On Wednesday 19 March, at the Anniversary Dinner of the Royal College of Anaesthetists, shortly after his ninetieth birthday, the Sir Ivan Magill Medal was presented to Professor T Cecil Gray. The dinner was held at the Institute of Electrical Engineers and Professor Gray and his wife were Guests of Honour.


In a moving speech, Peter Wallace, President of the AAGBI, completely surprised Professor Gray, in the presence of Professor Peter Hutton, President of the Royal College, Cecil’s wife Pamela and his son Dr David Gray.

The picture here demonstrates the joy of the occasion and the staff of Anaesthesia News joins Council members and all at the Association in congratulating Cecil on this achievement.
Vascular Anaesthesia Society of Great Britain and Ireland

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

CALL FOR ABSTRACTS
- CASE REPORTS
- AUDIT
- RESEARCH

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

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

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

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

Closing Date: 4 July 2003
Editorial

Reflections

Well, it’s happened. My changing room locker door is swinging open and my clogs will be auctioned off. I’ve noticed I’ve had a ‘minder’ with me for the last few lists, fortunately one of our better looking (female) SHOs. Yes, I may be retired but the sparkle is still there!

Time, perhaps, for some reflection on change. Change in the way the wonderful NHS has evolved, if that is the word and how this change has been reflected in the pages of Anaesthesia News.

The Naked Gasman (I’ve found out why he’s called that but money will have to change hands) has, as always, a perceptive eye. Who can forget signal flags up the drip stand and he’s bang on target this month with a blast at the consultant contract. Apart, perhaps, from the purchaser/provider split in the days of the Iron Lady, this must be the most divisive topic to hit the medical profession in my career. Sadly, I leave the NHS with the matter still uncertain.

The subject of awards and rewards for anaesthetists continues to be hotly debated and is, as yet, unresolved. We continue to be disadvantaged when compared to other specialities, although the Association has been trying long and hard to get the situation reversed.

The back page Zimbabwe column and, before that, Paul Fenton from Malawi have been a constant source of inspiration, providing a balance between what we in the NHS regard as normal and what others in far flung corners struggle for. Through Roger Eltringham and the WFSA, we have also helped by sending literature out.

Being involved with the Association for some years has been rewarding and enjoyable. As Honorary Membership Secretary and, latterly, the Editor of this splendid organ, I have enjoyed being ‘behind the scenes’ when decisions were taken or policies made. I have been involved in the production of several ‘glossies’, at least one of which has had a major influence on operating theatre work.

The excellent seminar programme run by the Association and the Specialist Societies should be mentioned. These continue to make an impressive contribution to the sum of knowledge of members. The newest entrant, the Tricky Vein Society, although it ran into some trouble by refusing to admit trainee members, has demonstrated how useful it can be to pool knowledge, exchange skills and stimulate discussion.

Sadly, it has not all been good news. Most trusts seem to experience the general erosion of standards by some managers, in an effort to ‘get more through’. Pre-operative assessment by anaesthetists is constantly being challenged, although the Association has been in the vanguard in recommending the setting up assessment clinics.

I am happy that I have been asked to continue as Editor until the September edition when Stephanie Greenwell assumes the editorial chair. And then it’s out to grass, although there is an Old Boys Club proposed. I suppose it will be called a Retirees Forum or some such, in order not to offend the ladies (and the new Editor).

Like Bob Buckland in recent editions, I have my pipe and slippers at the ready.

John Ballance

Syringe Labelling

The International Standard for syringe labelling currently used throughout Australasia and North America has been recommended for use in the UK from 1 May 2003. Extra vigilance will be required during the changeover as has been highlighted in communications from the AAGBI and RCA.

It is not our intention to give guidance to individual departments as to how to effect this change. Each trust will have differing circumstances. It is important, however, for Clinical Directors and those responsible for risk management to set a date for changeover such that two systems are not running in parallel.

This should be effected as soon as possible. It is important from a safety point of view that units do not delay the changeover date excessively. In a few months time the manufacturers will cease production of the old labels.
The majority speaks out

Guy Routh’s recent letter in Anaesthesia News amply defines a problem which faces both the profession and indeed the Government. On the one hand there is a minority group of politically successful consultants who are actively involved in medical management and usually are in possession of a higher award. He is clearly one of them. Their position and generous remuneration reinforce their view that all is well in the world. On the other hand there is a majority of disgruntled and disaffected consultants who, despite years of service and dedication, have received remarkably little recognition.

The last sentence of his letter “...would like to see the system changed so that the majority rather than the minority get some sort of recognition...” makes my point perfectly. Such sentiments are all very well when the money is already rolling in month after month.

No prizes for guessing which group I fall into!

Dr Peter Hilton, Consultant Anaesthetist, Morriston Hospital, Swansea

Jehovah’s Witnesses... an opinion

I have recently been involved in the anaesthetic management of a Jehovah’s Witness patient. He was presented unconscious with a life threatening condition that required transfer to a neurosurgical centre for an urgent operation. The patient was carrying an Advance Directive prohibiting blood transfusion and his family confirmed their refusal to any blood and blood products, whatever the consequences. The family beliefs were respected and acknowledged.

The family and their representative expressed fear and sadness if their patient was unidentified as a Jehovah’s Witness and they suggested that all Jehovah’s Witness patients should wear warning bracelets to identify them in emergency situations. The number of Jehovah’s Witness population is more than 150,000 in Great Britain and Ireland, and scenarios similar to the one described here are not uncommon. In view of the extreme devastating consequences when a Jehovah’s Witness patient is not recognised and receives blood products, I would like to put forward the family point and welcome comments in this matter.

Sahir Rassam, SpR in Anaesthetics, Wrexham


Not Boott

I was hoping that someone would write in about Jim Down’s article in the December issue, but Dr Humble (Anaesthesia News, March 2003) has added an error of his own. The first ether anaesthetics in England were certainly administered at Dr Boott’s house in Gower Street, but by his near neighbour, the dentist James Robinson, not by Boott himself. Both sites are marked by blue plaques, which feature in the current display of commemoratives in the Association’s Museum.

David Zuck

An apology

Although correspondence under the title ‘Service’ has now closed, I regret that the letter published on page 4 of April’s Anaesthesia News has caused offence in some quarters. The decision to publish was mine and I apologise for any offence caused by it.

John Ballance

Self esteem

Anaesthetists today like to compare themselves to a Stalinist statue to the working class. Men and women together, proud and square-jawed, facing into the rising sun of new opportunities and challenges, supported by the dialectic of College and Association. Parading, applauded by the proletariat, saluted by our Beloved Leaders every National Anaesthesia Day. So it is good to be brought down occasionally by the worldview of others.

If you care to register on the Lancet website, you will be asked to indicate your medical speciality from a long list. It starts; Addiction, Allergology [Sic!], Alternative medicine, Anatomy, Cardiology, ...and so on down the alphabet. In fact, so far down the alphabet that after 37 possible specialities they begin to ascend again; Veterinary medicine, Urology, Tropical medicine, Surgery, Stomatology...

And, after 70 entries, there we are. Anaesthesia. The last but two of the specialities that the Lancet considers of interest and importance. And whom have we pipped at the penultimate post? Other and None.

So much for Stalinist triumphalism.

Dr Ruxton

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John Ballance
More Dangerous Than a Toaster?

During the current strike by the fire service, our hospital trust in common with many others has been extra vigilant about potential fire hazards. This has included the removal of all toasters from theatre coffee rooms, as they are usually the culprits for triggering the smoke alarm.

On one of the days during the strike we were doing a trauma list and, since the patient was elderly, we used a fluid warmer. A few minutes into the operation we smelt smoke and to our dismay discovered the fluid warmer to be on fire, with flames coming from the lead. Obviously it was immediately disconnected from both the electricity supply and from the patient who was fortunately unharmed.

On inspection, the fire had begun where the flex left the coil housing and in the opinion of our MEMO department was simply due to wear and tear. The equipment had been satisfactorily serviced three months previously but was old, with a warranty that had expired in 1993.

We are sure that our hospital is not alone in sometimes using kit that looks as if it came out of the ark. However, we felt it rather ironic that having been denied a morale-boosting slice of hot toast that morning we then had to extinguish a genuine fire caused by the spontaneous ignition of our ancient anaesthetic equipment!

Drs R Spencer and H Wellesley, Bristol Royal Infirmary

Happy birthday, Cecil

It was with great pleasure that I received the last issue of Anaesthesia News and read what John Zorab wrote about Cecil Gray, now 90 years old. Cecil had an important influence in Brazilian anaesthesia during the growing decades of the fifties and sixties. I still remember the time I spent in his department in 1962, a very profitable month for me, learning from him and Jackson Rees. We met many times after that, in different parts of the world and I have always enjoyed his friendship and easygoing ways.

Please tell him that we all wish him our warmest congratulations on his 90th birthday.

Professor Armando Fortuna, Santos, Brazil

SEND YOUR LETTERS TO
The Editor, Anaesthesia News, AAGBI, 21 Portland Place, London W1B 1PY
or email anaenews@aagbi.org

Now, listen

Dr Lanigan makes an eloquent case for examination of the heart and lungs by an anaesthetist as part of the pre-operative assessment (Letters, Anaesthesia News, March 2003). Surely it is a pity that he has to make a case at all, for something that should be taken as read?

I sometimes anaesthetise patients in an elective orthopaedic unit, where it is a well known fact that the heart exists only in order to pump antibiotics to the bones. The pre-operative assessment of ‘minor’ cases is somewhat limited, and the only person who listens (with any degree of interest) to either heart or lungs will be the anaesthetist at the pre-operative visit.

I would also suggest that another benefit of doing so is to help the public realise that anaesthetists are, first and foremost, doctors - a fact that sometimes escapes our patients.

Frances O’Donovan, Dublin

In response

This is in response to Dr Rex Yetton’s article which appears in the Anaesthesia News, April 2003. I have just been regraded to an Associate Specialist from Staff Grade. He mentions that “it will be difficult to regrade without the FRCA or equivalent as this is a College recommendation for appointment”. I would like to point out that it is NOT necessary to have the FRCA or equivalent to be regraded since I do not have either but have been regraded.

Dr M N Imam, Associate Specialist, Stockton on Tees
Training in Anaesthesia in the United Kingdom and the Republic of Ireland have been linked for many years through similar training and examination structures, and indeed through the Association of Anaesthetists of Great Britain and Ireland. Next year, we will, with the establishment of the European Register of Specialists, broaden these links to include the European Union as a whole, and see greater mobility within the speciality. With this in mind I will endeavour to outline training and accreditation procedures currently in operation in the Republic of Ireland.

Specialist Training in Anaesthesia, including Pain Medicine and Intensive Care is a seven year programme, organised and supervised by the College of Anaesthetists in Ireland, RCSI. The training consists of a minimum of two years Basic Specialist Training and a minimum of five years Specialist Registrar Training.

Basic Specialist Training

Basic Specialist training is carried out in hospitals recognised for a specific duration of training by the College. It is of at least two years’ duration and prepares the trainee for the College’s examination in anaesthesia, similar to the UK system.

Specialist Registrar Training

Specialist Registrar Training is carried out through a National Training Programme, incorporating all the major regional training centres and disciplines. Entry requirements include a minimum of two years basic training in either Ireland or the UK and the possession of the primary FCA or its equivalent. Success in a competitive interview secures a place. There are currently 86 SpRs in anaesthesia in Ireland.

During SpR year 3, trainees may avail of a number of training possibilities, namely research, academia, or specialist training either at home or abroad. Prospective approval is required from the College for this ‘year out’. This is a popular year with SpRs, with many completing MSc/MD, taking up teaching posts, or enhancing their specialist training, often in exotic climes far from the British Isles!

Trainees must complete at least 18 months of years 4/5 in Ireland. The College may however allow trainees to complete the final six months of training in an alternative programme approved by the College of Anaesthetists, RCSI. This differs from training structures in the UK.

Examinations

Fellowship in Anaesthesia comprises two parts: 1) Primary examination, after completing one year of BST. The examination structure is similar to the UK. 2) Final examination, after 30 months of recognised training. It consists of an essay paper, MCQ, VIVA and a clinical case.

Accreditation as a Specialist in Anaesthesia

This is similar to the UK system. The College will implement the issuing of:

• a Certificate of Specialist Training;
• recommendation to the Medical Council for inclusion on the Register of Medical Specialists.

Certificate of Specialist Training

This is awarded on completion of a seven year programme in anaesthesia training, which includes:

• five years at SpR level 4 which must be spent in Ireland;
• all the relevant examinations;
• a two month module in pain management;
• experience in two centres in pain management;
• one two month module and four one month modules in Intensive Care Medicine.

Register of Medical Specialists

The Certificate of Specialist Doctor (CSD) entitles the holder to inclusion on the Register of Medical Specialists in other European States. Applicants for a CSD must:

• be an EU national;
• be a graduate of an EU medical school;
• have completed satisfactory training in anaesthesia as assessed by the College of Anaesthetists, RCSI;
• have completed the major part of their training in the Republic of Ireland.

Specialist Training in Intensive Care Medicine

The Irish Board of Intensive Care Medicine holds an annual Diploma in Intensive Care Medicine. Eligibility to sit this examination requires either 12 months training in Intensive Care Medicine in recognised centres (minimum two month modules), or six months Intensive Care with six months experience in a complementary discipline. The examination consists of a written paper, MCQ, VIVA and clinical examination.

Specialist Training in Pain Medicine

The Irish Pain Society in conjunction with the College of Anaesthetists, RCSI holds an annual Diploma in Pain Management. The entry requirements are three two month modules in Pain Management.
New Courses
September 2003 sees the initiation of an MSc programme for post-fellowship anaesthetists. This will be a modular based programme, incorporating complex clinical issues, management skills, and medicolegal / risk management, and will be conducted as a distance based programme with occasional on-site workshops / lectures.

Useful contacts for further information on training, examinations or any other issue: The College of Anaesthetists, RCSI and the Irish Board of Intensive Care Medicine. Telephone +353 1 6614412. Website www.coairl.net

The Anaesthetists in Training in Ireland. Website www.iris-hanaesthesia.com

Further information will be available in the GAT Handbook which will be published in early Summer, 2003.

Ruth Fanning, SpR in Anaesthesia
Irish Representative, GAT Committee

UNIVERSITY OF OXFORD

Anaesthesia in Difficult Circumstances
Difficult Locations and Developing Countries
13–18 July 2003
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A five-day course intended both for those interested in anaesthesia in developing countries and for those involved in anaesthetic planning for military and disaster situations. The course will consist of lectures and clinical and technical demonstrations. Residential accommodation will be provided in St Catherine’s College.

TOPICS INCLUDE:
• Draw-over anaesthesia • Intravenous techniques
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Also see our website – www.nda.ox.ac.uk

You can write to the Editor at the following address
The Editor, Anaesthesia News, AAGBI, 21 Portland Place, London W1B 1PY
or email anaenews@aagbi.org

18 and 19 June, Team Training for Critical Incidents, for nurses and clinicians (£270)
8 and 9 July, 2 Day Paediatric Anaesthesia Critical Incident Day (GRL), for occasional paediatric anaesthetists (£275)
5 September, Medical Emergencies Course, for SpRs and consultants in Emergency Medicine, ITU and Anaesthesia (£200)
9 October Low-Flow Anaesthesia Course, for anaesthetists (£150)
14 October, NCCG Critical Incidents Day, for non-consultant career grade anaesthetists (£150)
16 and 17 October, Transport for the Critically Ill Course, for all grades (£275)
21 October, Paediatric Anaesthesia Critical Incident Day (GRL), for occasional paediatric anaesthetists (£160)
22 and 23 October, Team Training for Critical Incidents, for nurses and clinicians (£270)
30 and 31 October, Obstetrics and Gynae Course, for obstetric anaesthetists
3 November, Simulated Airway & Ventilation Emergency Course, for SpRs and consultants in Emergency Med, ITU and Anaesthesia (£150)
13 November, Mature Consultants Course, for mature consultants in Anaesthesia (£150)
14 November, Medical Emergencies Course, for SpRs and consultants in Emergency Medicine, ITU and Anaesthesia (£200)

Specific departmental courses can be arranged upon request (fee negotiable)
Includes coffee, tea, biscuits and lunch. CEPD points approved; five points (for one day) and eight points (for two day courses)
For bookings please contact Jane Southway, Secretary on Tel (0117) 927 7120 or Alan Jones, Centre Manager, The Bristol Medical Simulation Centre, UBHT Education Centre, Level 5, Upper Maudlin Street, Bristol BS2 8AE. Tel (0117) 342 0108, email alan@simulationuk.com; and/or visit the website at http://simulationuk.com (this contains course details).
Ann Arbor is a town in the USA with a population of 200,000 which encompasses the University of Michigan (U of M). The U of M Hospital ranks amongst the top ten medical institutions and represents one of the most advanced healthcare facilities in the United States. The Great Lakes State of Michigan is shaped like a hand. If you stare into your right palm, Ann Arbor, or A2 as it is affectionately known, is located around the great thenar eminence, south of your lifeline and only a twenty-minute drive from Metro Airport, Detroit which is your nearest major city.

Ann Arbor may be described as a sleepy university backwater yet it comprises the arts, golfing greens, excellent parks, shopping malls, gourmet restaurants and a wide variety of bars and microbrewery pubs. The college football team is one of the most famous in the country and their stadium the biggest in the States, accommodating in excess of 110,000 fans. It provides an excellent environment for families yet may be a little tame for pleasure seeking singletons. For real city excitement regular weekend pilgrimages to Chicago are a must.

The climate follows the seasons, yet is highly unpredictable. Tornado warnings in the spring, a hot and humid summer, a colourful fall and heavy snowfall in winter, sprinkled with the occasional hailstorm at nearly any time of the year.

We chose to take a year out, after completion of our fellowship examinations and prior to completing our CCST, to become Visiting Instructors in Anesthesiology. The post is usually for one to two years, which coincides with the maximum length of your newly acquired J1 work visa, special Clinical Academic Limited License and Board of Pharmacy Controlled Substance License. These licences are only valid for your institution of employment and enable one to practise without supervision and act in an ‘Attending/Consultant’ capacity. There is no need to possess any of the USMLEs (United States Medical Licensing Examinations) or Board Examinations for this job.

As Visiting Instructor you enact the decisive consultant role. In general you cover two to four operating rooms (ORs) and the buck certainly stops with you. In each OR your resident or nurse anaesthetist administers the anaesthetic whilst you guide, train or take over and act in a Big Brother capacity.

There is currently an acute shortage of anesthesiologists in the US. This should remain so for many years to come and offers plenty of opportunity for post-fellowship Specialist Registrars to work in a similar position at one of the many teaching institutions throughout the States. The job is pretty demanding and we would only advise experienced Registrars in the last two years of their training to consider it. The post is not a fellowship programme, however research and other projects are possible if motivated in this area.

At the University of Michigan, the main sub-speciality posts include cardiothoracics, general surgery, liver transplant with vascular surgery, obstetrics with plastics and burns, and paediatrics. The Visiting Instructor starting pack includes your own office, personal computer, secretary and an educational allowance of $6,000, which is usually spent on work conferences in locations such as California, Colorado or Hawaii. The administrative side requires that you simply ‘sign here’ a doorstep dossier of papers and essentially everything is then sorted out on your behalf. The effort involved is definitely worth it. There are no set starting dates - the Department of Anesthesiology is happy to accommodate you whatever time of the year. This may not be the case in other departments.

Accommodation is generally arranged via current rotators and ex-pat members on the Anesthesiology Faculty who rent houses at favourable rates and are readily prepared to guide you in the right direction. There are otherwise numerous letting agencies advertising properties on the web. Moving continent is initially expensive yet remuneration for the Visiting Instructor is excellent. In addition, the U of M provides an interest-free loan on arrival to help you get started. Some institutions in other parts of the States offer relocation expenses.
Be warned, the workday commences EARLY! The OR starts at 07:30 prompt and usually doesn’t finish before 17:00. All lines, epidurals etc need to be in situ prior to 07:30. Michigan State has the highest population of morbidly obese people in the US. The Michigan Unit, a weight measurement representing 300lbs, is common currency in these parts. The experience gained is invaluable. You learn skills from the new world, teach skills from the old world and after a three month adaptation period start to enjoy yourself tremendously.

What many don’t realise is that the Anesthesiology Resident programme is only three years duration in the USA. The Residents receive an intense training, however practically speaking they are at the level of a second year Specialist Registrar at best. They are usually a pleasure to teach and tend to look forward to being assigned to ORs covered by the ‘Brits’. Another point to note is that the typical US surgeon’s ego is significantly bigger than that of his/her typical UK counterpart. They also often have significant influence on the way a patient is anaesthetised, so be prepared to bite your tongue and put things down to cultural differences.

The American medical system is completely different to that in the UK. Fortunately, the U of M routine is simple. Elective patients are usually ‘assessed’ over the telephone and are then reviewed pre-operatively in the holding room — an area like recovery where the pre-op procedures are also performed. There are no anaesthetic rooms, so the patient is anaesthetised in the OR. Postoperatively, they are wheeled to the Post Anesthetic Care Unit (PACU), i.e. recovery. Here the management of patients is already largely run by the surgeons. All patient notes are computerised and accessible from computers throughout the hospital. They can also be accessed from your home PC via the internet.

The Visiting Instructor programme at the U of M has been established for many years. The Rotators form a welcoming ex-pat community within Ann Arbor. Every effort is made to ease the transition from UK to US living. The natives are friendly, the experience is fantastic and we would, without hesitation, highly recommend a year or more in the States to any future interested parties.

Chris Seifert, Specialist Registrar, Southampton
Alex Bullough, Specialist Registrar, Oxford

Groups of Anaesthetists can continue to care for patients

The Office of Fair Trading (OFT) has just announced the results of their 14-month investigation into 10 groups of Anaesthetists who were alleged to have contravened section 2(1) [the Chapter 1 prohibition] of the 1998 Competition Act. Six groups (Southampton Anaesthetic Services, Norwich Anaesthetists Group, Morriston Cardiac Anaesthetic Group, Tunbridge Wells Group of Anaesthetists, Fylde Group of Anaesthetists and Guildford Anaesthetic Services) were totally cleared of acting against the public interest. In the remaining four cases, who have not been named, but had more complicated arrangements, there was considered to be insufficient evidence that they were acting against the public interest and files have been closed.

The full report can be found at www.oft.gov.uk/Business/Competition+Act/Decisions/Anaesthetists+groups.htm and gives details of the relevant facts for each group cleared.

This is clearly a victory for patient care, and means that the groups will be able to provide a comprehensive anaesthetic service in their locality. It vindicates the groups of anaesthetists who have come together to provide this service and also the AAGBI for recommending doctors to develop this way of working.

Last Spring, shortly after the Association became aware of the OFT investigation, the President invited OFT representatives to visit Bedford Square. They met with officers of the Association who were able to explain some of the background to the issues and our advice on group practice. The OFT representatives said they would inform us in advance if there had been any infringements so that we could comment. They have not been in touch but they also said that after their decision if any new groups wished to operate in different ways from the existing ones then they would be prepared to give them advice, for which they may make a charge.

The OFT’s investigation was initiated by a complaint, made in May 2001 by AXA PPP Healthcare, whose complaint to the OFT regarding the Newchurch Relative Value Scales was similarly dismissed last year. It is a pity that Dr David Costain, the Medical Director of AXA PPP, has been reported as saying that the decision is disappointing, as it clearly supports the benefits of anaesthetists working in groups and being able to provide information on fees to their patients.

The AAGBI has met with AXA PPP regularly in the past to discuss mutual interests and common issues and is disappointed and surprised that AXA PPP initiated the investigation, at considerable public expense and when the OFT is particularly busy, without firstly seeking the opinions and assistance of anaesthetists to solve any perceived problems.

Writing for Anaesthesia News

Anaesthesia News is always happy to receive copy of articles, reports, travel stories and opinions. Most will be accepted although some editorial revision or abbreviation may be necessary. Letters to the Editor are particularly welcome. There are several ways of sending your work to your Newsletter and it should arrive at least four weeks before the intended publication date. A Word file, posted on a disk or sent attached to an email is best, although typescript may be scanned. Please send photographs, of reasonable size and in colour, either as a jpg file attached to an email, or as ‘hard copy’. Our contact details are: 21 Portland Place, London W1B 1PY. Telephone 020 7631 1650. Fax 020 7631 4352. Email anaenews@aagbi.org
One of my four medical brothers was an ophthalmic surgeon in the RAMC from 1939 until 1945 and served with a Mobile Ophthalmic Unit in North Africa, Italy and Greece. He published his experiences in the British Journal of Ophthalmology and included some details of anaesthetic management.

John Zorab

The following is an extract from his paper.

“For more than six months, I was associated at various CCSs with the advanced sections of a maxillofacial and a neurosurgical unit, often sharing an operating theatre and an anaesthetist. This association, which came to be widely known as ‘The Trinity’ was most satisfactory from all points of view. It enabled all wounds above the neck to be dealt with at one centre, with one anaesthetic and, not least important, it gave all three specialists valuable experience in other closely allied specialities. For what I learned from this association, I shall always be grateful to Major HV Slemon, RCAMC, Major Murley, RAMC (later, Sir Reginald Murley, PRCS*), Major EJ Dalling, ADC, and Major RP Harbord, RAMC, the anaesthetist.

The type of anaesthesia was determined by the requirements of the particular case. This unit does not carry an anaesthetist for the very good reason that he would seldom be fully employed. In normal periods, the services of an anaesthetist can usually be borrowed for the small number of operations performed. During a battle, when an anaesthetist could be fully employed, the CCS anaesthetists are too busy. Occasionally, one was attached for temporary duty from a non-working unit, but I often had to give my own general anaesthetic - an unsatisfactory practice. While working with the ‘Trinity’ an anaesthetist was shared by all three units, and he frequently had three anaesthetics under supervision simultaneously. This arrangement was satisfactory only so long as the three teams were either sharing a large theatre or were working in adjoining theatres. Nearly all jaw, face and head cases that needed general anaesthesia needed endotracheal intubation and could thereafter be safely left on the Oxford vaporiser under observation. Comparatively few eye cases - less than 20% - could be done under local anaesthesia, partly on account of other injuries requiring general anaesthesia, and partly because having only recently been wounded in battle, most patients were not in a fit condition psychologically to undergo an operation under local anaesthesia.

It was found that the anaesthetic of choice was a continuous pentothal drip. It was given as a half per cent solution in normal saline or glucose saline with an ordinary intravenous infusion set, combined with cocaine drops in the eye, morphia and hyoscine premedication and continuous oxygen via an intranasal pharyngeal tube. This gave a very smooth anaesthetic with the minimum of trouble, practically no respiratory movements of the head, little or no post-anaesthetic cough or vomiting, and could be continued for as long as was required. As much as 3.5 grams of pentothal was given on occasions for long combined cases with no ill effect.”


Abbreviations:
CCS - Casualty Clearing Station
RAMC - Royal Army Medical Corps
RCAMC - Royal Canadian Army Medical Corps
ADC - Army Dental Corps.
PRCS - President, Royal College of Surgeons

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Final FRCA Examination
Intensive Preparation Course

The Bristol Crammer

Monday 22 September– Friday 26 September 2003

This five day course includes sessions on examination technique, intensive therapy, new drugs, current topics, and practical subjects (ECGs, X-rays), as well as mock examinations and performance analysis. Conducted by national and local experts at Burwalls Conference Centre, Bristol.

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

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

Course Director: Dr S Underwood FRCA.

Some accommodation available.
Course Fee £400 (includes coffee, lunch and tea).
Nearly 300 delegates from around the UK met on Sunday 26 January 2003 for the 14th Anaesthesia Update in Belle Plagne, French Alps. This five day annual meeting, organised by Drs Bernie Liban, Tom Hollway, Neil Soni, and Vivien Thomas is consistently the best of its kind on offer and one of the most enjoyable. This year’s course was no exception!

The great strength of these meetings is that the majority of talks are given by the delegates themselves on topics in which they have personal expertise. Trainees are encouraged to give presentations alongside consultants. The organisers blend these volunteered talks into a programme which is extremely wide ranging and very informative. They also endeavour to widen the horizons of the delegates by inviting speakers on more diverse topics such as surgery, radiology, patient safety training, medicolegal updates, the internet, and drugs in sport. Running in parallel with these plenary sessions were the always popular workshops, this year on pain, regional anaesthesia, teaching and training, TOE, ultrasound guided vascular access, issues of consent, and database management.

The standard of presentations was extremely high and not all can be mentioned. There was an excellent prize paper competition for both trainees and consultants. The worthy trainee winner of a palm pilot, once again generously sponsored by Pharmacia Ltd, was Helen Hulme-Smith. The consultant winner of a bottle of champagne was John Barcroft. The guest lectures were as usual something to look forward to. Professor and Mrs Strunin, regular attendees, gave a fascinating insight into the world of greyhound and racehorse breeding. Nobody who heard Dr Andrew Charlton’s amazing account of the separation of Siamese twins in Manchester could have remained unmoved by it. Nor could anyone forget Mr Dennis Calthorpe, an orthopaedic surgeon, ‘lecturer extraordinaire’ on spinal injury and on timing of surgery after major trauma, who presented wearing a bow tie and frock coat!

A metre of powder snow fell during the week providing excellent skiing opportunities for all, and making up for last year’s paucity of snow. The skiing highlight of the week was the St Georges Cup race, in essence a handicap event, which was won by Dr Peter Cole from Leeds. The handsome first prize on offer, sponsored by Inghams Travel, was a free holiday from Inghams’ brochure. Second and third placed participants also won free holidays, courtesy of the Hotel Eldorador, and La Plagne Tourist Office respectively, ensuring that the race was as usual hotly contested.

Although this meeting has grown in size considerably over the past few years, it has not lost its friendliness, and newcomers as well as regulars still enjoy the camaraderie of the meeting. It is an excellent place for gossip, exchange of ideas and even solving problems. The week came and went all too quickly and the majority of the delegates will already be planning for next year’s meeting. Early booking is advised!

Nick Denny, Queen Elizabeth Hospital, King’s Lynn
Unlike some scientists who make an important discovery, but fail to follow it through, Henry Hill Hickman was persistent as well as perceptive. In his short life (1800 to 1830) he realised that 'suspended animation' could be induced by the inhalation of 'foreign gases' and he backed this up by carrying out apparently painless operations on animals after they had inhaled carbon dioxide. He then tried hard to get his results verified by experienced men of science and obtain, as he put it, "the benefit of their eminent and assembled talent, and emulous cooperation."

We do not know why Hickman, a general practitioner in Ludlow, became interested in the concept of anaesthesia in an age when few people regarded it as either feasible or particularly desirable, but he was, quite simply, a humane man who hated inflicting pain on his patients: "There is not an individual who does not shudder at the idea of an operation, however skilful the Surgeon or urgent the case, knowing the great pain that the patient must endure, and I have frequently lamented, when performing my own duties as a Surgeon that something has not been thought of whereby the fears may be tranquillised and suffering relieved."

We do not know, either, why he chose carbon dioxide. It may be because he thought it was safe: "I have never known a case of a person dying after inhaling carbonic acid gas, if proper means were taken to restore the animal powers..."

Anaesthesia in some of his early experiments was probably achieved as much by hypoxia as by the gas, but in his fifth experiment, on an adult dog, "animation was suspended for 17 minutes, allowing respiration occasionally to intervene by the application of inflating instruments. I amputated a leg without the slightest appearance of pain to the animal."

After seven experiments, Hickman wrote up his results in February 1824. Humphry Davy saw the pamphlet, was enthusiastic about it and offered to present it to the Royal Society - but he never did, perhaps because the anti-vivisection lobby was becoming very active at that time.

Hickman did not give up. In 1828 he went to France to petition Charles X who had offered a reward to anyone who could produce anaesthesia. Charles' investigating committee was hostile to Hickman's work, bar one member. The exception was Baron Larrey, the surgeon who, during Napoleon's winter campaign in Russia, had noticed that amputations were comparatively painless if the limbs were very cold. Larrey said that Hickman's work deserved the attention of surgeons and offered to verify his experiments. Hickman spent at least eight months in Paris and towards the end of his stay he was joined by his wife Eliza.

Fast-forward now to 31 January 1975, when I anaesthetised a 73 year old man for repair of a hernia and excision of a hydrocoele. At the pre-operative visit he mentioned that his wife was "related to an anaesthetist". Such disclosures are often 'code' for: "It had better be a good anaesthetic because I have a friend in high places" so I was both relieved and impressed to find that the 'relative' was none other than Henry Hill Hickman. During the patient's stay in hospital, I met his wife - Hickman's great-great-grand-daughter, and that summer I was invited to their home where two tables were set up in the garden. Afternoon tea was laid out on one; on the other was an amethyst and citrine bracelet in its original case with an inscribed card in the lid.

The deliciously coy inscription on the card reads: "For Mrs. Hickman with the kind love of a gentleman she has a slight knowledge of – bought in the Palais Royale July 31, ’28". With another pen was added: "and given to her Nov 10 at half past 9 o’clock at Meurice Hotel, Paris".

Larrey, like Davy, did not live up to his promise. Hickman returned from Paris a disappointed man and was dead within two years.

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Meeting Chair: Dr Mike Sury, GOSH, Department of Anaesthesia, Great Ormond Street Hospital for Children NHS Trust

8th Annual Congress of the British Society of Orthopaedic Anaesthetists, London, 14th November 2003 
PROVISIONAL ANNOUNCEMENT AND CALL FOR ABSTRACTS 
For abstract submission forms and full congress details contact: 
Meeting Chair: Dr Mike Hetreed (RNOH, Stanmore) 
c/o bsoa@btopenworld.com / Telephone: 020 7323 9911
Dr Ray Towey FRCA was a consultant in Guy’s Hospital London, has worked for the past 10 years in East Africa and is currently working in northern Uganda.

Africa has a great capacity to put you into both shock and awe so as I write this letter from St. Mary’s Hospital Lacor in Gulu northern Uganda forgive me for borrowing the sound bite from the US military planners for we here are also in a war zone in more ways than one. The real enemy in our situation is poverty, poverty of medicines, equipment, infrastructure, trained personnel, management and the poverty is indeed shocking. However what is awesome is the capacity of staff and especially my African colleagues to cope with these deprivations and with amazing good humour to actually deliver a high standard of medical and surgical care, much cherished by the local community. In another way we are also in a war zone in that there has been a war continuing in northern Uganda for over 15 years and road ambushes by rebel troops are a weekly occurrence. This is not a high tech. war. There are no B-52 carpet bombing payloads or cruise missiles or weapons of mass destruction, (or should I say weapons of mass injury/murder), but for the local population being killed or injured by a AK 47, a rocket propelled grenade or landmine, all by the way imported from the so called ‘developed’ world at a handsome profit, is just as devastating as being hit by high tech. killing systems. For us in the hospital the sense of security is good, that is while we remain in the hospital. Travelling is another story.

We care for both the government and the rebel injured and probably most importantly because the local mission in the person of Brother Elio will give a decent burial to any fatal rebel casualty, as an institution we have not been a target. This is awesome in a conflict that has defied almost all moral bounds in its cruelty. Last week in our ICU we had the incongruous sight of one rebel soldier lying next to one government soldier. The professional response of the staff to treat all injured the same is exemplary and yes it is awesome when you consider how much the local people have suffered in this conflict. We are about 4 hours driving distance from the capital Kampala, on a tarred road. In my analysis I divide the world into three areas, the rich northern countries, the capital cities of the so-called developing world, and the rural areas of the developing world. In short we are in the final category, in some ways the final frontier. In my time I have worked in all three areas and each has its own stresses not to be minimised. We are a five theatre suite and we have the capacity to work all five at any one time though this is unusual. With so little resources how do we manage that? In a nutshell skilled dedicated staff and appropriate technology. Many anaesthetists are technophiles and I plead guilty. This article will reach you via the Internet by way of a radio modem and a modified boosted GSM type mobile phone. This connectivity from our location continues to amaze me. It is indeed a small world though much divided.

Our anaesthetic practice is founded on spinal blocks and draw over ether and halothane. It is hard to know what we would have done without the EMO and OMV vaporisers made by Penlon in Abingdon. If there are any Penlon staff out there, many thanks! A supply of oxygen is always a concern for the rural practitioner and our hospital uses both oxygen concentrators and cylinders. Our paediatric ward has the capacity to treat 16 children using DeVilbiss oxygen concentrators with flow splitters and this frees up the cylinders for theatre use. Many thanks to Sunrise Medical, Wollaston, in the West Midlands! Hopefully this year we will also have oxygen concentrators for theatre and we then anticipate a major reduction in oxygen cylinder usage in the hospital. As we can only obtain cylinders from Kampala, a journey not undertaken lightly, a move to oxygen concentrators will be much appreciated. To see this appropriate technology making a substantial contribution to the patient care in this remote area is a most satisfying experience. I think it would be fair to say that our anaesthetists can give very good conditions for almost all surgical procedures with our basic equipment. Of course we have limitations. It is appalling to see a patient in theatre with a ruptured uterus because she has been in labour for two days having had no access to any analgesia or any proper care transferred from a more remote area, or to watch someone bleed to death because we have no fresh frozen plasma or platelets, or to walk away from a patient dying from respiratory failure because our capacity to ventilate is limited to just a few hours.

Probably the most appalling example of inequity is the knowledge that a large proportion of our patients are HIV positive but cannot afford treatment. The shocking truth is that profit for the so-called ‘developed’ world comes before life giving treatment for the rest. The national debt of Uganda is about $4 billion and each year $50 million is still being paid back to western banks in debt repayments. It continues to amaze me that most Africans have so little bitterness in the face of this appalling inequity. When $780 billion per year is spent on the world’s armed forces, $17 billion on pet food in Europe, I have to ask, why is Africa still paying debt repayments and has almost no anti-retroviral drugs? In global terms this amount of debt is small change but for our patients it is a life to death change, so if you could help me with an answer to that question I would truly be in shock and awe.

Ray Towey
raytowey@africaonline.co.ug
Show your support for the AAGBI

Have you read a piece of anaesthetic research recently and thought that this piece of work was significant and could affect the practice of your speciality?

Were you aware that the AAGBI is now the single biggest financial supporter for anaesthetic research in the UK and Ireland?

Have you been to a Seminar at 21 Portland Place, the new home of the AAGBI, recently and felt that the new premises are a fitting home for UK and Irish Anaesthesia?

Have you wondered how the AAGBI manages to fund all this activity?

I hope that I might be in a position to give you some answers to these questions and also to suggest how YOU could help in the future.

The income to the AAGBI comes from a number of sources. The subscriptions that you pay to receive the benefits of membership, from advertising revenues in both Anaesthesia and Anaesthesia News, from receipts for Seminars and Meetings, from investments watched over by the Finance Committee and the Honorary Treasurer and from donations from Industry and Members. The recent move to new premises was funded largely by utilising existing assets (which included the receipts for the sale of 9 Bedford Square) and from significant special donations from some of our Industry friends such as Intavent, Datex-Ohmeda and Draeger. Furthermore, we were very fortunate in the two years leading up to the move to receive, out of the blue, two very significant legacies from individual members of the Association.

One problem of using up our assets in purchasing a new property has been that they (like any bank account) can only be used once. If you know how to do otherwise please let me know.

So here we are now, in our wonderful new home with plans for the future and ideas for investing even more in membership benefits, more meetings and seminars, improvements to the museum and library, research etc etc but with a significantly emptier bank account, lower investment returns and increasing costs of existing services. The Honorary Treasurer has promised that he would not increase the Annual Subscription to purchase the new premises and he has kept that promise. However, if we wish to continue to play our most significant role in funding anaesthetic research in these islands, we need to look to other sources of income. We are actively pursuing corporate sponsorship for every penny we can raise and several companies have responded well to our requests. We are trying hard to reduce waste within the system and, hopefully, this will result in savings that you are completely unaware of.

But, and there is always a but, there IS one way the Membership could help. Would you consider making a bequest to the AAGBI Education and Research Trust? It is easy to do. You could simply write a Will (surely you have done that already) which includes a sum to be given to us. It could either be a specific sum (and yes we would be happy for ANY sum) or it could be a percentage of the residue after other specific bequests have been met. Please specify the Education and Research Trust of the AAGBI as this is our charity arm and it would simplify matters for us and for your executors.

If you have already made your Will, a simple Codicil adding a bequest to the AAGBI could be made and this piece of paper would be left with your Will and form part of it.

It is a good idea but very easy to put off doing, and once you put it off it is easy to forget, so please do it TODAY. We promise we will not do anything to expedite its receipt. So once you have completed the simple act you can forget about it. Oh, and thank you very much indeed.

Michael Ward, Vice President
**Literature for anaesthetists in developing countries**

**Success of recent appeal**

In the busy turmoil of our everyday work, it is very easy to forget that the problems that we face are dwarfed by those experienced by our colleagues in the developing world.

They have to struggle to maintain even a rudimentary service in the face of shortages of equipment, drugs and training. When difficult problems arise, many have no colleagues to consult and no literature to which they can refer, since the cost of journals and textbooks is far beyond their resources.

There are obviously limits to what we can accomplish in our efforts to help alleviate their problems but, with a minimum of effort on our part, the provision of basic literature for them is both affordable and achievable. Whilst we are swamped with more literature than we can possibly digest, their modest requirements are left unsatisfied.

There has, however, been a magnificent response by members of the Association of Anaesthetists of Great Britain and Ireland to a recent appeal in this newsletter for journals to be sent overseas. Already, over 200 anaesthetists have begun to send their own journals, on a regular basis, at their own expense, direct to anaesthetists in 60 countries throughout the developing world.

This gesture, although small in itself, has been appreciated out of all proportion by the recipients and has done a great deal to improve morale and reduce the sense of isolation and hopelessness felt by many.

The WFSA maintains a list of colleagues in the developing world who have requested literature. As this service has become more widely known, the list has expanded so that more donors are continually needed.

In addition to journals, textbooks are also urgently required. Many UK anaesthetists retire each year and are left with textbooks for which they have no further use. Others may have slightly older textbooks which are surplus to requirements. Instead of throwing them out, or allowing them to accumulate dust on bookshelves, they could be put to great use in the developing world, where they would be read and re-read by many who have no literature whatsoever.

Anyone willing to donate journals or reasonably up to date textbooks is asked to contact the Chairman of the WFSA Literature Distribution Committee, Dr RJ Eltringham at the Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN, who will be pleased to provide the name of a worthy recipient. A modest outlay on postal charges, if made by sufficient people, can produce tangible improvements in the practice of anaesthesia in even the remotest corners of the world.

It is satisfactory to report that, in the UK and Ireland, anaesthetists have not lost their reputation for generosity. Other national associations of anaesthesia have expressed an interest in this initiative and it is hoped that the example set by the members of the AAGBI will soon be followed by others.

Roger Eltringham

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(Comments taken verbatim from feedbacks February 2003)
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“Made concepts understandable.”
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“Made us realise our loopholes in knowledge.”

MSA@rlbuh.nwest.nhs.uk
We should be told

Why weren’t we told that if we didn’t vote for the cunning plan to make us work evenings and weekends instead of normal working hours for the same money it would be forced on us anyway? The only difference seems to be that, whereas on the original contract (you know, the one most of England and a lot of the rest of the country voted ‘no’ for) we would be eligible for pensionable pay increments if we met impossible targets, this new deal seems to offer us non-pensionable, non-recurring bonuses for meeting the same impossible targets. Furthermore, this money will be paid to local Patient Care Trusts, to whom our Trusts have to bid for the money that was originally put aside for our pay rises! If the Trust meets its targets, then 50% of our money is shared amongst all those members of staff deemed to have met the impossible targets. (It is not clear what happens to the other 50% of our pay-rise money, I suspect the Trust pockets it.)

My Trust, (£26M overspent, no CEO or Finance Director – don’t ask) has already told the consultant body that there is no way we can meet next year’s waiting list targets anyway. As anaesthetists do badly in any carving up of additional payments, what hope do we have of a decent share in these non-existent bonus payments? We must insist on parity with our surgical colleagues. Why should we put up with 25 or 30% of nothing? We must insist on 50% of nothing!

Eny fule kno that we can kiss goodbye to a pay-rise or renegotiated contract until there has been a regime change in the Ministry of Health. I hear the Iraqi Minister of Information may be available, and he certainly appears to have ideal attributes for the post.

In spite of all this, we still have our lighter moments and enjoy the usual camaraderie, even with our surgical colleagues. Although one of our orthopaedic surgeons (I think it was the holistic one – the one who looks at the whole bone, not just the fracture) recently demonstrated knowledge outside his immediate area of expertise. He was heard to explain to one of his trainees that the epidural space was that time on the theatre list between 0830 and 1030. That’s it, the gloves are off, no more Mr Nice Guy.

SOWCHA

FRCA EXAM PRACTICE STUDY DAYS

FINAL: Tuesday 10 June at Kent and Sussex Hospital, East Sussex.

Course organiser: Dr Barbara Bray, East Surrey Hospital
Enquiries to: 01737 768511 ext 6046.

PRIMARY: Friday 19 September at Darenth Valley Hospital, Dartford.

Course organiser: Dr Pauline Vine, Princess Royal University Hospital, Orpington.
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Course Fee £30 including lunch
Places limited so apply early!
Hospital Acquired Infections (H.A.I) are responsible for up to 5000 deaths a year and a huge financial burden to the NHS\(^{(1)}\).

**Fight back with Anti-Microbial Breathing Systems**

Silver Knight™ Range from Intersurgical

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

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

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

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

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

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

The signs of life are unmistakable at a family fun-day held in the spacious gardens of a senior regional diplomat. A spacious house with beautiful gardens, tennis court and swimming pool! Then tragedy! A five year-old boy was found at the bottom of the unfenced pool. Emergency personnel managed to resuscitate the child, who was then transferred to the ICU for further care. Early, aggressive management did not have the desired effect. The blank stare from lifeless eyes in this child was not encouraging. Warm water drowning with unknown submersion times is usually associated with poor outcomes. The vegetative state of this child could be described in terms of “the lights are on but there is no sign of life”.

The Harare international airport at 5am in the morning has all its lights on but there is no sign of life two hours before take off at the check-in counter. Having to wake the night guard and disturb the cleaner from a similar state of relaxation in order to check in for an international flight is not what you would normally expect. “Wait a little while”... we are told, actually a long time, patience, ah... eventually a door opens and a messenger comes to tell those waiting that the responsible person will be coming in a little while.

For most Zimbabweans the early morning is quite a contrast to that of the airport staff. In the high-density suburbs the early morning is busy. People have to start early to walk to work, there is not enough disposable income to afford a bus, and only the fortunate have bicycles. People off to join a bread queue or any queue as it is bound to be for something that is needed at home. Zimbabweans are said to have the highest IQ in Africa! This is because I queue for bread, I queue for petrol, I queue for cooking oil, I queue for margarine and so forth. On a farm or in a rural village there is a bustle of activity at daybreak. There is always something to be done, water to fetch, wood to cut, food to be picked, animals to care for. The list is endless.

In the African bush there is a chilly stillness in the predawn atmosphere full with the promise of the new day. As dawn creeps over the horizon the bird life bursts into song announcing its arrival. The call of the mourning dove so typical of Africa, the buzzing of bees on their first flight of the day, and the raucous “cherrrrring” chatter of the guinea fowl all add to the chorus. What a comparison between the official organs of society and the normal people of Zimbabwe. Is it apathy or exhaustion, lack of energy or a hangover from the party last night? The signs of slowdown, shutdown, malfunction or non-function are common in the area of officialdom. Just like the bakery that is full of the aroma of fresh bread but has no bread for sale.

Essential to all medical training is the ability to detect the presence of the signs of life in unconscious patients. These signs are clinically easy to detect and can be measured using a variety of different monitors. This is usually done so that a record can be made as to the progress of the patient. During anaesthesia the absence of response to noxious stimuli, usually provided by the surgeon, is only achieved by careful titration of anaesthetic and analgesic drugs. Some anaesthetic trainees have great difficulty in getting the balance right. One notable individual, probably the single worst anaesthetic trainee I have known or have ever heard of, had the philosophy of “if there is movement then there is life”. If the patient lay still then it was difficult to know if they were dead or asleep, so he always ensured that he had his ‘signs of life’ all the way through the anaesthetic, the patient wiggled to every stimulus! If they didn’t have purposeful movement in response to stimuli the anaesthetic was turned off until there was some response. Fortunately, after having been bailed out of jail to complete his weekend call he was sent to ‘bless’ another department with his presence. His simplistic understanding of the signs of life was flawed especially in the area of anaesthesia.

The signs of life principally involve the normal functioning of an intact brain. Both the five-year-old lad in the post-drowning vegetative state and the failed anaesthetic trainee in different ways fail to exhibit appropriate signs of life. Unfortunately, there are many in the official organs of our society who also fail in ‘the signs of life test’. We are unfortunately unable to ‘bless’ some other country with them. There are international sanctions in place on their shipment.

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