College response to them, are posted for us to view and make comment.

The remainder of the session was extremely entertaining and light-hearted. There were many hilarious and useful tips for Power Point presentations (animated with a slightly dubious air guitar demonstration) in a superb talk from Dr Harrop-Griffiths.

Dr Bricker gave a highly informative talk on the evolution of the exam. Then, having amused us with some secrets from the other side of the exam table, he finished with encouraging words for future FRCA candidates.

During the AGM, Dr Sarah Harries was elected for a further term as chairman of the GAT committee and four newly elected members, Drs Dick, Whyte, Bahlmann and Hunt, were welcomed to the committee. The trainee conference opened with a lively and competitive debate between Drs Aveling and Bogod on ‘Midwives should be trained to site epidurals in labour’ which was defeated. This was followed by a sobering comprehensive overview of the effects of the imminent European Working Time Directive by Dr Maguire (BMA Junior Doctors Committee).

The conference finished with an informal discussion led by Dr Nevil Hutchinson. The main topic of discussion was the shortened CCST document published by the STA. It became clear that many delegates were unaware of the existence of this document and the enormous implications for our training and ultimate career paths therein. Delegates were encouraged to visit the association website at www.aagbi.org/trainee, to view the MESB and STA documents, in addition to the response to these by the GAT committee and the Royal College of Anaesthetists.

The submissions for the registrar and audit prizes were of an extremely high standard and congratulations go to Dr Twigg who won the registrar’s prize for ‘a randomised evaluation of the performance of single use laryngoscopes in simulated easy and difficult intubation’ and to the audit prize winner, Dr Krishnan, for his audit on ‘postoperative pain: perception, realisation and management in a developing country’.

The Pinkerton Lecture is invariably a highlight of the GAT ASM and this year was no exception. Professor Routledge’s lecture on drug safety, using the analogy of the events leading to the sinking of the Titanic, was highly informative, compelling and, above all, alarming.

The penultimate session effortlessly removed a lot of the mystery surrounding some of the less common forms of modern monitoring and was followed, finally, by a lively debate concerning whether anaesthetists still have a role in A and E. The overwhelming view was that we do!

The workshops were of the usual high standard and our thanks to all the leaders who put so much effort into the prepa-
ration and repeated presentation of each workshop. The TIVA workshop, organised by Professor Kenny, gave a superb introduction to the TIVA Trainer, which can be downloaded for a trial period from www.eurosiva.org.

The airway workshop, organised by Dr. Williams, provided plenty of opportunity for practising fibre-optic intubations, use of the ILMA and of the manuvent insufflator. By the end of the final workshop, the teams had the usual cabin fever that accompanies the six consecutive workshops on the trot at a GAT ASM.

As for the social side, well, it was quiet really. Apparently, there was a bucking bronco, the consumption of a small lake of vodka red bull, violent moshing and air guitar to a band who played God save the Queen better than the Pistols themselves, a troupe of performing balance artists from Leicester, clap press ups with a difference, a trip to Alton Towers and two all night parties for over 100 people in a 12 foot by 6 foot room – but we don’t remember any of this.

Robbie Williams’ home town did us proud. So, thank you once again Elis Hughes, Ian Smith, Jo Barnes (and her gang) and the people of Stoke for putting up with us.

Dr Jim Down, Honorary Secretary, GAT
Dr Catriona Connolly, Vice-Chairman, GAT

Writing for Anaesthesia News

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

Our contact details are: 9 Bedford Square, London WC1B 3RE. Telephone 020 7631 1650. Fax 020 7631 4352. Email anaenews@aagbi.org

Apology

The June 2002 Anaesthesia News contained an article by Dr Neil Adams, Honorary Secretary, History of Anaesthesiology Society, reporting the 5th International Symposium on the History of Anaesthesia 2001. We omitted to acknowledge that a copy of Dr Adams’ article also appeared in the May 2002 issue of the Newsletter of the European Academy of Anaesthesiology.

NEAR MISSES

Near Miss Incident:

Another drug administration error

Description: A woman in labour requested epidural analgesia and an epidural catheter was sited uneventfully. The anaesthetist’s usual practice was to institute the epidural block with a bolus dose of 10 ml of 0.125% bupivacaine. This was achieved by diluting 10 ml of bupivacaine 0.25% with 10 ml of normal saline and a 4 ml test dose of this mixture was then administered down the epidural catheter. It was then noted by the anaesthetist that the 100 ml bag of what they thought was normal saline was actually 500mg of metronidazole (Flagyl). These bags are almost identical and the epidural trolley on the delivery suite had been accidentally stocked with bags of metronidazole instead of normal saline. The patient had therefore received approximately 10 mg of metronidazole epidurally. The epidural catheter was then flushed with 10 ml of normal saline and no further drugs were given. The woman had a normal vaginal delivery shortly afterwards.

Outcome: The woman was followed up for 72 hours and had no neurological symptoms and no untoward sequelae.

Action taken: The Data Sheet Compendium was consulted and, whilst metronidazole is not recommended for epidural administration, thankfully it contains no neurotoxic preservatives. The incident was fully documented in the patient’s notes and a critical incident form was filled in. The patient was given a full explanation of what had happened and was seen by a consultant anaesthetist daily until discharge from hospital on the third post-natal day.

Lessons learnt: Always check the contents of intravenous drug bags personally. Metronidazole is now kept in the refrigerator on our delivery suite, well away from bags of normal saline.
Pain Society Annual Scientific meeting, April 2002

This year’s Pain Society annual meeting took place at the Bournemouth International Centre from 9 to 12 April. With more than 850 delegates, it is clear that the meeting remains one of the most important events of the year for many pain specialists. As always, there was a packed scientific programme reflecting the diverse membership of the Society.

Acute pain services still fragmented
Research from Christine Wakefield, a pain management sister at North Manchester General Hospital, showed that, although it is over 10 years since the Royal College’s report into pain after surgery was published, some patients are still poorly served in terms of pain management. She conducted a survey of hospitals in the Northwest of England to find out how pain services in the region have developed since the report and whether those that exist meet its standards. She contacted 33 hospitals and carried out a telephone survey with a member of the pain team, achieving a remarkable 100 per cent response rate.

Her findings were varied. Twelve years after the report that was supposed to make pain management a priority, a surprising 19 per cent of hospitals that performed surgical procedures were still without an acute pain service. Where they existed, 40 per cent were integrated with the chronic pain service, although the staffing levels of the acute pain teams were wide-ranging. Three quarters of services ran at least one dedicated consultant session each week, although some ran as many as five sessions. Similarly, nursing staff time ranged from one to 3.75 WTE, with an average of 1.8 WTE. Most services (77 per cent) had no weekend cover from a member of the acute pain team but did have a link nurse system in place.

There was slightly more compatibility between hospitals on the types of pain relief available. Nearly all (98 per cent) ran a ward-based PCA and epidural service. However, intrathecal opiates were offered in less than half (48 per cent) of the hospitals surveyed. Acute pain services in the Northwest of England remain fragmented, concluded Wakefield and, despite the fact that integrated acute and chronic services seem to be gaining popularity, some of the services do not meet the standards set out in the 1990 report.

Search still on for best option for postoperative pain
As always, the question of what method of pain relief to use after surgery attracted many papers. Research from Christine Wakefield, a pain management sister at North Manchester General Hospital, showed that, although it is over 10 years since the Royal College’s report into pain after surgery was published, some patients are still poorly served in terms of pain management. She conducted a survey of hospitals in the Northwest of England to find out how pain services in the region have developed since the report and whether those that exist meet its standards. She contacted 33 hospitals and carried out a telephone survey with a member of the pain team, achieving a remarkable 100 per cent response rate.

Her findings were varied. Twelve years after the report that was supposed to make pain management a priority, a surprising 19 per cent of hospitals that performed surgical procedures were still without an acute pain service. Where they existed, 40 per cent were integrated with the chronic pain service, although the staffing levels of the acute pain teams were wide-ranging. Three quarters of services ran at least one dedicated consultant session each week, although some ran as many as five sessions. Similarly, nursing staff time ranged from one to 3.75 WTE, with an average of 1.8 WTE. Most services (77 per cent) had no weekend cover from a member of the acute pain team but did have a link nurse system in place.

There was slightly more compatibility between hospitals on the types of pain relief available. Nearly all (98 per cent) ran a ward-based PCA and epidural service. However, intrathecal opiates were offered in less than half (48 per cent) of the hospitals surveyed. Acute pain services in the Northwest of England remain fragmented, concluded Wakefield and, despite the fact that integrated acute and chronic services seem to be gaining popularity, some of the services do not meet the standards set out in the 1990 report.

Guidance expected on use of epidurals
The subject of how to use epidurals safely and what to do if they fail caused heated debate among delegates who called for guidance on best practice.

In a poster presentation, pain specialists from Milton Keynes General Hospital argued against the use of epidural (PCEA) analgesia in favour of simpler techniques that require less nursing time and resources. They looked at the analgesic outcomes of 38 patients who underwent total knee replacement and found that pain scores and movement were slightly better in the epidural group but only statistically significant on day three after the procedure. Although PCEA was the most effective method of pain control, other factors need to be taken into account in the clinical setting. PCEA was also the most expensive, time-consuming and management dependent technique used and simpler methods such as a spinal with a PCA may work just as well.

Dr Andrew Vickers, consultant in anaesthetics and pain management at Royal Lancaster Infirmary and chairman of the Society’s acute Pain Special Interest Group, admitted there was much confusion and uncertainty about how best to use epidurals. He promised that new guidance on the safe use of epidural analgesia after surgery was being compiled. The guidance is due to be appear in the next Pain Society newsletter and would be published after a period of consultation.

According to Dr Vickers, the guidance will address many of the issues pain specialists are uncertain about, such as where patients should be looked after, essential equipment, monitoring intervals, personnel levels required, protocols and audit.

Dr Jonathan Bannister, consultant anaesthetist at Ninewells Hospital, Dundee who led a discussion on epidurals, suggested that, if staff are dedicated and well trained, then epidurals can be used just as safely as wards on which they can be used in ICU or HDU.

New option for postoperative pain relief
In views of the findings relating to PCA opiates and epidurals, a new agent introduced at the meeting will be a welcome addition to post-operative pain relief strategies. Pharmacia launched parecoxib (Dynastat), the first injectable selective COX-2 inhibitor, at a satellite symposium. Parecoxib, the pro-drug of valdecoxib, is welcome because it avoids the major side effects that deter doctors from using traditional NSAIDs in many patients, said Dr Richard Langford, consultant anaesthetist and director of the Academic Anaesthetic unit at St Bartholomew’s Hospital in London.

“There are about 25 non-steroidal and they do a lot of good but they also have a significant downside. Although only a very small percentage of patients come to grief on NSAIDs, the adverse reactions can be very serious,” he said. “Deaths from NSAIDs in the UK fall between those from asthma and those from road traffic accidents.”

In the presence of inflammation, COX-2 is activated to synthesise prostaglandins involved in producing pain, more inflammation and fever, explained Dr Langford. The advantage of inhibiting just COX-2 and not COX-1 is that this does not disrupt platelet function or cause gastro-intestinal ulceration.

It is these side effects that deter doctors from using traditional NSAIDs immediately after an operation, especially in patients who...
have orthopaedic surgery, such as a knee replacement and are already at increased risk of bleeding, explained Dr Langford.

Studies in patients undergoing hip replacement, hysterectomy and dental surgery have shown that a single dose of parecoxib is as effective as a single intravenous dose of ketorolac (30 mg) and better than morphine (4 mg). It begins to act as quickly as these comparative agents (7-13 minutes) and its analgesic effect lasts at least as long. In addition, patients’ demand for morphine drops up to 36 per cent with parecoxib, reducing the risk of morphine-related side effects.

Despite the fact that pain units are now well established in most hospitals, up to 45 per cent of patients still suffer one or more episodes of severe pain after surgery, said Dr Langford and pain management after surgery is something that can still be improved upon.

“There are still major areas of unmet need in postoperative care. At least 30 per cent of our patients in day care are suffering ill-effects and there are areas where parecoxib will offer substantial benefit,” he added. “We now have a parenteral formulation of a coxib which is convenient and safer than the traditional NSAIDs.”

Poor pain relief has lasting effects
Medical journals regularly carry reports of how poorly pain is managed after surgery but little research has tackled how this affects a patient’s health once they return home. To redress the balance, Dr Eloise Carr, from the University of Bournemouth, looked at how pain after surgery had affected 85 women who had major gynaecological surgery. As well as assessing all the women for several outcomes from their notes, 37 patients were interviewed over the telephone four to six weeks after their operation. The results showed that most women reported significant pain immediately after surgery and, in a quarter, this was still present 10 days postoperatively. Pain control after surgery was clearly inadequate and led to psychological distress and sleep disturbance. Dr Carr suggested that better links between primary and secondary care and recognition of the full impact of poor pain control would help to improve patient outcomes after surgery.

Services may be forced to split to meet targets
On the issue of how services will develop in the coming years, Dr Andy Vickers predicted that, without a huge expansion of current pain teams, new targets being set for the provision of pain services will be almost impossible to achieve.

The Government’s new recommendations that patients should have to wait no longer than 13 weeks to see a pain specialist have slashed the previous target time in half and will push services to the brink, he said. On top of this, it is being suggested that pain services should provide a minimum of 15 consultant sessions each week for every 100,000 per head of population.

“For Morecambe Bay, the new targets would mean that we should have 50 consultant session every week – that’s a rise of 500 per cent from our current provision of 10 sessions a week. How are we expected to provide this expanded service?” asked Dr Vickers.

Nurses could play a bigger role in easing the pressure on pain services, especially as nurse prescribing gains momentum, suggested Dr Vickers, but hospitals are already struggling to fill nurse vacancies. The only way services may be able to expand to accommodate this level of provision may be to separate acute and chronic pain services.

“I am a great believer in integration of services but fear that a split may be forced on us by increasing demand,” said Dr Vickers. “Pain management programmes will come under increasing pressure to show that they are safe, effective and good value. We face a great responsibility to make sure that we set the future agenda, before someone else does.”
On route to New Zealand, I took the opportunity to work as a consultant anaesthetist in the Cayman Islands for three months. The Cayman Islands, also known as the British West Indies, are governed by Britain. They are located in the Caribbean and consist of three main islands, Grand Cayman, Little Cayman and Cayman Brac. The hospital is situated in George Town on Grand Cayman, the largest of the islands, being 22 miles long. The hospital is relatively new, having been completed in 1998. The hospital has 114 beds, an eight bedded combined ITU/CCU unit and three theatres in which over two thousand procedures are performed each year. The hospital serves a resident population of just over forty thousand, ten thousand of which are Cayman nationals and the rest are mostly Jamaicans, North Americans and Europeans, along with one million tourists per year, mostly from the USA. The nearest referral hospital is in Miami.

Before you can register for work in Cayman, you first need to have seven years postgraduate experience, be on the medical register in America, Canada or the UK and have a job offer. On arrival, I was met at the airport and a rental car and accommodation had been arranged for which 75% was paid by the hospital and the rest from my salary. Rental accommodation in the Cayman is expensive and generally costs in the region of two to three thousand pounds plus per month for an apartment / small house, whilst car hire costs around one thousand pounds per month. However, this is offset by having a tax free income thanks to King George III. It is said that the King was so grateful to some Cayman people when they rescued some sailors that he declared the island tax free. Food is also expensive as it is all imported, the exception being on full moon day when whopper burgers are 99 CI (Cayman Island) cents. Unlike in the UK a hospital parking permit is a bad idea as this increases your chance of being clamped especially if you have parked in a public area of the car park due to limited staff parking areas.

The anaesthetic department staff consists of three consultant anaesthetists, one nurse anaesthetist and one anaesthetic assistant. The job contract does not detail a job description or hours of work. However, by rough calculation, it works out to be just over 80 hours of work per week with 32 hours being fixed daytime commitments and 48 hours being on call after 4pm and weekends. The fixed daytime commitments include theatre lists, covering ITU and Maternity and running anaesthetic clinics. The clinics are particularly useful as they allow ten minutes of quality time to be spent with each patient. During this time I can assess each patient for anaesthesia, order any investigations which have not been done by the surgeon and answer patients’ questions about the anaesthetic. Any patient except emergencies not seen at clinic would not be booked for theatre. This process was very effective at minimising cancellations on the day of surgery.

The workload itself is very variable and includes anaesthetising all age ranges from babies upwards, giving sedation for all colonoscopies and gastroscopies and giving extradural steroids for pain patients. The patient population contains a high number of obese patients with many in the 120 to 180 kg range and, of these, a lot have both hypertension and diabetes and the same surnames. This provides many a challenge for cannulation and postoperative breathing. As there are no qualified ODPs, my job also entails being the ODP which includes preparing all anaesthetic and monitoring equipment. This does make me feel somewhat exposed if something untoward were to occur.

When on call, you cover Maternity (600 deliveries per year), ITU and provide anaesthesia for all emergencies. Some of the emergencies are private cases and this is a sore point within the department as, for reasons unexplained, you are not meant to charge a private fee. However, if one had private practice insurance, there is nothing in the contract to stop you charging. On call is covered from home and the workload varied but I would estimate that about 10% of the time is spent in hospital. Other services provided include ward based epidurals for analgesia. Unlike the UK, I also have to note everything that I use (equipment and drugs) for patient billing purposes.

As in most hospitals, there is a fair amount of politics and one common phrase you will hear at the hospital is “soon come”. I am at times surprised by the lack of some basics such as nasogastric feeding tubes and the apparent absence of quality assurance processes, with no audit, morbidity and mortality meetings and no anaesthetic critical incident reporting systems. However, I suspect all this will “soon come”. Probably due to the varied medical backgrounds of the medical
and nursing staff, many of the adopted practices are based on a mixture of American, Canadian and British practice. This might explain why adult breathing circuits are changed for each case but there are no bacterial filters to protect the anaesthetic machine. Even so, many patients view the hospital care as being about the best in the Caribbean. This might be due to the mostly consultant delivered service.

Outside work, the Cayman Islands have much to offer. The climate is hot all year long but prone to storms and the effects of hurricanes during the autumn. Grand Cayman is surrounded by clear, warm turquoise water. Among the attractions are the seven mile white sandy beach, a turtle hatchery / rearing centre, botanic gardens, blow holes and submarine trips. Cayman is also famous for its snorkelling and diving sites where one can hand feed stingrays and dive along reef walls which have sheer drops in waters with very good visibility or you can do some deep sea fishing. One of my favourite sites is Rum Point. This has a lovely sandy beach where music is provided several days a week and the water is crystal clear and shallow for hundreds of metres. Here, I am able to watch stingrays and large fish in the shallows and snorkel over the coral and many fish to the right of the pier. The island is also home to many endangered and unique species of plants, birds and wildlife such as the blue iguana, of which there are less than 200.

There are also many good restaurants and bars which have regular happy hours and, if you buy a drink at some of them, you can have as much food as you like in the evening for free! Both US and CI dollars are accepted in all stores. When driving on the roads, care needs to be taken as many tourists forget to drive on the left and this has resulted in several head on collisions. Also, when it rains the roads become flooded as there is no drainage system, apart from the natural porous drainage through the island. Outgoing telephone calls are particularly expensive, being about £2 per minute using public telephones to ‘phone the UK. However, you can book time to use the free internet facility at the hospital. This is in great demand and quite often you cannot get to the computer at your allotted time due to other work commitments.

During my stay, I have found the Cayman people very friendly and I have been able to experience a different environment for providing anaesthetic services. The outdoor life is fantastic and a welcome change for three months.

Dr M Holt FRCA,
Consultant Anaesthetist, Grand Cayman
Mersey School Anaesthesia and Peri-operative Medicine

FINAL FRCA EXAMINATION

SAQ Weekend Course
6pm Friday October 18 to 4pm Sunday October 20

MASTER CLASSES IN STYLE AND TECHNIQUE AND SUPERVISED PRACTICE AND ANALYSIS

£275

Limited to twelve

FOR DETAILS OF AVAILABILITY, VENUE, ACCOMMODATION AND THE REST, PLEASE CONTACT MSA@rlbuh-tr.nwest.nhs.uk

NORTH BRISTOL NHS TRUST FRENCHAY HOSPITAL

ANAESTHESIA FOR DIFFICULT LOCATIONS, DISASTERS AND DEVELOPING COUNTRIES

11-15 November 2002

A five day non-residential course intended for those interested in anaesthesia in developing countries or involved in anaesthetic planning for military and disaster situations.

This course has the approval of the Royal College of Anaesthetists for 25 external CME credits.

COURSE FEE: Non-residential £325

APPLICATIONS: forms and further details from:
Dr Claire Jewkes Consultant Anaesthetist and Course Director Department of Anaesthesia Frenchay Hospital, Bristol BS16 ILE.
Direct Line: 0117 970 2020
Mersey School Anaesthesia and Peri-operative Medicine

PRIMARY FRCA BASIC SCIENCES

THE MERSEY SELECTIVE

A COURSE TAILORED SPECIFICALLY AND ONLY FOR CANDIDATES SITTING THE PRIMARY EXAM IN THE WINTER 2002

The course is concerned to cover some of those areas of the syllabus considered to require special attention and elucidation, the aim being to explain and to simplify.

Verbatim extracts from the feedbacks of the Mersey Selective, June 2002:

“The course has shown me the level of knowledge that I would need to acquire to pass the Primary FRCA”

“...some of the lectures have clarified difficult concepts and elusive topics e.g. Pharmacokinetics and Statistics”

“I realised what I am expected to know”

“This was a well organised course in so much as to let me know just how much more I really needed to know prior to the exam”

“A lot of very difficult topics were extremely well covered”

“Basic principles were well explained”

“I did a primary science course in... and I have to say I found this course a lot more beneficial”

“The idea of selecting topics is a very good one”

“It is an excellent course which has given me a message to work harder and made me understand certain topics...”

“Many difficult areas that are poorly covered in textbooks are explained very clearly and patiently, dispelling many myths and misconceptions you infer from textbooks”

“This course has made me realise that I do not know as much as I thought I did and the depth that is required”

“I commend each and every tutor for making the effort in ensuring that we understood the topics covered”

“Enjoyable well run course, encompassing areas not well covered or dispersed over various texts”

“Excellent course. It gives us direction and content. Aware of how much more we have to work”

“I thought the course was very well organised and covered the majority of the difficult topics from the syllabus and made me aware of what areas I need to pay particular attention to before the exam”

Monday September 30 – Friday October 4

£350

It is emphasised that the course will only be of real benefit to trainees who are seriously approaching the threshold of the examination.

For details and application form (email only please)

MSA@rlbuh-tr.nwest.nhs.uk
DIFFICULT AIRWAY SOCIETY

ANNUAL MEETING

21 AND 22 NOVEMBER 2002

COMMONWEALTH INSTITUTE, LONDON, UK

A two-day meeting with national and international speakers, workshops, free papers, posters, trade stands, annual dinner and good company

Programme
Views from the Royal College and the Netherlands on airway training
Focus on the laryngeal tube, Airway Management Device, Proseal LM
Airway management taught in simulators in the UK and Australia
Airway care in the resuscitation room – who should do it?
Quality management and fiberoptic intubation, Trachlight
Free paper presentations and posters, both with prizes

Free Papers (Deadline 13 September)
400 words, max 3 references sent to:
Dr Anil Patel, Anaesthetic Department, Royal National TN Hospital, Grays Inn Road, London WC1X 8DA.
anil.patel@rh.nthames.nhs.uk
Six free-paper abstracts may be published in Anaesthesia

Cost: £220 for DAS members, £240 for non-members, Dinner £35
Apply: Diane Wallis, DAS 2002, Anaesthetic Department, St Thomas' Hospital, London SE1 7EH, UK
diane.wallis@gstt.nthames.mhs.uk
Cheques made payable to ‘DAS London Meeting’
www.das.uk.com

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 inspire trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation.

Dr John Cole (Sheffield) was the first winner of the Evelyn Baker medal in 1998, followed by Dr Meena Choksi (Pontypridd) in 1999, Dr Neil Schofield (Oxford) in 2000 and Dr Brian Steer (Eastbourne) in 2001.

Nominations are now invited for the award to be presented at the WSM in January 2003 and may be made by any member of the Association to any practising anaesthetist who is also a member of the Association.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary by 4 October 2002.

Further information is available on the website www.aagbi.org or can be obtained from the Association of Anaesthetists (email: nancydobson@aagbi.org)

Association of Anaesthetists of Great Britain and Ireland and Royal College of Anaesthetists

INTAVENT RESEARCH FELLOWSHIP 2002

Applications are invited for the Intavent Research Fellowship. This Fellowship is available for one or two years to fund research in anaesthesia, intensive care, pain relief and training in research methods. The work should be undertaken in Great Britain and Ireland. Preference will be given to projects that involve predominantly clinical research. Projects that involve the application of basic science to anaesthesia must have clear clinical relevance.

Applications should be made on behalf of a Department of Anaesthesia in Great Britain or Ireland by an individual who is both a Fellow of the Royal College of Anaesthetists and a member of the Association of Anaesthetists of Great Britain and Ireland. Please note that it is not necessary to identify a proposed Fellow at the time of the application: the successful applicant will be required to appoint an appropriate individual to the post of Fellow and will be responsible for supervision and training of the Fellow. The Fellow must be an anaesthetist in training in Great Britain and Ireland.

Further information and application forms are available from: Nancy Dobson, the Association of Anaesthetists of Great Britain and Ireland, Direct Line: 020 7631 8807, or email: nancydobson@aagbi.org
Closing date for applications: Friday 8 November 2002
**Eastern Deanery**

**Clinical Fellowship in Regional Anaesthesia**

based at Addenbrooke’s Hospital, Cambridge and Queen Elizabeth Hospital, King’s Lynn.

Beginning February 1, 2003.

A one-year post for SpRs in Year 3/4 under the auspices of the NHS and University Departments. Incorporates opportunities for training in peripheral and central nerve blocks, research, audit and teaching. Approved for training by the Postgraduate Dean and the Royal College of Anaesthetists.

Interviews in late September 2002.

Further details from:
Dr MJ Herrick (Cambridge) 01223 217434
Dr NM Denny (Kings Lynn) 01553 613583
email: martin.herrick@addenbrookes.nhs.uk

---

**Newcastle Upon Tyne Hospitals NHS Trust**

**Anatomy and regional anaesthesia for upper and lower limb nerve blocks**

Organised by the Department of Anaesthesia, Freeman Hospital and the Anatomy and Clinical Skills Centre, University of Newcastle Upon Tyne.

A practical anatomy demonstration.
Discussion of techniques and equipment.
Two day eyes-on demonstration of techniques in the operating theatre.

Cost £450 includes course dinner on Tuesday night and refreshments.

Date of this course 9–11 September 2002.
This course is specifically designed for those with a knowledge of regional techniques and would ideally suit consultants, SPR 4-5 and permanent staff.

Further information from Donal Shanahan 0191 222 6969, Donal.Shanahan@ncl.ac.uk.
Course website: http://prat.ncl.ac.uk

---

**PAIN CLINIC PROCEDURES COURSE**

Dr SJ Dolin, St Richard’s Hospital, Chichester
Dr N Padfield, St Thomas’ Hospital, London

**A ONE DAY COURSE FOR THOSE WHO WOULD LIKE A CONCENTRATED BRIEF EXPOSURE TO PAIN CLINIC PROCEDURES**

- Small group teaching (maximum of eight participants);
- Classroom-based teaching of indications, complications and evidence base of commonly performed pain clinic procedures;
- Practical demonstrations of a selection of:
  - Radiofrequency lumbar facet denervation
  - Radiofrequency cervical facet denervation
  - Radiofrequency trigeminal ganglion lesion
  - Sympathectomy (RF/chemical)
  - Coeliac plexus blocks
  - Cervical epidural
  - Nerve root injection
  - Thoracic epidural
  - Stellate ganglion block
- Five CME points;

**PRICE:** £125 to include lunch and refreshments
**DATE:** Thursday 3 October 2002
**LOCATION:** Day Surgery Unit, St Richard’s Hospital, Chichester
**CONTACT:** Pain Relief Department 01243 831475 or Email: pain.clinic@rws-tr.nhs.uk

---

**THE ASSOCIATION OF ANAESTHETISTS of Great Britain and Ireland**

**DEPARTMENTAL PROJECT GRANT (up to £25,000)**

The grant is to enable a department of anaesthesia to pursue a research project, either by the purchase of equipment 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 Nancy Dobson, Association of Anaesthetists of Great Britain and Ireland, direct line: 020 7631 8807 or email: nancydobson@aagbi.org

Closing date for applications: 15 November 2002
Association Educational Awards are only open to members of the Association of Anaesthetists of Great Britain and Ireland.
THE TORBAY PERICRITICAL CARE DAY

Friday 13 September 2002
The Toorak Hotel, Torquay, Devon

Organised by Dr M Mercer, D Golightly and Dr M Swart.
5 CME points accredited.
An interactive multiprofessional meeting covering:

- Patient Risk Assessment
- Early Warning Systems
- The ALERT Course and ICU Education
- Outreach
- Latest Political Developments

Faculty including:
Dr David Goldhill, The Royal London Hospital
Dr Vicky Osgood, Queen Alexandra Hospital, Portsmouth
Mavis Spencer, NHS Modernisation Agency

Day delegate: Nurse £40, Doctor £60
Day delegate and evening meal/breakfast/accommodation: Nurse £90, Doctor £120

Costs include lunch and use of extensive leisure facilities

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

Oxford Difficult Airway Workshops

6th Oxford Difficult Airway Workshop
St Catherine’s College, Oxford University
Wednesday 16 October 2002

7th Oxford Difficult Airway Workshop
St Catherine’s College, Oxford University
Wednesday 12 March 2003

The Difficult Airway Workshop is for trainees and consultants wishing to refresh and update skills in managing patients with a difficult airway. The course aims to discuss the management of the anticipated and unanticipated (including the can’t intubate, can’t ventilate) scenarios. There are lectures, videos and interactive discussions, and over two hours of hands-on workshops to reinforce the theory and to refine manual dexterity.

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

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

Course organisers:
Dr Mansukh T Popat and Dr Stuart W Benham

Registration fee: £150 Recognised for 6 CEPD points

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

Journals and Textbooks Wanted

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

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

This generous gesture has been greatly appreciated by the recipients, many of whom have no access to any other literature. More donors are now required and it is hoped that other readers will wish to do the same. Textbooks that are surplus to requirements are also badly needed and would be greatly appreciated. The WFSA maintains a list of those anaesthetists in the developing world who have requested literature. If you feel able to help, please contact Dr RJ Eltringham, Literature Distribution Committee, World Federation of Societies of Anaesthesiologists, Floor 8, Imperial Square, 15-19 Kingsway, London WC2B 6TH.
Regional Anaesthesia Course  
**Tuesday 17 September 2002**

Eyes on course with demonstration in theatre (via video link), workshops and lectures.
Upper and lower limb blocks.
Interpleural blocks.
Psoas compartment blocks.

For application form and programme, please contact:
Shirley Robson, John Hammond Department of Anaesthesia, East Surrey Hospital, Canada Avenue, Redhill, Surrey RH1 5RH. Tel: 01737 768 511 ext. 6046.

---

**COMPROMISED AIRWAY COURSE**

*October 10 and 11, 2002*

Department of Otorhinolaryngology and Department of Anaesthesia and Critical Care, Leicester Royal Infirmary

**Aims:** This course is aimed at medical staff involved in airway management.

**Day One:** Lectures and tutorials on the pathophysiology of airway compromise. Tutorials on assessment and management of compromised airway, including techniques of surgical and percutaneous tracheostomy.

**Day Two:** Practical demonstrations and hands on experience in performing surgical tracheostomy, percutaneous tracheostomy on cadaver specimen. It will also include difficult intubation on dummy models, as well as modules using simulation of clinical scenarios.

**Course fee:**
Day one only £100 (incl. lunch, refreshments and certification).
Both days £300 (incl. practical hands on session, course manual, lunches, refreshments, course dinner and certification)

Further Information and application form from:
Mrs Tina Craig, Course Co-ordinator, Clinical Skills Centre, Leicester Royal Infirmary, Leicester LE1 5WW.
Tel 0116 258 6123, Fax 0116 258 6123
email Tina.Craig@uhl-tr.nhs.uk

---

**St Mary's Anaesthetic Rounds and Training Seminars**

**SMARTS XI: RECENT ADVANCES IN PAIN MANAGEMENT**

*Friday 18 October 2002*

Education Centre, 2nd Floor, Mint Wing, St Mary's Hospital

0900–0925 Registration and Coffee
0925–0930 Welcome Address
Dr M Platt, Consultant Anaesthetist – St. Mary's Hospital
0930–1000 Pain Management in Obstetrics
Dr S Ward, Consultant Anaesthetist – St. Mary's Hospital
1000–1030 Pain and ITU
Dr N Moore, Consultant Anaesthetist – Glenfield Hospital Leicester
1030–1100 Coffee and Trade Exhibition
1100–1130 Upper limb nerve blocks
Dr W Harrop-Griffiths, Consultant Anaesthetist – St. Mary's Hospital
1130–1200 Lower limb nerve blocks
Dr S Gautama, Consultant Anaesthetist – St. Mary's Hospital
1200–1300 Lunch and Trade Exhibition
1300–1330 Palliative Care and Pain Management
Dr A Naysmith, Consultant in Palliative Care – St. Charles Hospital
1330–1400 Cannabinoids in Pain Management
Dr P Farquhar-Smith, Specialist Registrar – Chelsea and Westminster Hospital
1400–1430 Aspects of Chronic Pain Management
Dr M Platt, Consultant Anaesthetist – St. Mary's Hospital
1430–1500 Coffee and Trade Exhibition
1500–1530 ‘Capsaicin’ and Pain Management
Dr G Towlerton, Consultant Anaesthetist – Chelsea and Westminster Hospital
1530–1600 Management of Cardio/Thoracic postoperative pain
Dr S Jagger, Consultant Anaesthetist – Royal Brompton Hospital

For further information, please contact Dr Brian Dornan on 0207 886 6666 bleep 1440.

CME Accreditation applied for.
Applications are invited for a Research Fellowship tenable for up to two years.

Further information and application forms are available from the Association website: www.aagbi.org or Nancy Dobson, Association of Anaesthetists of Great Britain and Ireland, direct Line: 020 7631 8807, or email: nancydobson@aagbi.org

Closing date for applications: 18 November 2002

Association Educational Awards are only open to members of the Association of Anaesthetists of Great Britain and Ireland.

Advertising in Anaesthesia News

Anaesthesia News reaches over 8,000 anaesthetists every month and is a great way of advertising your course, meeting or seminar. Advertisements are accepted from anaesthetic societies and organisations, courses run by recognised ‘anaesthetic bodies’ and those judged to be of interest to members of the Association of Anaesthetists of Great Britain and Ireland and without obvious commercial intent.

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

<table>
<thead>
<tr>
<th>1 month</th>
<th>2 months</th>
<th>3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Page</td>
<td>£485</td>
<td>£650</td>
</tr>
<tr>
<td>Half Page</td>
<td>£250</td>
<td>£380</td>
</tr>
<tr>
<td>Quarter Page</td>
<td>£140</td>
<td>£190</td>
</tr>
<tr>
<td>Eighth Page</td>
<td>£85</td>
<td>£110</td>
</tr>
</tbody>
</table>

The prices are exclusive of VAT which is charged at the standard rate unless a valid VAT Exemption Certificate can be submitted. Prices as at 1 May 2002.

Contact Nicola Heard on 020 7631 8805, by fax on 020 7631 4352 or e-mail nicolaheard@aagbi.org

BRITISH SOCIETY OF ORTHOPAEDIC ANAESTHETISTS

‘From the Cradle to the Grave’
Seventh Annual Scientific Meeting, Teesside

Friday 15 November 2002
5 CME Points applied for.

Further details available from:
Lisa Wake, Dr Susi Strang and Associates, BSOA Conference Office, Villa Farm Cottage, Newby, Middlesbrough TS8 0AE.

Tel: 01642 310022, Fax: 01642 324827
Last week a weighty tome from the NHS Modernisation Agency landed with an ominous thud on my desk. It included results of a patient questionnaire ‘Had an operation?’ I groaned inwardly. Surely not another exhortation to be more patient centred? A brief scan, however, revealed the recommendations to be entirely consistent with my own self-centred needs.

Apparently, the overwhelming desire of patients is for reduced waiting times. I could not agree more and look forward to wasting less of my time waiting for them to arrive at the hospital or come out of the toilet/bath/smoking room so I can see them pre-operatively. Waiting for the surgeon to arrive at the beginning of the list and put the last stitch in at the end are two more waiting times I would like to see reduced.

Patients would like a choice of transport to theatre and so would I. Rocket perhaps? They also request fewer cancellations. Well, fine – perhaps if the surgeons pulled their collective finger out, turned up on time and cut a bit faster we’d get more done in the time. Patients would like the ward staff to greet them, introduce themselves and explain what they are doing. That would be fantastic. In fact, just being able to find a nurse on the ward who knows what is going on would be an improvement.

The patients would like adequate time to read consent forms and the opportunity to ask questions. I’m all for this. Perhaps I could ask a few of my own. Questions such as, “Why didn’t you read this at home and at your leisure during the last two weeks?” “What was it that persuaded you to have sausage, egg and bacon for breakfast this morning, followed by your glibenclamide?” “Why did you get your tongue pierced with an Exocet missile yesterday when you knew you were coming to hospital today?”

Patients would like privacy for these discussions. Once again, I am in full agreement. Could I just add that it would be a real bonus if the cleaner did not need to Hoover vigorously under the bed at the time?

And all of this is before we have to obtain formal consent for anaesthesia. Can you imagine what it is going to be like then? I recently had to obtain maternal consent for a 12-year-old Albanian refugee having dental extractions. The consent form for dental anaesthesia consists of about two sentences, one about risk and the other offering choice of induction and further information. This took about half an hour to translate into Albanian and, at the end of this, the mother had one question. Did she have to come into theatre, as she was afraid she would pass out? At which point the erstwhile sullenly silent child interrupted angrily, “No! I don’t effing want her in there and I’m not having any effing needles either!” So I administered a gas induction and reflected ruefully on the local policy of placing refugees in poor housing developments.

I am becoming increasingly fed up with the need to provide more and more information to patients who so frequently decline to take any responsibility for their own health or treatment. This is not shifting the balance of power. It is shifting the balance of time and I have none to spare. The result, therefore, is that I am able to give fewer and fewer anaesthetics, which increases waiting times! Not quite the result the patients or indeed the DOH are looking for, I think you will agree.

Appreciating patients would also like a name of someone they can contact if they experience any problems after discharge. No problem, so long as it is not mine. I’m afraid I am already fully occupied learning how to introduce myself in Albanian over the sound of a Hoover!
Letter from Zimbabwe

Eye camps

In Zimbabwe our ailing government is reneging on its responsibility to provide medical care and our health service infrastructure has collapsed, even for essential services. Recently, one patient, after many hours of waiting, walked out of casualty and hung himself in the hospital grounds. One feels his reason was despair.

There is one area where patients are still cared for within the public health system. The government eye hospital functions for those that can afford it. In addition, private practitioners provide so-called ‘eye camps’. I was recently asked to join one of these, in a hospital at a small mining town 200km from Harare. The team went for two days, returning after a round on the morning of the third day. Because the first cases were being done under local anaesthetic for which I was not needed, I was asked to arrive in time for supper on the first day. I took a friend to help with the driving. It was a beautiful drive, with the last 90km on a side road that went through erstwhile commercial farming land. It was sad to see huge fields of weeds.

We found the hospital easily enough. Outside, a decrepit machine was boring for water. Inside was very empty. We learnt that the hospital had belonged to the mine which was now closed. Some of the services were being kept going by staff from a Mission Hospital in the area. We found the theatre by following two blind men being led by hand by an orderly. It was a hive of activity with two tables and twenty cataracts completed. We were told where to find our house for the night and the children for surgery the next day. The house was clean, had a wonderful view, but not a drop of water in the taps. A bucket of water was brought. The surgical ward was staffed by one Nurse Aid, busy discharging the cataracts to the care of their relatives. I was waiting for help with my pre-op round when the night sister arrived. She was Malawian. I played my trump card and asked if she knew Dr Fenton. “My husband’s greatest friend”, she assured me. I was in.

The next morning I got to the theatre early. They were cleaning as the water was ‘on’ for an hour. All the towels used the previous day and ‘disposable’ gloves, provided by the eye surgeons, were being washed and put out in the sun to dry. They would later be re-sterilised for general cases. How do you run a theatre without water, I wondered. Each eye patient had a new pack with essential sutures and syringes, provided by donors. The instruments were chemically sterilised and reused. There was an urn of water from which an assistant let out a few drops to rinse off the Cidex. The surgeons wore the same gown all day, changing their gloves for each patient. I was assured the patients were followed up by an ophthalmically trained nurse and there was no infection. I found not being able to wash my hands very trying and surreptitiously used the hot water left over at teatime.

The worst moment was when one of the Mission Doctors appeared and said he must interrupt to do an emergency Caesarean section. I agreed to give the anaesthetic. The spinal went in all right but the drip was pulled out as the patient was positioned. The elderly blood pressure machine then failed. At this point the surgeon, knife in hand, looked at me enquiringly and said that we would now pray. I thanked God fervently for the old fashioned monitor of a finger on the pulse. It was a bloody procedure and, afterwards, all I wanted was a shower. We decided to leave the others, even though it was late, and make for the nearest town which has a motel. The Landrover had not got over its incarceration by the police at the time of the election and was stalling. We shot up the twisty entrance to the motel with considerable relief: that bath was bliss.

We read of Eye Camps worldwide. Here is a challenge to surgeons out there – what else can be done under local anaesthesia? How about a Hernia Camp?

Ruth Hutchinson
Rhutchinson@healthnet.zw