CME in Uganda

The AP debate - what you really think

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Anaesthesia Delivery Re-imagined.
The Ugandan Society of Anaesthetists held their Refresher Course in Kampala at the end of April, with funding obtained from the International Relations Committee of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the World Federation of Societies of Anaesthesiologists (WFSA). The course was organised by Dr Sarah Hodges who is working long-term in Uganda, along with her Ugandan colleagues Dr Margaret Okello and Dr Cephas Mijumbi.

Two courses, each of three days duration, were run on separate weeks with a total of 305 anaesthetic officers attending. This was a phenomenal attendance given that there are around 330 anaesthetic officers looking after the Ugandan population of 22 million. In addition, all of the 3 Ugandan medical anaesthetists and postgraduate students attended.

The course was made up of lectures in the morning and small group tutorials in the afternoon, and the program ran from 0830 until 1800 each day. At the end of each morning session, a quiz was held which was completed on the third day, and prizes of books donated by Oxford University Press were awarded. In addition, many items of equipment donated by the lecturers were awarded, such as paediatric T pieces which are highly sought after in Uganda as they are in extremely short supply.

During the course it became increasingly clear that anaesthesia in Uganda has some major problems with individuals working in very difficult circumstances, particularly in rural areas. Shortages of even the most basic resources are a real problem, and much of the equipment is old and in need of replacement. Many units are short of oxygen and spinal anaesthesia equipment is not always available. This is not ideal for anaesthetising for Caesarean sections, one of the most common operations. Outside of the major centres most patients are anaesthetised using an EMO and ether, or ketamine. Monitoring is clinically based, with most anaesthetists limited to a pre-cordial stethoscope and manual sphygmomanometer. Pulse oximeters are rare. For the visiting UK and Irish lecturers, it was clear that many of our colleagues working in Uganda are extremely committed to their patients and do an amazing job in the most depressing of circumstances. Anaesthetists like them, we believe, are the unsung heroes of world anaesthesia.
The tutorials covered a number of areas and it was fascinating to discuss how to manage complex obstetric and general anaesthesia cases and also paediatric surgery with minimal resources. It was useful to be able to clarify many issues, including the need to change from using 5% dextrose in paediatric surgery. Although resources are in short supply, anaesthesia given with good clinical skills still saves many lives.

During the course the Glostavent was demonstrated to all the candidates and the value of concentrator oxygen established. A questionnaire was filled in by all delegates looking at what was required in their unit to make anaesthesia safe.

Due to the generosity of Oxford University Press, and the AAGBI Overseas Anaesthesia Fund, each delegate received a copy of the Oxford Handbook of Anaesthesia. For many, this was the first textbook they had personally owned and the pleasure of receiving such a gift from their UK colleagues was very clear!

Undoubtedly the highlight of the course was the quiz mentioned earlier. However, for the visitors, it was a sobering experience to realise that items such as disposable T pieces, and even single face masks, were prized possessions.

The lecturers were generously part-funded by travel grants from the Royal College of Anaesthetists, the Association of Paediatric Anaesthetists and the AAGBI. Moyna Bill (Belfast), Ellen O’Sullivan (Dublin), Isabeau Walker (London) and Iain Wilson (Exeter) were joined by Sara Rees, working for 6 weeks in Uganda, and Robert Neighbour from Diamedica, the Glostavent manufacturer. The lecturers were kept very busy during the course and it was certainly an unusual way to use annual leave. The experience left all of us delighted to return to the high quality NHS we enjoy! The T pieces given away during the quiz were kindly donated by Intersurgical UK Ltd.

The overall cost of the two courses was £9,400 including transport for the delegates from the rural hospitals, hire of facilities, all board and lodging for the delegates and printing of certificates – an astonishing average of £31 each!

Our thanks go to Sarah Hodges for organising our two weeks – a distinguished and inspiring anaesthetist, whom we are proud and privileged to know. Our overall memories are of a group of anaesthesia colleagues struggling to care for their patients, and their appreciation of the AAGBI for contributing and making their CME possible. Their enjoyment at meeting colleagues from the UK and Ireland was apparent, and it was fascinating to discover the similarities as well as the differences in the way anaesthesia is practised in such different environments.

Moyna Bill
Ellen O’Sullivan
Sara Rees
Isabeau Walker
Iain Wilson
annual congress 2006
Aberdeen
50th anniversary meeting
19-22 september 2006

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update
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- Morbid obesity
- Difficult airways
- Education in anaesthesia
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- Depth of anaesthesia
- Free papers
- Acute and chronic pain
- Intensive care
- Psychology in the workplace

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- The ageing anaesthetist on call
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<tr>
<th>Attendance</th>
<th>AAGBI Member</th>
<th>Non member</th>
<th>Retired member</th>
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<tr>
<td>Whole Congress registration fee</td>
<td>£400</td>
<td>£500</td>
<td>£200</td>
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<td>Tuesday 19 &amp; Wednesday 20 only</td>
<td>£225</td>
<td>£275</td>
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<td>Thursday 21 &amp; Friday 22 only</td>
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2 pm Sunday 17th – 4 pm Friday 22nd September
Liverpool Medical Institution

Sample Subjects from Course Menu

<table>
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<tr>
<th>Physiology</th>
<th>Pharmacology</th>
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<td>Altitude &amp; Depth</td>
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<td>Mechanics</td>
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<td>Acid &amp; Base</td>
<td>Statistics</td>
<td>Measurements</td>
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Extracts from Assessments of the The Mersey Selective May 2006

‘A very good course.’
The lectures on damping and pharmacodynamics and pharmacokinetics stood out
‘Pharmacokinetics was excellent thank you’
‘Lunch very good. MCQ’s in am and homework night before very good.’
‘Overall very good organisation of the course, keep up the good work, thank you’
‘Very well organised, took good care of candidates’
‘Many difficult topics covered well! Thanks!’
‘Very happy that I attended this course. Very useful course’
‘Excellent food.’
‘References paper excellent!’
‘The course showed me where I am. It explained how huge the syllabus is!’
‘Excellent lectures’
‘Excellent- I look forward to the MCQ and OSCE/Viva course’
‘I liked the MCQ practice.’
‘Topics well focused on Primary exam. Topic range and balance good. Physiology topics are of particular importance and value’
This is what we want. Great.’
‘Everything about statistics made simple! Excellent explanations in simple terms’
‘Covered a lot clearly’
‘Superb’
‘A lot to cover but an excellent overview’
‘Brilliant’

Please see Website (Classes & Courses) for further Assessments
For Application Forms & etc WWW.MSOA.ORG.UK
Under New Management

I have had my competencies signed off, my supervision has been reduced to level 4, my training is complete... I’ve been given command of the good ship “Anaesthesia News”. It’s a daunting prospect, but I’ll give it my best shot. It is customary on these occasions to pay tribute to one’s predecessor – so I’m going to. Stephanie Greenwell has handed over the newsletter in good health. From the feedback we get we know anaesthetists and many others (but possibly not midwives) enjoy reading the journal as it has evolved in the last few years – and much of the credit goes to Stephanie. I know how hard she has worked to make sure an interesting, eye catching product arrives for you every month – which is why I’m having sleepless nights now!

I’m the fifth editor of Anaesthesia News, which will be twenty years old next year. Each editor has contributed something different to develop the journal, and I hope I will be no exception. I have a few ideas up my sleeve, but I promise not to make wholesale changes all at once. Every time my daily newspaper is remodelled, it puts me off my cornflakes for weeks (I’m still not quite reconciled to the Daily Telegraph’s tabloid sports supplement), and I would not wish to upset our loyal readers so early in my editorial career. To continue the naval metaphor, it’ll be “steady as she goes” – for a while anyway! I just want to get a few issues out that are up to the standard Stephanie has set, and take it from there. I have the support of a great team – Amanda McCormick is our designer, Claire Elliott handles the advertising and co-ordinates operations, and my two assistant editors, Iain Wilson and Mike Wee, are old hands.

Of course, the journal is only as good as the stuff you send us – so keep it coming in. If you’ve got something to say, let us hear it – just because we’ve never printed anything along those lines previously, it doesn’t mean it won’t be considered. Anaesthesia News has no formula – well, ok, only a very loose one – so get your thoughts down on paper and send them in by email only please to anaenews@aagbi.org. Do you remember the BMJ’s Personal View before it got hijacked by political correctness? If it was good and vaguely relevant, it went in. For Anaesthesia News the same applies. Articles should be 750 - 1000 words with a couple of pictures/illustrations if appropriate (don’t forget the picture captions). The only thing we don’t do (or hardly ever) is scientific studies – the Association has a big white journal that deals with that side of things. Top of my wish list is to find a cartoonist – does anyone else remember PEEP, who was in an anaesthesia newsletter (I’m not even sure it was this one!) in the 1980s? His/her work was priceless. PEEP, if you’re still out there, please get in touch! If you have talents in that area, please contribute – if we get lots, I may even run a contest and persuade our treasurer to come up with the cash for a small prize! (In charge for ten minutes and blowing the budget already).

One of my other Association hats this year is Chairman of the International Relations Committee, and in this issue we have a report on a course for Clinical Officers in Anaesthesia run in Uganda. The Association was one of the sponsors of this course, both directly and also in assisting with travel costs for some of the UK and Irish based lecturers who went out to participate. I think the best bit is the costing – three days of residential education delivered for an all-in cost of £31 per head. I’m passing the article on to the Association’s events team! This was one of the first projects where the IRC main budget and the Overseas Anaesthesia Fund (which you donated) were able to work together – IRC sponsored expenses, and OAF paid for some of the books which were donated to participants.

I hope those of you who received Membership Survey forms a couple of months ago returned them. The Association hasn’t undertaken a feedback exercise on this scale for a long time, and this month Alastair Chambers reports on the results of the questions about Anaesthesia Practitioners, the subject which was the main impetus behind the commissioning of the questionnaire. Further results will follow in future editions.

I trust you are coping with our new format seminars pull-out. This month we also have the application form for CME day on November 4th – as this is the only paper application form you will receive, don’t throw it away if you are intending to come!

I hope the variety in this issue, plus input from many of our usual contributors means that the editorial handover (like training will be soon) is “seamless”.

Hilary Aitken
It was my second visit to the DOCTORSUPDATES Anaesthesia Forum organised by Bernie Liban and his efficient committee - but I am concerned that the secret formula for the ideal conference may not be quite so secret for much longer. I had been impressed, on my visit to the same venue two years previously, by the scope of the programme, but in October 2005 I think that the organisers may have excelled themselves.

The program consists of lectures and workshops from 8am to 12noon and an evening session before dinner which delegates’ partners frequently choose to attend as the topics are of more general interest, and are often discussed further over dinner. No slacking is allowed as there is a strict regime to ensure attendance, but in the afternoons there is plenty of time to improve one’s golf, play tennis, enjoy a swim or just take the air. With fellow anaesthetists for company I found that a significant amount of additional informal learning went on during these relaxed afternoons.

The conference is held in the Club Med complex in Da Balaia, Portugal, so the food and wine is predictably good, fresh and plentiful. The accommodation is comfortable, and the Gentils Organisateurs (GOs) are helpful and enthusiastic, encouraging delegates to join in the group activities. All this helps to create an atmosphere in which it is easy to exchange views and ideas both within the lecture hall and outside it. Gentle sporting competition continues throughout the week, with a light-hearted sports afternoon mid-week with prizes for excellence in a variety of arenas (including best sun-tan this year!)

My personal interest is in regional analgesia for orthopaedic surgery, and there was ample to interest and educate me. There is an excellent balance between new information and refresher courses, and the four-day program well-deserves its 15-point allocation of Continuing Professional Development points. 2005 saw a wide ranging set of lectures covering topics such as current thinking on anaesthesia for AAA, up to date management of patients undergoing LSCS, and the safety of epidurals in patients on anti-platelet drugs. Concurrent with the lecture program there were splendid small-group workshops on anaesthetic, legal and financial issues. Speakers ranged from research registrars to professors and are clearly selected both for their skills as presenters as well as their expertise. A distinct blurring of ranks takes place when the lectures are top-quality, but delivered by people in shorts and flip-flops. The pre-dinner speakers amused and informed on HIV, the Russian theatre siege and healthcare in the Victorian era: it appeared that nobody was put off their dinner despite some graphic slides.

Usually I would recommend a good conference. This was a very good conference, and I left feeling informed, updated, rested and rejuvenated. Places are limited so it’s not something I want to publicise to my colleagues…

Dr Georgina Jefferies
Consultant Anaesthetist
Wirral Hospital Trust
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Evelyn Baker Medal
An award for clinical competence

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

Dr John Cole (Sheffield) was the first winner of the Evelyn Baker medal in 1998, followed by Dr Meena Choksi (Pontyprridd) in 1999, Dr Neil Schofield (Oxford) in 2000, Dr Brian Steer (Eastbourne) in 2001, Dr Mark Crosse (Southampton) in 2002, Dr Paul Monks (London) in 2003, Dr Margo Lewis (Birmingham) in 2004 and Dr Douglas Turner (Leicester) in 2005.

Nominations are now invited for the award to be presented at the WSM in January 2007 and may be made by any member of the Association to any practising anaesthetist who is a member of the Association.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary by 5 October 2006.

University Hospitals
Coventry and Warwickshire
NHS Trust

EPIDURAL WORKSHOP
18th September 2006
Clinical Sciences Building, Walsgrave Hospital, Coventry
Course Director - Dr. K. Ramachandran

The workshop is ideal for senior house officers in anaesthesia who are inexperienced and/or are about to embark on obstetric anaesthesia module. It includes anatomy, pharmacology, issues in obstetrics, trouble shooting problems and postoperative management of epidural infusions in patients undergoing major surgery. The highlight of the workshop is the hands-on practice session on pig and simulators models.

Course Fees £180 for doctors (includes lunch/refreshments)

For registration please contact Rachel Davies on Tel: 034 7696 8722
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LESSONS LEARNT FROM LIFE AT THE LIMITS
Speakers include: Prof John West, Prof Jim Kass,
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A one day event looking at extreme environment physiology and the lessons learnt from ‘life at the limits’

London, 6th June 2006
Meeting Chairs: Dr Kevin Fong & Dr Mike Grocott
Full details at: www.ucl.ac.uk/anaesthesia/meetings and email: uch.acru@btinternet.com

5th Evidence Based Peri-Operative Medicine

- Professor David Bennett (London, UK), Goal directed therapy
- Professor Henrik Kehlet (Hvidovre, Denmark), Enhanced surgical recovery
- Professor Monty Mythen (London, UK), Is there a problem with UK surgical practice
- Professor Don Poldermans (Rotterdam, Netherlands), Beta Blockade and surgical patients
- Professor John Sear (Oxford, UK), Anaesthesia and hypertension
- Professor Mervyn Singer (London, UK), Glycaemic control
- Professor J.A.W Wildsmith (Dundee, UK), General vs Regional anaesthesia

London, 6th & 7th July 2006 ~ Meeting Chairmen: Dr Mark Hamilton & Professor Monty Mythen
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“Dingle 2006”:
8th Current Controversies in Anaesthesia and Peri-Operative Medicine
27th September – 1st October 2006
CALL FOR ABSTRACTS ~ £1000 IN PRIZES
Program & full details available on line at www.ucl.ac.uk/anaesthesia/meetings or
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FIRST ANNOUNCEMENT
BSOA 11th Annual Scientific Congress
Friday 10th November 2006, Oswestry
(Administered by the CFA on behalf of the British Society of Orthopaedic Anaesthetists)
2006 Congress Chair: Dr Chris Emmett
Register for information by emailing: uch.acru@btinternet.com
Difficult Airway workshops have become a regular feature of airway management training in the UK. Several teaching hospitals as well as DGHs have set up well-recognised workshops to identify, plan a strategy and familiarise participants with equipment to manage a difficult airway.

The anaesthetic department at Wexham Park Hospital has regularly been conducting airway workshop for anaesthetic and A&E trainees for the last 3 years. This experience has encouraged us to share our skills and train others. A group of Consultants from Wexham Park Hospital, Slough, Berkshire, along with theatre practitioners set out to Budapest on a cold wintry morning with the cheerful news that the temp in Budapest was a balmy –10°C (compared to Moscow at –40°C). They went to conduct a workshop on the Difficult Airway at the invitation of Brigadier General Laslo Nagy of the Hungarian Difficult Airway Group at the Central Military Hospital in Budapest.

This was a repeat of a very successful workshop conducted by the same group in 2005. The meeting started off with lectures on the anticipated and the unanticipated difficult airway along with a talk on different types of equipment available to get an anaesthetist out of this sticky situation! The incidence of a nightmarish scenario of “cannot ventilate and cannot intubate” is less than 0.01% of all anaesthetic cases but it can leave a devastating legacy on the doctor concerned and a catastrophic tragedy for the patient and relatives. The keynote lecture was given Dr Mansukh Popat, President of the Difficult Airway Society of UK, along with lectures by Dr Shaun Scott and Dr Roy Fernandes. After the lecture there were lively case discussions on different scenarios. This was followed by a hands-on workshop on manikins where the delegates came to grips with different techniques on handling the airway. There were about 35 anaesthetists from all over Hungary who attended this workshop. The delegates were extremely enthusiastic and very receptive, for most of them this was their first experience in handling a fibrescope. The quality of the equipment available made some of the faculty very envious, remembering the struggle to pass various committees in order to obtain even the most basic kit!!

On this occasion the unique feature was a hands-on workshop conducted the following day on cadavers at the Hungarian Forensic Institute. We believe this was the very first occasion when cadaver training has been used to master different airway control techniques.

The feedback from the delegates reflected a very high level of satisfaction with the workshop and requested that this be a regular annual feature.

The workshop was organised by Dr Jairaj Rangasami and the other members of the group were Drs Peter Thomas, P Olah, T Pataki, T Tamm & R Iyer, ably assisted by Barry Richards, Peter Norval and Chantell Etheridge.

It was nice to be back to a cold London morning with the added joy of having the taxi breakdown in the Heathrow tunnel and Chantell having visions of being surrounded by police! Fortunately help was at hand and we got towed out till help arrived. At least it gave an opportunity to photograph the Concorde!

Rangu Iyer
Consultant Anaesthetist
Wexham Park Hospital
Log – an official record of events during the voyage of a ship or aircraft
Logbook – a book containing an official or systematic record of events  (Source: The Oxford English Dictionary)

An anaesthetic trainee’s logbook is both a tool and record. I believe the logbook is important to direct us through the various stages of our training, and it is also a vital tool for trainers to help in the assessment and appraisal of trainees. The design of such a logbook should aim to provide accurate and relevant information without it becoming a time-consuming Herculean task. It needs to satisfy the needs of the trainee and trainer and be able to generate reports that are useful and meaningful.

Logbooks exist in both paper and electronic versions. The paper logbook is still being used, though the convenience of data entry and production of summary results has made the electronic version more popular. Irrespective of the version used, the Royal College of Anaesthetists has recommended a minimum standard data set. The widespread availability of high performance personal digital assistants (PDAs) and computers have made the process of repetitive data entry and large database management a simpler exercise. Other methods available to compile a logbook include using the operating theatre IT systems to provide a record of all cases in which you are involved, or using web based systems.

The Royal College of Anaesthetists launched its original electronic logbook in March 1996, which was designed using the SCATA (UK) dataset. Since the original Psion/ Symbian program, various Windows PC versions, MAC versions and programs for handheld devices have been developed. The latest versions are downloadable free from www.logbook.org.uk or from www.scata.org.uk . These programs also have detailed user and troubleshooting guides. Some of our more IT literate colleagues have developed their own electronic versions based on MS Excel, MS Access and similar applications.

The annual SpR Record of In-Training Assessments (RITA) and periodic SHO training reviews require trainees to present a summary of their logbook, which must be based on the RCA minimum data set. Hence, in spite of the wide array of programs available, the RCA logbook continues to be the most popular version amongst trainees.

The logbook fulfils a slightly different function for trainer and trainee –

Trainee – It provides a personal audit of clinical activity and performance, highlighting areas of proficiency, areas of work needing attention, level and extent of supervision and the variety of clinical experience gained.

Trainer – It provides a record of the trainee’s clinical activity, the extent of training versus service provision needs and helps in the setting up of future, achievable goals for the trainee and in manpower development.

With the current emphasis on competency-based training, the biggest drawback to the current logbook has been the lack of confidence in its ability to assess competence. In the survey conducted by M C Nixon at the GAT meeting in 1999, 97% of the responding trainees did not believe that the current logbook assessed competence. Furthermore, fewer than 67% of SpRs had had their logbooks assessed at RITAs. Problems have also been highlighted in the maintenance of logbooks for Pain Management and Intensive Care Medicine modules due to the wide variety of clinical presentations, events and procedures applicable to the specialties.

Newer logbooks would need to incorporate the needs of competency-based assessment and the changes brought about by “Modernising Medical Careers” and PMETB. With the current upward trend in the usage of handheld devices in medicine, they are bound to help trainees by being a ready reference source at the point of care, for instance in drug dosage and infusion calculations, personal study and research and in their flexible utility software.

Finally, if all goes wrong and you are unable to furnish a logbook in time there are a number of common excuses used about digital logbooks. I’m sure you will be able to work one out, but beware - your training committee has probably heard them all before!

M K P Prasanna, GAT committee member
St Thomas’ Hospital, London

Internet sites:
www.scata.org.uk     www.rcoa.ac.uk     www.logbook.org.uk

References:
Nixon MC. The anaesthetic logbook - a survey. Anaesthesia 55(11):1076-. 1080

Mystery Author Sought!
An article which had unfortunately become separated from its author details was recently forwarded to Anaesthesia News by the GAT committee. It’s about the factors taken into consideration when applying for a consultant post. If you are the author, please contact Anaesthesia News (anaenews@aagbi.org) so that it can be published in a future edition.
New NHS Cardiac Arrest Procedure Unveiled

From our correspondent Scoop O’Lamine

Since treatment for cardiac arrest is now not recognised under tariff arrangements, the NHS has developed new guidelines for managing this emergency. Anaesthesia News has been given an early version of the proposed protocol and also some details of the emergency equipment which will soon replace standard resuscitation kits.

According to Mr I. Will Savem, NHS Finance and Protocols division, cardiac arrests will now be known as an “unexpected turn for the worse” to avoid the distress associated with the prior terminology. This new patient-centric phraseology was developed during a dynamic, consensus-finding focus group, involving patient representatives. The protocol follows:

Patient discovered with an “unexpected turn for the worse”

Check pulse

↓

No pulse = “dead”

↓

Kettle on

↓

Pulse present = “not dead”

↓

Kettle on

↓

Fast bleep “Breaking Bad News Co-ordinator”

↓

Phone

↓

Med Reg

↓

Tea

↓

Alert porter for the special trolley that no one knows what is inside

↓

Tea

↓

This new protocol should allow much easier training for doctors and nurses to work together as a team. There are also considerable savings to be made for hard-pressed NHS Trusts with this new approach. “Traditional ALS courses to manage death are expensive, often as much as £370 each; the new training course, including the new equipment which will need to be purchased, will be much cheaper, as the five minute learning opportunity required only costs around 57p” asserts Will.

A photo of the equipment to be immediately available on all wards is shown.

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: 13 October 2006

Association Educational Awards are only open to members of the Association of Anaesthetists of Great Britain and Ireland
The AAGBI Council has recently endorsed the concept of holding regional seminars. To date, four regional seminars have been held—three in Scotland over the past two years, and one in Northern Ireland last autumn. Delegate places for all these seminars were fully booked shortly after the first announcement and the feedback on rolling the seminars to out-of-house venues has been very positive. Council is keen to encourage enthusiasts in other regions to consider co-ordinating regional AAGBI seminars.

Why bother?
The Association seminars continue to be popular and frequently oversubscribed, mainly because the speakers are of the highest calibre and the programmes are designed to facilitate travel to and from the seminar in one day. Each one is held usually no more frequently than annually, so it makes sense to repeat popular seminars in the regions to offload some of the waiting lists.

For those of us who do not live within a short train journey from London, or near an airport served by a low cost airline, a one-day seminar in London is not cost-effective in financial or time-management terms. Whilst the Portland Place experience is undoubtedly a pleasant one, attendance often requires a night away from home and a late return, resulting in the inevitable juggling of clinical and domestic commitments on the night of the seminar.

One advantage of organising a regional seminar is that you can choose an appropriate subject and run the seminar at a venue that is convenient for you and your colleagues. Another massive advantage is that the seminars department at the Association does all the administration for you. For those of us who are short of secretarial support (i.e. most of us!), this makes the organizing of a seminar rather pleasant and hassle-free!!

Getting Started- How it worked in Scotland
A few years ago, under the auspices of the AAGBI Scottish Standing Committee, I undertook a survey of all the anaesthetists working in Scotland to assess the strength of support for regional seminars. The response was overwhelmingly positive. The AAGBI Council considered the result and agreed that we should hold a ‘pilot’ seminar in a location favoured by the majority of respondents—i.e. somewhere in central Scotland.

Challenges for the first seminar included:
- Finding a suitable location
- Choosing a ‘ready-made’ oversubscribed Portland Place seminar whose speakers were prepared to travel
- Ensuring the comfort, hospitality and technological standards of Portland Place
- Ensuring we didn’t make a financial loss for the Association
To name but a few!

The first Scottish seminar was held in the Conference Centre at Perth Royal Infirmary in March 2005 and ran most successfully—despite unexpected freak weather conditions on the day.

The seminar subject was ‘Cardiac Risk in Patients Undergoing Non-Cardiac Surgery’ which had originally been held in Portland Place and organised by Dr Virginia Brown (London). She sought agreement from all her speakers to travel to Scotland and we worked together with the seminars department from Portland Place in the planning and co-ordination.

We received some additional financial support by holding a small trade fair.

Difficulties?
There were various “challenges” with the first seminar. Two colleagues from my department in Dundee assisted—Dr Matthew Checketts stepped in at the last moment to save us from an audiovisual nightmare and did a truly superb job. In addition Dr Paul Currant helped with registration. In particular, we were all indebted to the driver of the snowplough who dug our caterer out of her house in deepest Perthshire in time to feed us a wonderful lunch!

We learnt many lessons from the first seminar and were primed to troubleshoot early for the most recent seminars. As a result, they went without a hitch—(almost!).

Progress
Approximately a year ago I undertook a field trip with Ellen Morley and Nicola Heard from the Association seminars and events departments to seek potential venues for this year’s seminars. Our inspection of Scone Palace, Perthshire, came at the end of a trek around many conference facilities in central
Scotland. As soon as we drove through the grounds and approached the Palace we were convinced that it would surpass the levels of splendour expected for the seminars. On further inspection, it looked ideal.

This year we ran two seminars in Scone Palace - on 6th and 17th March.

‘Intensive Care in the Operating Theatre’ was originally organised by Dr Iain Wilson (Exeter) in Portland Place. This was repeated in a larger London venue last year, jointly organised with Dr James Pittman (Exeter). However, there is still a long waiting list to attend this seminar in London. We made a few changes to the London programme, to accommodate the natural evolution of the programme and to include Scottish expertise. The day was a great success with very positive feedback from delegates and speakers alike.

On 17th March we ran “Peri-operative Blood Conservation”. This was previously organised in London by Dr Virginia Brown (London), and prior to that, by Dr Dafydd Thomas (Swansea). We made some changes to the programme and speakers to reflect the rate at which blood issues are evolving and to include the expertise of accomplished experts working locally. This was also a huge success, as judged by delegate and speaker feedback. The standard of scientific and clinically relevant presentations was superb on both days and justified the fact that both seminars had been fully booked months in advance and currently have waiting lists.

Are you up for it?
If you are interested in co-ordinating an AAGBI seminar in your region and you are sure that there is a local need for it, then just do it! If I can do it you can be confident that it’s not that taxing, although it does require some effort! Our colleagues in Northern Ireland have already taken up the gauntlet and have run a successful seminar in Belfast. The Scottish seminars have been attended by anaesthetists from throughout the United Kingdom and the Republic of Ireland and the feedback has been extremely supportive of continuing these on at least an annual basis.

You will receive tremendous support from Ellen and David in the Seminars department at the Association They have had years of experience and are highly skilled in dealing with any unscheduled surprises- or disappointments! If you fancy the idea of organising a seminar locally that is of interest to your own clinical practice, but you can’t face the hassle of accounting and administration, this could be the solution you’re seeking!!

For the first seminar, it may be helpful to get a little team together from within your department to share the workload. However, as with any successful project, members of the team need to be carefully chosen. Choose colleagues you can work with and who have a track record of being totally reliable. This is a venture for those who ‘do’ rather than those who ‘delegate’- at least that’s how it worked for me!

Getting started in your area
For further information please contact Ellen Morley or David Williams at Portland Place on ellenmorley@aagbi.org or davidwilliams@aagbi.org in the first instance. Once you have had agreement from your speakers they will communicate with the seminars committee and help with co-ordinating the date and venue for the seminar, as well as all the finer details as required. In addition, I would also happily pass on any tips that may be of help getting you started.

Go on. You know you want to!
Good Luck!!
Catriona Connolly
(Consultant Anaesthetist, Dundee) c.connolly@doctors.org.uk.

CLEVELAND SCHOOL OF ANAESTHESIA

FINAL FRCA CRAMMER COURSE
MCQ & SAQ
Based Interactive Tutorials
THE JAMES COOK UNIVERSITY HOSPITAL
MIDDLESBROUGH

11 – 13 September 2006
A three day intensive course
Course Director: Dr Dave Murray
Programme includes Mock MCQs, SAQs, and Tutorials
Non-residential course fee: £300

To secure your place please contact:
Mrs Elaine Tucker – Course Administrator
School of Anaesthesia, Cherten House
The James Cook University Hospital
Marton Road, Middlesbrough TS4 3BW
Email: elaine.tucker@stees.nhs.uk
Tel: 01642 854601

Places limited to 12

PLEASE NOTE: BOOKINGS WILL NOT BE HELD WITHOUT A COMPLETED APPLICATION FORM ACCOMPANIED BY A CHEQUE. CANCELLATION CHARGES APPLY AND NO REFUNDS WILL BE GIVEN FOR CANCELLATIONS WITHIN 4 WEEKS OF THE COURSE.
THE MERSEY WEEKENDS

Final FRCA SAQ Weekend
“The Mersey Method”
14.00 Friday 15th – 16.00 Sunday 17th September

Master Classes in the Mersey Method of Approach to the SAQ Paper
Supervised Practice & Analysis - Refinement of Style
Time Management - Discipline
Preparatory Homework
Candidates will be required to contribute to an SAQ Homework Exercise

Primary OSCE Weekend
14.00 Friday 22nd – 16.00 Sunday 24th September

Master Classes in range of OSCE Stations
Introduction to Simulation OSCE Station
Group Analysis of OSCE Stations
Preparatory Homework
Applicants will be required to contribute to an OSCE Homework Exercise

Message from the Course Faculty
“With the important 2 from the MCQ in his or her pocket, a candidate will have to be unnecessarily careless not to get a 2 from the OSCE if you have attended this course. Thus, he or she will then be very unfortunate to fail both vivas.”

Primary FRCA Viva Weekend
2.00 pm Friday 6th - 4.00 pm Sunday 8th October

Intense Presentation Practice
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Candidate Assessments & Application Forms
www.msoa.org.uk
Education for Anaesthetists is a prime objective of the Association of Anaesthetists. To this end it organises a programme of highly popular seminars.

Seminars are held at the Association of Anaesthetists headquarters, 21 Portland Place, London, W1B 1PY.

We aim to time seminars so that it is possible for those attending to travel to and from the venue on the day of the meeting, without the need to stay overnight.

A hot lunch and refreshments are provided free of charge for everyone at the seminar.

**How to book a seminar**
For availability, to look at programmes and download individual application forms please see the website at www.aagbi.org. Alternatively you can complete and send the generic application form enclosed in this section (please photocopy to apply for more than one seminar).

Unfortunately we are unable to reserve places or accept telephone bookings.

**Cancellation Policy**
All cancellations must be received in writing. Written cancellations received two weeks or over before the seminar will be subject to an administration charge of £20. Delegates cancelling after this date will be liable to pay the full seminar price unless the Association considers there to be exceptional circumstances that would warrant a refund.

**Waiting List**
If we receive applications and the seminar is fully subscribed, your payment will not be processed and you will automatically be placed on the waiting list. Should a place become available through cancellation, we will contact those on the waiting list on a first come – first served basis. When a repeat seminar date is fixed, we will write to all members on the waiting list before we advertise the seminar generally.

To be placed on the waiting list, please e-mail David Williams at seminars@aagbi.org.

Please note that you cannot attend an Association seminar if you have not applied in advance. Health and Safety codes dictate we are unable to admit anyone who arrives on the day without prior arrangement.
New Seminars

For comprehensive information, listings, programmes and availability please see the Association Website www.aagbi.org before booking.

DIFFICULT AIRWAY PROBLEMS
Wednesday 8th November 2006

Organiser: Dr Ralph Vaughan, Cardiff

- Assessment of the airway
- Anaesthetising the airway – and practical awake fibreoptic intubation
- The management of the known difficult airway in adults
- The management of the known difficult intubation in children
- Interesting case studies including trauma airway
- The management of the unexpected difficult intubation, especially in obstetrics
- Extubation problems

CURRENT TRENDS IN PAEDIATRIC ANAESTHETIC PRACTICE FOR THE NON-SPECIALIST
Tuesday 28th November 2006

Organiser: Dr Andy Tomlinson, Stoke-on-Trent

- What’s new in resuscitation and airway management
- What’s new in breathing systems and filters
- Dilemmas on the day of surgery: the difficult child & acute clinical problems
- Optimum pain relief following day-case surgery
- Paediatric sedation
- Intravenous fluid management
Directions

The AAGBI is located in central London, just north of Oxford Street and within easy access of underground stations. Great Portland Street is a 4 minute walk. (Circle, Hammersmith and City and Metropolitan Lines)

Oxford Circus is a 7 minute walk. (Bakerloo, Victoria and Central Lines)

Regents Park is a 5 minute walk. (Bakerloo Line)

The National Rail stations of Paddington, Euston and King’s Cross are all nearby a few minutes journey by taxi. All of the other London Termini can be reached by underground or taxi.

We are situated within a controlled parking area, parking meters are available in the surrounding streets.

Travel advice can be obtained from www.transportforlondon.gov.uk where you can download underground and bus maps and also view the latest travel updates.

To check latest national rail information go to www.railtrack.co.uk

PLEASE NOTE THAT THE SEMINARS LISTED BELOW HAVE BEEN PREVIOUSLY ADVERTISED AND MAY ALREADY BE FULLY BOOKED – PLEASE CHECK OUR WEBSITE FOR AVAILABILITY: www.aagbi.org

ORGAN DONATION SEMINAR
Tuesday 5th September 2006

ANAESTHESIA FOR PATIENTS WITH ENDOCRINE DISORDERS
Wednesday 6th September 2006

LEADERSHIP: AN INTRODUCTION
Monday 11th September

CLINICAL EPIDURAL ANAESTHESIA
Wednesday 4th October 2006

GAT: THE CONSULTANT INTERVIEW
Thursday 5th October 2006

AWARENESS AND DEPTH OF ANAESTHESIA
Thursday 12th October 2006

HISTORY OF ANAESTHESIA: FROM TOOTHACHE TO PAIN MEDICINE
Monday 16th October 2006

ANAESTHESIA FOR LIVER RESECTION SURGERY
Wednesday 18th October 2006

YOUNG CONSULTANTS: BALANCING THE BOOKS
Thursday 19th October 2006

OPHTHALMIC ANAESTHESIA
Tuesday 24th October 2006

ULTRASOUND IN REGIONAL ANAESTHESIA
3RD NATIONAL SYMPOSIUM
VENUE: ROYAL COLLEGE OF PHYSICIANS
(PLEASE SEE WEBSITE FOR FURTHER INFO)
Monday 13th November 2006

REDUCING THE RISKS IN VASCULAR SURGERY
Tuesday 14th November 2006

MAGNESIUM; A 21ST CENTURY PANACEA? IT’S USES IN ANAESTHESIA AND INTENSIVE CARE
Thursday 23rd November 2006

Seminars Calendar
Booking a Seminar

To book a place on a seminar, please complete this form and return to: David Williams, Association of Anaesthetists, 21 Portland Place, London, W1B 1PY or fax to: David Williams 020 7631 4352. For availability, see website www.aagbi.org or telephone 020 7631 8862. We regret that we cannot accept telephone bookings.

Title of seminar ..................................................................................................................................................

Date of seminar ..................................................................................................................................................

Membership no ............................................ Male/Female ...................................................... Title .................

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Name of hospital (not trust) .............................................................................................................................

Special dietary requirements ............................................................................................................................

Please pay by Sterling cheque drawn on a UK bank and made payable to the Association of Anaesthetists;
Credit Card (only Visa/Mastercard/Delta); or Switch. One cheque per seminar application please.

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Cancellation Policy
All cancellations must be received in writing. Written cancellations received two weeks or over before the seminar will be subject to an administration charge of £20. Delegates cancelling after this date will be liable to pay the full seminar price unless the Association considers there to be exceptional circumstances that would warrant a refund.
CONTINUING MEDICAL EDUCATION DAY
Saturday 4 November 2006
Royal College of Anaesthetists, Churchill House, London

Registration Fee: £195.00

The Continuing Medical Education Day is organised jointly by the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists. All anaesthetists are eligible to attend and trainees are particularly encouraged to apply. This meeting is approved for CME purposes.

The Continuing Medical Education (CME) Day will comprise 18 lectures held in three different rooms, thus allowing participants to attend a total of six lectures. The full programme is listed overleaf. Whilst every attempt will be made to allocate your first choice of lecture, we do also ask you to indicate a second choice in each case.

The registration fee of £195 includes lunch. Extended summaries of all the lectures is also included in the fee.

FURTHER INFORMATION AND A LOCATION MAP WILL BE SENT TO YOU APPROXIMATELY TWO WEEKS BEFORE THE MEETING

Cancellations received in writing before 06.10.06 will be subject to an administration charge of £25. Delegates cancelling after this date will be liable to pay the full meeting price unless the Association considers there to be exceptional circumstances that would warrant a refund.

To attend the Continuing Medical Education Day, please complete the form opposite and return it with your registration fee to:

The Events Team, Association of Anaesthetists, 21 Portland Place, London W1B 1PY,
Tel No: 0207 631 8805/8, Fax No: 020 7631 4352, Email: meetings@aagbi.org
## Program

**Pre-operative assessment**  
Dr James Down, London  
9:30 - 9:50

**Obesity and anaesthesia**  
Prof Alastair Chambers, Aberdeen  
9:50 - 10:15

**Obstetric haemorrhage**  
Dr Geraldine O’Sullivan, London  
9:50 - 10:15

**Valve disease and anaesthesia – aortic stenosis**  
Dr John Gozard, London  
10:15 - 10:50

**Chronic pain for the general anaesthetist**  
Prof David Rowbotham, Leicester  
10:20 - 10:45

**Tackling track and trigger**  
Dr David Goldhill, London  
10:20 - 10:45

**Opioids in anaesthesia – an update**  
Dr Jonathan Thompson, Leicester  
11:00 - 11:20

**Resuscitation in the operating theatre**  
Dr Jerry Nolan, Bath  
11:00 - 11:20

**Difficulties of consent and child protection for the anaesthetist**  
Dr Kathy Wilkinson, Norfolk  
11:00 - 11:20

**Transfusion**  
Dr Dafydd Thomas, Swansea  
11:20 - 11:40

**Neuromuscular blockade**  
Dr Killian McCourt, Belfast  
11:20 - 11:40

**Herbs, potions and anaesthesia**  
Dr Judith Hall, Cardiff  
11:20 - 11:40

**Ultrasound - how to find what you want to hit**  
Dr Stefan Schraag, Glasgow  
12:45 - 13:05

**Accidental awareness in anaesthesia**  
Dr Giles Morgan, Truro  
12:45 - 13:05

**Inter-hospital transfers**  
Dr David Scott, Edinburgh  
12:45 - 13:05

**Successful and safe blocks for the non-regional anaesthetist**  
Dr John Picard, London  
13:10 - 14:00

**Day care anaesthesia – pushing the limits**  
Dr Ian Smith, Stafford  
13:10 - 14:00

**Trauma**  
Prof Ian Greaves, Middlesbrough  
13:10 - 14:00

## Registration Form

Please complete the form below and return it with your registration fee to:
The Events Team, Association of Anaesthetists, 2 Portland Place, London W1B 1PY
Fax No: 020 7631 4352, Email: meetings@aagbi.org

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Select SIX lectures, ONE from each session and a 2nd choice. Please indicate the NUMBER of your 1st and 2nd choices in the boxes provided.

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## Registration Fee

**£195.** Please pay by Sterling cheque drawn on a UK bank and made payable to the Association of Anaesthetists;

Credit Card (only Visa/Mastercard/Delta); or Switch.

Card/Switch Number .................................................................
Expiry Date.............................. Issue No (Switch only) ......................... Security code (last 3 digits on back of card) ....
Cardholder’s Name .................................................................
Cardholder’s Signature ................................................................ Date .................................
Well, we’re still waiting to hear about the changes to the NHS Pension but no news is no news so here’s an article that could potentially save anyone with a FSAVC a pile of cash in charges. It stems from the recent reforms to pension legislation, which swept away a good number of over-complicated and restrictive rules.

FSAVCs were often advised as top-ups to your NHS Pension during the nineties. They were especially suitable if you were trying to fund for early retirement, where added years might not have been possible. As contributions weren’t made from your payslip, your employer couldn’t know that you were engaged in tunnelling activities. Equally, with the only in-house AVC being that from the Equitable Life, the ability to choose your FSAVC provider was in retrospect a rather useful feature of FSAVCs!

I see many doctors who now have quite substantial FSAVC funds, and almost without exception they are suffering from the effect of high charges, which eat rather more than one would now reasonably expect into their investment growth. In fairness, these charges were typical of pensions at the time, and although personal pensions were effectively price-capped in 2001 under the ‘stakeholder regime’, no such Government intervention was ever applied to FSAVCs. The latter thus often sport an interesting range of mysterious and somewhat opaque charges that can tot up to a reasonable percentage each year – ‘policy fees’, ‘capital unit charges’, ‘reduced allocations’, and so forth.

Until April 6th this year (the apocalyptically-named ‘A Day’) you weren’t able to get any tax free cash out of FSAVCs. As long as your provider will allow it, and not all will, you can now take up to 25% of the fund in such a way. That’s great in itself, but perhaps the greater freedom is that pre-A Day you couldn’t really transfer your FSAVC anywhere but to another FSAVC, and only then if you planned to keep on making contributions. Unless your provider prohibits it (and I haven’t found one yet that does) you can now move your FSAVC to a cheaper stakeholder or personal pension, where the only charge is likely to be an annual fund based charge of about 1%. Or of course to your Self Invested Personal Pension (SIPP), if that applies to you.

Naturally, if your FSAVC charges you penalties for taking your business elsewhere, you need to be confident that you’re still likely to do better in the new arrangement. In any transfer, whether there are penalties or not, you really must take independent financial advice.

For further information on any of the above please feel free to contact Dr Mark Martin at markmartin@doctors.org.uk

Caption contest

Association members Iain Wilson, Phil Bayly, and William Harrop-Griffiths decided to forgo the check-in queues for travel to ESA in Madrid. But can you supply a caption? Bonus points will be given to entries containing the words "mid", "life", and "crisis".
By Dr Seema Quasim
SpR Anaesthesia
Warwickshire School of Anaesthesia

Every anaesthetist knows the value of an oropharyngeal airway and most anaesthetists have read about the eye signs of anaesthesia. But how many anaesthetists know anything about Guedel, the man who developed these ideas?

Arthur Ernest Guedel was born on June 3, 1883, in Cambridge City, Indiana. He attended a grade school in Indianapolis but his family were poor and could not afford to send him to a high school. Instead, he was sent out to work at the age of 3. A machine shop accident led to the loss of the first three fingers of his right (dominant) hand. In spite of this, he continued his education on his own, under the guidance of a high school teacher. Through his own efforts, he passed the entrance exam for the Medical College of Indiana, graduating five years later, with first honours.

It was during his internship at City Hospital in Indianapolis that Guedel first ignited his passion for anaesthesia – a passion that would alter the specialty and has ensured his place as one of the pioneers of anaesthesia. As an intern, he administered ether and chloroform to patients, which was common practice for interns of the time, and continued to provide anaesthesia when he moved into general practice in 1909.

In 1911, Guedel wrote a paper in the Indianapolis Medical Journal on the administration of nitrous oxide in obstetrics. Kikovich had proposed this in 1881, yet in practice ether and chloroform were exclusively being used for analgesia in labour. Guedel devised a technique with a mixture of air and nitrous oxide, which could be self-administered by the patient. He recognised the advantage of the woman controlling the pain relief herself, stating “she soon learns that her relief depends upon the results of a race between the actions of the gas and the pain, with the gas winning always if given an even start”.

During World War I, Guedel served under the American Expeditionary Force in France. When America entered the war in April 1917, not a single member of the 491 medical officers of the US army was a trained specialist in anaesthesia. During this time he had to teach nurses and orderlies how to administer anaesthesia safely. He standardised the clinical observations which were used at that time to estimate the depth of ether anaesthesia. Guedel created a wall chart with a grid of physical signs which allowed untrained personnel to assess the depth of ether anaesthesia and is still reprinted in most modern texts of anaesthesia. These principles formed the core of his later text Inhalational Anesthesia: A Fundamental Guide, first published in 1937.

Guedel’s observations led clarification of these signs, as well as additional signs. Crucially, he better defined stage 3 into four planes. His observations of the eye signs during all the different planes were a new method of gauging depth of anaesthesia. The eye signs included the activity of the motor muscles of the eyeball, pupillary dilatation and the eyelid reflex. This is tested by gently raising the upper eyelid with the finger. If the reflex is present, the eyelid will attempt to close at once or within a few seconds. The eyelash and corneal reflexes, though now well known to us, were not mentioned by Guedel.

In April 1919, Guedel returned to America and presented the chart at a meeting of the Indianapolis Medical Society that very same month. In 1920, the only anaesthesia journal of the time, Anesthesiology, published the chart. Guedel continued working on his chart, further refining it based on his careful observations of clinical cases. A series of four articles on his signs and stages of anaesthesia appeared in 1935-36. A 1972 study of minimum alveolar concentrations (MAC) of various anaesthetic agents documented that the pupillary changes of ether correlated with its alveolar concentrations, confirming Guedel’s observations.

After returning from the war, Guedel resumed his private practice but his passion for science was still there. In 1928, he moved to Los Angeles in California. He created a laboratory in the basement of his home and continued to improve on the some of the most basic equipment in anaesthetic practice: the oropharyngeal airway, cuffed endotracheal tube and the Guedel laryngoscope.
GUEDEL OROPHARYNGEAL AIRWAY

The original airways were made of metal, but this was far from ideal. Guedel designed an oropharyngeal airway made from black rubber. It had a flattened cross-section and a straight bite block section. The pharyngeal section had an anatomical curve and an oval flange prevented over-insertion. Guedel’s original paper describing this most important piece of airway equipment filled just 14 lines of a half column in the Journal of the American Medical Association in 1933. In 1933, the Foregger Company (New York City, USA) patented the airway for the American market and produced the new airway in different sizes. In the UK, Medical and Industrial Equipment Limited (London, UK) took up its manufacture.

THE CUFFED ENDOTRACHEAL TUBE

Guedel knew that endotracheal tubes did not protect against aspiration and to try and achieve this, he glued dental dams and the fingers of surgical gloves to the outer wall of tubes. His first experiments were on isolated animal trachea which his local butcher donated to him. In 1928, in conjunction with an anaesthetic colleague, Ralph Waters, he developed a new endotracheal tube with the inflation bag situated in the trachea just beneath the larynx. His most dramatic experiment was in his own dog, named “Airway”. He anaesthetised and intubated his dog with a cuffed tube and then submerged the dog in an aquarium filled with water. The dog remained anaesthetised for one hour in this position. At the end of the demonstration, the dog was pulled from the water and anaesthesia stopped. The animal recovered from the anaesthesia and was extubated and then bounded out of the auditorium.

Guedel worked very hard. His personal motto, according to Waters, was “maintain flying speed”. But he suffered from insomnia and self-medicated with barbiturates. In an attempt to counteract the hangover effect, he then started to take amphetamines in the mornings. But he recognised that he had become addicted and managed to stop taking these drugs. In later life he became disabled by arthritis and ischaemic heart disease and he retired from clinical practice in 1941. His contributions to the field of anaesthesia have not been forgotten though. He was the first American to receive the Henry Hickman Medal of the Royal Society of Medicine, London in 1941. In 1950, the American Society of Anesthesiologists recognised him with the Distinguished Service Award. Arthur Guedel died in Los Angeles in 1956.

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www.cpmc.org (accessed 20/05/2006)
A Tale of Two Ships

On June 22nd 1948 the S.S. Empire Windrush docked at Tilbury. Its passengers had come to Britain in the hope of working hard and of improving their lives. They initially met hostility and prejudice, but most persevered and were quietly successful. In time it seemed as though they and their descendants had always been here. These early venturers were later joined by many others responding to the unmet staffing needs of the National Health Service. For many years, they too quietly prospered and helped to keep the NHS going, and all was good in the land. More came in their wake, and they also worked hard and were rewarded.

But it came to pass that the landlord moved to Brussels. The new landlord looked unfavourably on the recent passengers, and commanded that they be replaced by new passengers, who must be found from within the lands of Europe. And so it was that on March 7th 2006 a new ship was commanded to be built. Its name was to be the S.S. Empire Bumsrush.

Adrian Taylor
Consultant Anaesthetist
North Tyneside General Hospital

Dear Editor...

Should we use unified colours for emergency drugs packaging?

Recently, while preparing for the start of an operating list, I was surprised by the variety of packaging used for atropine.

To my mind this kind of medication, which may be needed quickly in an emergency, should be clearly recognisable.

Ideally the packaging should be the same colour as the universal syringe labelling system, which is green for atropine.

Fidel Bayshev
SpR, Wycombe Hospital

Photo: J. Reilly

Holy Starvation Policy!

I wonder whether any of your readers have considered how long after receiving the holy sacrament a patient must wait before elective anaesthesia? We certainly hadn't until recently.

A 14 year old girl presented for a mastoid exploration, on an afternoon list. She had eaten breakfast with a drink at 7am and later went to church where she received communion at 9.30am - small piece of rice paper and a sip of wine. How long should one wait thereafter?

We decided on the middle ground and anaesthetised her at 1.30pm (4 hours post communion). She received a gas induction with subsequent endo-tracheal intubation. Her anaesthetic was without incident – after all God was on her side!

Matt Turner FRCA Specialist Registrar
Naomi Goodwin FRCA Consultant
Department of Anaesthesia,
University Hospital Wales,
Cardiff

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Matt Turner FRCA Specialist Registrar
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Cardiff

Photo: J. Reilly
McForeign Body
We recently had the pleasure of anaesthetising a 5 five year old boy for removal of an oesophageal foreign body (pictured).

He had ingested the offending article one hour after devouring a meal from “The Golden Arches”.

We hoisted the obstruction out with Magill’s forceps assisted by a Miller blade.

If the picture is not too clear we should point out that the foreign body in question was a key ring (provided gratis with his meal) imprinted on which were the ironic words “Supporting families with children in hospital”. On the back it said “I’m lovin’ it”.

Alex Long SHO
Richard Eve SpR
Department of Anaesthesia
Torbay Hospital

Sold down the river: but by whom?
Royal Colleges make easy targets for editorial writers, but Stephanie Greenwell overlooked a significant factor in her June editorial. The question is not simply “Have we been sold down the river”, but must include “and by whom?”.

In not actively opposing the Anaesthesia Practitioner project (fundamentally opposed to it though I am) when it came to College Council, I had to acknowledge two crucial points. Firstly, if the specialty did not get involved others would develop the role anyway, and involvement would at least allow some measure of control. Second, the basic proposition (physician supervised, non-medical anaesthetists) was difficult to resist given that many outside the specialty were well aware that a good number of British anaesthetists have been prepared to give up hard-won holiday entitlement to go to Sweden and other countries to earn some spare cash by working in just that setting.

I think is too early to say that we have been sold down the river, but if we have, British anaesthetists who went to Sweden and elsewhere should recognise that they bear some measure of responsibility.

J.A.W. Wildsmith,
University Department of Anaesthesia,
Ninewells Hospital & Medical School,
Dundee

A novel approach to Obstetric Haemorrhage
Whilst innocently surfing the ’net during an obstetric night on-call, I stumbled across the following snippet from a review of an American book unambiguously titled "Hemorrhage" (2002, Eugene, Oregon: Midwifery Today, $18.00, 80 pages, paperback):

"Several articles describe a variety of methods to treat hemorrhage, should it occur, including an eye-opening Traditional Chinese Medicine model of diagnosis and treatment that may completely change your notions about hemorrhage."

Perhaps the saving made by administering Ginkgo biloba and tiger penis soup, rather than blood products and Factor VIIa could be channelled into bailing out bankrupt trusts?

Cynically yours,

Mark Barley
SHO Anaesthetics
Queens Medical Centre,
Nottingham
Pay Protection

I was encouraged by reading the GAT page article on pay protection in June’s Anaesthesia News.

I am currently working at a Trust where I have been contesting pay protection for seven months (commencing three months before I started the post). It is an extremely arduous task and one fraught with stress and strain: however, I wanted to encourage any others in your readership to persevere with similar claims with the aid of the BMA. The medical personnel department have tried to make this process as difficult as possible, however, the BMA’s assistance has proved extremely useful and it appears as though there is light at the end of the tunnel.

It has been brought to my attention that a previous employee at the same Trust has been successful at obtaining pay protection (albeit a year after leaving!) and so it IS worth all the effort.

Pay protection is an entitlement and NOT a luxury, and I urge all those in a position to claim it to contact the BMA.

Dr Amit Pawa
Anaesthetic SpR
London

Reference:
Pawa A, 'My pay protection puzzle'. BMA News, January 28th 2006, pg 10

MMC..the 23rd Psalm

MMC is my shepherd; I shall not want.
It maketh me to lie down jobless:
It leadeth me beside the canyon of stupid orders.
It destroyeth my soul:
It leadeth me from the paths of righteousness for God-knows-whose sake.

Yea, though I walk through the valley of the shadow of the Department of Health,
I will fear no politician: For thou art not with me;
Thy rod and thy staff, they beat me.
Thou preparest a theatre table before me in the presence of my APs
Thou anointest my head with turmoil; My cup taken over.

Surely SHO’s one and two will follow us all the way to New Zealand,
and we will dwell in the House of the surfboard, forever, and ever...Amen.

Nick Preston
SHO Anaesthetics, Royal Devon & Exeter Hospital.

More on Northern Ireland

I note that this subject is now closed but may I be permitted a final word? The correspondence has reminded me of what was nearly a very embarrassing episode in 1974. I was then the Hon. Secretary of AAGBI, one of whose duties was to organise the Annual Scientific Meeting, including the trade exhibition. One of the exhibiting companies had agreed to provide us with a wallet for each of the participants. The wallets duly arrived at the office, packed in cardboard boxes. I clearly recall opening the first box to see what the wallets were like. I picked one out and admired it. It was in navy blue with the Association’s name prominently displayed. It looked rather nice. I then did a double take, froze, and said “Oh dear”. (Indeed, It might have been something stronger!) There was I looking at about 400 very nice navy blue wallets with, picked out in gold lettering on the front, “The Association of Anaesthetists of Great Britain and Northern Ireland!

I was aghast. It seemed that I was about to cause an international incident. Not only was the name of the Association wrong, but we appeared to have excommunicated all our members from the Republic of Ireland. In fact, the company, realising that the error would do no good to AAGBI or to them, took the wallets back and replaced them with new ones with the error corrected. What neither the company nor I expected was that many of our Irish members thought it hilarious and the offending wallets rapidly became a collectors’ item. For many years, I kept one as a souvenir but I fear that now, like several dozen other meeting wallets from round the world, it has gone to a charity shop. Does anyone still have one?

John Zorab (Bristol)
London

Dear Editor...
The Anaesthesia Heritage Centre has developed an educational booklet on the history of anaesthesia, together with a teachers’ guide and a loan box. The booklets are aimed at Key Stage Three. Booklet 1 is for average-to-higher ability children whereas Booklet 2 is aimed at those working below average.

If you would like a copy of the booklets and the teachers’ guide they can be downloaded from our website (www.aagbi.org) or you can contact the Heritage Centre on 020 7631 8806/8811 or via email: heritage@aagbi.org

OAA Meetings

In his article about SAS Doctors and National Meetings, Dr Siddique asks at whom such meetings are aimed? (SAS Page, Anaesthesia News, p35, June 2006) At the Obstetric Anaesthetists’ Association (OAA) our remit is “to promote the highest standards of anaesthetic practice in the care of the mother and baby”, and one of the ways we pursue this cause is to run educational meetings designed for, and open to, anyone and everyone interested in obstetric anaesthesia. Audience participation is actively encouraged at these meetings, and speakers are chosen for their various specialist expertise, not because of status. Currently there are 143 SAS members in the OAA (out of a total membership of 2000).

Anyone wishing to contribute and further the practice of obstetric anaesthesia may submit abstracts for presentation at the Annual Meetings, and all members are eligible to stand for election to the OAA Executive Committee.

Dr Paul Howell, Chairman, OAA Meetings Sub-Committee

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

Due to the volume of correspondence received, letters are not normally acknowledged.
August Crossword
Compiled by Ranjit Verma

Across
1 Wrong biro but only used after obtaining owner’s consent! (9)
4 Of the mouth (4)
6 Lost accrual worked out on these machines? (11)
11 Softly (7)
13 Relies (7)
15 Dario’s sun is now quite extinct I’m afraid (9)
16 Question (3)
17 Honey maker (3)
18 Paul ate at a high mountainous level? (7)
20 Possesses (3)
22 Perform for an entire ant? (9)
23 Selects (7)
27 A Celtic language (5)
29 Her Majesty’s Lancastrian title (4)
30 Expenditures (5)

Down
1 Capture (3)
2 Bird of prey (3)
3 Grants pander to our parents’ parents? (12)
7 Leading (5)
8 Cool Len a commissioned military officer? (7)
9 Sir, point toe up to increase your chances! (13)
10 Subside (4)
12 Utilize (3)
14 A bag of sorts (4)
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17 Alkaline (5)
18 Knickers (5)
19 Aeon (3)
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25 Fully grown acorn (3)
26 Model for a painter or sculptor? (3)
28 Jump (3)

Sudoku
from Ranjit Verma

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Email: eosullivan2000@eircom.net

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The Association of Paediatric Anaesthetists was formed 33 years ago by a small group of dedicated consultants who worked within children's units in the UK and Ireland. Many of these founder members are still with us, and remain important “names” in Paediatric anaesthesia. Despite the many changes that have occurred, particularly in the last 10 years, they continue to support the APA and attend the Annual Scientific meetings. It is a tribute, both to their enthusiasm for the speciality and the organisation which they set up, that they remain keen to do so!

The APA now has over 650 members and since 1994, when regulations were relaxed to include all consultant anaesthetists with a paediatric interest, the main area of growth has been from the DGH and University hospitals. We also have a substantial and very loyal overseas membership which comprises about 30% of the total. As well as making it possible for all consultant anaesthetists to join the APA we have recently introduced two additional categories of membership - Affiliate (for UK and Ireland based SAS grade anaesthetists), and Trainee (for UK and Ireland based SpRs).

APA Council has also grown, with membership from all parts of the UK and from overseas, and co-opted members from the AAGBI, RCoA, PICS and, recently, lay representation. We have regular meetings with the RCPCH and British Association of Paediatric Surgeons, and this year we will run a joint half day educational event in the autumn with the latter. The APA is consulted by all these organisations, as well as the Royal College of Surgeons, DH, RCN, Health Care Commission and CEMACH.

Although the APA’s activities have become more diverse, its main aim remains the promotion of education and standards in paediatric anaesthesia. With this in mind our annual scientific meeting continues to be an important focus, not least because it is when the membership meets together en masse. This is crucial to the success of any Body i.e. a strong network of individuals who come together regularly to debate what’s new and have a jolly good time in the process. Within the three day programme, there has been a policy of alternating a refresher course with a meeting with another specialist society. In recent years we have met very successfully with ACTA, ABRA and DAS. Next year’s meeting in Manchester will include a joint day with ESRA, which should be extremely popular.

In 2005 Professor Andy Wolf, who chairs the Scientific Committee of the APA, proposed that we form a clinical trials group to facilitate a research “network” in paediatric anaesthesia, and this group has had two successful meetings to date. At a point in time when clinical research is under extreme threat, this is an important move.

Other activities of the SC include planning the ASM programme in conjunction with local organisers, the judging of abstracts submitted, and the annual award of a research grant of £5000. In addition to this, the Guidelines group of the APA, formed in 2005, is currently looking at four different key areas- PONV, Acute Pain, Perioperative Fluids and Patient/Parent advice for paediatric epidurals. This work is being led by multidisciplinary groups around the UK each chaired by an enthusiastic expert, is funded by the APA, and orchestrated by Dr. Neil Morton.

As a means of improving communication with regional groups and lead doctors, the APA has recently set up a Linkman scheme. The first meeting of this group was held in Cardiff at our ASM in May, and another is planned for November. The hope is that this new group will be shaped very much by the membership, and is being led currently by Dr. Jane Peutrell and Dr. Alison Carr.

The APA Interdepartmental peer review scheme was initiated by Dr. Peter Crean (current APA President) in 1999, and reviews have been conducted nationally in many Children's and University hospitals. When College visits are subject to change with the increasing role of PMETB, it may be that this type of visit has an even more important role in subspeciality anaesthesia.

Those involved with the running of specialist societies may be interested to learn that the APA is in the process of becoming an incorporated company limited by guarantee. This process has been supervised by our recently retired Treasurer Dr. Neil Morton. We hope that it will provide more financial security for the organisation.

We would welcome all anaesthetists with an interest in paediatrics to the APA. Trainee membership is now available for UK and Ireland based SpRs. More information and details about how to join can be obtained from our website at www.apagbi.org.uk

Dr. Kathy Wilkinson, Hon Sec, APA
(kathy.wilkinson@nnuh.nhs.uk)

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The death last Easter of Miss Joyce Baxter at the age of 84 will remind some of the older officers of one of the defining moments of the Association. Joyce was our first full-time administrative secretary and she saw us through the transition from a small, rather amateur organization living a hand-to-mouth existence, to the large, fully professional body that we now are.

Up until 1968, the Association had been served by an office known as the Joint Secretariat, housed within the Royal College of Surgeons (RCS) in Lincoln's Inn Fields. A number of specialist societies were served by a succession of secretaries in a cramped office, we ourselves sharing a filing cabinet, a cupboard and a secretary with the orthopaedic surgeons.

The 1960s and 70s were turbulent and changing times, both nationally and within the NHS. Medicine was progressing rapidly and anaesthesia was on the steepest part of its learning curve, in the midst of its most rapid development in research and clinical practice. By 1968 our President Dr Pat Shackleton and our Honorary Secretary Dr Phillip Helliwell decided the challenges were such that we must have our own full-time administrative secretary. How fortunate they were to find someone of the calibre of Joyce Baxter. Her CV was impeccable. A scholarship to Christ's Hospital, followed by service in the Auxiliary Territorial Service (later the Women's Royal Army Corps) in the Second World War when she worked at the top secret Bletchley Park centre where Enigma and other secret codes of the German intelligence were cracked; those who worked there kept secrecy so absolute that only decades after did we know Joyce was amongst them. After the war she worked for charities, including as a social worker for Dr Barnado's, as senior administrator to the Girl Guides and later as personal secretary to the Lord Lieutenant of Norfolk. Clearly the demands of worthwhile public service appealed to her.

Joyce joined the Association in 1968, shortly after I took over as Honorary Secretary from Philip Helliwell. As the new girl I learned an enormous amount from her, not only about the organisation of a large body, but even more importantly, the value of accuracy and precision, how to write minutes and how to use time constructively. A lively and attractive personality, she taught us all the value of keeping a sense of humour at all times.

For a while we kept our office within the RCS, but in 1971 we moved into accommodation in BMA House, where we remained until 1985 when we acquired our own house at 9 Bedford Square.

Joyce recalled the early days in her own inimitable fashion:

“The Association's affairs were carried out in half an office, with the President's Entertainment Fund (in other words gin) kept in the filing cabinet. The surroundings may have been modest but the Association's output definitely was not. I never ceased to be impressed by the range of topics and issues on which the Association formulated views and presented evidence to official bodies.”

It is typical that she made no mention of the huge part she herself played, virtually single-handedly, in making it possible for the Association to meet all these demands. She said later that the five years she spent with us were the most enjoyable of her working life.

Joyce handed over to Ann Muir in 1973. She retired to Dorset, though continuing some work including that as a school bursar. She retained her interest in the Association and enjoyed hearing news of the world of anaesthesia on the occasions I visited her there. We should remember her with gratitude.

[I am indebted to Dr Tom Boulton’s history ‘The Association of Anaesthetists of Great Britain and Ireland 1932-1992’ and to a personal communication from Peter Leppard, nephew].

Aileen K Adams, Cambridge
At the annual Linkman meeting in September 2004, several Linkmen asked that the members of the Association were surveyed about their views on Anaesthesia Practitioners, and the President gave an undertaking that this would be done. Council decided to proceed with a postal questionnaire survey of all ordinary and trainee members i.e. excluding retired and overseas members. Although it would be possible to accurately estimate the views by surveying a random sample of the membership, it was felt important to allow every member to make their view known. Council also felt that such a major exercise should not only ask about Anaesthesia Practitioners, and that opinion should be sought on a number of other important topics.

Many topics could have been covered but it was agreed that the questionnaire should not exceed four sides of A4. A commercial company with considerable experience of conducting similar research was employed to conduct the survey, including piloting the questionnaire, collating the responses and inputting all the data. The response to the questionnaire was encouragingly good. Over 2000 consultants returned forms (out of a total of almost 4500) giving a response rate of 46%. Although the overall numbers for SAS doctors were much smaller, their response rate was higher at 56% and the trainee response rate was 22%. The methodology used (anonymous returns) does not permit useful analysis of responder bias but there did not appear to any gross discrepancies in the range of returns from different regions or from different age groups.

A single article would be very lengthy if it covered all the results so in this issue, I will only report on the views on Anaesthesia Practitioners. For almost all questions the views expressed were very similar for different grades of staff, different regions and also different age groups. The overall views are therefore presented rather than broken down into subgroups.

Less than one fifth of respondents felt that there would be a need for Anaesthesia Practitioners in their hospital within the next 10 years with another fifth neutral on the statement. Less than 30% of consultants would be willing to supervise two Anaesthesia Practitioners in nearby operating theatres but over half would not be willing to do this. However more than half felt it appropriate to have an Anaesthesia Practitioner doubled up in theatre for a long or complex case with less than a quarter against this suggestion.

Perhaps not surprisingly, the balance of opinion was fairly firmly that the employment of Anaesthesia Practitioners would not increase patient safety, would decrease efficiency in the operating theatres and would not decrease the cost of anaesthetic services. Opinion was more divided on the effect on the education of medical anaesthetists, and although a majority felt that this would not improve, almost 40% felt that it would improve.
Many members may feel that these results are not a great surprise. However, the pilot projects are still at a relatively early stage and it really is too soon to come to a considered judgement about what place, if any, Anaesthesia Practitioners should have in anaesthetic practice in the UK. Perhaps the view which has been expressed recently - that their main usefulness will be in supporting consultants who are undertaking a major, complex or particularly lengthy case without being accompanied by a trainee - has some merit. However, comments made from the audience at the Winter Scientific Meeting strongly supported the suggestion that such a role could be carried out by an individual who had considerably less training that the current Anaesthesia Practitioner programme. It would be interesting to look into this further – perhaps with qualitative research – to find out exactly why those who do not wish to supervise two APs in nearby theatres have that view. The main driving force for the pilot scheme was the view that there simply would not be sufficient medically qualified anaesthetists to provide the service which was required. If that remains the case, then introducing APs to a system where a majority of consultants are unwilling or at best reluctant to supervise two is unlikely to make a major impact on service provision. Without further information on this, it would be unwise to make strong predictions on the outcome of any development of this new grade in the NHS.

Further articles will appear in future issues of Anaesthesia News about other matters covered in the survey and a fuller account will be available on the website.

Alastair Chambers
Honorary Secretary
I wonder how many remember Dr Beeching. He wasn’t a medic, of course, or no government ever would have listened to him. No, he was some sort of accountant, a whizz-kid before the term had been invented. His task, which made him famous (infamous), was to advise the government in the late ‘50s how to make the railways lose less money.

The government of the 40s, socialists you will remember, had nationalised the railways and the next government, Conservative, were among the first to notice that nationalised industries do not naturally make profits, or not that one, anyway. And although the man who invented monetarism and a good deal of Thatcherism (E. Powell) was in the Treasury at about that time, the option of denationalisation did not seem to cross government minds. Dr Beeching was brought in to advise, and he advised closures. Branch lines were unprofitable: shut them down. Never mind that they were never meant to be profitable per se, only to bring custom to the main lines. They did not profit; they were closed. The country was converted from one with a comprehensive, working rail transport system to one with a scanty, undeveloped set of roads. Motorways ensued, but that is another story.

There are parallels with the current moves to close hospitals. The first parallel is that units are being closed because they do not do what they are not intended to. The second is that the consequences have not been thought through.

Failure of hospitals to break even is no surprise, especially after decades of the wrong sort of investment. Failure of the health service as a whole to break even can of course be explained by the legions of advisers, whose salaries alone are enough to put the NHS in the red, and whose advice is simplistic and ill timed. Closure (disguised as merger) is all they can think of, like Dr Beeching. 50 years from now, perhaps health care provision will have been reduced to big cities only, like the railways, with 25 hospitals, each of 4,000 beds. This is the logical conclusion of current trends.

Isn’t it laughable? We have the 4th largest economy in the world, after US, Japan, Germany, or had until recently. Even the vile Broon’s efforts have not pushed us more than a couple of places back, and we still have a thriving, rich economy. Yet we are closing half our acute hospitals because we can’t afford them. This is in spite of the fact that the tax take as a percentage of GNP has just shot to 42%, worse than Germany, and at its highest point since Mrs T. As I mentioned in an earlier piece, if we had the same number of ICUs as Michigan, we would have over 800, not the probably less than 200 we will soon have. Grumble if you will about the US, how it’s not the same, etc., but remember their economy is looking pretty shaky, yet they still seem to have nearly four times as many acute units as we have.

The NHS is past the point British Leyland reached when Red Robbo ran the unions. It only works at all because of the determined or addictive behaviour of its professional employees, struggling to work in spite of our own Red Robbos, who in our case are managers, not union leaders. One might draw comparisons with bands playing on the Titanic.

Meanwhile, we are training record numbers to become specialists and there is medical unemployment, but consultant numbers are again frozen because of ‘overspend’ and immigration is effectively suspended. And still units are being closed. The service is poor and getting worse, but the Minister thinks its fine (“…best year ever…”). It is madness!

Worse still, while roads could take up some of the slack from the railways Beeching closed, we do not have any alternative to our current system. Little hospitals missing crucial facilities cannot do the job of DGHs, and the private sector is unable or unwilling to take up the slack. We have nowhere to go from here.

I have wondered before whether there is anyone in any senior position prepared to stand up to the government and say “Stop”. I thought it was unlikely, as that kind of person does not generally inhabit the corridors of power, or not for long. Any who gets there by accident soon gets booted when he/she shows signs of recalcitrance. But when we have a 50% closure plan being implemented, and no prospect of an alternative service provider, perhaps someone ought to stand up and shout stop. Perhaps someone already on the top merit award, with no further ambitions. Any volunteers?

De Quincy works at a DGH near you