This month...

John Dick reports on a very successful GAT ASM in Portsmouth

Last report from President Peter Wallace

Matthew Size writes a letter from Malawi

Dr de Quincy muses: DoH or MoD?
Portsmouth was the venue for the 37th Annual Scientific Meeting of the Group of Anaesthetists in Training. The town itself, which is in fact an island, resounds with British maritime history: Royal Navy ships would have collected their gunpowder and cannon balls in Gunwharf Quay, and it is the final resting place of many famous ships, such as Henry VIII’s Mary Rose and Nelson’s HMS Victory. Dr James Lind was a physician at the nearby Haslar Hospital, and conducted one of the earliest clinical trials to find a cure for scurvy.

The meeting began with a superb talk on “Nelson’s golden hour” by Dr Gordon Craig. He remarked on the era when physicians were known as ‘scholars’ and ‘gentlemen’, and surgeons labelled as ‘barbers’ and ‘journeymen’! He then re-enacted Nelson’s fatal injuries at Trafalgar to consider whether Nelson would have survived with modern trauma care.

The first session on environmental/military medicine was fascinating. First we heard from Major Sundeep Dhillon about his experiences on Mount Everest, and the physiology of hypoxia. Group Captain Neil McGuire then outlined how aero medical repatriation is carried out by the armed forces - probably the gold standard for patient transfers. He mentioned that most of the transfers are performed during the night (a bit like ours then!). Finally, Commander Bob Sawyer explained the physiology and the dangers involved in escaping from a submarine. His talk was both achingly funny and chillingly real.

The afternoon began with a sobering session on the topic of ‘the sick doctor’. Colin Berry started with a sensitive talk entitled “Boozing and abusing for experts”. In this, he outlined his research and also that of the Association working party on ‘Substance abuse amongst anaesthetists’. Dr David Saunders spoke very cordially about the ‘Help for the sick doctor’ scheme that he was instrumental in setting up. The last lecture was from the psychiatrist Professor Ilana Crome who updated us on the current thinking within her profession on ‘dependence’. The final session was amusingly titled “Bleedin’ Hell” and covered the recent history of blood transfusion, conservation strategies and artificial oxygen carriers.

The first party was held on the gun deck of the HMS Warrior, the first ironclad warship. With the sun setting beautifully over the harbour there was plenty of food and drink below decks to prevent scurvy, and a rock band played to keep all hands amused (apparently drawn from local medical talent!).

Day two kicked off with a session on medico-legal matters given by solicitors who have clinical negligence as a special legal interest. Interestingly, there were talks from both viewpoints: defending and claiming against NHS Trusts. We have been warned!

There were six presentations for the registrar’s prize. Such was the quality this year that four were awarded prizes. The winner was Dr Daniel Wheeler with the results of his web-based survey to assess doctors’ confusion with the different means of expressing the concentration of drugs in solution. A very clever research idea, and I’m sure I wasn’t alone in the audience in muttering ‘I wish I’d thought...’
of that!” The audit prize was hotly contested with 33 entries and was won by Dr S Lewis.

Thursday afternoon began with the AGM in which Dr James Down gave an excellent presentation on the roles of the GAT Committee, and welcomed two new members (congratulations to Dr Chris Meadows and Dr Jane Sturgess). Drs Nevil Hutchinson and Karen Kerr, who are leaving the Committee after many years of hard work, were thanked sincerely for their efforts.

I thought that the trainee conference was a resounding success this year. Three speakers gave short, clear presentations on topical subjects that stimulated great discussion from the floor for the following 40 minutes. First, Dr Peter Maguire updated everyone on the latest on the European Working Time Directive, followed by Dr Sara Hunt who explained the emerging role of Anaesthetic Practitioners (having visited two hospitals where APs are currently being trained). Finally Dr Simon Whyte outlined the developments with the new ‘Hospital at night’ scheme, and where anaesthetists may be involved.

The Pinkerton lecture is always fascinating, and this year we were not let down by Admiral Frank Golden. He spoke about the physiology of immersion related deaths that claim half a million lives per year worldwide. Some of the subjects he covered included fresh versus salt-water immersion, critical aspiration volumes, the cold shock and diving reflexes, hypothermia, survivals after prolonged immersions and post rescue collapse.

FIFA had very kindly scheduled the England - Switzerland Euro 2004 game to start just after the Pinkerton lecture and, following the 3-0 win by Rooney and Co, we segued neatly to the Annual Dinner! Guests were welcomed with a champagne reception with music provided by the Royal Marines Band. A four-course banquet followed before “The Booze Brothers” came on stage and rocked the house. In the next-door bar there was the opportunity to let off some steam at bar bungee or beam jousting, and the night finished with a great set on the decks by the DJ who seemed to choose just the right tracks.

The following morning most people were feeling pretty ‘gatted’, but there was a great turnout nonetheless for an excellent session all about ‘Critical Decisions’. Dr John Knighton gave a clear presentation of evidence based medicine issues in ITU. There followed an excellent ethical debate surrounding case scenarios entitled ‘Turn me on, turn me off’ which stimulated a lot of participation from the floor. ‘Obesity’ was the final topic to round off the meeting. There were interesting talks from a dietician, a surgeon and an anaesthetist about this expanding phenomenon.

The lectures were held in the impressive Guildhall (The Darkness played there a few week’s earlier) and lunch was taken out on the steps, bathed in sunshine, ‘Kids from Fame’ style. The Association events team did a fantastic job in helping transform the lecture auditorium into a dining room and dance floor in time for the Annual Dinner: a big thanks to Jo Barnes, Nicola Heard, Caroline Strickland, Natalie Finn and Emma Hollington!

Our thanks go to the local organizing committee, chaired by Dr Marie Nixon (a former GAT chairman) and to Dr Andy Pitkin (who kept the GAT Committee informed of progress) for providing such a great meeting. Well done!

John Dick
Honorary Secretary
GAT Committee

A Memorable ASM

For those who missed the Portsmouth ASM, GAT will be at Oxford next year. Between now and then the committee will continue their work on the Hospital at Night project and the anaesthetic practitioner pilots. We will also be looking at the training surveys completed at the ASM and shall be producing some results. For non-committee members there is plenty to keep you busy:

The annual consultant interview seminar is now tri-annual, with the next one running on August 31. This seminar always attracts a waiting list, as places are limited to just 10 to facilitate the interview practice available. So get your names in now.

If you’re not quite ready for your consultant interview, then perhaps obtaining some financial or leadership advice will be good use of your study leave. Both these seminars run in September, the finance seminar has its inaugural airing and a success first time round will secure a continued run.

The working abroad seminar is set for November. The seminar works in conjunction with the Working Abroad Guidance Handbook, the 2nd edition of which was launched at Portsmouth. The handbook is available from the Association website, those attending the seminar will receive a hardback copy with registration.

In the meantime keep an eye out for the consultant supervision guidance that the Association will be releasing shortly.

As always, if you wish to contact GAT you can access the committee via the AAGBI website or email GAT@aagbi.org. The website is continually being improved so, if it has been a while since you last visited, do ‘pop’ in. All our publications can be accessed, as can reports from GAT meetings and correspondence we have sent on behalf of the trainee membership. If you would like to leave GAT a question, please feel free.

Karen Kerr
This will be the last report I will submit to Anaesthesia News before my term of office as President is completed in September. It has been a privilege to serve as President and a most enjoyable experience, if somewhat stressful at times. Based in Glasgow, the downside has been all the travelling, but if I am honest, I don’t complain about the travelling that I have undertaken to represent the AAGBI at various international meetings in Europe, Australia and Canada! These visits have confirmed the high respect with which the Association and British anaesthesia is viewed throughout the world. The contribution that our members have made, and are continuing to make, was emphasised at the recent World Congress in Paris, where British anaesthetists were acclaimed. This reminded me that it is wrong to limit one’s horizons to local priorities and it is worrying that, in the current contract discussions, many Trusts are loath to accept any responsibilities outside local clinical duties. Clearly each Trust has a duty, as part of the NHS as a whole, to accept external contributions for the greater good of the NHS. Trusts must not become excessively parochial but we, in turn, must be responsible and ensure that time requested as professional or duty leave is justified and used effectively to ensure that patient care benefits. Locally, we all know a few colleagues who might manipulate the system, but the Association will demand recognition for the committed majority of anaesthetists who offer more than is expected in support of the NHS, whether on Advisory Committees, in Postgraduate Education, or on Association, College or other Specialist Society duties.

At the moment contract doubts do not appear to have affected the number of those interested in serving on Council of the Association. Voting papers are circulating, three candidates to be selected from the twelve who are standing. While it is important that Trusts release members to contribute, it is also essential that the Association is efficient with their time, and to this end we are currently reviewing the meeting’s calendar to reduce the number of trips to London to a minimum. We are also taking a look at utilising the new electronic world to see if more can be done without direct contact e.g. video conferencing. Council members do spend a lot of time on the affairs of the Association, and I am very grateful for the support I have had in the past two years. Useful “Glossies” continue to be issued which become very important facets of clinical governance in every Trust. Checking anaesthetic equipment 3 (2004) is an example in which we can be proud of our contribution, particularly after the EGBAT Report on blocked tubes. Work continues on new and updated guidelines. I believe the next to be published on fatigue will have an important effect on new working practices imposed on us following the restrictions of the Working Time Directive.

Our events and seminar programmes are of the highest priority, and are extremely popular with members but take considerable time to organise. With CPD as a mandatory component of appraisal and revalidation, the new Annual Congress is indicative of how we wish to expand this role. Another area where increasing advice and support will be required is on contractual matters and working practices, particularly with the potential fragmentation of the Health Service, not only between the different countries of the UK, but within England in Foundation Hospitals and Independent Treatment Centres. Although the BMA will continue as the principal negotiating body, there will be a need for specialist advice for anaesthetists and that is a role the Association will undertake. As ever, this will require more resource and time but is a crucial service for our members. It is also important that your views are communicated to the many new bodies influencing the NHS, such as NICE, NPSA, CHAI and NCAAI. I believe it is a positive feature of the specialty that there are two major bodies to represent us. We must use the Association and College in a complimentary rather than a competing manner to emphasise the important contributions that anaesthetists make to healthcare. As President of AAGBI, I am co-opted on to the College Council and there is a reciprocal arrangement with our Council. It is important that our two bodies sing, if not in unison, certainly in harmony. Peter Simpson, the President of the College, shares these views, even down to joint karaoke attempts which were reported in these very columns! Be assured, however, that the College and Association have very clearly delineated, differing responsibilities and there will always be occasions where emphasis and priorities are perceived differently. As in any healthy family, there will be the odd squabble.

An example of this is in the introduction of non-physician anaesthetic practitioners to the UK workforce. A couple of years ago the College and Association appeared to be heading in different directions. The whole question
is possibly the most difficult matter I have had to deal with in my term as President, but with sensible discussion and cooperation, both the College and Association are now speaking with one voice and influencing the process by major input to the Stakeholder Board which is directing the piloting of these initiatives. My initial instincts, like many of you, was that this was not a route we would wish to go down, but on calmer consideration, to stick our heads in the sand or give an absolute “no” would have been foolish and, indeed, ineffective. We have to examine all possible answers to the major shortfall in the anaesthetic workforce, and we must also accept that change is coming to everyone in the NHS, with similar initiatives already in place in surgery and medicine. What appeared a huge threat originally, is now organised in local pilot schemes supervised by anaesthetists, with the College taking the lead in setting the academic standards and competencies. The College will also probably regulate emerging anaesthetic practitioners, when and if the time comes. We now have a major influence on future developments, which is preferable to having some hare-brained scheme imposed on us with attached political agendas. It will however require close observation, and is yet another matter that will take up Council’s time and wisdom.

Much of my time as President has been involved with the development of 21 Portland Place. If you have not yet visited, you are possibly fed up with being told how wonderful it is. I will not repeat the “spin” but “DO” come and see what your subscriptions have achieved. Completing my term brings certain comforts; my successor, Mike Harmer will have the task of agreeing a compromise with WTD working practices, and also dealing with the complications of the possible introduction of Anaesthetic Practitioners. The proposals to reduce training time is fundamentally RCA business, but suggestions from Trusts of how resultant emergency rotas might be run with consultants will require the AAGBI to take action.

Lots of things to do! Don’t be daft and think that everything was perfect a few years ago. There is now more money in the NHS to improve services. Anaesthetists must take a lead in directing how improvements should be achieved in the areas we are expert in. If we do not rise to that challenge in the NHS, we will deserve confirmation of our current position in independent practice, where we seem to accept that we are less valuable than our surgical colleagues.

I would be bitterly disappointed if my successors accepted that suggestion.

Peter Wallace
Private Practice 2004 and Beyond
Maritime Museum - Albert Dock, Liverpool
Friday 19th November 2004

- The NHS, Private Practice and the need for a Properly Trained and Flexible Medical Service
  Professor Roger Dyson
  Former Director of the Clinical Management Unit, Keele University

- The Position of Private Practice and the NHS
  Mr Frank Burns, Chief Executive, Wirral Hospital NHS Trust

- Once Earned, how do you keep it?
  Mr Ken Murphy and Mr Giles Garlik, SMA Group, London

- Will Private Practice Survive in Great Britain?
  Mr Rob Royce, Head of Policy Developments & Provider Relations BUPA

- How to Organise a Successful Private Practice
  Dr Ray Stanbridge, Director of Stanbridge Associates Ltd, Lincoln

- Working Together - Three Successful Models
  - Group Practice
    Dr Sean Tighe, Consultant Anaesthetist, Grosvenor Nuffield Hospital
  - Partnership
    Dr Keith Stevens, Consultant Anaesthetist, Wirral Anaesthetic Group
  - Chambers
    Mr Gerard Martin QC, Exchange Chambers, Liverpool & Manchester

FEE £395.00
Includes lunch and refreshments
Application & further details:
Christine Lyth, Surgical & Anaesthetic Services, Murrayfield Hospital
Holmwood Drive, Thingwall, Wirral, Merseyside CH61 1AU
Tel: 0151 929 5403  Email: Sasdocs@aol.com

14th National Acute Pain Symposium
2nd & 3rd September 2004
Gateway Theatre and Moat House Hotel, Chester

Topics include:
- Modern initiatives in acute pain management
- Recent advances in post-operative pain
- Pain after amputation
- Acute pain management in the addict
- Burn pain
- Pain in sickle cell disease
- Relevance of pain suppression during GA
- Acute pain in the primary care setting
- Post-operative nausea & vomiting
- Pain measurement in children
- Pain in the paediatric day case patient
- Practical training in epidural insertion
- Medical cannabis

Registration fee:
Medical personnel £290  Nurses, physios, pharmacists £150
(Includes lunches, teas, coffees)

Application & further details:
Georgina Hall, Department of Anaesthetics,
Wirral Hospital NHS Trust, Arrowe Park Road, Upton, Wirral CH49 5PE
Tel: (0151) 604 7056  E-mail: Georgina.Hall@whnt.nhs.uk
Organised by Wirral Hospital NHS Trust & NE Wales NHS Trust
APPROVED FOR 10 CEPD POINTS

Courses offered in 2004/5
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)
30th June; 10th September; 3rd November

ACRM and Obstetric Anaesthesia The principals of ACRM, as above, with an obstetric theme for consultants and staff anaesthetists. (£250)
Please call for dates.

Instructors Course (2 days) For multi-professional generic instructors concentrating on the logistics of running courses and the art of debriefing. (£400)
11th & 12th November

Paediatric Anaesthesia Aimed at consultants and senior SpRs dealing with children regularly or occasionally, using principles of high fidelity medical simulation. (£250)
15th September; 24th November

Paediatric Critical Care Aimed at all grades of clinicians and nurses involved in stabilisation and care of critically ill children. (£250)
9th June; 13th September

ODP Course Dedicated to post-qualified ODPs using a high fidelity manikin and first class audio visual links. (£150)
30th July; 19th November; 9th March 2005

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 paediatric A&E. (£125 – for Nurses) (£185 – for Doctors)
12th July

Conscious Sedation (adult) To learn to recognise and deal with emergencies during sedation for non-anaesthetists. (£190)
18th August

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

Registration and other details: Please contact Administration, Simulation Centre,
GCPC, Chelsea & Westminster Hospital, 369 Fulham Road, London, SW10 9NH
Email: simcentre@chelseawest.nhs.uk
Website: www.chelseawestnhs.co.uk
Tel: 020 8 746 8632  •  Fax: 020 8 746 8155
I write this having just returned from the GAT ASM in Portsmouth. I love the GAT meeting; the science is excellent, liberally sprinkled with a good dash of entertainment, the workshops are fantastic value and the social programme superb fun. Moreover, the sun shone on Portsmouth and England beat Switzerland! This year, it was one of my tasks to help judge the audit prize poster competition, and it was no mean feat, with over 30 entries of a very high standard, all representing hours and hours of hard work.

Trainees represent almost half of our entire membership, and to see the enthusiasm and spirit which they bring to this annual event should reassure us all that the Association is a strong organisation with a guaranteed future.

Unfortunately, only half of Council Executive were able to attend, the ASM clashing with the Common Interest Group in Quebec to which the President, Hon Sec and Hon Treasurer jetted off. I reckon we ‘Cinderellas’ didn’t have such a poor deal however, and free of the stringent influence of the Hon Treasurer, we were able to approve some extra prizes to reflect the high standard and number of entries, both to the poster competition and the registrar’s prize!

Thursday afternoon included a full session on Working Time Directive, the Hospital at Night and New Ways of Working in Anaesthesia. These hot topics represent massive change in our working practices and trainees are right to be wary of the effect they might have on training. It was pointed out that, of the 25 core competencies required for the HAN team, anaesthetists have 23. The other 2 are reducing a fracture and delivering a baby - many of us can probably do those too! However, just because we are ‘competent’ does not mean we are the only personnel who can deliver critical care. There has to be a balance. We can be reassured that not only the Association, but the GAT Committee itself is keeping a very close watching brief on developments in all three fields so that at least there will be no surprises.

Never has there been such a period of upheaval and change in the NHS, and a feeling of uncertainty amongst all staff. This is reflected in the almost daily e-mails to the Association from members facing pressure from management e.g. to give up on-call rooms and compromise on anaesthetic assistance. The members of Executive work very hard to dispense support and advice.

I’m sure my colleagues and I are not alone in working in a trust that is pleading poverty and asking the consultants to accept less back pay than they are due with the new contract. I can’t imagine why this has come as such a surprise to our managers. I’m not very good at sums but, offering 11 sessions across the board, surely they could have calculated the anticipated bill for back pay 15 months ago using a formula something like this:

\[(a \times b) - c \times d\]

Where \(a\) = number of consultants taking up new contract, \(b\) = average monthly salary for 11 PA’s, \(c\) = old monthly payroll and \(d\) = number of months of delay, obfuscation and begging about.

Moreover, you don’t have to be a rocket scientist to conclude that both the cost, and consultant anger and impatience will rise with \(d\).

And this is just the start. We’ve got ‘Agenda for Change’ for non-medical staff to get through next. No doubt the basic assumption that we are all not doing enough and ‘accountability’ will increase efficiency (decrease waiting lists) will prove flawed, and the bill will be much higher than expected. Like us, the nurses, physios etc. will be asked to be reasonable and accept less than they are due in the interests of patient care.

Well, to paraphrase one of my colleagues - I give regularly and generously to charity, but the NHS is not on my list.

Stephanie Greenwell
Dear Editor...

Aptitude testing for SHO recruitment

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Claire Nightingale, High Wycombe.

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Furthermore in 1987, well before the introduction of clinical governance and audit, the Association of Anaesthetists was instrumental in setting up the National Confidential Enquiry into Peri-operative Deaths (NCEPOD). Mortality directly attributable to anaesthesia is now extremely rare at approximately 1 in 250,000 operations, and every day our members provide uneventful anaesthesia to around 10,000 patients, as a result of their care, training and expertise.

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Dr John Carter, Chairman Safety Committee AAGBI

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Financing for Patient Choice Contracts

There has been recent comment in the anaesthetic literature regarding the pricing of the contract for waiting list and ‘patient choice’ work, in particular the reimbursement rate for anaesthetists. A problem arises when these patients are contracted out to the private sector.

It is a cornerstone of the NHS pay structure that consultants in all specialties are paid on the same scale. This continues for waiting list initiative lists with surgeons and anaesthetists being paid the same rate for this extra work.

The new patient choice schemes deal with NHS patients, and as such should be reimbursed on the basis of equal pay for equal work as with all other NHS work.

Patients from ‘Patient’s Choice’ are not private patients, but are paid for from the NHS. There is no reason why the historical bias between surgical and anaesthetic fees should be applied to them. It certainly would not be if their procedures were carried out in an NHS hospital. It appears the the anaesthetists are unfairly subsidising the contract for this work simply because it is being done in a private hospital.

I feel that if this work is to expand, as we are told it is, then a strong lead has to be given by our representatives to maintain the status of the specialty.

Yours sincerely, Paul M Bailey, Consultant Anaesthetist, RNTNE Hospital, London

David Whitaker, the Hon Sec. issued strong advice to all Linkmen in the early June on this precise subject, with instructions to disseminate to all members. The Association can only make recommendations. In the trust setting, clinical directors and, indeed, individuals should insist on equal pay for equal work on NHS patients. I am printing a copy of the e-mail in case your Linkman has omitted to pass on this information. Ed.

8th June 2004

Dear Linkman,

We are now becoming aware of some of the details of proposed terms and conditions being offered by Treatment Centres for NHS work. Nuffield for example has won a contract from DOH for mainly orthopaedic work in 37 of its 44 hospitals between now and March 2005 and is suggesting rates of pay for anaesthetists much less than our surgical colleagues. This is NHS work and anaesthetists should accept nothing less than equality with surgeons. This was a founding principle of the NHS and a concept managers easily understand. If your Trust wishes to second you to a Nuffield Hospital the same employment principles should be maintained, all the other clinical standards are contractually supposed to be the same in the Treatment Centres. If departments stick together and demand equality, the work they are being asked to do will not get done without their agreement. If this goes unchallenged it creates a bad precedent for the future of the health service.

Experts on fair pay state the factors to take into account are skills, knowledge, effort and responsibility and if they are similar then the pay should be equal (http://www.eoc.org.uk/). Anaesthetist and surgeons have already been paid equally by the NHS since 1948, and are paid equally in other fields, such as pharmaceutical, medico legal, and commercial.

We recommend:

1. Your department ask for equality of pay in any such proposed arrangements and make the above points to the managers involved, both the NHS managers drawing up staff secondment agreements, and the Treatment Centre ones requesting the service. They should be referred to other examples of their colleagues good practice e.g. in Cardiff and Bristol were this type of work has been equally paid for some time.
2. Try and get your Department of Anaesthesia involved at an early stage in any such negotiations in future to avoid these misunderstandings. Even managerially this always makes sense in the long run.
3. Please keep us informed of the terms being offered locally so we can gather a national picture to inform our advice to members.

Yours sincerely
David Whitaker, Honorary Secretary
Public Perception of Anaesthetists

I wonder how many readers watched the television programme “Scream! The History of Anaesthetics” by Dr. Phil Hammond on Channel Five recently, and if their reaction to it was similar to mine. The programme note in ‘Radio Times’ stated, “The story begins in pre-anaesthetic 19th-century London, where operating theatre audiences witnessed the blood and screams of fully conscious patients in surgery, and moves on to chloroform, novocaine and modern pain-relief drugs”. One might be forgiven for anticipating an interesting and informative account that would help to promote the public understanding of our specialty.

The programme commenced by giving a description of the early days of surgery, where the patient was fully conscious but manually restrained, whilst having a limb amputated without the benefit of any form of pain relief. It concluded by comparing this with the modern practice of performing surgery, also with the patient fully conscious but totally pain free, e.g Caesarean Section under spinal anaesthesia. No problem with that but some of the intervening content of the programme was, to say the least, somewhat controversial. Dr. Hammond described how in the early days of anaesthesia for surgery, anyone who worked in the operating theatres could administer the anaesthetic. These included “dimwits, no-hopers and drunks” and it was a group of these same dimwits, no-hopers and drunks who got together to form The Association of Anaesthetists. So much for the founding members of our Association, but according to Dr. Hammond it would appear that the present membership has not progressed much over the years. We are apparently “an odd bunch, slightly introverted, stressed and suicidal”. I feel sure that if Tom Boulton watched the programme he must feel most aggrieved that he was denied the benefit of Dr. Hammond’s advice and expertise when he was researching and writing his definitive tome on the “History of the Association of Anaesthetists: 1932 –1992”.

We were asked the rhetorical question, “What happens when the anaesthetic goes wrong?” Apparently the dose of anaesthetic has to be just right: not enough and the patient could wake up during the operation; too much and the patient might not wake up at all. A patient who had fallen in to the former category and suffered awareness during anaesthesia, described her distressing experience. This presumably was included to demonstrate that progress had nevertheless been made since the days of manual restraint during surgery; one could infer that this was no longer essential and could now more satisfactorily be achieved by the use of muscle relaxants. Whilst accepting that such incidents can unfortunately and occasionally still do occur, it can have done little to promote confidence in members of the general public watching the programme. The good news however, was that if you were lucky enough to have your operation at one particular named hospital, all would be well because they had a device which could identify if the patient was indeed awake. The bad news was that other hospitals do not have this equipment.

Two consultant anaesthetists also appeared in the programme, but I find it difficult to believe that they could have been aware of its content other than their own personal contributions. I imagine that having seen themselves portrayed on national television, they will be wishing that they had not been party to it and that they could now disassociate themselves from it. National Anaesthesia Day will most certainly have its work cut out to counter the damaging portrayal of our specialty by Dr. Hammond. Might an official complaint to the Broadcasting Complaints Commission perhaps be forthcoming from the Association?

John Francis. Retired Consultant Anaesthetist, Exeter

Pre-operative Screening Howlers

Dr SB Vohra, Consultant Anaesthetist at City Hospital Birmingham has sent me two sets of amusing pre-operative screening notes.

In the first, the patient, a diabetic with ischaemic heart disease listed for cataract surgery, is noted as having an allergy to angina.

The second patient is apparently suffering from a little known condition noted as Fuch’s Dystrophy (however, the first ‘h’ looks remarkably like a ‘k’) and, not surprisingly under the circumstances, anxiety and unstable angina!

Ed.
Major obstetric emergencies and trauma course – an anaesthetist’s perspective

Having decided that I wanted to become an obstetric anaesthetist, I enrolled myself for the Major Obstetric Emergencies and Trauma course held in London. The course director was Dr Sara Paterson Brown, Consultant Obstetrician at Queen Charlottes & Chelsea Hospital. As an anaesthetist, I always wondered if obstetrics is as difficult as the surgeons make it look. With that view in mind, I read the manual and set off to attend the course.

On the morning of the first day the faculty, which consisted of obstetricians, anaesthetists and paediatricians, introduced themselves. They were a very keen bunch and were very helpful. The topics that were covered ranged from obstetrics to anaesthesia, including paediatrics. All the lectures were fantastic. To mention just a few, we were taught how to manage an airway, trauma in a pregnant patient, massive haemorrhage and eclampsia. I have to mention the skill stations and moulages in particular. They were great fun and educational, of course. I had to treat a patient with eclampsia in one of my moulages. Many times, I felt that dealing with the airway was much easier than treating eclampsia. It was very stressful. Thank God, the dummy survived my management!

At my other skill station, I was trying to deliver the baby, when oops the shoulders got stuck! Yes, shoulder dystocia (an obstetrician’s nightmare). Even though I knew that I was dealing with a dummy, I could still feel the palpitations and the stress. Sitting at the bottom end, I was really glad that I was not an obstetrician in real life. Eventually, I managed to deliver the baby in one piece.

By the end of the third day, I was really exhausted but clinically felt more confident and complete as an obstetric anaesthetist. My respect for the obstetricians had increased immensely and what is more – I had been selected to become an instructor.

It was very interesting to meet so many obstetricians in one place. I was impressed to see how much confidence they have in anaesthetists. I would strongly recommend the Major Obstetric Emergencies & Trauma course to all obstetric anaesthetists.

A place for this course can be booked by contacting the Advanced Life Support Group based at Manchester, Their website is www.alsg.org and telephone number is 0161 794 1999.

Kausi Rao
Anaesthetist, St Mary’s Hospital.
Paddington
kausirao@yahoo.com

When in doubt – blame the anaesthetic

While perusing my Daily Telegraph recently (and no, it wasn’t during a list) I came across an article entitled “I’m not too Posh to Push” in which the wife of a slightly famous actor described her experiences following her outlandish decision not to have an elective Caesarean section. (It is an interesting reflection on our times that a description of a relatively normal labour and delivery makes half a page in a national broadsheet newspaper).

It was all fairly familiar stuff, and to her credit, the author acknowledged the immense difference made by an effective epidural. However the bit that made me sit up and take notice was her litany of aches and pains the next day, which included “swollen hands and feet – a side effect of the epidural” (my italics). You know and I know that she thinks this because some midwife or obstetrician, too lazy to explain the real reason, told her this.

Every anaesthetist will have come across patients who attribute any number of bizarre symptoms to “the anaesthetic”. Indeed, while not wishing to ignore the role of anaesthetic agents in PONV, I have often thought the fact that a surgeon has been rummaging about your insides for an hour or two might have something to do with it. But no, it’s always the anaesthetic that made them sick – because the surgeon told them so. It’s just too easy isn’t it – blame the anaesthetic and move the ward-round swiftly on to the next patient.

My own personal favourite came while I was seeing a patient pre-operatively and, during my enquiry about previous anaesthetics, the patient volunteered the information that their face had “swelled right up” after anaesthesia. Immunology is one of my many grey areas, but fearing some ghastly angio-neurotic oedema-type thing, I felt further enquiry was warranted. When did this start? – the day after the operation. This didn’t sound quite right, and my next question revealed all. What was the operation? – removal of wisdom teeth! I said I thought the problem was more likely to be related to the operation than the anaesthetic specifically. “Oh no Doctor, the surgeon said it was the anaesthetic.” I bet he did!

Am I being too paranoid here? Should I rise above it?

Or does anyone else have a better example of a bizarre “side effect” of anaesthesia?

Hilary Aitken
**The Training Wot I Got**  
*(Academically not a LOT!)*

**Adrian Padfield**

While President of the History of Anaesthesia Society, I have encouraged older members to talk about recent history of which they had been part. On retiring from the Presidency, this is an anecdotal swansong. It may remind older AAGBI members of their own ‘training’ and be an eye opener for younger ones.

I’m not sure when I decided to ‘do’ anaesthetics; perhaps during 2nd MB Pharmacology in 1956/7. As clinical students, we were paired for our month of anaesthetics. My group had an odd number and I ‘arranged’ to be the spare experienced anaesthetist. I’d been using a dangerous agent only to be used by anaesthetists in the 1st edition of Wyllie and Churchill as a transducer on the patient’s finger. Using an Army surplus throat microphone I made a pulsemeter which, like many other instruments developed as a by-product of the war, was later to be valued in anaesthesia. I went to an electronics evening class in Walthamstow and I made a pulsemeter as a transducer on the patient’s finger. Derided by older consultants, I used it for measuring the blood pressure. Looking at my diary I find entries for lectures at the Middlesex with no luck. After Christmas 1962 I left Devon between snowstorms.

January and February 1963 were very frustrating. At SHO in Anaesthesia interviews I was told they needed someone with previous experience to go on-call at once: Catch 22 if ever there was. I did two GAs in A & E there with (Prof) Tony Adams. There were still JHO posts at London teaching hospitals and I was interviewed at the Middlesex with no luck. After Christmas 1962 I left Devon between snowstorms.

I started an SHO job at Barts in September with enough experience (about 400 anaesthetics at the West London) to go on call at once. There were 3 SHOs, 2 or 3 registrars, 1 SR and a part time lecturer, I think, and six consultants. We worked hard; at the end of 12 months (actually 10: 4 weeks hols and 5 weeks off with fractured transverse processes) I’d given 1107 anaesthetics. Apprenticeship teaching was the norm but there were convivial evening meetings. The Faculty ran free 6 pm lectures on Mondays for Primary and Wednesdays for Final but on call interfered with attendance. It was suggested we go to Charles King’s shop for equipment demonstrations but we had to get an afternoon off. While laid up with my back, I saw an advert for a pharmacology post in Cambridge. It seemed a good way to study for Primary so, when better, I asked Professor Quilliam in the Medical College for advice; a place quickly appeared in his department! I became a ‘full time’ academic for two years (though I did some anaesthetics in vacations) belying the title of this paper so I won’t dwell on it. I started in October 1964 and to my surprise passed Primary first time. I got a CIBA Research Fellowship for the RSM and regularly attended Anaesthetic Section meetings on Friday evenings. The Section was the forum for research and discussion in anaesthesia then; specialist societies had barely started. In the run up to Final we were told to read the Proceedings of the RSM to spot possible exam topics. In March 1966 I went on the 2 week Faculty Final course, it cost £31.50 (no study leave or expenses) and it didn’t help!

I did a 2 week locum at the Brompton in October 1966, and on 1st November became a registrar at St George’s. I began at the Royal Dental Hospital, Leicester Square but after one month I realised that six months would be too much. I managed a change, and having anaesthetised over 750 dental patients in 3 months as well as on call cases at Hyde Park Corner, I went to Atkinson Morley’s, Wimbledon. In six months I anaesthetised 300+ neurosurgical patients. Teaching was by apprenticeship and weekly tutorials at 8 pm run by two younger consultants, but it wasn’t always possible to get to them because of on call or fatigue. In April 1967 I went to the 4th Junior Anaesthetists
Meeting in Leeds: I got study leave and expenses but had to write a report. It was very stimulating; John Nunn was the leading light amongst many other names.

In August 1967, I rotated to the Royal National Orthopaedic Hospital and worked at Stanmore and Great Portland Street. The final fellowship was proving elusive; I was knackered so I resigned and left St George’s on 30th November. I did a 4 week locum at Harefield where some interesting/obscure anaesthetic techniques were used, got a registrar post at the Royal Free and started on 1st January 1968. This was closer to home in Islington and less strenuous work and on call (about 650 anaesthetics in the year but I don’t remember a lot of teaching) so I managed to pass the FFA in July. If I hadn’t; I was all set to emigrate. At Hampstead General Hospital I had my first experience of mentoring though it wasn’t called that then. Dr Massey Dawkins encouraged and guided me, and later had a profound effect on my career (I also became adept at epidurals). I applied unsuccessfully for London SR posts but there was an expansion in SR numbers elsewhere. It was a time of change; I recall a registrar with FFARCS who was appointed consultant in a desirable place: Hereford. An RFH consultant told me it was more difficult to become an SR than a consultant when I got an SR post in Bristol that autumn. Both hark back to the Chief Assistant/SR as the top of a pyramid of trainees.

By arrangement, I put off going to Bristol for 4 months so that I could rotate to the Brompton in January 1969 for cardio-thoracic experience. Dr Ian English was a very good, practical teacher but I never wanted to do cardiac work again. Starting at the BRI in May 1969, the work was fairly simple; a new experience was attending the anaesthetic committee though completely ignorant of local politics. I felt I was polishing techniques but learning little new. This changed; Colorado General in Denver needed another SR to be a guest lecturer. I’d passed ECFMG in October 1969 so it was available and went for 6 months in November 1969. At the RSM, an American Professor had castigated British anaesthetists for negligible monitoring and John Powell had come back from Denver saying the same thing. I found out why; US anaesthesia residents only gave 600 anaesthetics in their 2 year stint (I’d done at least 4500) but teaching was formidable. 7.00am start with a short presentation by a resident on a prepared topic, followed by discussion and a review of the day’s operations: about 20 in 10 Operating Rooms. I supervised 2 or 3 residents (I only gave 3 or 4 anaesthetics in 6 months) and taught. At the end of the day, about 3pm, there was another teaching session, which often included the Professor reading from Wylie & Churchill Davidson.

British anaesthesia at the time was second to none but the training was long and the hurdles (exams) not always relevant. I became a consultant having had good experience in all branches of anaesthesia and confident I could cope with nearly every situation. Will this be the same with today’s shorter training with less practice and more theory?

Only time will tell.

(A much fuller version of this article was presented at the HAS Summer meeting in Grange over Sands. This will appear in the History of Anaesthesia Society’s Proceedings.)
Temperature Management
...why bother?

AAGBI Annual Congress 2004
Cardiff
Thursday 23 September
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The Association were asked to contribute a group of lecturers to the Annual Winter Meeting of the Slovak Anaesthesia Society. This meeting was held in the Eastern corner of the Slovak Republic in the High Tatras Mountains, a popular local skiing resort.

Sadly, the President and President-elect were unable to attend due to last minute problems and three representatives from the AAGBI boarded the early morning flight from Heathrow to Prague on the morning of the 18th February. Dr’s Birks, Vaughan and Wilkinson had volunteered to give two lectures each on the subsequent mornings and, after a short stop in Prague, changed planes to travel to Kosice in Eastern Slovakia. Here there was snow on the ground and more coming down as they were met by Dr Marian Mandelik a representative from one of the sponsoring trade exhibitors Nutricia. Marian spoke good English, was a qualified veterinarian and drove with a speed and enthusiasm that might reduce even Tommi Makkinen to a state of severe anxiety as he juggled looking at and talking on his mobile phone; at times all at once. After a fascinating tourist stop in the medieval town of Levoca we entered the snow fields and forests of the Tatras National Park to be delivered to our hosts at the Helios Hotel where the meeting was being held. We had missed the first day of the Congress and were told that there were some 120 registrants from a pool of some 600 Slovakian anaesthetists (a greater proportion than attend an AAGBI meeting!). Supper, a few glasses of local wine and some further discussions with our main host, Dr Stefan Trenkler, reduced our pulse rates below SVT levels again and enabled a rapid onset of sleep.

The following morning was grey with a little falling snow, now at about 4 foot depth in the car park. We learnt we had missed the morning fun run (a 07.30 start with a cast of 7 hardy anaesthetists) but were in good time for breakfast. Following hasty (and very professional) AV transfer of our lectures from discs to hard drive, we were ready to go at 08.45 hrs. Ralph, Dick and I were welcomed in the lecture theatre by the Slovak Society President, Dr Milan Ondercanin, who then handed over to the chairman of the session, Dr Stefan Trenkler. Stefan, a member of the Association, who is also on the CENSA Board, introduced us and our topics in turn. Ralph gave an overview of difficult intubation, I spoke on current thoughts in day surgery and Dick reviewed the current anaesthetic management of obstetric practice in the UK. Each of us was presented with a local pottery souvenir of the occasion and we were able to return the gift exchange with carefully selected items of AAGBI merchandise. All of the scientific presentations were well received and, following a series of probing questions in both Slovak and English, the meeting adjourned for coffee in the trade exhibition.

There were 14 trade sponsors present at the meeting, some local and some international. Drug companies, equipment manufacturers, monitoring specialists and items of disposable equipment were very similar to those seen at an AAGBI meeting. There was now a break in the scientific presentations until 1500 hrs to allow registrants to avail themselves of the facilities of the spa hotel, including massages, electrotherapy and inhalational therapy (none of us tried these!) or to brave the many and various skiing opportunities both downhill and cross country for which the area is justly famous. As is often the case, Abbott Laboratories had stolen a march on the other companies by hosting an outside refreshment trolley serving hot tea with brandy together with smoked cheese or hot sausage and mustard on bread.

Despite temperatures outside of -6C this proved very popular as a precursor to winter sports activities.

Suitably hatted, gloved and coated the three AAGBI lecturers were then taken on a local tour by minibus with a local English teacher guide who soon realised into what bad company she had fallen. We visited a local out-doors museum of houses at Vlkolinec which had been moved to the site from all around Slovakia to form a typical village. Then we moved on to the ski slopes and went up the funicular railway to see the view (over lunch) and watch the skiers, before returning down the mountain to visit a nearby village and walk around. On returning down the mountain to visit a nearby village and walk around. On returning to the hotel, we found that the final scientific papers were being completed and were in time to change for a very hospitable buffet reception with optional band and disco. This was the time when we were able to meet a full
spectrum of anaesthetists (together with some spouse surgeons!) from all parts of the country, and to develop an exchange of ideas on a very wide range of topics. All of us were taken with the enthusiasm and dedication of our colleagues.

The following morning we were ‘on parade’ again with three more presentations chaired this time by Dr Vladimir Kollarik. This time Ralph talked about the problems associated with extubation, I spoke about the pharmacology of current and future inhalational agents and Dick spoke on the management of eclampsia and pre-eclampsia. These were again all well received and, following an even longer discussion period that included searching questions on the nature of our training and Board exams, we repaired for coffee in the Trade.

Once again, our afternoon was free and this time we made our own way round the local resort on foot (and sometimes, due to the treacherous nature of the snow and ice, on bottoms!). Further souvenirs were bought, some refreshment taken, and a most relaxing walk and sights experienced. It is unusual to look at a postcard of a blue lake in sunshine surrounded by flowers only to realise that you had just walked right across it through the snow and ice. Skiing was obviously very popular, both with locals and those from further a field. Car registrations from Poland, Lithuania, Romania, Germany and Hungary were common. One of the reasons might well be that complete hire of all necessary equipment for skiing cost £3.00p a day!

We were hosted to a delicious meal that evening in a nearby restaurant to which we walked in -9C temperatures and returned in -16C! Somehow the return journey seemed faster and quite warm! After further farewells to our hosts, we repaired to bed.

The final day was a long trek home. A fun drive back to Kosice with Marian, who had mellowed apparently during the meeting, and induced only a few cardiac arrests in the back seat. We were able to visit the magnificent castle at Bojnice, one of the largest in Central Europe dating from the 12th century as well as the historic centres of Presov and Kosice before arriving at the airport for our flight to Prague and then on to Heathrow.

We came home enthused and encouraged by the welcome and hospitality we had received from this relatively new National society. We had all learnt in equal measure to the teaching we had offered, and we had made and renewed some vibrant friendships that we hope will endure for the future.

We would encourage others to take advantage of future invitations to help foster international relations whenever they can.

David Wilkinson.
MESEY SCHOOL
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e-mail: carol.baggaley@nuth.northy.nhs.uk Telephone: 0191 223 1059 Fax: 0191 223 1180
Generals

The NHS is unmanageable. Everybody knows that, except the DOH (or is it DH, this week?) So why bother trying? A good question. Here’s another: could the NHS be made manageable? Well, no luck so far, but is it possible?

One thought is to compare it to other organisations, but the only problem is that the NHS is (one of) the biggest organisation(s) in the world. Once the Red Army was ahead, but the NHS continues to outlast the Berlin Wall. No other army, except maybe the US’s, compares. But hang on, you say, these organisations delivered: they invaded Afghanistan. Both of them (jury still out on the 2nd). They have done lots of other things they were meant to, without 4 year invasion waiting lists or 4 week tank turn around times. OK, there are supply problems, but not even John Prescott is perfect, so how can an army be? So why don’t we model our own beloved NHS on an army system. OK, let’s think about that.

There are several features about Army organisation that substantially differ from NHS management. No, I do not mean that cowards and deserters are shot, though shooting might be a useful management tool to have available (for managing the managers!). I mean, for example, that all senior managers (generals) are soldiers, having come up through junior grades in a variety of sub-specialities (Infantry, Cavalry, Artillery etc.) What if all senior managers were doctors! That might have some major advantages, such that every senior manager would have the sense of whether someone they are managing is doing their job properly.

Second, in the British Army, at least, you cannot become a general with an IQ of less than 140. I appreciate that this might stop certain specialties featuring heavily on the management roster, but it might get rid of, for example, those whose plans include elective lists on Good Friday, because their list is always on Fridays.

Then there is the fact that keeping up the morale of the troops is seen as a very high priority, rather than an unwanted by-product of work (unwanted, as in “Enjoying your work? That’s like stealing from the company!”). Army officers spend a great deal of their time going round their units, talking to their subordinates, seeing what is going on, praising and encouraging, boosting their morale. When did we last see a senior manager, or anyone above deputy assistant pen-pusher, even trying to find out what’s going on, let alone expressing support.

Another thing the Army does to make things work better, to overcome the anonymity of a giant organisation, is engendering an esprit de corps. Regimental ardour, trying to do better than the other team, and so on. Certainly no excess of that sort of attitude in the “modern” NHS. What do we get when we show up our larger neighbour? We do more joint replacements here with half the number of surgeons of our former competitor down the road, the result? We are now in the same trust, and they get all the funds because their waiting lists are longer. Yes, an army approach to esprit de corps would be a very good idea, even if all it meant was that successful units were not punished. Rewards would be too much to hope for.

But what do we actually have? None of the good, only the bad bits of Army management – overburdening bureaucracy, stultifying nit-picking interference, pompous bullshit – plus new inventions all of the NHS’s own, impossible edicts from on high, documents to tell us to do what we have been doing for years, plans to restructure training for the benefit of a placeman’s career. Even Army methods might be better, you say.

Not really, though. For a start, the army is doing something very different from us. Not just killing rather than curing, but more that it is trying to get lots of people doing the same big thing at once, winning a battle, say, rather than trying to get lots of people working towards lots of tiny, individual objectives, continuously. We do not fight battles, more a series of low level engagements. Our drivers are not honour and glory, but problems solved and patients supported. And structures differ too, where mostly all specialties work together in units rather than single specialties having their own units, so esprit de corps might be a bit bygged by in-fighting and bed blocking. And who has ever heard of a surgeon or physician, any consultant, for that matter, who accepted that there was anyone above him in a chain of command?

No, all in all, I think, not the Army model.

Back to plan A: denationalise.

De Quincy (Dr de Quincy is a consultant in a DGH near you)
Nitrous Oxide has been used for painless dental extraction since 1844. As a medical student during the war I was taught to anaesthetise patients in the dental chair with nitrous oxide and AIR. The nitrous oxide came from a cylinder on the floor controlled by a foot valve; then came a reservoir bag, from which twin tubes led to a nose piece with a valve which allowed the nitrous oxide to be replaced by a breath or two of air when the patient became too cyanosed. This procedure was once described as controlled anoxia!

By the time I qualified in 1945, machines such as the Walton were readily available. These had oxygen, which could be given in percentages from nought to 100. This gave a false sense of security, as it was found that the settings varied on every machine and really indicated “no O2, some O2, more O2, and all O2”. Vaporisers were available so that vinylthene, trilene or halothane could be added to the gas/oxygen mixture. The Goldman inhaler, which gave up to about 2% halothane, was an effective and inexpensive one, in which the glass reservoir for liquid was the same size as the reservoir on a car petrol pump, so a cheap replacement was available if it was dropped and broken.

Occasionally ethyl chloride was sprayed on the mouth pack to stop mouth breathing when anaesthesia became inadequate (I never dared to do this!)

It was usual for the dentist to provide the anaesthetic machine, nitrous oxide and oxygen, while the anaesthetist (who was sometimes another dentist or a doctor with limited anaesthetic experience or training) provided any other drugs and equipment, such as endotracheal tubes and a laryngoscope (if he had one and knew how to use it!).

General anaesthesia in the dental surgery was very popular. It was estimated in the nineteen sixties that more than half a million patients a year underwent dental anaesthesia at the hands of the dentist who was also removing the teeth, (occasionally all of them). There were very few deaths reported, either because this was not as dangerous in practice as it is in theory, or perhaps because the media were less organised than now in publicising medical mishaps. As the older dentists retired, this practice faded away and practitioners with adequate training and experience provided dental chair anaesthesia.

I was perhaps ahead of my time in that I encouraged parents to stay during induction of anaesthesia in their children, provided that they left before the extractions took place. I used methohexitone through a 27 g needle; I did try althesin, but soon gave this up after the local GP rang me up to find out what I was using after three patients from my afternoon dental list of six turned up at his evening surgery with a rash.

When I started as a maximum part time consultant in 1953 the fees for dental anaesthesia were 10/- (50p) if one, two or three teeth were removed, and £1 if four or more were extracted! This is not quite as little as it sounds, as my salary then was only £1332 per annum.

At one time I was giving nearly 1000 dental anaesthetics a year in two school dental clinics and two dental practices. I occasionally gave anaesthetics in the dental chair at a hospital for people who were known in those non-politically correct days as the mentally subnormal. Their fellow patients were kindly, and seeing their friends hungry would try to pass them food or drink when no one was looking, hence the remark of the Chief Male Nurse “I can promise you that seven of your eight patients have had no food or drink, but I cannot tell you which seven!”

The dental chair had limited movement. One afternoon I had to place two patients on the floor to intubate and resuscitate them, so I decided that in future these patients would be better dealt with on a dental list in a general hospital.

I did try ultra light anaesthesia with methohexitone for conservative dentistry, but was not very happy with this technique although it became very popular for a while. Well-publicised mishaps, together with the medico-legal requirement for large amounts of expensive monitoring equipment, have resulted in the demise of general anaesthesia in the dental surgery. Unfortunately, this has sometimes resulted in a wait of up to a year for treatment in hospital for some patients who in the past would have been dealt with during the “dental gas” session the same or following week.

David Rowlands
RESEARCH FELLOWSHIP
Applications are invited for a Research Fellowship tenable for up to 2 years

Further information and application forms are available from the Association website:
www.aagbi.org

or Carol Gaffney, Association of Anaesthetists of Great Britain and Ireland,
Direct Line: 020 7631 8812, or email: carolgaffney@aagbi.org

Closing date for applications: 15 October 2004

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

ANAESTHESIA FOR LASER SURGERY 2004
IN CONJUNCTION WITH THE 21ST CLEVELAND (UK) INTERNATIONAL HANDS-ON LASER COURSE
ONE DAY COURSE – 7TH OCTOBER 2004

Departments of Anaesthesia, Otolaryngology and Head and Neck Surgery, James Cook University Hospital, Middlesbrough.

This course will cover:
• Laser Physics
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• Anaesthesia for laser airway surgery
• Paediatric airway surgery
• Critical incident management in laser emergencies
• Hands on laser use for all delegates
• Guest speaker – Professor Chris Dodds

Educational approval: 5 CPD points

The Cleveland Laser Course is recognised by the European Laser Association, the British Laser Association and the International Society for Lasers in Medical Science.

Course Fee £150

Further information and application form from:
Mrs A Ellis, Course Co-ordinator
Dr S Williamson, Course Organiser
Head and Neck Office, Department of ENT Surgery, James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW
Tel 01642 854023, Fax 01642 854090
Email: angelal.ellis@stees.nhs.uk; sean.williamson@stees.nhs.uk

Vascular Anaesthesia Society
Of Great Britain and Ireland

ANNUAL SCIENTIFIC MEETING
13TH AND 14TH SEPTEMBER 2004
CHURCHILL COLLEGE
CAMBRIDGE UNIVERSITY

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, K Floor, Royal Hallamshire Hospital, Glossop Road, Sheffield, S10 2JF.
Tel: 0114 2712510
Fax: 0114 2713771
Email: j.heppenstall@sheffield.ac.uk

Closing Date: 4th July 2004
“DINGLE 2004”
6th Current Controversies in Anaesthesia & Peri-Operative Medicine
Dingle, Co. Kerry, Ireland 13th-17th October 2004 — LIMITED PLACES REMAINING
!!!REGISTRATION FORMS NOW AVAILABLE!!!
Download: www.ucl.ac.uk/anaesthesia/meetings / Email: uch.acru@btinternet.com

CARDIOPULMONARY EXERCISE TESTING TRAINING
London ~ 6th September 2004 or 15th November 2004
One day of thematic lectures and practical sessions on CPX
Lectures and Practical Session include: Introduction to Exercise Physiology ~ Practical Demonstration of CPX ~
Guidelines for the Interpretation of CPX
Lecturers include: Professor Monty Mythen ~ Dr Hugh Montgomery ~ Helen Luery
Contact: Helen Luery c/o uch.acru@btinternet.com ~ www.ucl.ac.uk/anaesthesia/meetings

OESOPHAGEAL DOPPLER TRAINING ~ CME APPROVED
Lectures and Practical Sessions on:-
• Validation and comparison
• Physiology of cardiac output
• Waveform interpretation
• Critical review of the literature
• Cost effectiveness and outcomes
• Clinical application
Contact: Dr Mark Hamilton c/o
uch.acru@btinternet.com
www.ucl.ac.uk/anaesthesia/meetings

 Provisional Announcement’s for 2005
• KnO2wledge - Lessons from Life at the Limits
  20th and 21st January
• 2nd Paediatric Sedation: Developing Safe Practice ~ 3rd and 4th March

The Royal National Orthopaedic Hospital Stanmore
Anaesthetic & Critical Care Jamboree
19th, 16th, 17th September 2004
Day 1: Core Orthopaedic Anaesthesia - (A didactic course primarily for anaesthetic trainees)
Day 2: Advanced Orthopaedic Anaesthesia and Critical Care
Day 3: Spinal Surgery and Injury: Anaesthesia and Critical Care
Meeting Chair: Dr David Goldhill, RNOH, Stanmore
Further Details www.moh-stanmore.org.uk/pgmecourses.asp / Telephone: 020 8909 5326
We are almost pre-conditioned to think that the first and most important protection is immediate life cover - but is this true?

The old cliché that financial planning is about making provision for the effects of dying too soon (life cover) and living too long (pensions and investments) has never been more true than it is today. We still tend to conveniently forget what may go wrong in between, such as ill health, unemployment or accident. 15 years ago Critical Illness Cover arrived in the UK to help fill that gap in between, and Income Protection was also developed to fill the need for protection in event of long term sickness.

But surely the chances of actually needing to claim on one of these two benefits are pretty low?

Well the statistics say otherwise:

- Men have a 1 in 4 chance of suffering a heart attack, cancer or stroke before age 65 and women have a 1 in 5 chance (aged 20-40).


- The chances that a working man will suffer a serious breakdown in health lasting more than 6 months rather than dying before age 65 are 16 to 1.

  Source: http://www.moneyextra.com

Is the greatest need for an individual still Life Cover, as it has been perceived for many years? In some cases this may be the case, but it really depends on your personal circumstances. If you are single and/or renting your home then it in almost all circumstances Income Protection will be of far greater importance than pure Life Cover. When incapacitating illness or accident strikes, Income Protection funds all the bills, whereas with Life Cover there would be no pay out.

It is also important to assess the quality of the cover provided by these contracts, as at first glance they may appear all the same, but the reality is very different. It may be tempting to just pick the cheapest product available, but what is the use of this if, in your time of need, the contract does not pay out due to a minuscule ‘get out’ clause in the policy conditions. Professional advisers research the market of these contracts in detail to ensure that their clients take out a policy that ‘does what it says on the tin’. In the case of Anaesthetists with the NHS, the protection provided by the NHS is 6 months full pay for the first 6 months of illness, 6 months half pay for the next 6 months, then after a year no cover at all. Income protection offered by certain providers will match the benefits offered by the NHS to ensure the individual is comprehensively covered. Other factors they take into consideration include extra benefits such as career break options and hospitalisation benefits, exclusions on the plan, and the claims history and reputation of the product provider.

Where does that leave us? Life Cover is and should remain vital to those with mortgages and dependants, but perhaps we should start to make Life Cover together with Income Protection the twin pillars of our financial planning; far more than we have in the past.

For more information and expert advice, please speak to Dr Mark Martin of 20Twenty Independent 020 7400 8625.
The Association of Anaesthetists
of Great Britain & Ireland

RESEARCH GRANT

The Research Grant is aimed at those undertaking research in Great Britain and Ireland

GRANTS UP TO £15,000

RULES

Theoretically there is no limit to the number of research grants that may be awarded. Funds are available for the purchase of apparatus for specific projects and the application should enclose a precise quote from the manufacturer. The applicant must indicate why a particular make has been chosen. Such apparatus remains the property of the Association and must be labelled as such. At the end of the project or after such interval as seems appropriate, ultimate disposal of the apparatus will be considered by E & R. It is the express wish of the Association that any equipment will continue to be used for research in airway equipment or technique, case scenario, teaching or audit.

For further information and an application form please visit our website: www.aagbi.org or email info@aagbi.org or telephone 020 7631 1650.

Application forms should be forwarded to the Honorary Secretary,
The Association of Anaesthetists
21 Portland Place, London W1B 1PY
THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

ANNUAL CONGRESS

Cardiff International Arena
21st - 24th September 2004
NOT TO BE MISSED!

For information on Registration, Travel and Accommodation, please visit our website
www.aagbi.org or contact us at
meetings@aagbi.org or 020 7631 8805

BOOK YOUR STUDY LEAVE NOW!
THE MERSEY SELECTIVE

The object of the exercise is to advise the candidates as to the challenge of the Primary FRCA and as to a method of approach to that challenge. Further, it is hoped that they might get some insight into their readiness to face the challenge and as to how much work has is to be done.

As much as is considered possible in the time available, an attempt is made to address some of the more difficult or obscure areas of the syllabus with a view to explaining and simplifying them.

If these aims are achieved within the unavoidable constraints of time, the course merits a Mark of 5. If the course fails to achieve these aims and is considered to have been a waste of valuable time & study leave, no more than a Mark of 1 is merited.

The Marks awarded at the closure of the last course (May) were:-

34 Replies – 1 Mark of 3. 12 Marks of 4. 21 Marks of 5

Feedback Responses (May 2004)

(Are you glad you came?) “Yes, Yes, Yes.”
(Are you glad you came?) “Most definitely”
(Are you glad you came?) “Yes, Yes, Yes!!”
(Are you glad you came?) “Yes. Very much”
(Are you glad you came?) “Definitely yes. Would recommend”
(Are you glad you came?) “Of course, no doubt about it”
(Are you glad you came?) “Yes I will surely pass on the message about this course”
(Are you glad you came?) “Yes definitely!! Thanks”
(Are you glad you came?) “Yes I am”
(Are you glad you came?) “Yes I am indeed”
(Are you glad you came?) “Definitely. Worth it”
(Are you glad you came?) “Yes I am extremely happy with its worth”
(Are you glad you came?) “Very glad”
(Are you glad you came?) “Oh Yes!”
(Are you glad you came?) “Very happy & satisfied”
(Are you glad you came?) “YES - DEFINITELY”
(Are you glad you came?) “Yes! Definitely – Will recommend it to everyone”
(Are you glad you came?) “Very glad”
(Are you glad you came?) “Yess….ss”
(Are you glad you came?) “Yes, thank you”
(What should we exclude from the next course?) “Nothing!”
(What should we exclude from the next course?) “Nothing need be excluded”
(What should we exclude from the next course?) “None”
(What should we exclude from the next course?) “Please do not exclude anything from this course”
(What could usefully included in the next course ) “Some tea – early morning Please!!!”*

* The only response to this question

Monday 13th September – Friday 17th September
Please See Website For Details/Application Forms Etc
WWW.MSOA.ORG.UK
THE MERSEY SELECTIVE

A course tailored for trainees intending to sit the Primary FRCA 30th November 2004.

Feedback Comments (May 2004)

“It had (sic) been an excellent course”
“Extremely useful and an eye opener”
“Every lecturer has put in a lot of effort & time for the benefit of us, the juniors. HATS OFF! They are doing a great service to the speciality. I feel greatly indebted to them”
“Well organised. Good content. Covers the essentials”
“Made us think and get us involved”
“This is what we want – areas that need explanation of concepts that are difficult to grasp”
“Excellent lecturers, content & emphasis pitched at the correct level for the exam”
“The topics and principles are brought together nicely w/good clinical illustration & application”
“MCQ practices were excellent”
“I really enjoyed the course lectures, all the lecturers were great. Hats off to them!!”
“At the outset I would like to wholeheartedly thank (……..) for organising such an excellent course. In addition I would like (them) to introduce a course somewhat similar to this, but for those candidates who will be sitting the Primary exam after more than 6 – 8 months”
“Good value for money”
“Fantastic time (although the weather was bad the last day) Good food. What else do we need …..?”
“Fairly speaking, the topics are well picked. No wonder the course had a good name and a real value for money”
“Involvement of the speakers was excellent”
“…..lecturers were very good at elucidating difficult topics”
“Handouts were all very comprehensive”
“Superb food”
“Gives a good indication of what exam involves – has definitely made me realise I need to work much harder”
“Most difficult concepts (for me) were made easy”
“The food was excellent!!”
“This course has clarified several difficult concepts for me”
“It has been a very good experience. Some difficult topics …have been explained very well”
“The lectures have been of a very high standard and have managed to explain and shed light to many subjects that I’d been finding difficult to understand”
“Excellent job”. Keep up the good work. A big heartfelt thanks to all those people who selflessly did the lectures”
“Personally I would have preferred to attend this course one/two months earlier as it has illustrated that there are many topics that are poorly explained in textbooks and I have been misunderstanding/misinterpreting them. I think this lecture-based course provides a good base with which to go on and study with gusto & is a good pointer in the right direction”

Monday 13th September – Friday 17th September
Please See Website For Details/Application Forms Etc

WWW.MSOA.ORG.UK
The Diploma in Anaesthesia, Trauma and Critical Care has been developed as a result of the efforts of several Consultant Anaesthetists in the Mersey region (collectively known as ATACC) and with the co-operation of Professor Martin Leuwer of the Department of Anaesthesia, University of Liverpool. The Diploma is being considered by the University of Liverpool with the prospect of becoming the qualification “DipATACC UoLiv”. It aims to be the “gold-standard” qualification for doctors and others providing advanced medical care during the early management of the multiply injured patient.

For the past four years the ATACC group has taught resuscitation and management of the critically ill trauma victim. The ATACC provider course is not didactic but encourages discussion of “state of the art” theories and methods. It is tailored to the needs of British doctors who may be called upon to provide sophisticated care for trauma victims both within and outside of hospital. The three-day provider course is delivered by means of lectures, tutorials and skill stations. It also includes a half-day session when doctors are shown how to work with the fire service in resuscitating patients as they are extricated from a motor vehicle accident. Candidates are assessed by MCQ’s, a skill station and a trauma moulage. On completion of the course, candidates should be proficient in:

- provision of care at the scene of injury;
- transfer of the unstable patient to hospital;
- resuscitation in the emergency room
- emergency imaging of the trauma patient (notably the FAST scan)
- aspects of Intensive Care Medicine relevant to the trauma patient.

The provider course is open to applicants from both a medical and non-medical background. The course assumes familiarity with advanced management of airway, breathing and circulatory problems. This assumption is made because these conditions are the most imminent threat to life, both at the scene of injury and on arrival in hospital. In practice, the most successful candidates have a background in Anaesthesia or Emergency Medicine. There have also been a number of highly able ODP’s, Ambulance Paramedics and Firemen.

ATACC runs a Medical Response Team (MRT) in conjunction with Mersey Regional Ambulance Service (MRAS). The MRT comprises a team of four: a Rapid Response driver from MRAS, a technician/radio-operator, the team doctor and a fourth person who can be a trainee or observer. The team is operational from 18:00hrs to 02:00hrs on Friday or Saturday of most weeks. It is MRT policy that the team doctor has passed the provider course and has anaesthetic skills. The MRT has been operational for more than a year. It has become clear to all involved that providing excellent medical care from soon after the time of injury has markedly improved patient outcome. ATACC has established the Dip ATACC in order to face future challenges. Namely:

- to promote excellence in traumatology;
- to encourage further research in trauma;
- to recruit more trained doctors to man the Medical Response Team;
- to encourage teaching of techniques to trauma-care providers.

Candidates for the Dip ATACC need to achieve a good pass on the provider course. They need to submit a dissertation of 5000 words on a current trauma topic or a 2000 word research project of publishable standard and attend a viva-voce examination at which the thesis is presented. They need to demonstrate good teaching ability on two provider courses. Finally, they need to take part in the Medical Response Team under supervision on at least two occasions. Satisfactory performance in all aspects will lead to the award of the Diploma which is currently under consideration by the University of Liverpool with the intention that it will become a University ratified qualification.

Enrolment for the Diploma costs £400, made payable to “Anaesthesia Trauma and Critical Care” (which has applied for registered charity status). Candidates who have recently passed a provider course are welcome to apply.

All applications please to David Southern.

David Southern, ATACC Examinations Organiser dasouthern@doctors.org.uk
FRCA, BSc Hons, DipIMC (RCS Edin)

Peter Barrett, ATACC Faculty Treasurer
FRCA

Mark Forrest, President of ATACC
atacc.doc@virgin.net
FRCA, BSc(Hons)

Prof Martin Leuwer, University Department of Anaesthesia, University of Liverpool.
Fresenius Kabi are delighted to announce sponsorship of a satellite symposium dedicated to issues on ‘Fluid Therapy’ and the patient management lifecycle. The programme, which is presented by eminent speakers, is outlined below and promises to raise questions on appropriate fluid management in different hospital settings and how choices of fluids used in each setting have implications on subsequent areas.

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>17:15</td>
<td>Fluid management in the Pre-hospital</td>
<td>Dr Mark Forrest and A&amp;E patient&lt;br&gt;Consultant Anaesthetist, Warrington Hospital / ATACC Medical Director</td>
</tr>
<tr>
<td>17:40</td>
<td>Fluid management in the surgical patient</td>
<td>Mr Dileep Lobo&lt;br&gt;Senior Lecturer in Surgery / Consultant HPB Surgeon, University Hospital Nottingham</td>
</tr>
<tr>
<td>18:05</td>
<td>Fluid management in the ICU patient</td>
<td>Dr Peter MacNaughton&lt;br&gt;Lead Clinician Intensive Care Unit, Derriford Hospital</td>
</tr>
<tr>
<td>18:30</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

As registered delegates to the Annual Congress of the Association of Anaesthetists, this seminar is free to attend.

To register your interest in this event please contact: AAGBI, 21 Portland Place, London, W1B 1PY, Telephone: 020 7631 8805, Fax: 020 7631 4352.

We look forward to hearing from you and hope to welcome you on the day.
Inaugural Meeting of the Society of Anaesthetists of UK & Sweden

21 Portland Place was full of “ja”, “tack” and “nej” on the 5th and 6th of May when it hosted the Inaugural Meeting of the Swedish and British Anaesthetists.

The idea for such a meeting was the brainchild of Dr Bhaskar Tandon, Consultant Anaesthetist, Diana, Princess of Wales Hospital, Grimsby, who had spent considerable time working in Sweden in earlier years and felt that the anaesthetists in both countries had much to learn from each other. He was right!

Indeed the response, whilst slow at first, was overwhelming and the Intavent Room was filled to overflowing with an audience of 45 UK members and 35 members of the Swedish Society of Anaesthetists.

The programme, drawn up by David Wilkinson and Michael Ward was an eclectic one designed to educate and amuse the audience, and involved a mixture of British and Swedish Anaesthetists. Following a welcome from our own Peter Wallace as UK President, a session on the position of Academic Anaesthesia in both countries (Prof John Sear, Oxford and Prof Sten Lindhal, Stockholm) proved of historical and current interest.

A general discussion on the advantages and disadvantages of the various colloids was most instructive (Dr Peter Gosling, UK on Starch solutions, Prof Monty Mythen, UK on Gelatin and Dr Hugo Haljamae, Sweden on Dextrans). We are only one thousand miles apart and yet our current practices are very different – does it make any difference?

A general discussion on the future of the embryonic organisation then followed, with general agreement that we must “do this again”. The Swedish Society will therefore arrange a meeting in Uppsala, in May of 2005 but a formal ‘Society’ and Committee was felt to be unnecessary. It was agreed to toast the new friendship at dinner that night, held close to the AAGBI HQ.

The next morning we were all ready to start again and spent the first session on the development of Day Surgery in each country and how it has changed our practice. Baskhar Tandon, UK and Mats Enlund, Sweden explored the explosive growth in day surgery, and the session culminated in a successful debate on the subject “This house believes that regional anaesthesia should be the option of choice for day case hernia surgery” Moderated by Michael Ward, Oxford, the case for was made by Prof Rawal, Sweden, and against by Ian Jackson, UK.

After lunch the final session looked at a number of aspects of the Anaesthetic Team, and we were pleased to welcome the President of the Royal College to discuss the inevitability of enlarging our current anaesthetic team. David Bogod, Nottingham brought us up to date on his local development of training non-physician obstetric epiduralists, but the opposite case was then argued for Sweden by their President, Lars Wiklund.

The meeting closed with a feeling that a most enjoyable, educational and successful couple of days had been spent together and all welcomed the promise of the return engagement in May 2005 in Uppsala.

Dr Michael Ward, June 2004

Letter from Malawi

Mathew Size

Three months ago I gave up the opportunity of a registrar job in London to come and work for a year in the anaesthetic department of the Queen Elizabeth Central Hospital (QECH), Blantyre, Malawi.

Malawi is a small but densely populated country in Southern Africa. It is one of the poorest countries in the world, with 64% of the population surviving on less than $1 per day. It has approximately one doctor per 101 000 people. The QECH has approximately 1000 beds and operates with greater than 100% bed occupancy. It is one of the three tertiary referral hospitals in the country, and as such receives patients from a wide catchment area of southern Malawi.

My day starts with a handover at 7:40am, when the patients for the day’s lists are discussed and the on call cases and ICU patients are reviewed. There are currently four anaesthetists in the department: two Dutch consultants, myself and another SHO from the UK on a three month voluntary placement. When the two Dutch consultants leave in July, there will only be me!

Fortunately, clinical officers do the vast majority of clinical work. The clinical officers are Malawians who have completed 18 months anaesthetic training at the School of Anaesthesia in Blantyre. There are currently 12 anaesthetic clinical officers and 14 trainee anaesthetic clinical officers (TACOs) who staff the ten theatres and cover on call. As physician anaesthetists, we do a one in four week-long on-call from home and take charge of the four bed ICU.

Today I am looking after the three main theatres; we also have three obstetric and gynaecology theatres, an eye theatre, burns theatre and a minor theatre, all at remote sites around the hospital. Before the first patient arrives, the clinical officers set about checking the machines and equipment. We use drawover systems with Oxford Miniature Vaporizers. Oxygen concentrators supply oxygen and compressed air to drive a Manley Multiventilator. We have excellent Datex monitoring which gives us ECG, NIBP, SpO2, agent monitoring and end tidal CO2 in most theatres.

Continued...
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... it stands alone

The SOLUS single use laryngeal mask airway is ideal for use in anaesthesia and emergency medicine. The SOLUS embodies all the classic features of a laryngeal mask airway with a number of new refinements. The single use SOLUS overcomes all concerns regarding cross infection.

For further information on the SOLUS laryngeal mask airway range please contact our customer care office on: 0118 9036 376 Or alternatively visit our website at: www.intersurgical.com
Over lunchtime I am called from my office to recovery. A patient who is generally poor.

The ward at night due to staff shortages, so postoperative care is for patients and one nurse during the day. Often there is no nurse at all on recovery our patients go back to the wards where there may be 70 our cleaners and porters! The situation is far from ideal. From Recovery is manned by three non-medical personnel who also double as our cleaners and porters! The situation is far from ideal. From recovery our patients go back to the wards where there may be 70 patients and one nurse during the day. Often there is no nurse at all on the ward at night due to staff shortages, so postoperative care is generally poor.

Over lunchtime I am called from my office to recovery. A patient who has been involved in an RTA has been rushed to theatre as he is unconscious and has obvious lower limb fractures. The accident and emergency department is very poorly equipped and staffed, and often sends severely injured patients directly to theatre where they will find an anaesthetist and surgeon. With the help of a clinical officer and a passing surgeon, we do a primary and secondary survey, gain IV access and intubate before taking him to theatre to deal with the open fractures. Postoperatively he goes to the ICU for ventilation and management of his head injury. We see an huge number of RTA victims, and the ICU is rarely without a patient with a severe head injury.

As a lecturer, my role is much more senior than I am used to in the UK. I tend to do much more supervising and teaching than hands-on clinical work. This also means that I spend most of my time with the most difficult patients, which is a fantastic learning experience for me, if a little stressful at times.

We do not have ODP’s here, and no separate anaesthetic rooms, so patients are anaesthetised on the table. One thing that I still can’t get used to is the need to reuse equipment. Due to shortages of both money and supplies we reuse everything, including syringes, endotracheal tubes and spinal needles.

The first patient is wheeled in and we obtain IV access, and attach monitoring. He is having a hernia repair and has been seen preoperatively by one of the TACOs. Unfortunately, although all the hospital staff speak English I don’t speak Chichewa, which makes communication with patients difficult. This patient is given a spinal anaesthesia with 5% heavy lignocaine by one of the TACOs.

Whilst the surgery continues I visit the orthopaedic theatre where a patient with an open fractured humerus is having an inspection of his wounds plus skin grafting. He has been given a standard induction of thiopentone followed by suxamethonium and intubation. He is maintained on halothane in air and oxygen and receives pethidine for analgesia. We do not have non-steroidal anti-inflammatory drugs or paracetamol. He is ventilated throughout the procedure without further paralysis (although we have a plentiful supply of rocuronium there is no neostigmine). The procedure is soon complete and we extubate him fully awake and take him to recovery.

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In theatre one today we have a general surgical list consisting of two inguinal hernia repairs, a circumcision, and a laparotomy for bowel obstruction. In theatre two we have an extremely varied paediatric surgery list encompassing a laparotomy for Hirschprung’s disease, two cleft palate repairs and a number of EUAs. Theatre four has an orthopaedic list, filled by the horrendous number of road traffic accidents. Theatre three is the emergency theatre, which at present sits empty awaiting cases.

In the afternoon I get involved with one of the emergency cases, a patient with peritonitis for a laparotomy. She is young but looks cachexic and although we do not know her HIV status, it is likely that she has AIDS. 36% percent of patients on the surgical wards were HIV positive in a recent study. She is septic with a low blood pressure and dehydrated. Pre-operative investigations are difficult to get here. A full blood count is relatively routine, as is a check for malarial parasites, especially in children and pregnant women. Urea and electrolytes are difficult to get. We cannot get liver function tests or any test of clotting function. She is coughing and a CXR would be useful, but to wait for one would mean a delay of around six hours. The patient is anaemic with a haemoglobin of 7g/dl. We have managed to secure one unit of whole blood, as a member of her family has donated to the blood bank in the hospital. If a donor had not been found, no blood would be available. Even in cases of severe haemorrhagic shock from trauma, ruptured uterus or ectopic pregnancy, all of which are commonly seen here, it is uncommon to get more than 2 pints of whole blood.

After some rapid fluid resuscitation in the corridor of main theatre, we induce with ketamine and suxamethonium. With further crystalloid resuscitation she becomes more stable and we are able to maintain her on halothane for the procedure. The surgeons find a primary peritonitis, washout and close. We extubate her fully awake, and send her back to the surgical HDU. ‘High dependency’ care is a relative term in Malawi. It means that oxygen and a pulse oximeter are available, and a higher likelihood of a nurse looking at the patient.

By 5pm all of the theatres are quiet and it is time for home. Days here vary massively from very routine and dull, through to manic and terrifying. I cannot speak highly enough of the clinical officers I work with. With very limited resources day after day, they give good, safe anaesthesia, and cope with everything that the hospital throws at them. It is a very humbling experience to work with them, and they have taught me a lot about working in this environment. Hopefully I have been able to teach them something too.

Email mattandlu@hotmail.com