This month...

Will Harrop-Griffiths reports on the Annual Congress in Cardiff

‘Named Consultant’ issue explained by new Hon. Sec. Alastair Chambers

New faces on Council

Useful tips for success in clinical excellence awards from the Naked Gasman
Extending over four days, comprising up to six simultaneous parallel sessions and being attended by more than 650 registrants, the Annual Congress was, in the opinion of almost all who attended, organised or contributed to it, a resounding success. The Cardiff International Arena was an excellent venue, and was able to accommodate our expanded and adventurous meeting admirably. Of course, you might expect the above views to be expressed by one of the team responsible for organising the meeting, but I can assure you that these views are simply a reflection of the opinions of those attending the meeting expressed in the feedback forms, via e-mail or personally during the meeting.

The standard of all the sessions was remarkably high, and all the contributors deserve our thanks for the effort they put in and our praise for the quality of their contributions. However, I hope you will forgive me if I indulge in a short list of what were, for me, the highlights. Professor Alan Merry’s Intavent Lecture (“The Missing Snake”) was a superb talk blessed by faultless, thoughtful delivery. The entertainment that followed, delivered by an eight-year-old harpist dwarfed by his instrument but not fazed in any way by the large audience, was memorable. The sessions on Retirement and Private Practice drew particular praise, underlining the fact that plenary meetings of this sort need to include topics of personal interest to practising anaesthetists in addition to sessions concentrating on science, recent developments, clinical education and debate. The two sessions on Death on the Operating Table were excellent, and culminated in a moving and intelligent presentation by Richard Plummer that gave all in the audience food for

Peter Wallace presents David Saunders with the John Snow Silver Medal
thought. Professor David Whittaker’s Mushin Lecture on forensic dental science was fascinating and informative, if a little grisly at times. Professor Chandra Wickramasinghe’s John Snow Lecture on “The quest for our origins” was an elegant and convincing proposal that life on Earth derived not from any primordial organic soup but from the building-blocks of basic life forms held within asteroids and comets and showered over the planet over millennia.

On the subject of primordial soup, the food was pretty good too. The catering in the venue was not, as so often happens, beset by long queues, and was appreciated by almost all who partook. The hog-roast and funfair narrowly avoided inclement weather and was great fun, and the reception in the breathtaking Art Gallery followed by the Annual Dinner in the City Hall were enjoyed by all. Okay, the after-dinner entertainment was held to be a little on the loud side by some of the more senior members of the Association (including me), but, to paraphrase Abraham Lincoln, you can’t please all the people all the time.

I enjoyed the Annual General Meeting – really! The successful functioning of bodies like the AAGBI depends upon formulaic and formal rituals such as the AGM, and it

Continued…
was, as ever, an opportunity to acknowledge the contributions of the award-winners to anaesthesia in the UK. Space does not permit me to mention all the recipients of the awards, but the award of John Snow Silver Medals to Peter Morris and David Saunders deserves mentions, as does the award of the Featherstone Award to Mark Bellamy and the Evelyn Baker Medal to Paul Monks.

The Workshops were well-subscribed and enthusiastically received. The Problem-Based Learning sessions on Obstetric Anaesthesia, Cardiothoracic Anaesthesia, Intensive Care and Pain were enjoyed by all who attended and presented them. This is a new development for Annual Congresses, and few of the registrants (and indeed few of the teachers!) were familiar with the format. However, their success means that they are likely to be repeated in future meetings.

I am particularly grateful to the specialist societies who willingly, enthusiastically and expertly contributed to this meeting: the Intensive Care Society, the Association of Cardiothoracic Anaesthetists, the Obstetric Anaesthetists Association, the Difficult Airway Society, Anaesthetists in Management, the History of Anaesthesia Society, the UK Chapter of the European Society of Regional Anaesthesia and Pain Medicine, the Pre-operative Association, the British Association of Day Surgery, the British Pain Society and the Society for Computing and Technology in Anaesthesia. I apologise if I have missed anyone out or got the names slightly wrong! The success of this and future Annual Congresses depends upon contributions from the specialist societies, and they should be warned that invitations will materialise regularly in the future.

The Trade Exhibition was also a great success. There was more room available than in many meetings in the past, and the result was that registrants were able to congregate within the exhibition and thereby be exposed to discreet product advertisement. I am grateful to all the companies who supported the meeting by exhibiting, and to Ian McMenemin for his assistance in the organisation of the exhibition. I must also thank those companies who sponsored sessions, workshops and satellite meetings.

While I am thanking people for their contributions, I must also direct my gratitude to all the members of the Council of the AAGBI who assisted with the meeting and, I assure you, they all did! However, my greatest praise is directed towards the members of the Staff of the AAGBI, without whom this adventurous and successful meeting would not have been possible. The Events Team, from whom we have come to expect excellence, exceeded even their own high standards. They all worked hard, but I will pick out Jo Barnes, Nicola Heard and Emma Hollington for particular thanks for their efforts.

It is time to get your diaries out. Flip to 20th – 24th September 2005. Write “Annual Congress of the AAGBI in Manchester” in the space allocated to these days. We hope to build on the success of Cardiff’s Annual Congress and to produce an even better meeting enjoyed by even more of our members. If you have any comments on the 2004 Annual Congress, or would like to make suggestions for next year’s meeting, please contact me on h.g@bigfoot.com.

William Harrop-Griffiths
Chairman, Events Committee.
“Meetings & Conferences”

2005 EVENTS

**OESOPHAGEAL DOPPLER MONITORING**

One day courses are held throughout the year in London, Edinburgh, Exeter, Birmingham and Brighton.
Topics include validation and comparison, physiology of cardiac output, waveform interpretation, critical review of the literature, cost effectiveness and outcomes and clinical application.

**CONTACT:** Dr Mark Hamilton

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**2nd PAEDIATRIC SEDATION: HOW TO DO IT SAFELY**

**INSTITUTE OF ELECTRICAL ENGINEERS, LONDON, 3 & 4 MARCH 2005**

“A conference for doctors, nurses and all health professionals involved in paediatric sedation. The content is targeted to improve the quality and safety of paediatric sedation services by disseminating knowledge, philosophy and skills about both the practical and the organisational aspects of sedation.”

**CONTACT:** Dr Mike Sury

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**CORE CURRICULUM ONE DAY COURSES FOR ANAESTHETISTS IN TRAINING, Middlesex Hospital, London**

A rolling program of one day courses individually covering Pain, ITU, Cardiac, Paediatrics, Obstetrics and Neurology.

**CONTACT:** Dr Ernie Grundy

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**KNOWLEDGE: LESSONS FROM LIFE AT THE LIMITS, UNIVERSITY COLLEGE LONDON – WEDNESDAY 27TH APRIL 2005**

“For a molecule upon which all human life depends our understanding of oxygen and its physiological role is far from complete. This conference will discuss the parallels between extreme environment physiology and critical care; covering the history and future of extreme high altitude research, lessons learnt and mysteries that wait to be solved.”

**CONTACT:** Dr Kevin Fong

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**4th EVIDENCE BASED PERI-OPERATIVE MEDICINE FOR THE HIGH RISK SURGICAL PATIENT**

**Institute of Electrical Engineers, London, 23 & 24 JUNE 2005**

**CONTACT:** Dr Sarah Chieveley-Williams

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**DINGLE 2005: 7th CURRENT CONTROVERSIES IN ANAESTHESIA & PERI-OPERATIVE MEDICINE**

**28th September-2nd October 2005**

Dingle, County Kerry, Ireland – **Contact:** Dr Jim Down

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**CARDIO-PULMONARY EXERCISE TESTING WORKSHOPS, UCL**

Held bi-monthly throughout the year, 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.
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**CONTACT:** Miss Helen Luery

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**MERSEY SCHOOL ANAESTHESIA & PERIOPERATIVE MEDICINE**

“If you feed the children with a spoon, they will never learn to use the chopsticks”

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<td>Lectures &amp; tutorials designed to cover the more esoteric aspects of the Primary Basic Sciences.</td>
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<td>(Trainees are advised to consider this course two to three months ahead of the MCQ paper)</td>
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For Details & Application Forms for all Courses [WWW.MSOA.ORG.UK](http://www.msoa.org.uk)
When I read about the Association’s move to its new sumptuous offices at 21 Portland Place, I wonder what you, the membership, think about it? What emotion does this raise in you? Apathy? (Who cares; it’s nothing to do with me). Pride? (Hurray at last we have somewhere even more special for anaesthesia). Anger? (Why are they spending all my subscription on this useless folly that I never go to?) Fear? (How much is this going to cost me now?) Confusion? (Why did they have to move? I liked 9 Bedford Square). Agitation? (Why don’t they just buy one place with the College as a Centre for Anaesthesia?) Disappointment? (Why did they buy something in London, again? Don’t they know that we all live elsewhere?) Maybe none of these, maybe all of these. Whatever the emotion, we would be very interested to know.

When the Association moved out of BMA House and took up residence at 9 Bedford Square in November of 1985, I think there was a sense of a ‘coming of age’. The Association had been very active since its inception in 1932 but we had been lodgers in ‘digs’. This move showed the world our current status and our potential for the future. All who visited that Georgian town house could not fail to be impressed by its style, space and atmosphere. The staff were welcoming (sometimes!), the rooms large and ideal for the various functions that transpired, and the catering (for those who came to the early seminar programme) was legendary.

Initial views of Council, and particularly some of the Officers of Council at that time, was this was to be a London home for anaesthesia. Members would be encouraged to visit at any time they came to London and they would be guaranteed a special welcome and a sense of belonging. Somehow this never happened. Those that were ‘in’; were very ‘in’ but ‘outsiders’ could easily find the premises rather daunting. Even newly elected members of Council found they were unsure where to go, where to sit and who to talk to. Just why the idea of a London home, to come and have a cup of coffee halfway through a long shopping trip, never gelled is difficult to pinpoint. Certainly rooms that had appeared large and open for use when two members of staff first moved in, rapidly filled up with more staff, books, desks, computers etc. with the increasing activity of the organisation. A constantly ringing telephone in the background is not conducive to hosting a welcome to a member who has just walked in off the street, when preparations are underway for the Annual Scientific Meeting the next week. Once a member saw that staff were very busy and that there was no apparent way to find a coffee machine or even the toilets then there was not the incentive to come back. So visits to Bedford Square tended to be just for seminars, and a regular ‘thing’ for Council members and those who were co-opted onto the many working parties. 9 Bedford Square had the appearance for some, if not many, as a select London club for those who were elected to Council.

Should one apportion blame for this? It is all in the past and so delineating ‘blame’ is a futile activity. I think that all staff and Councils must accept a proportion of responsibility for the way that any organisation functions. It is interesting to note that this was an era when some of the most sociable Presidents and Executive Officers held sway. If Baskett, Charlton and Saunders were ‘at-home’ then you could be pretty sure of a warm welcome, but of course they were not always there! The staff were busy with their daily activity and at that time, there were no ‘front of house staff’ to look after visitors. In addition, newly-appointed secretarial staff had no sense of who people were when they called in to say ‘hello’. If the President of the WFSA called, it meant nothing to many there and so it was easy to cause inadvertent offence.

Will things change in the new building? I hope so, but it is something that everyone has to work hard at achieving. The Association’s greatest strength is the width and depth of its membership; over 9000 members from home and abroad. What I would like to see, and I am sure Council shares my view, is the new premises become a ‘safe haven’ for all anaesthetists in a troubled world.

**Editorial**

New premises for us or a new home for you?

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www.TheAnaesthetistsAgency.com

Continued...
Editorial

New premises for us or a new home for you?

Are you passing through London with a few hours to spare? Call in, sit in the George Ellis Room with a cup of coffee or tea and read the papers. Come and wait there while your spouse goes shopping. Come down early for the theatre and spend some time looking at the Museum or working in the Archives (appointments for this would need to be made in advance with our heritage team, Trish Willis and Iris Boening). If there is a two hour gap between the end of your meeting and the time of the next train home; come to Portland Place and relax.

It is a big building; it has a lot of busy staff but now at the front desk you will find two very helpful people to guide you in the right direction and to help you find what you need. Kushla Skinner brings a refreshingly cheerful Australian perspective to the stresses and strains of a busy reception and telephonist position, while John O’Donoghue’s Irish roots ensure a ready smile and superb willingness as Facilities Manager to make your day more pleasant in any way he can.

Call in and see what you think. Is this a fitting building for your speciality? Does it represent the specialty of Anaesthesia as you want to see it represented? Come for a seminar if you can but just call in the next time you are in London and use the premises that you bought for your speciality. If you don’t then you have only yourselves to blame. Your elected Council and their co-opted colleagues are there on a weekly basis, trying to improve your lot at the coal face, and working very hard towards that end at weekends and evenings in addition, as they rewrite those glossies and revise those letters to Ministers etc.

Write to us with your views and come and visit when you are in town and tell us what you really think. Don’t be offended if the welcome is fractionally less effusive than it might be; remember everyone is busy and it may be that the Minister of Health is coming for a meeting in 30 minutes time and everyone’s focus is on that; or maybe it is just in the run-up to the next GAT meeting and there are wallets to pack and a million details to finalise. Even with this going on, you will still be welcome.

Make it happen, use the facilities, strengthen your Association and be part of, and contribute to, the next exciting decade of anaesthesia in Great Britain and Ireland.

Come and visit 21 Portland Place because it is yours and, after all is said and done, why would you buy an expensive house in London and then never use it?

David Wilkinson,
Vice President.

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2nd March 2005
Management of Obstetric Emergencies 1 Day Course, for O & G trainees & anaesthetists (£150) (To book Tel 0117 9595176)

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In September 2004 the Association of Anaesthetists of Great Britain and Ireland commenced a special postal franking in London – to commemorate the sesquicentenary of John Snow’s investigation of an outbreak of cholera. A pre-franked postcard (Snow’s photograph and facsimile signature on the front) was prepared for the Annual Congress in Cardiff. Note that the ‘postage paid’ was zero!

London’s third cholera epidemic began in September 1853, subsided during the winter and flared up again in July 1854. Between late August and the first few days of September 1854, there were more than 500 deaths in Golden Square, Soho – doubling the current cholera toll in the entire metropolis. At that time John Snow was the leading physician anaesthetist in London; he was also fascinated by cholera and had published a pamphlet On the Mode of Communication of Cholera in 1849.

The water companies typically provided running water only two hours a day; the rest of the time residents depended on cisterns and pumps. The most popular pump in Golden Square was at the corner of Broad and Cambridge Streets. On 3rd September John Snow (who lived at Sackville Street, just 5 minutes walk away) heard about the deaths and immediately suspected that the pump in Broad Street was the culprit. He inspected the water from this pump, but found it clear. Over the next two days he investigated the water chemically and microscopically, then decided that statistical methods were required.

On 5th September he obtained (from the General Register Office) a list of the names and addresses of those who had died of cholera in the districts of St James and St Anne, Soho. He found that nearly all the deaths were clustered within 250 yards of the Broad Street pump.

Snow requested an interview with the Board of Governors responsible for health in the parish of St James, and on 7th September he presented to them an account of his investigation. As a result, they ordered that the handle of the Broad Street pump be removed – this was done the following day. The cholera epidemic in Golden Square subsided. Further investigation revealed that the well supplying the pump was contaminated by a cesspool from a tenement in which a cholera patient lived.

John Snow was far ahead of his time in believing that the causative agent of cholera was waterborne. The overwhelming majority thought that cholera was due to noxious vapours in the air, ‘miasmata’. Though this incident became the most celebrated of John Snow’s many good deeds, his concurrent South London epidemiological study on cholera was a far greater achievement. Involving 300,000 people, this compared mortality from cholera between users of pure water (supplied by the Lambeth Company) and users of sewage-contaminated water (from the Southwark & Vauxhall Company). The study showed that water supply was the dominant determinant in cholera mortality. It was published in January 1855 (with a description of the Golden Square outbreak) as On the Mode of Communication of Cholera 2nd edition. Alistair G McKenzie, Hon Librarian, AAGBI.
Medic Alert?

Recently, one of my consultant colleagues asked me about a patient whom I had previously anaesthetised. He had visited her that morning and found her proudly wearing a medic-alert bracelet warning of a difficult airway. I remembered her well: an unexpectedly difficult grade 3 larynx, a failed rapid sequence induction and a loud shout for help. Fortunately when that help arrived there were no major problems and everything else ran smoothly. I visited the patient afterwards to explain what had happened. I also sent her GP a letter, labelled her notes and offered information about Medic Alert.

When later I asked him how things had gone he told me that he had similarly struggled with the Mackintosh blade, although he had had an easy grade 1 view with the Miller. He also told me (with a grin) how our ward and theatre staff, according to protocol, made her take off her alert bracelet on the ward before she arrived anywhere near an anaesthetic room.

Gareth Gibbon, SHO in Anaesthetics, Musgrove Park Hospital

MEWS from the North.

A Consultant Intensivist in the North East of England returned home a few weeks ago after a long day at work. He was cooking a pizza for tea when a distraught neighbour rang the doorbell. She was holding a small kitten, rescued from an animal sanctuary only a few hours previously. The small animal was floppy and gasping, with closed eyes, and looked moribund.

Still in lifesaver mentality, our hero squeezed the tiny animal’s chest, blew in its mouth, and was gratified to see its eyes open. A phone call to the vet for specialist advice was followed by a 40 minute car ride (resuscitation ongoing). On arrival at the surgery, the vet’s assistant triaged them at once, “Go straight in!”

With hope rising, our hero transferred his patient to the care of the receiving duty vet.

“Wait here please!” Animal and Veterinary Surgeon disappeared through a door into a room sign-posted Resuscitation.

Minutes later, the vet returned, alone.

“It just died. I even gave it intra-cardiac adrenaline, but that didn’t work, so I just gave up. Perhaps he had a virus or something!”

Another 40 minutes home by car ensued; this time in silence.

In summary, our highly trained specialist had focussed all his skills (and a considerable amount of extra-contractual time) in a beneficent, but ultimately, futile attempt to save a life. He also placed himself at increased risk in the following ways:

- Zoonoses.
- Road travel.
- Traffic pollution.
- The risk of hypoglycaemia through missing a meal.

At face value, the cost of treatment (clinical, emotional and otherwise) outweighed any immediate benefit to this individual animal and was therefore arguably futile, inappropriate and potentially maleficent, not only to the cat but also to the humans in the car. However the counter argument is that our colleague was able to view a bigger picture, thinking outside of the square so to speak: longer-term advantages of neighbourly goodwill and future babysitting facilities.

Whatever the ethical arguments of active versus palliative management in this case, there remains a need to predict and prevent emergency decision-making, allowing for more appropriate treatment planning i.e. earlier clinical intervention or earlier planning of palliation. Education of pet owners and vets will also help, but perhaps a scoring system based on physiologic values would be useful. We propose an adaptation of the original early warning scoring system. Perhaps, a dry nose and the inability to purr should be part of a ME(EO)WS score?

Dr Ian D Nesbitt FRCA DICM, Dr Joseph F Cosgrove FRCA
Consultants in Anaesthesia and Critical Care
Freeman Hospital, Newcastle upon Tyne
Email: ian.nesbitt@nuth.northy.nhs.uk
Greetings from Mumias in Western Kenya.

Thanks for all news!

I am a consultant anaesthetist on a 3 year career break (escape!) from new contracts and lip service appraisals in the good old NHS. My colleagues back at the “branch - surgery” in sunny Doncaster have been keeping me supplied with the more essential CME reading i.e. Anaesthesia News and the College Bulletin - which is more than enough to keep me abreast of developments in the speciality to which I will return in due course.

For reasons that I have difficulty in understanding myself, my GP wife and I decided that, after 25 years in our respective fields, we would do something different, and for the past 18 months have been jobbing medical officers in a district mission hospital in Kenya. Not much time or scope for giving anaesthetics as our three clinical officer/nurse anaesthetists are very competent and don’t need a great deal of help other than having the presence of their own “consultant” to assist/advice on occasions but, more interestingly, to enhance their standing within the hospital!

I have, instead, been too busy trying to be a general practitioner (thank God I have my own “in-house” consultant here!); surgeon (many interesting reflections there on transferring to the other side of the blood-brain barrier!); obstetrician; physician; paediatrician and ultrasonographer. While the experience has been, and still is, full of fun, fear, frustration and frolics, there are many interesting ways in which the critical care and pain management skills can be brought to influence local practice in these areas by the generalist MO that might not be quite so easy if I were acting as an anaesthetist.

Tim Hughes

More pillow talk

I enjoyed Dr McGrath’s letter ‘Grab a pillow’ in Anaesthesia News, September. May I add my own observation? I have been a regular attendee of cardiac arrests for over ten years. In that time I have rarely seen a pillow in evidence on my arrival. The reason for this it seems is that nurses are taught on wards that, after pulling the bed out at cardiac arrests and removing the headboard, they should then go on to remove the pillow as well. I have often had difficulty finding the pillow or persuading others of my need for it during a cardiac arrest. So if a pillow should be clipped to the wall in A&E, one should surely also clipped to the ward resuscitation trolley.

Jon Norman, SpR, North Manchester General Hospital

More strange allergies

May I add to the report of curare allergy from Pamela Laurie in Anaesthesia News of October 2004.

I had a patient who told me she was allergic to Adrenaline. When I asked her what it did to her she told me that it made her heart go faster. I didn’t like to tell her that was what it was supposed to do.

John Cook, Consultant Anaesthetist, Eastbourne District General Hospital

Malnutrition? Definitely!

Our preoperative assessment clinic recently sent me a set of patient notes for an opinion. Clipped to the front was a document I hadn’t seen before - the Trust’s Malnutrition Assessment Tool. An extensive questionnaire, this enabled the nurse in the clinic to spot any case of incipient malnourishment in patients scheduled for surgery.

Happily, this patient passed the test - no doubt something to do with the fact that she weighed 165kg.

Mike Jordan, St Peter’s Hospital, Chertsey
Parting Shot

I refer to Kate Bullen’s ‘Parting Shot’ in the No. 208 November 2004 issue of Anaesthesia News. It represents, more or less, the plight of many SAS doctors working in Anaesthetics Departments up and down the country.

SAS doctors are asked to cover junior trainees and senior consultants at the same time! And yet, so often they do not enjoy the rights and privileges of either trainee doctors or consultants. They are asked to be resident and first on call irrespective of their age and experience and can be asked to perform onerous duties. They are asked to anaesthetise for major operating lists on their own and are rarely given any assistance. Yet when the waiting lists initiative sessions are organised and private patients are on the lists, these doctors are not allowed to anaesthetise them.

Exploitation as defined in Oxford Dictionary is ‘make use of unfairly: benefit unjustly from work or actions of’. It is simply exploitation.

Ask ODA’s, anaesthetic nurses and surgeons. I believe they are the best judges of quality of work and dedication of these doctors. Listen to what they say about experienced SAS doctors with whom they work.

The next question Kate posed: Why did this Doctor X not want to take any action?

If it is the only job you have, a family to support and you have any self esteem at all, complaining about this kind of exploitation can seem petty and is a nuisance to the spirit. One has to get on with life and make the best of what one has. Otherwise what is the alternative? And what are the consequences of taking any action? Is it worth it?

I am glad that Kate brought it out into the public arena. I am quite curious what lead clinicians and medical directors make of it all?

Ramana Alladi

Unusual complications of general anaesthesia

I am stimulated by Ed Charlton’s letter (November 2004) to report another unrecognised complication of general anaesthesia. This occurred while I was a senior registrar at the Whittington Hospital, in 1953. I was anaesthetising a patient during the small hours, for what turned out to be volvulus of the small bowel. The solvent action of the anaesthetic agent caused about eighteen inches of terminal ileum to part company with its attached mesentery, an effect that became manifest when the surgeon finally managed to deliver it through the abdominal incision. It had obviously been caused by the anaesthetic, because his immediate reaction when he found himself holding this loop up in the air, rather like a bucket handle, was “What have you been giving her?”

Since the surgeon subsequently declined my suggestion that we should jointly write up this hitherto unrecorded action of nitrous oxide, my lips were sealed, he being a consultant. But my own chief, the late Otto Belam, took a great interest in the phenomenon. “Whenever you are going to do an emergency with him in future,” he said, “I want you to let me know, and I’ll come in”. Sadly, the opportunity to observe the effect again did not recur during the remainder of my time in post.

David Zuck
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- MCQ practice

**Course fee:** £450

For further details and an application form visit [http://www.nda.ox.ac.uk](http://www.nda.ox.ac.uk) or email pip.elpick@nda.ox.ac.uk or write to Miss P Elphick, Nuffield Department of Anaesthetics, Radcliffe Infirmary, Woodstock Road, Oxford, OX2 6HE

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**Assessment in the Workplace**

Monday 14 March 2005

- ‘International Centre for Life’
  - Times Square
  - Newcastle upon Tyne

- Assessment of technical skills.
- Assessment of non-technical skills.
- Assessment of knowledge.

Limited to 90 delegates

**Cost:** £125 for members/£150 for non-members

For further details, please contact: Barbara Sladdin, Administrator, Northern Schools of Anaesthesia, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP

Tel No: 0191 282 5081 or email: Barbara.Sladdin@trvi.nuth.northy.nhs.uk or visit [www.SEAUK.org](http://www.SEAUK.org)
The Neuroanaesthesia Society
Of
Great Britain and Ireland

ANNUAL UPDATE AND
SCIENTIFIC MEETING

21ST AND 22ND April 2005

The Marriott Royal Hotel, Bristol

Guest Speaker: Dr James Milledge

Head Injury Guidelines Updates: ISAT
Movement Disorders: Hypothermia
Co-morbidities: Thromboprophylaxis
Critical Incidents: Pain

Free Paper Session
Closing date for receipt of Abstracts 28th February 2005

Harvey Granat Memorial Prize for Trainees
Non-members and nursing staff welcome
See nasgbi.org.uk for details and application form

Dr John Carter and Dr Samantha Shinde, Department of Anaesthesia,
Frenchay Hospital, Frenchay Park Road, Bristol BS16 1LE
john.carter@north-bristol.swest.nhs.uk
samantha.shinde@north-bristol.swest.nhs.uk

2ND NOTTINGHAM REGIONAL
ANAESTHETIC COURSE
MAY 9TH - 10TH 2005

Upper & Lower Limb Blocks
Workshop-Based Small Group Teaching
Live Demonstrations
Ultrasound nerve location
Anatomy demonstration

Course Fee: £275

Course Organiser:
Dr Nigel Bedforth, Consultant Anaesthetist,
Queen’s Medical Centre, Nottingham

Application forms and further details from:
Louise Johnson
Course Administrator
Trent Simulation and Clinical Skills Centre
Queen’s Medical Centre, Nottingham NG7 2UH
Email: Louise.Johnson@mail.qmcuh-tr.trent.nhs.uk
Tel: 0115 9249924 ext 42113
Message from the Honorary Secretary

The Named Consultant

Taking over as Honorary Secretary of the Association is both a great privilege and rather daunting. One follows a line of many who have undertaken the role with distinction and through their efforts have contributed greatly to the specialty. One year as Assistant Honorary Secretary allows shadowing and observation of the role but nothing really compares to the reality of realising that for many duties the ‘buck stops here’. I must publicly thank my predecessor, David Whitaker, who has achieved much in the past two years and who has been a very wise and helpful source of advice as I take my first steps.

We live in rapidly changing times and there are many issues affecting the profession, the specialty and individual members. Council of the Association has spent considerable time and effort debating the issue of the ‘named consultant’. This has arisen because of the desire by the Departments of Health for clarity in defining exactly who is responsible for all aspects of patient care. This initiative goes far beyond our area of interest but nothing really compares to the reality of realising that for many duties the ‘buck stops here’. I must publicly thank my predecessor, David Whitaker, who has achieved much in the past two years and who has been a very wise and helpful source of advice as I take my first steps.

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no longer continue with on call. Finally, it is worth bearing in
mind that not being able to get up at 3am to deal with seriously
ill patients is not the same as only being fit to work between the
hours of 9 and 5, Monday to Friday. Some departments might find
it acceptable to have an individual contribute to the out-of-hours
work by providing daytime cover on some weekends or during
weekday evenings until say 10pm or even midnight. One of the
advantages of the new consultant contract is that out of hours
work is separately recognised. Although the total amounts are
presently small, when someone comes off the on-call rota this
does result in a decrease in their income, and a small increase for
those remaining. Under the old contract, the change in workload
was really done on a grace and favour basis and may have led to
some senior consultants not asking to relinquish on-call on that
basis or alternatively to some younger consultants feeling
aggrieved at their increased workload.

Space does not permit a review of more of the wide ranging
variety of questions which are posed, some of which would tax
the wisdom of those more sage than this Hon Sec. Enquiries from
other health professionals are usually related to topics on which
the Association might have given, or be considering, giving
advice, although sometimes all that is being requested is an
opinion from an anaesthetist. Enquiries from the general public
are also received and some of these might be more appropriately
directed to the local hospital department (or even the individual
anaesthetist who is going to be treating them). They are dealt with
sympathetically and in a manner which will hopefully not
prejudice the actions of clinicians who will provide treatment.
Enquiries from students and others who wish help with research
projects, sometimes claiming lack of support from their own
educational institution, are the bane of honorary secretaries in
many professional organisations and it is difficult to justify the
time and effort to provide support, far less be sure that it is
appropriate in the circumstances. However, it is sometimes
possible to point the individual in the right direction. Finally,
there are enquiries from anaesthetists practising in these islands
who are no longer members – some claiming they couldn’t afford
the subscription despite still working. These usually receive a
polite but short reply, if appropriate, directing them to the
relevant publications or advice. I hope that those who do
continue to subscribe to the Association consider that this is a
reasonable way to maintain the dignity of the Office without
providing those who do not contribute with the same level of
attention.

I have only just started out upon what appears a major journey
but no doubt in two years time I will wonder how it passed so
quickly. In the meantime, I will use all my best endeavours to
serve the Association, its Council and Members to the best of my
ability. I will not get everything right, certainly not first time, but
not for lack of effort or time. If I, or Council, get things wrong then
members should and must let us know. We are here to serve.

Alastair Chambers
Honorary Secretary
Charity at Christmas Time

Royal Humane Society

The Association of Anaesthetists has been donating financial support to the Royal Humane Society since the early 1990’s. The Society has its origins in the mid-Eighteenth Century. In 1767, a Society was formed in Amsterdam to try and resuscitate those who had drowned in their canals. The Proceedings of this Society were translated into English in 1773 by Alexander Johnson who suggested that there should be a similar Society in London. On the 18th April 1874, two doctors, Cogan and Hawes, met with several colleagues (but not Johnson!) and founded what would evolve over the next few years to the Royal Humane Society.

To encourage both local bystanders and medical men to attempt to resuscitate those who had been taken out of the Thames or local rivers and ponds, the Society offered two guineas for a 30 minute resuscitation attempt. After some dubious and even totally fake resuscitations, the Society decided to award medals and scrolls instead of money; but by this time the concept of life-saving and resuscitation had become accepted into medical practice.

Early resuscitation techniques included blind intubation of the larynx with metal tubes, mouth to mouth and mouth to nose expired air ventilation, as well as ventilation with bellows. The practice of cricoid pressure before intubation as well as the passage of oro-gastric tubes was well described, and even defibrillators were constructed using electrostatic generators and Leyden jars as capacitors.

The Society encouraged practitioners to write up new ideas and a whole series of booklets, pamphlets and reports emerged for which many received the Society’s accolade in the form of gold and silver medals.

The Association has been fortunate to have become the recipient of two sets of original resuscitation apparatus from the 1770’s, which illustrate the tubes and bellows of that era perfectly. These are on permanent loan from the Royal Humane Society and have been sympathetically renovated.

The Humane Society continues to reward bravery and life saving attempts with the award of medals and vellum scrolls at its Annual General Court, to which their Patron, HRH Princess Alexandra, is a constant attendee.

The Society depends totally on charitable donation for all its excellent work and the Association has been pleased to facilitate their endeavours through an annual donation. Members who wish to take on a similar role may contact the Humane Society at Brettenham House, Lancaster Place, London WC2E 7EP or access their website: www.royalhumane.org.

David Wilkinson, Vice President.

Keep up to Date

After many requests, the Association put on an exhibition of the cartoons produced by the late Philip Keep, at the meeting in Cardiff in September. The exhibition was opened by Philip’s widow Madeleine who spoke about the charity, Cancer Research UK, which will benefit from all cash spent by those who buy reproductions of the cartoons.

Madeleine Keep is pictured with President Mike Harmer, after opening the exhibition of 21 of the cartoons, many of which were published in Anaesthesia News, from September 1999.

Postcards of the cartoons can be viewed at 21 Portland Place and purchased at 50p each. Alternatively, mounted A4 reproductions are available at £10 each. Please apply to Claire Elliott at Portland Place, by telephoning 02076318817 or e-mail claireelliott@aagbi.org

An ideal stocking filler for a colleague who has everything!

John Balance

John has enclosed a copy of Madeleine’s favourite cartoon. Unfortunately, this is not available as a postcard. Ed.
Newly Elected Council Members

Prof David J. Rowbotham

David Rowbotham was a medical student, and received all his medical postgraduate training in Sheffield. In 1989, he moved to Leicester as Senior Lecturer and was appointed Professor of Anaesthesia and Pain Management in 1996.

He is Head of the Division of Anaesthesia, Intensive Care and Pain Management, University of Leicester and Honorary Consultant at the University Hospitals of Leicester NHS Trust. He is also Director of Research and Development for the University Hospitals of Leicester and a Trust Board member. He is Course Director for the University's successful multidisciplinary MSc in pain management.

Prof Rowbotham’s national responsibilities include Examiner for the Royal College of Anaesthetists, Advisor to the British National Formulary, and Honorary Secretary of the Association of Professors in Anaesthesia. He is a member of the IASP and EFIC research committees, and pharmacology and scientific grants committee of the European Society of Anaesthesiology.

He is Editor-in-Chief of Continuing Education in Anaesthesia, Critical Care & Pain and has been a Section Editor for the British Journal of Anaesthesia for many years.

Previous responsibilities include: Chairman, Pharmacology Committee, European Society of Anaesthesiologists; Council Member and Chairman, Scientific Programme Committee, Pain Society; President, British Anaesthetic & Recovery Nurses Association; Chairman, Royal College of Anaesthetists Working Party for the report Non-Steroidal Anti-Inflammatory Drugs in the Management of Postoperative Pain; Treasurer and Council Member, Anaesthetic Research Society; Chairman, Association of Anaesthetists working party on Guidelines for Post-Anaesthetic Recovery.

His research interests include the laboratory and clinical investigation of analgesics and management of acute and chronic pain.

In his spare time he roams around the Lake District and supports the best club rugby team on the planet (Leicester Tigers). He also pretends to be a golfer.

Dr Sean McDevitt

Sean is on the staff of Beaumont Hospital in Dublin and is a former Chairman of the Anaesthetic Department. His main clinical interests are in GU, Neuro and Maxillo-facial anaesthesia and his teaching interests are in anaesthetic equipment and safety.

Manpower resources and provision of anaesthetic services are a particular interest. The European Working Time Directive brings a new dimension to an existing staff shortage and failure to manage this problem will lead to major problems for the specialty.

He is well looked after at home, as he lives in an all female house. Rosemary has recently returned to nursing and Claire completed university this year with a degree in mathematics. Jennifer is studying Business and French, and Margaret will start university next year.

Away from work he plays golf to a handicap of 14, with an over-optimistic aspiration some day to play off single figures. There are still some wonderful links courses around Ireland that he hasn’t played yet.

A highlight of his summer for many years has been sailing with Dr John Dunphy around the wonderful cruising area of West Cork and Kerry. What better way to end a day’s sailing than watching the sun set over Baltimore harbour while sitting outside Bushe’s pub with a pint of Murphys.

New Chairman for the SAS Committee

Dr Ramana Alladi

I am both pleased and thrilled to inform fellow SAS members that I have been appointed as Chairman of the SAS Committee and a co-opted member of the Council of AAGBI. Some of you may remember that I have been a member of SAS Standing Committee since it was established two years ago. I work as an Associate Specialist at Tameside General Hospital, Ashton-under-Lyne.

I should first of all like to thank Kate Bullen for the splendid work she has done to raise the profile of SAS doctors in the Association. Now it is my turn to further her efforts. My main objective is to do everything I can to improve the quality of life, job structure and career progression for SAS doctors.
I need all your ideas and suggestions regarding what you would like the Association to do. I am very impressed by the sincere interest the President and Council members have already shown so far.

We need to increase the membership. I'd request all the present members to make special efforts to contact fellow SAS doctors and friends to join the Association. You all know the benefits of membership; help others to gain from them. The Membership department at AAGBI will only be too happy to give you all the information and guidance. You can e-mail Irma at irmaferran@aagbi.org and Natalie at nataliejfinn@aagbi.org direct or through the Association website www.aagbi.org.

I feel that at present there are very limited opportunities for SAS doctors to find jobs and to complete CCST training as SpR jobs are hard to get. It is my intention to suggest various ways of providing this training by creating appropriate jobs for SAS doctors. There are SAS doctors with postgraduate qualifications and vast experience who probably only need a short period to complete their training. I think it is ridiculous for the Department of Health to look overseas to fill consultant jobs when we have skilled doctors already serving in the NHS.

I believe that SAS doctors should be involved in teaching, training and possibly taking part in examinations. There is a need for separate funding and grants. Most present funding is aimed at either trainees or consultants.

I also want to get involved with the Association website, making it more informative, educational and interactive. Any members who are interested and have suggestions please contact me.

I have a lot of other ideas, but for now I wish to concentrate on these issues. Please take these points seriously and contact me with your ideas, we can achieve our aims. I very much look forward to hearing from you all.

Ramana Alladi

A technique that I learnt in 1949 for day-case orthopaedic manipulation patients proved invaluable when, in 1967, I sailed to New York and back on the R.M.S ‘Queen Mary’, as locum Ship’s Surgeon.

The orthopaedic patients required muscular relaxation for a short period, with a rapid recovery. About 500mgms of thiopentone (5%!) were given as quickly as possible through a large-bore needle, the lungs were inflated with oxygen while the manipulation was carried out, and redistribution of the drug around the body in the next few minutes allowed the patient to wake up quickly.

One evening, an eighteen stone (114 kg.) chef fell in the galley and dislocated his shoulder. His fluid intake had been continuous for several hours previously. The anaesthetic machine looked as if it had been transferred from Noah’s Ark, with some of it lost in the transfer. The nitrous oxide cylinder had been removed (and never replaced) some time previously, when there was a lethal mistake in production and all the N2O cylinders in the South of England had been recalled. The flowmeter consisted of perforated pipes under the water in a glass container and, by counting the number of holes from which bubbles of gas escaped, the flow rate could be calculated using a calibration chart...which had been lost. This actually did not matter, as there was nothing to connect the flowmeter and ether vapouriser to the facemask anyway. There was, however, a precursor of the Ambu bag with which to inflate the lungs.

First I managed to pass a wide-bore stomach tube to empty the patient’s stomach and, by strategically directing its end, partly empty the surgery of observers!

I had found out before sailing that disposable syringes were available. Unfortunately, the largest was a 5ml syringe of a make that allowed about a quarter of the contents to leak past the plunger onto the anaesthetist’s trousers rather than into the patient. Venflons did not exist, so I had to use a series of syringes filled with double-strength methohexitone to get the desired effect.

All went well. My colleague, the Principal Medical Officer, reduced the shoulder, and the patient woke up sufficiently to be helped back to a bed in the ship’s hospital a few minutes later.
The recent action by the Barnet and Chase Farm NHS Trust of padlocking doctors’ on-call rooms and charging for their use has brought to the fore the issue of rest periods during new full-shift patterns. That this policy has now been reversed after intense media coverage is irrelevant. A recent GAT Linkman survey (awaiting publication) shows that 16% of Anaesthetics departments report a loss of on-call rooms whilst others are under threat. Many Trusts have taken the standpoint that as other healthcare shift workers, such as nurses, do not have on-call or rest-rooms, there is no reason why they should be available for doctors. This article aims to set out the reasons why sleep facilities for Anaesthetists should be maintained.

Fatigue is the inability to continue effective performance of a mental or physical task, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the physical task, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep, and the three principal mechanisms that determine levels of fatigue are the circadian pacemaker, the time since last sleep.

The sleep mechanism can, however, be used to help counteract the seemingly immoveable circadian pacemaker effect by taking naps. These need only be of 40 minutes duration and there is good evidence to show that ‘power naps’ improve performance when working shifts [2]. The British Medical Association recognises ‘anchor naps’ at the end of shifts as being crucial in reducing fatigue in order for doctors to travel home safely [3]. These alone are good enough reasons to retain the current on-call sleeping facilities.

Any comparison of doctors working at night with nursing staff is like comparing apples with pears. Most nursing contracts are for 37 hours per week, up to 20 hours less than EWTD compliant medical staff. Consequently they have much more non-working time to take advantage of fatigue reduction methods. Even if ‘EWTD compliant’, most doctors’ working patterns are such that the shifts are not evenly distributed over time. Some weeks will have less than 30 duty hours whilst others have over 80. Sleep of course, cannot be stored up and saved for a rainy week.

In general, nursing staff have a more regimented pattern of work, with set tasks, routines and observations to carry out through night shifts. In contrast, the nature of out-of-hours anaesthetic work is inherently unpredictable, covering emergency calls as and when they occur. The NHS Modernisation Agency Report [4] shows that between 5pm and 9am, the highest proportion of anaesthetic workload is ‘urgent’, and must be carried out ‘at once’. This type of work requires alert, awake and aware doctors able to concentrate.

The Hospital-at-Night Project aims to place the anaesthetist at the centre of the out-of-hours emergency service. Whilst there is every pressure from NCEPOD and clinical governance to reduce the frequency and level of out-of-hours activity for the patients’ benefit, it would be improper to remove any existing facility for anaesthetists to improve their performance.

The role of the doctor is often that of sole responsibility for a particular service. A doctor on whom the hospital emergency service depends is under considerably more personal pressure to continue working whilst fatigued. This will result in poorer care for those treated out of hours.

The only fit-for-purpose facility to provide sleep or a timely nap is the traditional on-call bedroom, of which an individual has free disposal when required, undisturbed by others. Reclining chairs in communal rooms, as suggested in some Trusts, do not satisfy these criteria.

We each have an individual responsibility to limit fatigue in ourselves and those working with us. Equally, all Trusts have a responsibility to provide their patients with doctors who are in the best possible physical and mental condition, whatever the time of the day. After all, everyone’s underlying concern should be to prevent the deterioration of patient care - and keeping the existing on-call rooms is an effortless step to support this.

Dr Chris Meadows
The GAT Meadows

References
1. Smith-Coggin, Roskind et al, Relationship of day versus night sleep to physician performance and mood. Ann Emerg Med 1994; 24; 928-34
2. Howard SK, Rosekind et al, Fatigue in Anesthesia, Anesthesiology 2002; 97; 1281-94

The GAT Committee wishes everyone a happy and restful Christmas!
Obstetric Anaesthetists’ Association

Controversies in Obstetric Anaesthesia
2 March 2005, London

Another round of educational debates exploring some of the most topical and provocative issues in obstetric anaesthetic practice. The following issues will be debated: Thromboelastography should be available in every labour ward. PCEA is the technique of choice for epidural analgesia in labour. A wake fibre-optic intubation is a desirable skill for obstetric anaesthetists. There is no place in modern obstetrics for racemic bupivacaine. Simulators in obstetric anaesthesia are a waste of time. It is the right of every anaesthetist to refuse to participate in a maternal request abortion. A fun and interactive day for anyone who ever has to cover obstetrics. Come along, and bring your colleagues! 5 CEPD points.

Obstetric Anaesthesia 2005
12 – 13 May 2005: The Barbican Centre, London

The OAA have had its Annual Meeting in London for a decade and 2005 is the year for our biggest event yet: Obstetric Anaesthesia 2005. Organised under the auspices of the Group of Obstetric Anaesthetists in London (GOAL), a forum representing London obstetric anaesthetists. Obstetric Anaesthesia 2005 promises to be an exciting blend of science, opinion, fact and theory relating to obstetric anaesthesia and anaesthesia, with a flavour not just limited to clinical practice. It is the perfect opportunity to familiarise up on clinical and related topics, see the latest in obstetric anaesthetic research and meet new and old friends. Take this opportunity to enjoy the sights and sounds that make London the most exciting city in Europe, with its countless historical and modern attractions. Buckingham Palace, the Tower of London, the Houses of Parliament, the London Eye, museums, art galleries, theatres, shops, markets, restaurants, clubs and sporting events – London has something for everyone.

Final date for submission of papers: 14 January 2005
5 CEPD points.

Case Reports in Obstetrics and Anaesthesia
29 June 2005, London

Following on from last year’s highly successful meeting, a whole new set of obstetric cases and conundrums will be presented! This one-day meeting is aimed at anyone (anaesthetists, obstetricians or midwives) interested in the clinical management of obstetric problems. The busy day will comprise a mixture of obstetricians and obstetric anaesthetists, and a wide variety of clinical cases will be presented and discussed from a multidisciplinary perspective. An interactive audience voting system will be used to make this an interesting, sometimes surprising, day which will inflate the belief that the case report is dead!

5 CEPD points.

Information on all meetings may be obtained from:
OAA Secretariat, PO Box 3219 Barnes, London SW13 9RW, UK
Tel: +44 (0)20 8741 1311
Fax: +44 (0)20 8741 0611
Email: registrations@oaanaes.ac.uk
website: www.oaanaes.ac.uk

Age Anaesthesia Association

Annual Scientific Meeting
On
Pre-hospital and Peri-operative care
Friday 20th May 2005
Tall Trees Hotel, Green Lane, Yarm, Stockton, TS15 9PE

Last date for registration, free paper and poster submission 30th April 2005

Faculty
Dr Simon Baker, Middlesbrough, UK
Professor Chris Dodds, Middlesbrough, UK
Dr Irwin Foo, Edinburgh, UK
Dr Nicolai Foss, Copenhagen, Denmark
Dr Les Gemmell, Wrexham, Wales
Dr Chris Hanning, Leicester, UK
Dr Chris Heneghan, Abercarnoffyn, UK
Dr Emrys Kirkman, Durham, UK
Professor David Leaper, Cardiff, UK
Dr Michael Osei-Bonsu, Middlesbrough, UK
Professor Narinder Rawal, Orebro, Sweden
Dr Andrew Severn, Lancaster, UK
Professor Gwyn Seymour, Aberdeen, UK
Dr Guy Turner, Chichester, UK
Dr David Wilkinson, London, UK
Mr Malcolm Woollard, Middlesbrough, UK

Meeting organiser
Professor Chandra Kumar
Email: chandra.kumar@stees.nhs.uk

Application form & further details
Mrs Elaine Tucker, Conference Administrator, Department of Anaesthesia
The James Cook University Hospital, Middlesbrough TS4 3BW
Email: elaine.tucker@stees.nhs.uk
Tel: 01642854601, Fax: 01642854246

Local Anaesthesia for Ophthalmic Surgery
Friday, 11th February 2005, Middlesbrough

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in the Education Centre, The James Cook University Hospital, Middlesbrough on Friday, 11th February 2005. The meeting will include lectures and live demonstration of orbital blocks. Attendance is limited to 50 participants. Application form and information from Mrs Elaine Tucker (Course Administrator 01642-854601 email: elaine.tucker@stees.nhs.uk. Registration fee is £250 (BOAS Members £225) (inclusive of catering). Cheque payable to Ophthalmic Anaesthesia Education Trust Fund.

PROGRAMME

9.00-9.25 Registration
9.25 Welcome: Prof Chris Dodds, Middlesbrough
Chairman: Dr Robert Johnson, Bristol
9.30-10.15 Anatomical considerations for orbital block - Mr David Smerdon, Middlesbrough
10.15-11.00 Pharmacological considerations for orbital block - Dr Hamish McLaren, Leeds
11.00 - 11.30 Coffee break
Chairman: Dr A P Rubin, London
11.30 - 12.00 Review of eye blocks - Prof Chris Dodds, Middlesbrough
12.00 - 12.30 Complications of eye blocks - Dr Joseph Bayes, USA
12.30-13.45 Lunch
13.45 -17.00 Live Demonstration of Orbital Blocks

Demonstration co-ordinators: Dr Anthony Rubin, Robert Johnson, Prof Chandra Kumar, Mr Cheyan Deo, Mr Tim Dowd, Dr David Smerdon & Prof Chris Dodds

Retro and/ or peribulbar
Prof Chandra Kumar, Middlesbrough
Dr Anthony Rubin, London
Dr K L Kong, Birmingham
Dr Sean Titcher, London
Dr Sean Williamson, Middlesbrough

Sub-Tenon’s
Prof Chris Dodds, Middlesbrough
Dr Grainne Nicholson, London
Stevens’ Cannula, Inferonasal
Prof Chris Dodds, Middlesbrough
Greenbank’s Cannula
Dr Raju Chabria, Middlesbrough
Sub-Tenon’s
Mr Bartley MacNeela, Jersey

Infero-temporal
Dr Hamish McLure, Leeds
Kumar-Dodds Cannula
Dr Anthony Rubin, London
Stevens’ Cannula, Inferonasal
Prof Chris Dodds, Middlesbrough

Infra-temporal
Dr Hamish McLure, Leeds
Kumar-Dodds Cannula
Dr Anthony Rubin, London

Infero-temporal
Dr Hamish McLure, Leeds
Kumar-Dodds Cannula
Dr Anthony Rubin, London

Sub-Tenon’s
Mr Bartley MacNeela, Jersey

17.00 Closing remarks

Meeting Organiser and Course Director: Prof Chandra Kumar, Academic Department of Anaesthesia, The James Cook University Hospital, Middlesbrough TS4 3BW. Tel: 01642-854601, email: chandra.kumar@stees.nhs.uk
Thomas Clover  
(1825-1882)

Clover was born on 28th February over his father’s drapery shop at 6 Market Place, Aylsham, Norfolk. The site is now marked by a plaque. He went to school in Norwich and at the age of 16 was apprenticed to a local surgeon. In 1844, he proceeded to University College Hospital, London, where among his fellow students were Joseph Lister and Henry Thompson. He was in the operating theatre on 21st December 1846 when Liston amputated a leg under ether anaesthesia.

Clover qualified MRCS, LSA in 1847 and was appointed to the post of apothecary, later renamed resident medical officer, at University College Hospital. Here he operated, administered anaesthetics and taught students. He obtained the Fellowship of the Royal College of Surgeons in 1850 and set up in private practice in 1853 at 3 Cavendish Place, where he lived for the rest of his life. Here, in his workshop, he made prototypes of his many inventions, most of which were produced commercially. He was a skilled lithotritist, and designed the Clover crutch to hold the patient in the lithotomy position. But the greater part of his life was spent as an anaesthetist.

Appreciating the importance of knowing and being able to control the concentration of chloroform, in 1860 he designed his large reservoir bag that was filled with a known concentration of chloroform vapour in air before the start of the anaesthetic. This established a safe maximum, which could be diluted by admitting air at the facemask. This apparatus was shown at the International Exhibition of 1862 and was adopted by several of the major London hospitals. In the well-known photograph of him demonstrating its use, he ostensibly has a finger on the radial pulse and he was always critical of any apparatus that did not allow the anaesthetist to have one hand free for this purpose.

Clover played a major role in the Chloroform Committee of the Royal Medical and Chirurgical Society in 1863, and is thought to have drafted its report. This recommended that 5% chloroform vapour was the safe upper limit.

His main hospital attachments were to University College where he lectured, and the Dental Hospital. In private practice he was much in demand by dentists who publicly contrasted the pleasure of operating with Mr. Clover with their anxiety when the patient’s own doctor gave the chloroform.

When the use of nitrous oxide was demonstrated by TW Evans at the Dental Hospital in 1868, Clover immediately saw its advantages and rapidly adapted his apparatus for its use; he also designed a sequential nitrous oxide-ether inhaler. But the apparatus for which he became best known, his portable regulating ether inhaler, the subject of several modifications and illustrated in every textbook of anaesthetics for the next fifty years, was the one he least liked to use himself. Its portability ensured its popularity.

Clover’s other inventions included a nosepiece for dental anaesthetics, a spring-loaded dental prop, an oral airway, a device for the rapid performance of laryngotomy, and a ‘funnel-shaped India rubber tube for conveying the anaesthetic to the back of the mouth during operations on the jaw’. This, which sounds very like today’s laryngeal mask, was exhibited at the 1881 International Medical Congress but sadly there is no surviving description or illustration.

Clover kept a careful record of his cases, and was continuously seeking advances in safety. From his mildly acrimonious dispute with Lister over the latter’s advocacy of the use of tongue forceps, he appears to have been the first to teach the manoeuvre of keeping a clear airway by holding up the chin.

Clover worked with the leading surgeons of the day and anaesthetised many famous patients, including the deposed Napoleon III, Alexandra, Princess of Wales, and Florence Nightingale. He enjoyed a rich social life, numbering authors, artists, and musicians among his friends. He married in 1869 and fathered five children. He was undoubtedly the leading anaesthetist of his day. He did not publish a textbook, but contributed articles to Quain’s Dictionary of Medicine. He spread his ideas by teaching, at meetings and in the journals. He died at his home on 27th September 1882, of the tuberculosis that had troubled him for most of his life. Many tributes were paid to his professional and personal attributes. He is depicted as the supporter on the sinister side of the coat of arms of the Royal College of Anaesthetists, and a biennial Clover lecture is delivered in his memory. He is buried in the Brompton Cemetery.

David Zuck
MERSEY SCHOOL
ANAESTHESIA & PERIOPERATIVE MEDICINE

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To Explain and To Simplify.

Extracts from Assessments Following The September Selective

“Very useful course – gave us an idea of what to expect in the exam”
“Concentrated on the difficult … and the commonly asked topics which was good.”
“Excellent lectures”
“Well run & organised.”
“This course was an eye-opener for me …..shows where I stand”
“It also tells us the depths of knowledge required for exam”
“Found it very helpful, especially good for difficult concepts”
“The course was excellent and all the sessions which were interactive were very good”
“Well balanced.”

“Excellent course. Helped to revise many basic concepts .. reminding me what I should know”
“I came for this course to see where I stand and it has been made painfully obvious that I have miles to go”
“Well organised. Topics as promised were those not covered as well in the textbooks”
“Excellent speakers.”

“Most of the difficult topics covered. VERY WELL EXPLAINED.”
“It is a very good course it helps a lot in preparing for the exam and in anaesthetic practice as well – it has
covered many topics within the stipulated time.”
“The contents of the topic were great!!”
“… has addressed some of my difficulties & has opened my eyes”
“I feel that all of the lectures, without exception, were well delivered, well prepared …”
“… covered most of the difficult topics which are difficult to understand.”
“… gave a good approach to the exam. I left feeling that I knew how to study for this exam …”
“This course is good quite extensive covering a lot of topics in 5 days. Though it becomes quite tiring by end of 5
days. All is worth it!”

“Food at Everyman Bistro was excellent, especially the salads & deserts. Cheers!!!”

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Tel: 0116 258 5291/email: ana@le.ac.uk
Dr Jonathan Thompson & Dr John Parker
Course Directors

Places are strictly limited

Division of Anaesthesia, Critical Care & Pain Management, Leicester Royal Infirmary

THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

Fourth Annual Open Meeting of the Scottish Standing Committee

Friday, 25th February 2005
Conference Centre, Stirling Royal Infirmary

This full day meeting will address core topics such as Latex Allergy, Airway Developments, and Head Injury Transfer. There will be discussions on new ideas around Non-physician Anaesthetists, Simulators, and the Hospital at Night. The guest lecture will be given by Professor Stuart Macpherson, Post-graduate Dean at Edinburgh University, on the subject of Modernising Medical Careers.

For further information and an application form, please contact: Ms. Caroline Strickland, Secretariat Coordinator, Association of Anaesthetists of GB.&.Ire., 21. Portland Place, LONDON, W1B
It's that time of year when consultants are frantically filling in their application forms for clinical excellence awards. That is, all those who have not given up all hope of fooling either local or national committees. When the forms where radically changed a few years ago the categories seemed to be almost totally irrelevant to clinicians, except those with direct control of a waiting list or who were public health officers. I duly completed the form, I have to confess, very much tongue in cheek. Where it said “describe how you have contributed towards achieving local NHS priorities” I wrote “I take a full part in waiting list initiatives”, thinking “they have paid me once for those already, they wouldn’t be so daft as to pay me again”. The next category was “blah blah heavy workload in pursuit of local NHS service goals”. Bit harder, this one. For a start, what is the difference between local NHS priorities and local NHS goals? Should I just write the same thing as in the previous box? I thought for a bit, wondered whether to mention that I sometimes moved the operating light if I thought it might speed up the list, and then came up with “early starts and late finishes on operating lists, and frequently work through lunch on all-day lists”. Under the category ‘Research etc.’ which asked applicants to give full details of their research team, I put “No research team, everything I write do myself; I share one and a half secretaries with 26 other consultants – in fact I am typing this form myself”. Next one – “Innovation and Improvement to the Service”. Hey, I was getting the hang of this now! What about “My innovative techniques in improving patient care are the frequent subject of our Clinical Governance meetings”. Not only did that mention ‘patients’, which is important, as lay people sit on these award committees, but I also got in a reference to Clinical Governance. Anyway I continued in that vein, and lo and behold, that year I was awarded 2 points! I think the reality was that hardly anyone else completed the forms as very few thought they could fill in any (let alone all) of the categories. The message is clear. You only stand a chance of winning if you enter the competition. After all, this is the reason I continue to do the lottery each week.

I am seriously amazed by the amount of work which goes into the whole process of awards. Having shared an office with someone who was on the higher award committees and also overseeing local awards, I became aware that the background work started in August and went through to February and took up enough time to account for all the SPAs for a year. Consider then the time spent by each individual consultant completing the ever-changing documents. Downloading one set of forms from the DoH website, only to find that this year the forms have changed yet again. (Silly me! The consultants most favoured by the award system have their own secretary to do this for them). Then there is the process of recommendation by National bodies. The more organisations that put forward your name, the better is your chance of success. Unfortunately, that means they expect you to have done something useful for their organisation. By the time you’ve worked your way up high enough in any organisation to be recommended by it for an award, you no longer need the extra money, as the kids have left home and the mortgage is paid off. On the other hand, you can at least prove you’ve been doing something useful with your SPAs, which will become more relevant in the future.

Talking of awards; one of the ‘Professional Executive Group’ (i.e. a general practitioner) of our local Primary Care Trust (PCT) came to speak to the consultant body of our Hospital Trust about “Gypsies” the other day. Well, it is pronounced “gypsy” but spelt GPSE which stands for General Practitioners with Special Experience (I think that means they’ve done an SHO post in an –ology during their training). This has been set up already in some parts of the country, with some success - or so we were told at this meeting.

Apparently this bunch of GPSEs will triage all hospital referrals in their area of Special Experience, treat those they can themselves and refer the difficult cases to hospital. For this they will pay themselves a sessional rate equivalent to a consultant with an A+ award (Level 12, Platinum). As the money available to PCTs is finite, there will then be less money to pay the hospitals for consultants to treat the more difficult cases, at an average rate of half of that which GPSEs get for simple ones! What really amazed me about this was that the GP had come to us to seek our support for this enterprise – since when did turkeys start voting for Christmas!

Nothing to do with awards, but if you were a government agency looking for members of the public to sit on a committee to prioritise various specific issues across the NHS, and wished to avoid the usual suspects, pressure groups etc, where would be the last place that you would advertise! Yup, right first time! The advert was placed in the ‘Grauniad’, and nowhere else. Will this be another committee of ‘Grolies’ (Guardian readers of limited intelligence in ethnic skirts) that any sane individual would avoid like the plague? Still, I suppose under a different government the advert would have appeared only in the ‘Torygraph’.

To close on a vaguely clinical matter; I was about to induce anaesthesia in a pleasant, well-spoken, elderly gentleman who presented for repair of bilateral inguinal hernias that had obviously been present for some considerable time. He displayed the typical stoicism and politeness associated with older generations. In my usual fashion, getting the patient in a calm and relaxed mood by suggesting they think of something pleasant, I asked him if he was looking forward to anything special. As the Propofol coursed through his veins, a smile enveloped his face and he whispered “The trouble with having a double hernia is that it completely obliterates your penis. I’m looking forward to seeing more of it in future”. Fortunately the LMA slipped neatly into place as both my assistant and the ward nurse were temporarily rendered totally incapable of providing any assistance.
I was delighted to be asked to judge this year’s art exhibition, held at the Annual Congress in Cardiff, as part of my duties as the artist-in-residence to the Association. Anne Sutcliffe, Dalvina Hanu-Cernat and Trish Willis had done a terrific job mounting and hanging such a wide range of exhibits and I was most impressed by the variety and quality of the submissions.

There were two categories to judge this year: photography, and works on canvas or paper. Judging such a varied collection of artwork is never easy, as direct comparisons cannot be made, so along with technical expertise and experimentation of the chosen media, I relied heavily on the subjective emotional response, which each work induced.

The entrants to the photography section were particularly strong. Chris King submitted two bodies of beautiful photographs, but it was his underwater shots which most impressed, not least because of the patience and technical experimentation he displayed in order to achieve them. A popular choice with the delegates, his vision was truly realised to produce a strong, magazine-quality series of underwater life. The winning shot ‘Anemone shrimp’ had such texture and colour as to be outstanding and earned Chris the Overall Winner prize.

Runner up, Anne Sutcliffe, also entered a full body of work, prepared, I believe, for her recent admission as a Fellow of the Royal Society of Photographers. ‘Mirror and memories’, a photograph taken in a deserted house in Ireland was both evocative and fragile, composed so carefully with subtle colours and a wonderful sense of balance.

Also, receiving Commended awards in Photography were: Will Lindsay for his stunning glacier shot; Neil Brookes’ split second sports timing; and Dalvina Hanu-Cernat’s limpid Lakes in New Zealand.

Comparing the works on paper or canvas was particularly difficult with so many styles and dimensions. A great deal of technical ability was evident with some artists exhibiting for the first time, while others were proficient regulars whose work was keenly awaited by the viewers. Many a delegate went home clutching a large addition for their walls as the week went on.

Eventually, I chose Niila Ghosh’s ‘Seated Woman’ painted sketch because I kept returning to it, due to its spontaneity and varied mark making with paint overlaying wax. This, added together with the beautiful colours, produced a vibrant, intriguing study, which slipped in and out of the background.

Donnie Ross was runner up in this section with a double-mounted watercolour entitled ‘Braemar’, which gave me much pleasure over the three days as I sat facing it at my table of work.

Commended awards in this section went to Fred Roberts for his cheeky orange study ‘Dutch fans eating satsumas on an Easy Jet flight’, John Edwards’ popular ‘Sandy Mouth Bay’ and Stephanie Greenwell’s ‘Landscape’.

One thing is very apparent. Anaesthetists and their families have no lack of enthusiasm for the arts. Though how doctors find the time remains a source of amazement to me! Here we have an exhibition which opens its doors to a whole range of talents and skills. I truly believe that artistic endeavours should be put out there to be seen. They require an audience to make them fully live and even the most modest entries should have their day. I do hope readers will be encouraged to enter next year. There is a friendly open policy, with no judgement on submission and a warm reception to all efforts. So if you have a hidden talent, take the plunge - and I know Anne would be pleased to welcome works on a whole variety of media, including painting, textiles, print, sculpture and craft.

Julie Brixey-Williams, Artist-in-Residence
Association of Anaesthetists

News from the Anaesthesia Heritage Centre:Presentation at this Year’s London MAZE

On 16th October 2004, the Anaesthesia Heritage Centre, as part of London’s Museums of Health and Medicine group, attended the London MAZE, an annual local history exhibition at Guildhall Art Gallery. This event is aimed at Londoners from all walks of life who are interested to learn about their heritage and traditions, and hopes to make them aware of some of the hidden treasures off the usual tourist path so they can arrange visit at a later date.

This year, the organisers offered the group four free stands due to the visitors’ increasing interest over the past years. On the day, visitors were not only able to collect informative leaflets about the museums, but were also able to try their luck in pill making, see how field doctors were equipped in the two World Wars and ask questions of special interest.

The Day was a big success, and the Anaesthesia Heritage Centre is already looking forward to attending next year’s event.
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Highs and Lows in Cardiff

On the Friday afternoon after the Congress I was taken to see Cardiff Bay. What a brilliant idea to create a fresh water lake at such a site by building a barrage. We started at the old Norwegian Church. By chance there was a breath-takingly beautiful exhibition of urban and rural photographs of Wales and Sweden. The captions were equally exciting. Half were in Swedish. The corner of a half timbered building in Malmo, with light coming from an upper window was labelled

I call architecture FROZEN music

I can shut my eyes now and rejoice in the beauty of that street corner in Malmo.

Across the road was the Visitor’s Centre. It’s exhibition was about WATER, and was aimed at children. The first display read

‘Water. A wild wicked wetness or a lovely lively liquid. A savage shapeless substance or a fun filled fluid.’

Fresh water - the world’s most precious commodity.

Another section said that few people die in the Sahara from lack of water, more are killed in flash floods. Perhaps they were unable to work out that if there is no water, there are no crops, and if no crops no food. There was a battered football, which purportedly had come down the Ely River. I said to a man next to me, ‘Those poor kids losing their ball’. (In the Third World you can be assured of a great welcome in any school if you bring a football). The man told me the purpose of the display was to stop people throwing rubbish into the water. There is a special vessel to pick up debris in the Bay.

Of course children must be taught safety. A call to the Harbour Authority gave the figures. One person has died accidently in the Bay in 5 years. More than a million children die annually of malaria in Sub-Saharan Africa. No water, no crops, no food, and certainly no money to buy mosquito nets.

I am not often angry, but I was that afternoon in Cardiff.

For the Congress, I will start with the low, which did not make me angry, just sad. It was the session on retirement. It was all about maximising your pension. Even John Balance, who of course gave an excellent talk, only put the money side of it in bold in his abstract. Surely the only really important thing about retirement is what you are going to DO in this wonderful 20 years of freedom. A yacht it seems is a good investment, but there was nothing about doing a course in navigation in case you drop the GPS overboard when you are crossing the Atlantic.

I decided that this year must be Retirement 1, and at the 2005 Congress there will be Retirement 2 full of ideas on how to spend the years — possibly even with VSO in, say, Rwanda.

Pretty well all the rest was a high. Excellent organisation, friendly people and good food. The topics were wide ranging and interesting, with just the problem of how to choose between Death on the Table, Ethical Issues, and Problems with Colleagues. I chose Ethics, Alan Merry in the Chair being the catch after that outstanding Intravent Lecture. I guess I had not given much thought to the Association before this year, just pleased that good people were willing to give their time, as Peter Wallace said to keep the show on the road. But actually our Association is quite special. We have been in the forefront in so many fields. We moved out from Anaesthetics to wider aspects of medical care quite early on. I remember travelling from Zimbabwe to London in the 80s for advice on how to cope with a sick colleague; and where do most of the people come from who shore up Anaesthetic Meetings in Third World countries. They come from our Association.

Being elected to Honorary Membership has made me disgustingly proud! Fortunately back in Zimbabwe I was bored. Being elected to Honorary Membership has made me disgustingly proud! Fortunately back in Zimbabwe I was bored. I taught the piano in a local primary school. We always start by washing our hands. Not this week. There was no water, not that anyone seemed particularly bothered.

Ruth Hutchinson