Draw-overs and drawbacks of anaesthesia in Cameroon

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Using my last chance for freedom before taking up a substantive consultant post in the UK, I decided to go "off the beaten track" for a year. The start of this adventure was in Cameroon.

Cameroon is situated in Central Africa bordering the Bight of Biafra, between Equatorial Guinea to the south and Nigeria to the west. The former French and British parts merged in 1961 to form the present country. Most of the country is French-speaking, except the North West Province which is English-speaking. Cameroon is relatively stable and, unlike many African countries, has not been involved in any recent conflict.

I spent eight weeks working at two mission hospitals run by the Christian organisation Cameroon Baptist Convention (CBC). These are private hospitals and, as is usual in Africa, patients pay for all medical services.

Flying over Bamenda Highlands from Mbingo to Banso hospitals was like being in a movie! A tiny plane, seating 5 passengers excluding the pilot, flew over the amazingly beautiful area of North West Province of Cameroon. Before the flight, all passengers were questioned by the pilot about their body weight and then seated accordingly, lightest at the back, heaviest at the front. I was given a seat near the tail. Below me were green hills and...
mountains, interwoven with white threads of waterfalls. Carefully cultivated fields on steep slopes exposed the brown-red soil of this fertile land. Everything glittered with the reflection of sunlight from zinc roofs, which protect people from sheets of water that could fall within minutes on every square inch during the rainy season.

Anaesthesia in Africa is often a poor and ignored "Cinderella". In some hospitals it is done either by the surgeon or theatre nursing staff with little formal anaesthesia training. As a result, anaesthetic deaths contribute significantly to peri-operative mortality. Doctors in Africa rarely become anaesthetists because of lowly status and pay, so it seems more realistic to concentrate on adequate training of nurses.

Lois Gibson, an Australian nurse anaesthetist had been running a 3 year training program at both hospitals. Although I came to Cameroon for 2 months to help her with teaching, I learned a lot myself. Lois is probably the most enthusiastic practitioner I have ever worked with and a real pioneer. The effects of her work are excellent. She has entirely changed anaesthesia at both hospitals from "ketamine and spinals only" to a service offering a variety of techniques, including general anaesthesia with muscle relaxation and regional blocks.

Both hospitals have around 250 beds and 3 theatres. Specialities include: obstetrics & gynaecology, urology, general surgery, orthopaedics and ophthalmics.

There were sixteen male trainees with varying amounts of operating theatre or nursing experience. Lois, with the help of visiting anaesthetists from UK or USA has taught them remarkably well. Simple protocols were used and students were trained to be organised and diligent. They were extremely enthusiastic so it was a real pleasure to teach them. They had to pay for the training and their monthly allowance had to be paid back to the hospital after graduation. This seemed harsh, but so is life in Cameroon. Education is valued highly and always comes at a price.

The trainees were using excellent books including Australian "Safe Anaesthesia" by Bartholomeusz, British "Anaesthesia at the District Hospital" by Dobson, and an absolute gem of anaesthetic knowledge - 6 monthly "Update in Anaesthesia" issued by World Anaesthesia. Laminated protocols for all sorts of clinical situations and drug doses were readily available, attached to each anaesthetic trolley.

Part of the anaesthetic adventure was learning how to use the equipment. The OMV (Oxford Miniature Vaporiser) is indeed "miniature" - only about 20 cm tall. It combines well with the hand-operated Oxford Bellows and an oxygen concentrator. This trio, with the addition of plastic tubing, an Ambu E valve and a big plastic bin-liner acting as an oxygen reservoir results in a portable, simple and reliable anaesthetic machine which does not need compressed gases.

The OMV is an effective vaporiser, which has temperature compensation provided by a mixture or water and antifreeze. Halothane was the most commonly used agent.

The oxygen concentrator is a "dream machine" providing 95% oxygen to a maximum flow of 5 l/min by extracting nitrogen from air. It requires minimal servicing and can run for many years.

Continuous flow anaesthetic machines are very impractical here as pressurised gases in cylinders are very expensive and their delivery unreliable. Africa is often the graveyard of second-hand donated equipment, including anaesthetic machines. During my previous visits to African hospitals in Ghana and Guinea, I have seen sophisticated pieces of equipment both broken and unused. A system using OMV+ Oxford Bellows + oxygen concentrator is so simple that the user can easily learn to service it.

Intra-operative monitoring involved pulse oximetry, automated blood pressure measurement and the constant presence of the anaesthesia provider. Is an ECG absolutely necessary in the population with very low risk of ischaemic heart disease and an average life expectancy of around 50 years? If arrhythmias occurred, we switched from halothane to a ketamine infusion. The disappearance of ectopics confirmed that they were induced by halothane.

Continued on back page...
I have just returned from the third Open Meeting of the Association’s Scottish Standing Committee. To the majority of you south of the border, devolution is probably an irritating mystery, but it is a fact of life and the success of this meeting indicates to me that the Association can meet these new challenges effectively. There was a large attendance, scientific lectures, a spirited discussion about the new consultant contract (with management and medical views) plus a keynote lecture from the Scottish CMO, who clearly understood the differing functions of the specialty’s Association and College.

I have done my best to promote relationships between the RCOA and AAGBI to ensure that we cooperate in the interest of anaesthesia as a whole. That is not to say our views and actions are entirely similar. As an example, the proposal for non-physicians in the anaesthesia team was a College initiative which surprised the Association. However, on reflection, a negative response from AAGBI would have been self-destructive. We have therefore cooperated and hopefully influenced the process for the better. I am aware that a number of members still have doubts but, together with the College, we have ensured that, to avoid the strife that occurs in the USA, pilot sites are led by anaesthetists and the new practitioners are in an entirely supervised role. The first six pilots are just off the ground and another three dozen departments are queuing up to become involved. This should not be viewed as an easy option for short staffed departments, nor an immediate answer for EWTD. David Greaves with the NHSU is defining a curriculum for the required qualifications, which are likely to extend to a two year MSc. There is need for further information about these developments and we will organise a conference in London on the 7th of July 2004 to bring everyone up-to-date. Details should be available by the time you read this.

The consultant contract is another major change to our practice and I hope you have found the advice we have published, supplementary to the BMA, helpful. I was impressed at the WSM that the attitude shown by the specialty was professional, realistic and flexible. If managers are as responsible, job plan negotiations should be untroubled. However, we hear some Trusts are playing ‘hard ball’, particularly with SPAs. It is important that all anaesthetists ensure that they spend appropriate time guaranteeing their CPD, appraisal and revalidation standards. The AAGBI will support members in achieving a satisfactory conclusion to their negotiations. At the moment, our information is largely anecdotal, but when reality strikes, let us know of difficulties and we will help.

Just as we officially opened Portland Place, major upsets emerged. Lesley Murphy, our Chief Executive, announced unexpectedly that she foresaw her future career development out of the AAGBI, and sought a satisfactory arrangement to facilitate her resignation. This was a delicate legal matter that took some time to organise and I regret that members were not fully apprised of the situation more promptly. Lesley has now officially left the Association and we wish her good fortune in achieving her ambitions. The staff remaining at Portland Place are talented and committed, and with internal reorganisation in-house, we believe that our functions will be well served without a designated CEO. The management structure will be “flatter” with four departments responsible to Executive and Council. Jo Barnes will head membership services and events, Karen Grigg, administration and secretariat, Liz Keegan finance and Trish Willis heritage. This new arrangement seems to be working well at the moment but we will obviously be reviewing the structure over the next year.

I am pleased that with a new and better base, that we are expanding our services for members, more Seminars, a new Annual Congress, meetings around the country and an extended Anaesthesia News. We have experienced difficulties with various computer and IT developments but shortly you will have an updated website with interactive facilities for booking meetings and paying subscriptions online. In retrospect, the move to Portland Place took more of our energies and attention than we had anticipated but I am confident that the Association is now back on course.

Peter G M Wallace
PPP, RELATIVE VALUES, AND WAITING LIST WORK

Last Autumn AXA PPP sent letters to a number of surgeons concerning the fees of anaesthetists who worked with them. At a subsequent meeting with Dr Derek Machin, BMA Private Practice Committee Chairman, Dr David Costain from AXA PPP retracted their letter and confirmed that Consultant Anaesthetists had the right, as all other consultants, to set their own fees.

Later this year BUPA and other insurers are planning to introduce the Relative Values Scale, developed 4 years ago by Newchurch. The publication of this is expected to be a significant change. The timing is yet to be confirmed but it may be phased in between July and October. This could help by informing patients preoperatively of the anaesthetist's expected fee.

‘Choice’ is a new NHS development to offer patients choice over when and where they are treated. Pilot schemes are already operating in a few areas and by summer 2004, all NHS patients waiting over six months for surgery will be offered a choice of moving to another hospital or provider. The latest details are available on the DoH website www.doh.gov.uk

One of the great achievements of the NHS was that all Consultants were equal both in rank and remuneration. Caring for NHS patients is NHS work irrespective of whether it takes place in an NHS Hospital or a private facility. Payment for waiting list work should therefore be the same for all Consultants. The payments for surgeons and anaesthetists should be the same. This is a principle most managers easily understand and a survey showed last year that 77% of waiting list sessions in the NHS were remunerated equally. However, in some places negotiations still take place with the surgeons first and then anaesthetists are asked to service them. Express your interest in being involved at an early stage, so that they are not undermining the one of the basic principles on which the NHS was founded, and negotiate equal pay for equal work.

David Whitaker Honorary Secretary

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EACTA 2004

European Association of Cardiothoracic Anaesthesiologists Association of Cardiothoracic Anaesthetists (UK)

June 9-11, 2004
London, UK

Information, hotel booking and registration is available on-line at: www.eacta.org

Further details may be obtained from: Busola Oguntula, Specialist Society Support Officer, Association of Anaesthetists of Great Britain & Ireland, 21 Portland Place, London W1B 1PY. Tel: 0207 631 8816. Email: Busola@aagbi.org
Jim Dougal
Immediate Past Convenor, Scottish Standing Committee

The Meaning of Life – or Death?

“Something contentious”, requested your Editor - who, be under no illusion, must be obeyed. “Something from the heart”, she added, “something to fill the mailbag”. Well OK, I have always found the heart somewhat easier than the head.

Feeling deeply under-equipped to tackle the meaning of life, I was prompted to wonder about the nature of public opinion and representation on the Association and the BMA. Mrs. Thatcher’s view on the nature of society was that there was no such thing. A little nihilistic perhaps, until I read a small article on the front of BMA News. (Like you dear reader I concentrate on heavyweight publications). The article reads, “not one single member of our doctors decide panel believes the current UK organ donation system is working” - fair enough. It goes on - “2 in 3 of our panel favour a system of presumed consent for organ donation”. My initial reaction was - who are these people? Now for all I know, they may represent the majority view, but they do not represent those to whom I speak. Admittedly, these are my friends and therefore a very small sample. I would be surprised if the BMA view was consistent with that of the majority of intensivists who, next to the transplant community, have the closest relationship with potential organ donors and their relatives.

The current system allows us to make our views known by speaking to relatives and by carrying a donor card. Relatives, however, have the final say and unfortunately a substantial number do refuse permission for organ donation. A “soft opt-out” system may be preferable. The emphasis here is on the wishes of the potential donor. Their relatives are asked what they believe the patient (and now potential organ donor) would have wished. There is still an implicit ‘get-out’ clause for relatives should they wish to exercise it. Whether relatives should have this right is too difficult a question for today, but the increasing use of advance directives will probably remove it.

The ultimate utilitarian view was expressed at a meeting by a Procurator Fiscal who felt it was the moral duty of all fellow citizens to give up their organs (not offer, mind you) on the point of death. One man’s Utopian dream is another man’s nightmare.

My professional experience of death is in intensive care. My personal experience of family death is almost exclusively at home, with the body of our loved one looked after by the family, many of whom are nurses. In hospital, the administrator may be the individual in “lawful possession of the body” but most families have a greater emotional ownership of their dead than that phrase encompasses.

Non-heart beating organ donation (NHBD) involves patients who donate organs immediately after death has been diagnosed by cardio-respiratory examination. They are not brain stem dead. Such initiatives will hopefully increase available organs for the many who so badly need them. I am all in favour of a carefully and sensitively orchestrated process, controlled NHBD. Uncontrolled NHBD in A&E or after cardiac arrest may be a different matter. This involves a stand-off period after death is diagnosed and then the institution of CPR and femoral cannulation to perfuse vital organs. Many would have no objection to this process but it would be a step too far for me. As a fellow intensivist said with a certain irony, he did not wish doctors to interfere with the process of his own death.

Ninety per cent of the population support organ donation. Most people also want fewer cars on the road - except theirs, of course. Most of us balance altruism with a dose of self interest. I do feel the poorer for placing a boundary on my altruism but we are all more or less subject to our prejudices. It remains my view that organ donation should continue to be viewed as a gift. I do not believe there is good evidence that a move to presumed consent would increase the number of available organs. I find the concept of presumed consent just that - presumptuous.

Enough of my navel gazing. My initial question really concerned public opinion and representation. Lay representation is important but we must acknowledge its limitations. On transplant groups we find representatives of organ recipients and of donor families. As a friend of mine said (JCH personal communication) you never find representatives of the society for the potentially brain dead.

On that note, and as a possible applicant to join such a society, I would ask you to represent yourselves. Well, that is it! I am feeling better with that off my chest. If you have got this far - thanks. Just one more favour though. All that is required for the mail bag to wither is for good men and women to write nothing. I know that is not the nature of our Association.
Dear Editor...

**Crayoning During Anaesthesia**

Thank you for your kind remarks concerning the policy document Crayoning During Anaesthesia which I wrote in May 1989. I enclose a signed copy of the original document – I now have only two originals left.

I was a registrar in Dunedin NZ in 1987 and 1988 while Barry Baker was Dean of the Australasian Faculty of Anaesthetists and also Professor of Anaesthesia. During that time, the FANZCA monitoring document was being written and we discussed many of the draft copies.

I wrote ‘Crayoning During Anaesthesia’ whilst I was a Staff Specialist in Townsville North Queensland. It was the result of reminiscences with John Stokes (at that time still a Consultant in Dunedin) about the anaesthetic charts produced by one of the other cardiac anaesthetists in Dunedin who subsequently moved on to become Professor of Anaesthesia in a non-Sydney NSW teaching hospital.

I could not possibly name that person could I?

Kind regards,
Stephen Swallow
Hobart, Tasmania

The Association is deeply grateful to Stephen for this generous donation of such an important addition to our heritage collection. It will be archived appropriately at 21 Portland Place and we will print it in full next month. Ed

**Dear Editor...**

**Diet or Science?**

I enjoy Dr de Quincy’s articles very much, but feel I have correct his statement lumping the Michelson-Morley experiment with phlogiston and theories behind the Atkins diet.

Michelson and Morley showed that the speed of light is constant both parallel and perpendicular to the Earth’s orbit, which disproved the theory of ‘The Aether’. Einstein later explained the findings in his Special Theory of Relativity.

Michelson went on to win a Nobel prize for his work.

Andrew Kitching
Consultant Anaesthetist
Reading

Many thanks for allowing me to reply to Dr Kitching, and I bow to his superior knowledge. In my defence I would point out that it was the theory I was dismissing, not the experiment which disproved it, but no doubt I had the nomenclature wrong. Apologies! de Q.

**Professional and Medical Negligence**

I thank Ruth Fanning for her observations on professional and medical negligence. I agree that anaesthetists need to “provide a level of care consistent with ...our peers and recognise our deficiencies ...” However; adherence to good practice will not keep ALL of us out of trouble ALL of the time.

Dr Fanning did not touch on the consequences of human error which may lead to patient death and criminal prosecution for manslaughter. These cases, although rare, are usually compounded by system deficiencies and may happen to the most competent of colleagues. Assessment of clinical competence and review by the GMC may enable the anaesthetist to continue to practise with the health trust’s agreement, but a criminal charge of manslaughter may proceed. The criminal charge may hang over the doctor, his family, and the department for several years.

I propose that the College lobby on our behalf to alter the legal pathway in such cases. In addition, we examine why we are so slow to produce solutions to recognised system deficiencies such as multiple compatibilities of connections etc.

Name and address withheld for personal reasons

**A Year to get Over the Anaesthetic...**

Shortly after undergoing surgery, performed under TIVA with epidural analgesia, I visited our local general practice for a change of dressings. The practice nurse warned me that I would take a year to get over it, “because of the anaesthetic”. The presence of a 6 inch surgical wound was, of course, completely overlooked. We will make little headway towards improved recognition while the sort of nonsense that is so convenient an excuse for the surgeon continues to be put over by colleagues.

The appreciation of modern anaesthesia that we have tried so hard to instil in the general public is needed also in our nurses. Surely more could be done during the early stages of nurse training, before attitudes become entrenched, to avoid this sort of misunderstanding?

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St. Richard’s Hospital,
Chichester

SEND YOUR LETTERS TO:
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or email: anaenews@aagbi.org
Crisis Command: Could anaesthetists run the country?

Anyone who watched "Crisis Command", a recent one-off programme on BBC2, will have been amazed at the cack-handed way in which a team of business leaders and lawyers responded as 'ministers' to a series of terrorist and other disasters afflicting an imaginary London.

From the very first decision they had to make, whether to triage over 200 severe burns victims or try to save them all, it became obvious that a team of anaesthetists could do considerably better.

According to the Radio Times blurb, "A series is being planned for later this year." A Golden Opportunity for a team of anaesthetists to demonstrate who they are and what they can do to a large public audience. It may not be peri-operative medicine, but as publicity it would sure beat another "Killer anaesthetist to blame" headline.

The Association should sign up to take part as soon as possible, and recruit a team. Failing that, any colleague who would like to 'run the country' should contact me!

For more information about the programme, go to its website: http://www.bbc.co.uk/crisiscommand/index.shtml

Dr.John R.Davies

Public Perception of Anaesthetists

The public perception of what our jobs entail has been a much-debated issue. I read recently how the Association of Anaesthetists was pleased to find an anaesthetist to be cast in Holby City by an actor who was equally impressed with our career. Indeed, when asked if he would much rather be cast as a surgeon, his reply showed that he had an understanding of our demanding job.

Unfortunately, this said programme did us as much disservice on 8th December. This particular episode showed a femoral embolectomy on a young lady and, as the camera pulled away from the surgeon, I was appalled to see the anaesthetist reading a broadsheet newspaper. Indeed the anaesthetist would have difficulty even seeing the patient as the paper was at such an angle to obscure any contact.

National Anaesthesia days have been held to increase awareness, but the level of trust placed in us by the Public will not be helped by this inaccurate portrayal. It was repeated the next week, said anaesthetist completing the crossword.

I feel this bad image will do us no good at all. I wonder if any readers have been asked about their newspaper reading habits since this screening?

I have written to the BBC to ask if they might put this right somehow and await a reply!

Louise Sherman
SpR Anaesthetics, Bristol

Don't hold your breath Louise! Ed

Caption Competition

Let's see......two Presidents....... both forked out a lot of money on new premises recently.........The song would be "Who wants to be a millionaire" by Cole Porter (1956) sung initially as a duet by Frank Sinatra and Celeste Holm.

For an encore they would be inclined to sing "Money's too tight to mention" by Simply Red (1985)

Combined Mallampati score - clearly a trick question since both Presidents are phonating (in "G" I think).

Tony Turley
At least they are singing in tune. Congratulations Tony – you win!

Ed

Caption Competition 2

I would contribute ‘Loving me, Loving you’ or ‘There he goes, just wobbling down the street!’

Oh! no that is not a song title.

And can you make me anonymous?
TO TRAVEL HOPEFULLY [1]
(A Journey to Toronto)

By D.D.C. Howat

On September 14th 1960, the following appeared in a London evening paper:-

MEDICAL AEROPLANE LOAD

I heard today of an aeroplane incident that might well have deprived a considerable number of British hospital patients of an expert anaesthetist during operations. The aeroplane was a four-engined Douglas DC. 7C charter flight carrying part of the British delegation to the quattrennial [sic] conference of the World Congress of Anaesthetists in Toronto.

On board were many of the most eminent anaesthetists in the country, led by Dr. Geoffrey Organe, director of the department of anaesthetics at Westminster Hospital. We developed engine trouble an hour out of Shannon, one of the passengers... tells me... 'We were naturally fairly worried. There were more than 80 people on board. It could have been a serious thing for medicine if the plane had crashed'.

Fortunately, after a tense flight, the aircraft reached London Airport safely. Quite apart from the appalling loss of life, a crash would have been catastrophic for the medical profession.

Many parents with young children make a practice of flying separately in order to spread the risk. In spite of the obvious saving in money by hiring charter planes, it might be wise for men of irreplaceable talents, like doctors and scientists, to do the same.

Anaesthetists were sometimes appreciated, even in those days. Here is the real story.

On 30th August 1960, about 80 anaesthetists took a plane specially chartered from British Overseas Airways (as it then was). We were due to leave Victoria at 7.30 PM and arrive in Boston Mass., at 6 AM the following morning, spend a day and a night in Boston, visiting the Massachusetts General Hospital during the day and being entertained in the evening by Dr. Henry K. Beecher, the Professor of Anesthesiology, at a large barbecue at his home. On the following day, there would be a ten-hour journey by Greyhound Coach to Montreal, where we would spend three nights before travelling on by train to arrive in Toronto on the afternoon of the 4th. What follows is a brief account of the journey.

At 7.30 PM at the BOAC Victoria Air Terminal we were told there was a strike of loaders at the airport but the clerks were trying to cope. Some of us repaired to the bar; others slept. We were taken to a hotel in Victoria for dinner, eventually reaching Heathrow at 11 PM to take to the air at about midnight.

We couldn’t cross the Atlantic in one hop without refuelling and must stop off at Shannon Airport. After an hour there, we took off again at 2.30 AM.

We were over the Atlantic about an hour later, when there was a lurch and the tannoy was suddenly switched off while the pilot was still chatting to us. One of the engines was leaking oil and we had to return to Heathrow, most of our fuel must be jettisoned and on no account must we smoke. We could see a thin trickle of what looked like petrol escaping from the engine just beneath the flames (it was difficult to see what effect our not smoking would have). Our load being too heavy for three engines, we would have to fly south over the ocean at 2-3,000 feet until most of the fuel was discharged. We were served a four-course meal at 4 am!. We were all a bit subdued on the return flight. One of our number said later he had seen flames coming from one of the port engines before the announcement and had wanted to tell a hostess about it but was afraid he would get a snoopy answer, so kept miserably quiet. We could not help remembering the gleam in the eyes of our junior colleagues as they said “you’re not travelling in a charter plane” or made laughing references to bombs hidden in the fuselage - rather a popular trick in the States at that time.

We landed at Heathrow just before dawn. One slept during the return and thought he was in Boston, another phoned his wife to tell her what had happened and was soundly trounced for wasting money phoning from the States. As we settled down to sleep, we were roused to go and have a breakfast of greasy eggs and bacon. Eventually, we boarded a replacement plane at 10.30 AM minus a rather attractive blond German lady anaesthetist, who had fallen asleep in the lounge and had not heard the take-off call. She was brought out by taxi. I said to my neighbour “If that had been you or me, we would just have been left here.”

This time we flew 400 miles off-course to avoid a storm in mid-Atlantic, flying at 15,000 feet over the tip of Greenland, down the coast of Labrador and the Gulf of St. Lawrence to New England. No question of refuelling!

We landed in Boston at 11 PM our time (6 PM local time) after 12.5 hours in the air and over 24 hours with little sleep. The barbecue for 80 people arranged by Dr. Henry K. Beecher had to be cancelled. It was said that he was eating chicken for weeks afterwards!
At 10.30 AM we boarded two Greyhound coaches for Montreal and we reached the Canadian border at 8 PM after two stops for tea and dinner. The Canadian customs officer couldn't understand why some of us were in one coach with our luggage on the other and insisted on examining every piece. "Oh God, Oh Montreal!" [2]. We eventually arrived at the Queen Elizabeth Hotel in Montreal at 11 PM. My wife arrived by jet aircraft after 6.5 hour flight from London and had to be restrained from enthusing about the speed of modern travel.

By now it was September 4th. We took a CNR train from the station (in the hotel basement). We were very comfortable in "parlor" cars and making comparisons rather unfavourable to British Railways, when smoke and flames began to pour from under our car. We stopped about 100 miles from Montreal. The trouble was a "hot box", the burning waste was removed and repacked with fresh, after being cooled by ice blocks from the kitchen car. Our train man (we were in the rear car) could be seen from the observation platform walking back and peering between the sleepers until he disappeared as a speck two miles back round a curve in the line. As someone said, "The Injuns got him, I guess". We resumed our journey but the same thing happened again. We had to leave our coach, take all our luggage and go forward four cars. We arrived in Toronto at 4 PM, six days after leaving London. Our reception more than made up for our chequered journey and we had a very enjoyable congress.

Both in Canada and later in the States, quite a few said "Gee, were you on that plane?"

Some of us had some odd experiences on the journey home - but that's another story.

References
A survey carried out at a BMA conference for Staff Grade and Associate Specialist doctors held in York in November revealed that implementation of appraisal for this group of doctors has been patchy. The issue of what information is needed to complete the necessary documentation causes appraisees concern. This article aims to clarify this.

Appraisal is a positive two-way process based on the seven headings of the General Medical Practice “Good Practice Guidelines”; namely, good medical care, maintaining good practice, teaching and training, relationships with patients, working with colleagues, probity and health. It uses information gathered on day-to-day activities, work and workload, self reflection on practice, audit and multi-disciplinary working. The appraisal itself involves a discussion and review of the information gathered, and identifies development needs.

All SAS doctors should be appraised, but only after receiving training on what the process is and what information is needed. If the nominated appraiser is not acceptable to the appraisee, there should be the option of a different appraiser who could be an SAS doctor who has undergone appropriate training.

Form 1 Background details.
This form lists your details such as name and current post. It is about you as an individual, and should summarise your career so far. Any experience and higher qualifications obtained in the UK or abroad should be listed to clarify your professional status. Membership of any medical societies should also be noted.

Form 2 Current Activities
You should include a description of your current post in the NHS stating details of on-call, emergency and out-patient work. Any other clinical work should be listed. If you have practising rights or admitting privileges at private hospitals, these should also be noted.

Non-clinical work such as teaching, management or research should be documented, as well as any work for regional/national organisations. Any other professional activities not otherwise included in the above should be listed.

You should include comments on your working environment and resources, especially if they cause obstacles to the provision of good care.

This form should include a copy of the current job plan. If you do not have a formal job plan, and there will not be time for a job plan review prior to the appraisal, a work diary can be used for the first appraisal only.

Job plan/work diary. This details your normal working week. Agreed service objectives, comparative performance data or College advice on workload should be listed. National/local standards should be noted.

If waiting list data is available for you as an individual, document it. List any difficulties there may have been with leave entitlements (study or annual), or with free time.

Form 3 Summary Record.
This is a summary list of all the reference documentation collected under the headings of “Good Practice Guidelines”

Good Medical Care. This concerns clinical competence, knowledge and skills. It involves the nature of work and the number of patients seen.

• Quantity of work done, such as operations performed as an individual or an assistant, number of letters or reports written, and number of relevant case conferences or meetings attended.

• Details of any external or peer reviews.

• A summary of relevant Critical Incident Forms.

• A declaration on any formal complaints that have been concluded and which happened since the last appraisal (or within the last 12 months for a first appraisal).

Maintaining Good Practice. This is to show that your competencies and knowledge have been updated. It is also called Continuing Professional Development (Continuing Medical Education and Work/Professional Life balance).

• Summarise any internal or external CME points accrued.

• Record attendance at local or national educational meetings.

• Document the title, date, venue and duration of courses attended.

• Collect and file attendance certificates.

• Summarise some meetings in more detail, especially if they caused you to reflect on, or change, your practice.

Teaching/Training. This is about your contribution to teaching other health professionals, such as students, training grades, nurses or paramedics.

• Detail teaching done in clinics, ward rounds, or theatre in terms of numbers of
people taught and also procedures taught, explained or observed.

- Note any presentations done at local or external meetings, including the type of meeting and the topic, date and venue of the meeting.

**Relationship with Patients.** This is about how well you communicate with patients and their relatives. It is to clarify whether you are approachable, and give polite full answers.

- Include a description of how you obtain informed consent.
- Note any “thank you” letters/cards received, or any complaints made.
- If patient feedback information is available, document it too.

**Working with Colleagues.** This concerns working in teams with other health professionals, and support staff such as secretaries/clerks, managers, ambulance personnel.

- Write a statement affirming good relationships (unless there is evidence to the contrary!).
- You may wish to include a letter of support from a colleague.

**Probit.** This about honesty and integrity.

- You can only state you are honest, unless there is evidence to the contrary.

**Health.** Make a statement about your health.

- Documentary evidence is not needed if you are healthy.
- Controlled medical problems not affecting your work need not be declared, but you must document any health problems that do impact on your work.
- Time on sick leave may have affected your ability to attend educational meetings, and accrual of CME points.

**Management.** Note and indicate the duration of any management activity such as:

- Attending Directorate meetings
- Rota co-ordination
- Local Negotiating Committee work,

**Research and Audit.**

- Document any research activity, noting projects or proposals for research, and any reports or publications arising from research. If your service commitment, or a lack of resources, prevents research being carried out, then write a statement to that effect.
- Note any audit activity both local and national.

**Report on Personal Development Plan.** This will not be applicable on first appraisal.

- Review your personal development plan from the previous appraisal and state whether your goals were achieved.
- If they were not achieved note why e.g. course cancelled, or training arranged but not yet undertaken. Decide whether further action is needed.
- A recognised training need remains a need until fulfilled.

Once all the above reference documentation has been collected, give all pieces a reference number and transfer that to the summary record (form 3) in the correct order. Send forms 1-3 to the appraiser prior to the appraisal, with enough time for him/her to study them. Do not send all the reference documentation. Keep all reference documentation in a folder, and take it to the appraisal for discussion. At the end of the appraisal both appraiser and appraisee sign and date form 3 as an accurate record.

**Form 4.**

This is a summary written by the appraiser after the appraisal with the agreed action plan and new Personal Development Plan. The plan may include a requirement for a job plan review, especially if the appraisal was based on a work diary. If you are happy with the summary, then both appraisee and appraiser sign it as a true record. If you are not happy with it, ask to discuss it further and do not sign it off till both parties agree. In rare cases, the appraisal may need to be repeated by a different appraiser if there is no agreement.

**Form 5.**

This may have been amalgamated into previous forms by some Trusts. It concerns personal and organisational effectiveness, and can be used as preparation for appraisal. It is similar to a review of the job plan. It will be relevant in subsequent appraisals.

**Optional Detailed Confidential Account.**

This provides the opportunity, if wished, for a fuller, more detailed account which may help or inform subsequent appraisals. Serious concerns raised under any of the headings will necessitate immediate cessation of the appraisal before completion.

**Next Steps.**

It is the responsibility of the appraisee to forward the necessary documentation to their Chief Executive. Form 4 will definitely be needed, and for the majority of doctors forms 1-3 should also be sent. Do not send all the reference documentation, or the detailed confidential account (if used), but retain them all, as they will be needed for revalidation through the managed route. Try to achieve your goals from the Personal Development Plan, and start to collect documentation for the next appraisal.

**Summary.**

Appraisal is a positive two-way process to allow SAS Doctors to develop their careers in new and innovative directions, making the most of their existing skills, and encouraging the development of new ones. We should grasp the opportunity to demonstrate to our colleagues and the public that we can rise to this challenge.
Anaesthesia and The Hospital At Night

by Simon Whyte

The impending implementation of the European Working Time Directive (EWTD), coupled with the Government’s steadfast refusal to contemplate reconfiguration of hospital services, has created the dilemma of how to sustain provision of out-of-hours medical cover from August 2004. The proposed solution, the Hospital At Night (HAN) project, is currently being piloted in four hospitals. The principles underpinning this concept are that, if the competencies required to deliver out-of-hours care are identified, a multidisciplinary team of personnel that collectively possesses those competencies can be employed to provide them, irrespective of their professional training background. Clearly junior doctors will be a significant part of any team.

Who should be on this Out-of-Hours Medical Team (OoHMT) and who should lead it? The areas for which expertise is required out of hours can be categorised as anaesthetic, trauma, broadly medical and broadly surgical. The HAN Working Party is in the process of identifying the competencies required in each of these categories, but from an anaesthetic trainee perspective, two issues are immediately identifiable:

1. Only anaesthetists are competent to provide emergency anaesthetic service cover. These competencies are clearly prescribed in the College’s CCST documents and, at a minimum, include the need for an on-call anaesthetist to have passed a basic test, usually at 3 months of training.

2. Anaesthetists will possess some of the required competencies likely to be identified in the other categories, such as the pre-, peri- and postoperative management of surgical patients, the stabilisation of acutely sick medical and surgical patients, and advanced life support skills.

By virtue of point two, there is some pressure for anaesthetists to be a part of the OoHMT [1]. However, it seems inevitable that anaesthetic on-call cover will have to continue to be provided independently of the OoHMT. Some might argue that the routine provision of daytime NCEPOD and trauma theatres in most acute hospitals has now substantially reduced the out of hours workload for many anaesthetists to true “life or limb saving” surgery only. NCEPOD data and that collected by the College’s audit of anaesthetic department activity supports this claim to some extent, the need for anaesthesia out of hours remains unpredictable. Moreover, when it is required, it is often needed urgently and for hours at a time. Obstetric and critical care workloads are no respecters of the time of day, and the demands on anaesthetists for these services do not diminish out of hours.

Of further concern, the Royal College of Physicians correctly identifies the need for an OoHMT operational team leader to oversee the team members’ deployment, according to clinical priority. They presume that this will be a physician. However, with the fragmentation of higher specialist training in medicine into its various subspecialties, many medical SpRs now provide non-resident on call cover for their particular subspecialty. It was evident at a recent meeting of the Trainees Group of the Academy of Medical Royal Colleges that these SpRs do not expect to have to contribute to the OoHMT. There appears to be no willingness by consultant physicians to consider leading the team after 22:00, which raises the unacceptable prospect of relatively junior medical SpRs running the team. It is essential that OoHMT members be exposed to relevant experience. With the reduction in junior doctors’ hours, it is not reasonable for anaesthetic trainees to be deployed in service provision that does not contribute to their training i.e. the delivery of emergency anaesthesia, pain management and peri-operative care. In my opinion, to ensure that workload is distributed appropriately and to maximise training opportunities, the OoHMT must be consultant-led. The specialty of the team leader is less important than his or her ability to manage the team fairly and in accordance with team members’ training needs.

In conclusion, the development of the HAN project represents an opportunity to restructure the delivery of out-of-hours care by many specialties in acute hospitals. There is compelling evidence that clinical activity is low overnight, that scheduled evening work (between 17:00 and 22:00) could further reduce the night time workload (whilst providing training opportunities) and that non-medical staff could undertake a significant proportion of out-of-hours...
work. A shift from specialty- and grade-based cover to competency-based cover could help achieve working time directive compliance. However, our specialty should consider carefully whether it can commit its trainees and consultants to the OoHMT, (which is unlikely to repay with training, the rewards it would reap from anaesthetic expertise) when the skills required to provide out of hours anaesthetic cover for theatres, maternity and critical care cannot be cross-covered. It seems to me that there are simply not enough of us to reliably contribute to the OoHMT, in addition to providing an on call anaesthetic service.

References

What's going on?

Hospitals at night / Out of hours multidisciplinary teams. A working party will commence later this month looking at this issue. The aim will be to produce a statement containing the views of the AAGBI, to be released later in the summer.

Foundation year training. The government plans for foundation year training are expected to be submitted this month. There will no doubt be discussions as to whether foundation anaesthetic training should count towards training in anaesthesia.

Named consultant supervision. Discussions continue as the AAGBI prepares to produce a statement on named consultant trainee supervision.

GAT committee members sit on all these working parties, having a voice and reporting back to the group at GAT meetings. Reports can be accessed on the AAGBI website. Keep up to date by logging on. Be as involved as you can be.

9th Oxford Difficult Airway Workshop

9th Oxford Difficult Airway Workshop

Academic Street,
John Radcliffe Hospital,
Headington, Oxford
Thursday 3 June 2004

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 2 hours of hands-on workshops to re-enforce 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.

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

Registration fee - £150

Recognised for 5 CEPD points

All enquiries - Marguerite 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’

DIFFICULT AIRWAY SOCIETY
Free Money!

Too good to be true… not at all.
The Difficult Airway Society has funds available to support research / product development. No fancy forms to fill in, you don’t have to be in a high profile teaching unit (but if you are we won’t hold it against you).
Submit your research proposal / idea with costings to the DAS committee and it will be considered.
Or for an informal chat about your ideas / plans contact us and find out what could be your gateway to fame.

Contact : treasurer@das.uk.com
Or tel: 01604 545671 & ask for Dr Chris Frerk

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Courses offered in 2004

ACRM (Anaesthesia Crisis Resource Management) The integration of technical training and non-technical skills (human behaviour) to facilitate teamwork and situation awareness for consultants and staff anaesthetists. (£250) 28th May; 3rd Nov

ACRM and Obstetric Anaesthesia The principles of ACRM, as above, with an obstetric theme for consultants and staff anaesthetists. (£250) 30th June;

Instructors Course (2 days) For multi-professional generic instructors concentrating on the logistics of running courses and the art of debriefing. (£400) For details please call.

Consultant Paediatric Aimed at consultants dealing with children regularly or occasionally, using principles of high fidelity medical simulation. (£250) 14th Apr.

Paediatric Critical Care Aimed at all grades of clinicians and nurses involved in stabilisation and care of critically ill children. (£250) 17 Mar; 9 Jun; 15 Sep; 8 Dec.

ODP Course Dedicated to post-qualified ODPs using a high fidelity manikin and first class audio visual links. (£150) 13th Apr; 26th May; 30th July

Care of the Unconscious Child Scenarios and skills teaching to cover assessment and management of children with reduced consciousness, suitable for nurses and ODPs for recovery, sedation and paediatrics. (£250) 17 Mar; 9 Jun; 15 Sep; 8 Dec.

Specific Departmental Courses can be arranged upon request

Registration and other details: Please contact Administration, Simulation Centre, GCPC, Chelsea & Westminster Hospital, 369 Fulham Road, London, SW10 9NH

Email: simcentre@chelwest.nhs.uk
Website: www.chelwestsimcentre.co.uk
Tel: 020 8 746 8632  •  Fax: 020 8 746 8155
Please disregard the advert placed in last month’s *Anaesthesia News* requesting applications for the Datex-Ohmeda Research Fellowship. The fellowship is awarded every 2 years, and therefore will not be advertised until March 2005.

The current Datex-Ohmeda Research Fellowship was awarded to Professor JR Sneyd, Plymouth, for the 2003-2005 period. Please accept our apologies for any inconvenience caused. If you would like any further information, please contact Carol Gaffney on 020 7631 8812.

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**Obstetric Anaesthetists’ Association**

**Obstetric Anaesthesia - Versailles 2004**

**Friday 16th - Saturday 17th April 2004**

Jointly organised by Club des Anesthésistes-Réanimateurs en Obstétrique (CARO) and the Obstetric Anaesthetists’ Association (OAA)

This satellite meeting of the World Congress will be held at The Palais des Congrès de Versailles, which is just 12 miles south-west of Paris, next to the entrance to Louis XIV’s Château de Versailles, often considered to be the most outstanding château in the world.

The scientific programme is varied and contains a range of international speakers as well as free papers and some excellent workshops. The official language of the meeting is English. All details can be found on the OAA website: www.oaa-anaes.ac.uk

**Case Reports in Obstetrics and Anaesthesia**

**Monday 14th June 2004: London**

This one-day meeting is aimed at anyone (anaesthetists, obstetricians or midwives) interested in the clinical management of obstetric problems. The faculty will comprise a mixture of obstetricians and obstetric anaesthetists, and a wide variety of clinical cases will be presented and discussed from a multi-disciplinary perspective. Sessions include “Learning from case reports”, “Obstetric chameleons … or things may not be what they seem to be!”, “Clinical challenges”, and “Maternal mortality”. An interactive audience voting system will be used to make this an interesting, sometimes surprising, day which will refute the belief that the case report is dead! 5 CEPD points.

**Refresher Day in Obstetric Anaesthesia and Analgesia**

**Wednesday 13th October 2004: London**

A one-day course aimed at Consultants, Staff Grades and Associate Specialists who cover obstetrics on-call but who don’t do any elective daytime obstetric work. This course (repeated from 2003) will concentrate on practical aspects of current obstetric anaesthetic practice, and will also touch on some controversial issues.

Topics include current management of analgesia for labour, anaesthesia for emergency Caesarean section, what you need to know about pre-eclampsia and obstetric haemorrhage, and a joint anaesthetic-obstetric session on obstetric crises. Plenty of time will be allocated for audience questions and panel discussions.

This is your chance to pick the brains of an expert panel, and to ask all those silly little questions that you may be too embarrassed to ask at work ………!! 5 CEPD points.

**3 Day Course on Obstetric Anaesthesia and Analgesia**

**Monday 22nd – Wednesday 24th November 2004: Westminster, London**

This annual course, now in its 28th year, is the only one of its kind in the UK and has proved extremely popular with anaesthetists from both the UK and overseas. Leading specialists will present a wide range of core and relevant topics in obstetric anaesthesia and analgesia, including aspects of maternal medicine and fetal well-being. Many areas of current clinical controversy will also be explored and addressed. All presentations will be made using Powerpoint data projection, and registrants will receive an abstract book.

Whilst designed primarily for experienced anaesthetists with a commitment to obstetrics, this intensive course may also be of interest to trainee anaesthetists, midwives and obstetricians. In addition, senior anaesthetists who cover obstetrics on-call but do little (or no) elective daytime obstetrics may also find this a useful way of being brought “up to speed” with current practice and opinion. 15 CEPD points

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**Imperial School of Anaesthesia**

**Research Methodology Course**

24 – 27th May & 21st June 2004

- Research methodology for anaesthetic SpRs
- Interactive small group teaching
  - Tutor groups
  - A faculty of 20

**Venue:** Post-graduate Centre, Chelsea & Westminster Hospital.

**Cost:** £475.

**Application form available from:**

Ms Katherine Wong,
Academic Department of Anaesthetics,
Imperial College,
Chelsea & Westminster Hospital Campus,
369 Fulham Road, London SW10 9NH
Tel: 0208 746 8188
Email: katherine.wong@imperial.ac.uk

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**Registration Enquiries**

OAA Secretariat, PO Box 3219 Barnes, London SW13 9XR, UK
Tel: +44 (0)20 8741 1311  •  Fax: +44 (0)20 8741 0611
Email: registrations@oaa-anaes.ac.uk

Availability of places and on-line booking via our web site: www.oaa-anaes.ac.uk
Saturday 31st May 2003

A bright day. I got up at 7 am as usual and went running. Many people are doing physical exercise. When SARS first came a few months ago, people noticed the importance of living a healthy life.

The hospital asked a management consultant company to organise an outward-training programme for us. About 150 colleagues joined this one day programme. The main idea is to practise team work and the spirit of cooperation. It is interesting to see such a popular programme being practised in a state-owned organisation.

National news press. The Vice Minister of Ministry of Health has announced that the number of specialist SARS hospitals will be cut down from 16 to 7. The Sino-Japanese Friendship Hospital is one of them and we were told to keep working with SARS patients until the end of July.

Sunday 1st June 2003

The fifth day in quarantine. Life is getting boring again, no work but just relaxing day after day. We are doctors and nurses and such a life is hard to imagine. Our working days are usually full of being on call, working shifts etc.

More and more colleagues start to think about the immediate future of our hospital. We are supposed to finish the SARS vocation at the end of July and the hospital will be reconstructed, which will probably last three months. What will we do during this period? And what shall we be living on, since the hospital has no business? The basic salary, a small amount, is paid by the government and this should be guaranteed, but the major part of our monthly earning is from bonuses. If the hospital remains under construction, there will be no bonus for surgeons and anaesthetists. No operations, no bonus.

Other hospitals are gradually returning to their normal routine.

In the evening, at dinner time, I collected many signatures on a white T-shirt. All of us had such a T-shirt donated by a bicycle manufacture company. On it is printed “Angel in white” - in red. My colleagues wrote some nice wishes or blessings for me e.g. ‘Find a good mother-in-law (but not a husband)’; ‘Happy Your Day’ (today is the 1st June, International Children’s Day); ‘I O U’ (this is signed by a senior cardiac doctor, the boss of the ward to which I belong, but I am still confused by the three initials); ‘Remember 8th May’ (this is the day that we first received SARS patient), etc. etc. This will make a great souvenir, maybe to show the next generation.

A nurse from A10 ward had high fever of 38.5°C a couple of days ago and was sent back to the hospital under observation. Now she is OK and confirmed as not being a SARS case. We welcomed her as a hero, winning a victory with champagne in a cheerful mood! She is very happy as well!

I recall that I should have completed my MBA in Hospital Management today.

One confirmed case in Beijing today, and four suspected cases. To date there is a total of 5330 cases in mainland China, with 332 fatalities.

The End

E-mail from Anna in early February this year 2004

The Beijing Sino-Japanese Friendship Hospital completed its SARS mission in mid-July 2003, then undertook a renovation over several months before the hospital was able to resume its medical practice. Meanwhile, in August 2003, I began a six-month period with the World Health Organization’s China office as an "Administrative Assistant for Translation and Publications". My major task was to work with the SARS team at WHO China.

In December 2003, the very first SARS case of the current season appeared in Guangzhou city, capital of Guangdong Province. And then the second, and third... The WHO SARS team conducted intensive investigations in that region, and I was involved as well.

We talked with each of the three cases face to face within the isolation wards where they were kept and we went to their homes for an environmental investigation and further inquiry. I myself visited the home of the first case (a 32-year-old television producer) four times. The whole epidemiological investigation is just like a detective story and I would like to say that the "plot thickens" with each revelation.

Meanwhile, I am impressed by the devoted work that WHO China has been conducting, the spirit they show for their mission and especially the strategy they’ve adopted to cope with the challenging local situation.

I am now back at my clinical practice and will also be graduating with an MBA in Hospital Management very soon in April 2004.

Smile and Retain Smile.

Best regards, Anna Zhao from Beijing
Topics include:

- Attaining competency in IT for trainee anaesthetists
- Distance Learning
- Confidentiality & Data Security in NHS Systems
- Internet Security
- Development of a new product – from design to delivery
- Partnership Business Model – Home Office Project
- And more....

Free Papers
Trainee prize for the best presentation.

Session:
Would you like to present a paper/poster or set up a demonstration? Closing date for abstracts April 16th, 2004.

Conference
Fiona Leach, Westpark Secretarial Services,
596 Burton Road, Derby DE23 6DH
fionaleach@ntlworld.com

Conference Host:
Dr Ranjit Verma, President Elect - SCATA,
Consultant Anaesthetist, Derby City General Hospital,
Uttoxeter Road, Derby DE22 3NE. Tel: 01332-625549,
Mobile: 07973-922919,
Fax: 01332-295128, e-mail: rv2000@btinternet.com

To Join SCATA
Dr Anthony P Madden, Honorary Treasurer - Contact:
SCATA, Consultant Anaesthetist, Department of Anaesthesia, Southmead Hospital, Bristol BS10 5NB. Tel: 01179-505050, Mobile: 07778-417939,
e-mail: ap_madden@madden-33.freeserve.co.uk

BRISTOL MEDICAL SIMULATION CENTRE
FORTHCOMING COURSES for 2004

22nd January, Senior Consultant Refresher Course, for mature consultants in Anaesthesia (£150)
2nd & 3rd Feb, 2 Day Paediatric Anaesthesia Critical Incident Day (GRL), for paediatric anaesthetists (£275)
25th Feb, Management of Obstetric Emergencies 1 Day Course, for O & G trainees & anaesthetists (£150)
(To book Tel 0117 9595176)
19 March, Paediatric Anaesthesia Critical Incident Day (GRL), for paediatric anaesthetists (£160)
17 March, NCCG (SAS) Critical Incidents Day, for staff and associate specialist anaesthetist (£150)
26th March, Medical Emergencies Concepts Course, for SpRs & consultants in Emergency Medicine, ITU & Anaesthesia (£200)
1st April, Senior Consultant Refresher Course, for mature consultants in Anaesthesia (£150)
28th April, Management of Obstetric Emergencies 1 Day Course, for O & G trainees & anaesthetists (£150)
(To book Tel 0117 9595176)
29th & 30th April, Management of Obstetric Emergencies Course, for O & G trainees & anaesthetists (£250)
(To book Tel 0117 9595176)
26th & 27th May, Team Training for Core Critical Incidents, for nurses and clinicians (£270)
20th May, Medical Emergencies Concepts Course, for SpRs & consultants in Emergency Medicine, ITU & Anaesthesia (£200)
7th & 8th June, Two day Paediatric Course, for all levels of anaesthetist (£275)
1st July, Senior Consultant Refresher Course, for mature consultants in Anaesthesia (£150)
5th July, Ambulance Day, for all ambulance personnel (£80), To book Tel 0117 3428649
17th September, OSCEs, for Primary FRCA (£100)
24th September, Medical Emergencies Concepts Course, for SpRs & consultants in Emergency Medicine, ITU & Anaesthesia (£200)
4th November, Senior Consultant Refresher Course, for mature consultants in Anaesthesia (£150)

Specific Departmental Courses can be arranged upon request (fee negotiable)
Includes coffee, tea, biscuits and lunch. CEPD points approved; 5 pts (for 1 day) & 8 to 10pts (for 2 day courses)

For bookings please contact Jane Southway, Secretary on Tel (0117) 9277120 or Alan Jones, Centre Manager, The Bristol Medical Simulation Centre, UBHT Education Centre, Level 5, Upper Maudlin Street, Bristol BS2 8AE Tel (0117) 3420108, e-mail alan@simulationuk.com ; and/or visit the website at http://simulationuk.com (This contains course details)

Difficult Airway Society
Annual Meeting
24-26 November 2004
Leicester City Football Club Walkers Stadium
And Leicester Tigers Football Club

The meeting will commence with hands-on workshops on Wednesday 24 November at Leicester Tigers Football Club

Followed by

Two days of lectures, poster presentations & exhibition 25-26 November at Leicester City Football Club Walkers Stadium

www.scata.org.uk

NEXT MEETING – 6/7 MAY 2004
MIDLAND HOTEL, MIDLAND ROAD, DERBY DE1 2SQ

Topic: Attaining competency in IT for trainee anaesthetists
Distance Learning
Confidentiality & Data Security in NHS Systems
Internet Security
Development of a new product – from design to delivery
Partnership Business Model – Home Office Project
And more....

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THE ASSOCIATION OF ANAESTHESISTS
of Great Britain & Ireland
The Portsmouth and Southampton University Departments of Anaesthetics bring you...

GAT
2004
Annual Scientific Meeting
Portsmouth, 16 – 18 June 2004

NOT TO BE MISSED!
- Highly topical and educational scientific programme
- Guaranteed lively and energetic social programme
- Dinner on HMS Warrior
- Accommodation with sea views

BOOK YOUR STUDY LEAVE NOW!
FOR FURTHER INFORMATION AND BOOKING DETAILS CONTACT:
Nicola Heard
Tel: 020 7631 8805 Fax: 020 7631 4352
e-mail: meetings@aagbi.org

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The Mersey Selective Course
A five-day course of lectures & tutorials designed to cover the more esoteric aspects of the Primary Basic Sciences.
(Trainees are advised to consider this course two to three months ahead of the MCQ paper)
24 – 28 May • 13 – 17 September
07 – 11 February (05)

Primary Prep Course (MCQ)
A six-day course of intensive MCQ analysis intended only for candidates within weeks of sitting the Primary FRCA Examination
28 March (Sunday) – 2 April • 22 August (Sunday) – 27 August
21 November (Sunday) – 26 November • 20 March (Sunday) – 25 March (05)

Primary Prep Course – (OSCE/Orals)
A seven-day course of Master Classes, OSCE & Viva Practice, available only to trainees who have been successful in the preceding MCQ paper.
(Failure to ‘get a viva’ will merit a refund of the Course Fee)
7 May (Friday) – 14 May
17 September (Friday) – 24 September • 14 January (Friday) – 21 January 2005

Final FRCA (Booker) Course
Two weeks of SAQ Practice & Analysis
MCQ Practice & Analysis
Lectures/Tutorials
Candidates may register for both weeks or for either one of the two weeks
19 – 23 April • 26 – 30 April
27 September – 1 October • 4 – 8 October
18 – 22 April (05) • 25 – 29 April (05)

Final FRCA
S.A.Q. Weekend Course
Master Classes in Style & Technique
Supervised Practice & Analysis
2 pm Friday 12 March – 4 pm Sunday 14 March
2 pm Friday 10 September – 4 pm Sunday 12 September
(Not Available to Mersey Deanery Trainees)

Final FRCA
Viva Weekend Course
Friday 11 June – Sunday 13 June

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Recently I heard someone use the phrase “The goal-posts are have not settled yet on this one”, a useful evocation of the way many view the current situation relating to medical politics: each time we seem to have a slight grasp of what is going on, it changes. First we had Unfinished Business (aka Unfinished Training), promising an exceedingly brave (but not very new) world; then the follow up document, Modernising Medical Careers, which, many thought, had eliminated many of the unworkable infelicities and irrelevancies of the first. Listening carefully, ears, of course, to the ground, there are signs, however, that the grand plan of the first document is not in fact seen as the unworkable, barking mad, nonsense it clearly is. Recently a member of PMETB was heard pronouncing on implementation of Unfinished Business completely unmodified.

When it comes to ever mobile goal-posts, I reckon this comes from us catching occasional glimpses of decoys, the real goals being hidden in a DOH agenda.

When do you stop believing the cock-up theories, and move over to conspiracy ones? In general, cock-up rules, but in this case, I wonder. I think they have devised a cunning plan, and are keeping it from us. And who are they, you ask, who would use us so? Not the politicians, who have far too much to do seeking self-advancement, but the Civil Servants, today’s Baldricks. They control the politicians, since most politicians are extremely ignorant of departmental business. Even the greatest suffer thus, even Mrs Thatcher, when at Education. Those who resist are leaked and briefed against, especially when they are right!

What are the signs that they have a cunning plan? Firstly, that the Servants are concealing things from us. They present one face in public, and quite another when they meet doctors privately. Take Nigel Crisp, for example. At a doctors’ dinner recently he was noted to be diffident, polite, a mild mannered, Clark Kent-ish sort of fellow. But on the radio recently, I heard his clear, confident voice, more Ken Clarke than Clark Kent, delivering all the usual crap, of course, but doing it really well. I could not believe that was Sir Nige, but it was! Pondering the discrepancy, I could only conclude that the buffoon was an act. He is concealing his effectiveness because he does not want his plans known until the battle is won.

Nor is he alone in this concealment of effectiveness. Others have the same welcoming diffidence and apparent friendliness, but - perhaps less Machiavellian than Sir Nigel - let the odd contemptuous glance slip past their guard. Look for it next time you are with your chief executive, you’ll see what I mean. Then there is the PMETB functionary’s error alluded to above – perhaps only tactical, but revealing! It all adds up. Just because you’ve got paranoia doesn’t mean they aren’t out to get you. I think the Servants are up to something. But what?

Here we have to speculate, as they are covering their tracks with practised ease. But enough little elements of the plan do escape – such at the error mentioned – to allow a fairly confident conclusion. They intend to implement Unfinished Business, unamended, including the hidden agenda.

The totality consists of:

- 2nd Foundation Year (F2Y);
- Run-through training SHO-SpR (RTT);
- Eight training streams (not excluding anaesthesia, surprisingly);
- Shortened training – perhaps 5 yr to CCT, perhaps less – to “Specialist” status;
- “Higher Specialist” (read “SR”) training to become “Consultant”, to follow basic training but only for a select minority, the majority to continue as “Specialists” (read “Staff Grades”);
- Restructuring of the NHS to the German model: 1-2 “Consultants”, the remainder “Specialists” in each department.

Why do they want this? You could cynically say they have realised their mistake in imposing Calman training on us, and decided to bring back the SR, formalising the status of the long-term stuck-registrar as a “Specialist”. Some, more fogyish, might even welcome that.

More likely, however, they have come to believe the consultant body is too independent to implement their ornate plans for care delivery, and they wish to destabilise us preparatory to disempowering us. They like the European model, where they will only have to work with (stuff with gold the mouths of) Departmental Heads rather than numerous consultants. This is what the civil servants, and the doctors who work as civil servants, want; and once they have it, they have us!

What should we do? Is the plan a good one? Should we worry? We’ll be retired before etc. etc. – but then we will be the patients, having major surgery, etc. etc. Space forbids covering that this time: See next month’s thrilling instalment.

de Quincy.

(Dr de Quincy is a consultant at a DGH near you)
Two historic “firsts” took place at the Winter Scientific Meeting in London in January. The Presidency of the Tricky Vein Society (TVS) changed hands for the first time and its recipient, Dr Jack Strong, was the first Irishman to achieve this honour.

Dr Strong was ultimately a popular choice but the internal politics (some may say “wrangling”) of the fledgling society could have seen at least two other contenders win the accolade. What was originally hoped to be a friendly election based on a show of hands became one with much blood on the sand and eventually the Electoral Reform Society was called in, at no little expense, to organise a postal vote.

There is no doubt that the new specialist tricky vein societies that have burgeoned over the last two years had their sights on the presidency of the parent society and some, including the Paediatric Tricky Vein Society, the Difficult Airway and Tricky Vein Travelling Club, the Tricky Veins for Non-Physician Anaesthetists Society and the Tricky Vein Research Club have threatened to move out from under the umbrella of the TVS and set up their own societies. At time of going to press this issue has still not been resolved and has been compounded by the rumour that the College has offered cut-rate accommodation for these splinter groups. Ultimately it has to be assumed that it was the voting power of the combined Irish membership that swung it for Dr Strong with up to ninety percent of the Ulster membership ticking the appropriate box.

The out-going President of the society was under the orthopaedic surgeon’s knife while these dramas took place. Nevertheless Dr David Saunders was able to convey his congratulations to Dr Strong from the confines of his sick bed and also to request that I, in my capacity as honorary secretary and treasurer, hand over the badge of office to the new president (see photograph).

Due to a collaboration with the Society for Computing, Tricky Veins and Technology in Anaesthesia our outgoing President Dr Saunders was able to deliver the AbboQuickFlon Lecture, our society’s most prestigious honour, from the confines of his hospital recovery room. Dr Saunders showed data that indicated increasing difficulty in achieving cannulation at the first attempt was related to the degree of the “cannulator’s” hip flexion. He showed a series of graphs relating the diminishing extent of his own hip flexion to his First Attempt Success Rate (FASR) and with an $r = 1.0$ value. There can be no doubt that increasing handicap due to arthritis is associated with difficulty in cannulating tricky veins. Clearly the next stage of this work will be for our ex-President to show an improvement in FASR as his hip returns to its normal range of movement.

Our society continues to grow from strength to strength. Opinion is divided whether the multitude of specialist societies and devolved societies are healthy or not and the debate continues over whether non-anaesthetists should be welcomed as members. If we decide to be solely an anaesthetic specialist society, should we allow trainees to become members?

These dilemmas may still be with us next year and there is no doubt that Dr Jack Strong is going to have a busy term of office. Those consultant members of the AAGBI who are interested in joining the TVS can contact me by e-mailing roddie.mcnicol@apollo.fir or Carol Gaffney at carolgaffney@aagbi.org.
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“Confidence building + Focusing”
“MCQ wide ranging & testing”
“I really know (now) what the examiners expect from us”
“The contents of the course were well organised”
“It helped me to realise what to expect in the exam”
“Most of the lectures were fantastic”
“It definitely gave me a good insight in the syllabus and the missing gaps from my part”
“Overall I think the course was fantastic”
“I would have welcomed an 8am – 6pm day to learn more”
“Excellent syllabus/content with wealth of knowledgeable speakers”
“Generally lecturers spoke extremely well & explained & simplified things well”
“Very high standard of lecturing”
“Food was absolutely fantastic”
“Food at lunchtime was fantastic”
“I think it is essential to attend this course”
“I found it a very good exercise”

“It is very much useful & gave right direction”
“Good information on understanding difficult topics”
“In general, good speakers, exam orientated talks”
“A lot of very good animated speakers from (the) “real world”.
“Knowledge well relayed and generally with a practical aspect as well which made the more mundane subjects interesting”
“Very well organised, nice people”
“I have become more confident regarding some aspects of the syllabus”
“In general a high standard of presentation & teaching – thank you”
“My understanding in difficult areas has improved greatly”
“Excellent course. Topics were very appropriate & taught very well”
“Isomers, Statistics, Damping lectures excellent & my favourites”
“Gave me an idea what all I need to be prepared with before attending the Primary FRCA”
“Isomerism, Pharmacokinetics, Physics, Damping – well covered excellently”
“Over(all) a wonderful course which I will recommend to every trainee SHO in the UK”
“Pretty much useful course structure”
“The fact that this trivial point (Handouts before Presentation) is the only improvement I can think of reflects how valuable I have found the course”
“I am preparing my exam for August or November so this course in Feb 2004 has not only given me a good kick-start but also a belief that there is still a lot of gaps of knowledge needed to learn”

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In 1953 there were four posts advertised in Wales for consultant anaesthetists. Two hospitals had no applicants and the two of us who were appointed had been senior registrars for only one year. The lack of any published papers had no effect on my application.

My first “exposure” to research had come in 1950 in Cardiff. The anaesthetic records were put onto Hollerith (a sort of mechanical computer) punch cards and we were required to hand sort four page anaesthetic records in preparation for a paper on gallamine. Professor Mushin (rightly) required accuracy, and the number of recounts needed to ensure that the totals added up to 300 rather than 301 or 299 would have done credit to a closely fought by-election! When the Hollerith finally disgorged a year’s statistics, it produced (amongst other items) the information that retention of urine was a complication of “thiopentone, gas, oxygen and trilene” anaesthesia. Not surprising, as this was the routine anaesthetic for cystoscopic procedures! I decided I would only get involved in research in future if I came across a problem which interested me.

One morning, shortly after I had left for work, my wife slipped and broke her ankle. One of my two consultant colleagues was on holiday, and the other would be occupied at a hospital 20 miles away until about 7 p.m. At lunch time, my wife, a very determined lady, told me to get on with the anaesthetic as she had no intention of waiting any longer. I gave her an injection of methohexitone, and as she went to sleep she complained of pain! This gave me the stimulus to investigate. I soon found that rapid injection reduced the incidence of pain, so I standardised on a dose of 0.75 mg/kg, given over a timed period of 30 seconds. With this regime 10% of patients complained of pain, discomfort, warmth etc. All patients who complained of anything were questioned after they had recovered and half of them remembered something.

This was long before the days of ethical committees and informed consent. After consulting the manufacturers as to the safety of adding a small amount of lignocaine to the methohexitone, I found that this reduced the incidence of unwanted effects to 2% on induction and 1% with memory. I felt that this was a reasonably small number, so continued to use the mixture as my routine induction agent. This did not become well known, although a letter was published in Anaesthesia in 1969.

I was not an enthusiast for suxamethonium, partly because of the post anaesthetic aches and pains, but mainly because of a morning when I finished a short ENT list at 11 am but was still ventilating the last patient 3 hours later, there being no resident anaesthetic staff. Unfortunately, I was due at a hospital over 50 miles away for a 2pm list. When I heard that fazadinium might provide more rapid intubating conditions, I was able to obtain a supply for trial. My co-author was the computer expert from the drug company. He produced masses of tables, averages, etc., most of which we discarded in writing the paper; and the Editor removed about half of what we had left in!

Following this paper, I was approached by Dr Roy Hughes, who was developing atracurium for Wellcome, to undertake a clinical trial under routine operating conditions in a busy theatre in a small hospital. This was a practical rather than a scientific trial, as it would soon become obvious if a new agent caused delays in induction and recovery or provided poor operating conditions. Lists continuing much later than usual would soon lead to protests from surgical and nursing colleagues!

Llandudno Hospital had a very good local reputation. Only two of the 300 patients refused informed consent. When visited postoperatively, surprisingly few patients asked how the new drug had behaved. An unexpected event in the trials was the making of a film of an anaesthetic for inclusion in the promotional video, and it was interesting to see experts in an entirely different field at work.

After the launch of atracurium, I attended many anaesthetic meetings to describe my series of 300 patients. I looked into the incidence of skin rashes and the use of continuous infusions without sophisticated monitoring equipment. This provided continued research interest until I retired from fulltime work aged 63 (although I continued consultant locum posts until just past my 70th birthday).

My continuing atracurium adventures included not being met at the airport as expected and having none of the correct currency (Libya, Dubai, Norway), giving a talk to an audience of anaesthetists and finding most of them were not and using time-expired atracurium in Kurdistan (North Iraq), when for a short time I was the only anaesthetist in a city of 3/4 million, as all the local hospitals had closed while the city changed hands during fighting between rival Kurdish parties. My last use of atracurium occurred when I was 74, having been away from anaesthesia for nearly four years, but that is another story.
Dr Frank Walters is to be congratulated for devoting his entire RSM Presidential Address in October to the state of health services in poor countries, especially in Africa.

I can read the BMJ or the Lancet, or scour the websites of development agencies until cross-eyed, yet barely glean one useful fact. The truth about what is or is not going on seems to be the casualty of our western obsession for excellence on the home front, for believing contrived statistics and evidence, and the fearful, relentless pursuit of consensus opinion.

It is a fine thing that from being an obscure specialty news letter, Anaesthesia News is now required reading for the student of health development.

My guess is that we are currently, quietly and smoothly entering a third phase of Africa’s health catastrophe, under the wise guidance of health economists such as Prof. Jeffrey Sachs of Harvard. He is chairman of WHO’s Commission for Macroeconomics and Health (CMH - son of HFA, Health for All by 2000’, if you recall). I am guessing, since the citadels of development such as the World Bank, DFID and even the WHO give out no information (or ask for any). Health Development in poor countries has, for reasons I barely understand, become a state secret. (Only by including three letters B, B and C together, as though they represented the British Broadcasting Corporation, was I finally able to get a response from DFID London to my last article in Anaesthesia News on the failures of that organisation. It gave little away.)

Earlier phases were the failed transplant of traditional western-style health systems to the rich substrate of African-style health requirements, with only humanitarian incentives for the workers. Instead of down-sizing to fit local economics. This ‘Florence Nightingale’ model failed and the African doctors went to Manchester instead.

The aid donors spotted this and started another phase in the late 80’s, a more active process known officially as ‘projectisation’. (The Word speller won’t accept this word, but never mind: it has died already!) To be fair, they knew they would ultimately have to pick up the bill so, in this rushed scheme, outsiders told the Africans what to do in a particular field and expected it to be done in roughly 3 years per field. To make it even more improbable, all the clinical doctors were fired and the projects were designed by managers for managers. There were still some people on aid agencies’ staff called ‘Dr’ but they, like Darth Vader, had long gone to the Dark Side, and instead of treating or even thinking about the sick, they spent their days staring at computer screens, ticking boxes or doing other office-type activity.

Projectisation occupied the 90’s and was dead and buried at the end of that miserable decade for Africa. I saw the terminating memo signed by the bwana mkubwa at DFID: “No more ‘OUR Projects!’’. By order: D.Nab.” There may be a record of this decade of massive British Government expenditure somewhere.

Phase 3 is more or less inaccessible to the non-cognoscenti health worker, since it involves no health at all. This is how they get away with it: you fall asleep while reading. It is just economics, most usefully summarised by the document called NEPAD, launched with great pomp in May 2002 at the Canadian G8 summit but hardly referred to since (though a Google search will find it easily enough). Any African waiting for treatment under this phase will have a long wait. Even his children will have died before anything happens since it is the era of total system change in Africa. De-Africanising the continent, in other words.

Will there be a 4th phase at some time? This is why I applaud the efforts of Frank Walters in keeping the health of poor nations on the agenda, in print at least, if not enough in action. The 4th phase (assuming the 3rd fails as did its predecessors) may be a return to simple medical treatments and imaginative, clinically oriented projects conducted by enthusiasts – if any can still be found. Managers and accountants would be there, but in the background, ordering things and counting money but not making decisions. It’s so crazy it might just work.

Paul Fenton
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Teaching involved interactive lectures in the class, one to one instruction in theatre and teaching ward-rounds. I used "mind maps", drawing "spider diagrams" on a black or white board so my efforts were not effected by frequent power failures (which had the habit of happening at the most inappropriate moments) or the breaking of an overhead projector bulb.

The final exam for the most experienced trainees involved written paper, practical and viva. The viva, which took 1 hour for each trainee, included 10 questions on theoretical and clinical issues. After the exam a detailed feedback was provided. I must admit I enjoyed sitting on this side of the examination table for the first time.

I noticed the role of an anaesthetist was limited to intra-operative management. My trainees were the "creme de la creme" among nurses in the hospital and were perfectly capable of taking an active part in the optimisation of critically ill patients and post-operative pain management. I encouraged them to expand their involvement into the whole peri-operative period.

After managing several very sick patients with abdominal emergencies, I invented "Alex's law". This states: "every patient coming with an abdominal emergency to the CBC hospitals is profoundly dehydrated, hypovolaemic and oliguric (or anuric), unless proven otherwise". These patients, including children, would present very late, after visiting traditional healers (recognisable by the green, leafy stomach content). We introduced pre-operative resuscitation with appropriate volumes of saline (frequently 4 - 8 l within initial 3-5 hours) and only operated once their condition had improved. As there was no ICU or HDU, our task was to improve the patient's condition enough so they could return to the general ward after surgery. Without invasive monitoring, I was amazed how much information could be gained from simple basic clinical signs. Assessing capillary refill became my good and faithful friend, which together with urine output and moving "temperature line", provided an excellent guide to successful fluid resuscitation. The choice of fluids was between saline and blood. Blood was expensive and not always available so usually there was only one choice.

Analgesia was a rather neglected area, as pain was regarded as part of life. The most commonly used opioid was pentazocin (Fortnal), an agonist-antagonist, which caused more confusion and less pain relief then morphine. Oral preparations of NSAIDs, paracetamol and codeine were available but underused. I taught the trainees how to perform caudal blocks for children and also other simple regional techniques without the use of a nerve stimulator!

My time in Cameroon was also an interesting management and audit experience. Lois was an "action women" - she did not let good ideas disappear, she just did it! I learned not to get frustrated by the reality, which was often far from ideal. I was involved in the hospital audit of peri-operative mortality. I made recommendations and drafted a protocol for fluid resuscitation. We started weekly teaching on the basics of critical care for ward nurses. However, just a few hours after my talk on management of the sick child, which included DEFG = "Don't Ever Forget Glucose", a child died post operatively due to hypoglycaemia! I had to learn the word "Ashiah" meaning something like "sorry, that is life".

Fortunately, Mother Nature offered me a wonderful diversion to forget the stresses of the day: the fantastic green countryside, valleys, mountains, waterfalls and flowers. We did long walks to visit waterfalls or climb to the top of surrounding hills.

Visiting different churches every Sunday offered a fascinating insight into the life of the local people. We were often invited to sample traditional food like fu-fu and djama-djama. The friendliness and kindness of people were truly remarkable.

I was immensely impressed with the work done by Lois during her 2 years in Cameroon. I greatly respect her enthusiasm, knowledge, experience and teaching skills. I learned a lot from her. I was also impressed by my students and admired their enthusiasm.

I wish to thank WFSA for generously sponsoring my expedition. I am also grateful to Cook (UK) Ltd and Abbot Laboratories for their donations of precious equipment and medication.

References:
1 Safe Anaesthesia Lucille Bartholomeusz 1996. Currently being updated
2 Anaesthesia at the District Hospital Michael Dobson 1993
3 Update in Anaesthesia 6 monthly educational journal, also available on line www.nda.ox.ac.uk/wfsa/