Annual Congress in Aberdeen
Naked Gasman and Gas Flo at Christmas
Aisys®
Clinical excellence through patient-focused care

Exceptional Design
- Flexible and integrated, with the most advanced design, ventilation, vital signs monitoring and Advanced Breathing System (ABS™)
- Exclusive NVview™ Patient Displays so that you can position the patient and ventilation data and controls where you need them
- Can be integrated with your hospital information system
- Fully upgradeable to add new technologies as your needs change

Proven Clinical Excellence
- Superior ventilation for neonates to adults
  - Volume Control, Pressure Control, PSV/Pro® (Pressure Support with Apnea backup), Synchronized Intermittent Mandatory Ventilation, (SIMV) - Volume and Pressure, electronic PEEP
  - Tidal volume compensation
- Vital signs monitoring with our exclusive technology:
  - Patient Spirometry™ measures airway pressures, flow, volumes, compliance and airway resistance, breath by breath at the patient’s airway
  - Entropy aids you in monitoring the state of the central nervous system
  - Neuromuscular transmission (NMT) provides a continuous, quantitative measurement of patient’s responses to nerve stimulation and regional block

Anaesthesia Delivery Re-imagined.

GE Healthcare
71 Great North Road
Hatfield, Herts. AL9 5EN
T: 01707 263570
F: 01707 260065
W: www.gehealthcare.com

© 2006 General Electric Company
Edesto-Ohmeda Ltd, a General Electric company, going to market as GE Healthcare
DW0206
The AAGBI celebrated its 50th Annual congress in the “silver” city of Aberdeen on the North East coast of Scotland, where 500 delegates attended from all over the world with Australians and New Zealanders being particularly well represented.

The thrust of the questions put forward by members of the audience included concerns about MMC, the “Lost Tribe” of SHOs and potential unemployment for newly accredited SpRs. The panel answered fairly uniformly that whilst this deplorable state exists there was not much the RCoA or the Association could do about it. The Government was determined to drive these changes through and were not in a mood to listen or heed advice.

Tea was taken after this before everyone returned to listen to the Intavent Orthofix Lecture, delivered with great aplomb by Peter Wallace, Immediate Past President, AAGBI. His theme was an historical perspective of the NHS seen through his eyes and the key message was that whilst things look pretty stormy at the moment, things haven’t always been smooth in the past either. He reminded us of several periods when things looked equally gloomy, but his message was that we usually come through these changes eventually and things settle back into a more comfortable equilibrium.
Following his entertaining talk we were entertained by an excellent display of Scottish dancing and piping (bagpipes played indoors are quite deafening!), before adjourning to the Reception and Official Opening of the excellent Trade Exhibition.

The format of the conference comprised parallel sessions and workshops involving specialist societies. The main lecture sessions were divided into scientific sessions and “members’ issues” such as retirement and pensions, what is happening to the NHS, and how to deal with doctors with problems.

A particular highlight was the session on cardiopulmonary exercise testing (CPX) to test the cardiovascular fitness of patients for surgery by comparing their oxygen uptake and CO₂ production. The patients are tested in an exercise laboratory, similar to that used to test fitness in athletes and sportsmen. The patient is seated on an exercise bicycle and is attached to breathing circuits which can measure O₂ uptake and CO₂ production. These results are fed into a computer which is able to calculate the point at which anaerobic respiration starts. The magic number, we discovered, is eleven - an Olympic athlete would achieve thirty! In addition a twelve-lead ECG is monitored during the period of exercise to look for ischaemic changes. The risk for a patient undergoing major abdominal surgery can be stratified accordingly. This information can be used to give the patient the appropriate postoperative care - i.e whether they need ITU, HDU or can simply go back to the ward.

The session on equipment failure was novel, entitled “Equipment Failure- Where does the blame lie?” with the 90 minutes set up
like an official enquiry with David Bogod acting as “inquisitor extraordinaire”. It was highly educational and entertaining. The frightening revelation of this session was that there are virtually no performance standards for anaesthetic equipment, which is clearly something which needs to be rectified.

Each day workshops on difficult airways (Difficult Airways Society), regional anaesthesia (ESRA), ITU, finance, ophthalmic anaesthesia (British Ophthalmic Anaesthesia Society), liver and CPX were run. These proved very popular, and most were full before the meeting started.

There was an excellent free paper competition. Our congratulations to the winner Ewan Jack, SpR, Glasgow for his excellent paper titled “Cardiovascular changes after steady state anaesthesia”.

The AGM was chaired by Prof Mike Harmer, the outgoing President, who thanked Honorary Secretary Alastair Chambers for all his hard work and support, and Honorary Treasurer Dick Birks for his shrewd financial management. He also thanked the staff of the Association for all their hard work and unending support, in particular the events team who organise the conferences so excellently. He handed over the Seal of Office to the new President David Whitaker.

There was, as ever, an excellent social programme. The day preceding the opening of Congress, the Association organised its first golf event at the Royal Aberdeen Golf Club, which is hosting the 2011 Walker Cup. Whilst only ten people played they enjoyed an absolute treat. The sun shone over these magnificent links and the wind blew, providing a superb test. An informal competition was run and was won by Rob Law from Shrewsbury.

The culmination of the social programme was an excellent dinner and ceilidh at Ardoe House Hotel. Many members and guests wore kilts and it was a very colourful affair. The new President David Whitaker thanked Mike Harmer for all the hard work he had done during his previous two years and he also thanked Ian Johnson and William Harrop-Griffiths, together with members of the events committee and the events team who were responsible for and who organised the meeting. Many people participated in the dancing despite the absence of a “caller” and for most dances the floor was packed, although perhaps enthusiasm rather than skill was the cardinal attribute! The evening ended at around 1am with a lot of exhausted people. Sensible people retired to their beds but others continued the festivities in their hotel bars.

The following morning there was an impressive number of people seated by 9am to hear the first of two keynote lectures. The Draeger Medical Lecture on “Dental Anaesthesia and its Future” was given by Tony Wildsmith, delivered in his usual thought-provoking style. This was followed by a brief award ceremony and then the second lecture, the John Snow Lecture, was delivered by Mary Hassell, HM Coroner for Cardiff. This was a most enlightening, entertaining and thoughtful discourse on the history of this ancient office, which originated as a tax collector, evolving over the intervening period to the important role of investigating the cause of death. She went on to explain why she thought the coroner was the right person to investigate causes of death and also stressed that the role was not to apportion blame. Finally the meeting was formally closed by Professor Nigel Webster on behalf of the home team.

The Association looks forward to welcoming everyone to the Winter Scientific Meeting in London in January.

Nick Denny
When William Thomas Green Morton made history on Friday, October 6, 1846 using ether for a surgical operation and Sir James Young Simpson introduced chloroform in Edinburgh in 1847, it was in an era where physicians did not practice anaesthesia. It was only in the last decade of the 19th Century when the terms anaesthesia, anaesthetics and anaesthetist began to acquire the ‘professionalism’ of a medical discipline with the developing science of sleep and pain control during surgery. As they say, the rest is history. It is inconceivable today to imagine modern medicine without the discipline of anaesthesia or a hospital to be able to function without the services of anaesthetists.

I was minded to ponder about the challenges to our professionalism from several directions recently. Hospital Doctor recently highlighted the ‘clock ticking on professionalism’ when it reported that trainees from Northumbria Healthcare NHS Trust were asked to clock in and out during their working time just like factory employees. The trust insisted that there were no plans to extend it to senior doctors. The introduction of anaesthetic practitioners (or their equivalent) is being viewed by some as a threat; the increasing regulation of supporting professional activities and appraisal are seen by members as possible threats to their professionalism. But are these real threats? There are the day to day challenges when managers admit patients for major surgery on the day of surgery rather than overnight to ‘save’ beds and in one trust there is even a suggestion that the operation list start time should be defined as the start of surgery ignoring the pre-operative visit, the initial anaesthetic equipment checks and anaesthesia! I am sure our members can come up with many more examples.

We are fortunate that the public still hold doctors in high regard when compared to other professional groups e.g. lawyers, managers and politicians, despite the medical scandals of recent years. Opinion polls suggest that doctors are the most trusted profession in society, scoring even higher than the clergy! There are two levels of trust required by patients; firstly, trust that the person they see is who they say they are and can do what they say they can do. Locally, it is very much up to the Trust, the individual and members of the department to play their role. Secondly, patients put trust in the institutions to train, accredit and regulate the doctor. In anaesthesia, we are fortunate to have the College to oversee training and accreditation with the Association in a vital supporting role. What about professional self-regulation?

The public’s trust in medical self-regulation has been considerably dented after some high profile cases (Bristol and Shipman) coupled with the political hammering of the medical profession. The Donaldson Report if imposed may be the biggest threat yet to professional self-regulation by the General Medical Council. What is worrying most doctors is the proposed lowering of standard of proof for fitness to practice from the criminal standard beyond reasonable doubt to the civil standard based on a balance of probabilities. The GMC may lose the power of adjudication in serious fitness to practice cases and formal adjudication may be undertaken by a separate and independent tribunal.

But what is it that really makes a medical professional? The traditional attributes of mastery over a complex body of knowledge, code of ethics, autonomy, the social contract between society and the profession based on trust have all been subject to challenge
in recent years. Professional boundaries are being blurred increasingly with the introduction of nurse practitioners and nurse consultants. What are the public expectations of anaesthetists as a professional group? Of course our patients would not accept anything less that the highest standards in anaesthesia to permit safe anaesthesia through their surgery. The recent survey (1) of over 1500 patients being cared for by 31 consultant anaesthetists showed that communication skills vary between anaesthetists and that patients placed communication and empathy in the preoperative visit high in their list of required attributes. How is this possible if your pre-operative visit is curtailed because of bed pressures?

Patients would like to be listened to and they would expect their anaesthetist to act as an advocate for them. This partnership with patients is important especially with greater patient expectations. Patients do not trust managers. Therefore, one could put the case to our managers that it is not only important for the anaesthetist to assess the risk and obtain informed consent during the pre-operative visit but it is also of great importance to the patients themselves. In order to do this there needs to be arrangements in place for the pre-operative assessment and interview. This will also give an opportunity for the public to recognise the role of the anaesthetist which would otherwise be marginalised. A number of surveys have shown that a proportion of patients do not recognise anaesthetists as medical practitioners!

There are other characteristics of professionalism which may no longer hold. Altruism is admirable but it may lead to complacency. Mastery of the profession is another under scrutiny. While a certain body of knowledge is essential, anaesthetists need to ensure that they keep up with their knowledge and skills and most importantly to know when a situation is beyond their level of knowledge or skill so that further help can be obtained. Finally, professional autonomy is no longer valid in this day and age. Anaesthetists cannot do their ‘own thing’ and ignore standards, guidelines, revalidation and regulation. Indeed, the professional anaesthetist must embrace mutuality in terms of his or her relationships with other healthcare workers, their patients and society.

So, I do not agree that because we may be asked to clock in and clock out that our professionalism is at stake. I believe that professionalism is very much in the hands of the individual anaesthetist in one’s approach to patients and colleagues in mutual respect; one’s ability to keep high standards of expertise by life long learning and one’s ability to do the very best for the patients under our care. If we are serious about the latter we should have no worries about any form of regulation. Last but not least, we are indeed fortunate to have a strong College and Association to guide us along the way.

Have a Merry Christmas and an interesting New Year!

Michael Wee, Assistant Editor

CALL FOR ABSTRACTS

Abstracts are invited for case scenarios, oral or poster presentation. Papers accepted for presentation will be published in abstract form in the journal Anaesthesia*. Prizes for the best free papers, as judged by a panel of experts. Closing date for submission 1 June 2007.

*The Editor-in-Chief reserves the right to refuse publication.

For Abstract Forms and further information, please contact carolgaffney@aagbi.org

ROYAL MEDICAL BENEVOLENT FUND
PRESIDENT’S APPEAL 2006

The RMBF exists solely to support medical colleagues and their dependants who have fallen on hard times. Tragedy can strike unexpectedly and all too often does – not least to younger members of the profession and their families.

Your generosity will make a difference to the support we give throughout the year but it is at Christmas when such help is particularly needed and appreciated, especially when children are involved as quite often they are. We know from the many letters of thanks we receive just how much difference this makes and how much it is valued.

To find out more about our work or to offer help as a volunteer or make a donation please visit our website www.rmbf.org. I ask you to give generously reminding you that our funding comes only from fellow doctors and their families.

Sir Barry Jackson MS FRCS FRCP

BOOK YOUR STUDY LEAVE NOW FOR THE ANNUAL CONGRESS 2007

For further information about the congress, contact meetings@aagbi.org or go to www.aagbi.org
NHS Police warn of dangerous sect acting in hospitals

From our correspondent Scoop O’Lamine

The newly formed NHS Police (NHSP) have launched their first major operation after reports of strange behaviour occurring in NHS trusts around Christmas time. Chief Inspector Stu Pidley of the NHSP, explained that patient and staff safety could be at risk due to the behaviour of certain suspicious individuals.

"Over a number of years, there have been several sightings in different locations, of an obese elderly man wearing a distinctive red outfit, and a long, artificial white beard. This individual has been seen in many hospitals, often appearing at children’s parties, giving out unsolicited gifts and encouraging small children to sit on his knee and volunteer what sort of toys they would like to receive. Such is his power that a number of adult females have been seen to join in."

The NHSP, formed in 2006, are taking this information very seriously. "I am now convinced that we are dealing with some sort of emerging cult. At first I thought perhaps we were dealing with a eccentric benefactor interested in children, but from witness statements taken early in the investigation, it appears that the individual alleges he flies around the sky in a sleigh towed by reindeer and descends into children's bedrooms via chimneys."

Strangely, there have been no sightings reported since December last year, despite a 24 hour police watch on the paediatric ward day room in the Royal Bray Caleg Trust.

"At this point in time our best guess is that we are dealing with a dangerous, subversive sect, interested in deluding small children into believing in a fantasy world in order to brainwash them, for an undetermined purpose. We cannot rule out global terrorism at this stage", reports Chief Inspector Pidley. "CCTV footage has established that the red outfit is a disguise, and is often discarded by the individual after a period of child indoctrination. We urge all parents to be aware of the risk – however such is the hold that these individuals seem have over small children, we feel it would be unwise at this time to tell them this man is not real. Older siblings will be able to break this news in a more sensitive manner in the fullness of time."

The NHSP and the NPSA have issued a SANTA (Suspicious Adult - Not To Approach) hazard notice, asking the public to be aware and report any sightings to their local police. A brave member of the public was able to snatch a picture (see above) of one of these individuals last year, which will assist in identification.

Paranoia-Watch

In a national newspaper in October 2006, there was a full-page feature on NICE’s decision not to fund Alzheimer’s medication for sufferers in the early stages of the disease. A consultant in Old Age Psychiatry, Dr David Wilkinson, wrote about his frustration at the decision. Towards the end of an otherwise unimpeachable article he wrote, “But we can’t vote out NICE, an unelected quango made up of public health doctors, anaesthetists, and other health professionals, who do not have to face dementia patients and their carers.”

What did we ever do to upset Dr Wilkinson? On consulting the NICE website, I can find only one anaesthetist, representing RCoA on the Partners’ Council, which does not seem excessive. There is no sign of the hordes of anaesthetists whom he blames for this decision. In addition I am concerned that Dr Wilkinson seems to believe that when the elderly dementia patients on his ward fall and break their hips, the fairies spirit them away and make them better. As someone who used to have a regular trauma list, I know how much time I spent communicating as best I could with dementia patients and sometimes their carers. When you have to persuade a demented and potentially aggressive elderly patient that really, it would be in her best interests for you to stick a big needle in the back of her hand, I find communication skills are quite important!

What is it about our specialty that makes professional colleagues feel they can publicly denigrate us in this fashion? It wouldn’t occur to me to slag off a psycho-geriatrician for no reason in a completely unrelated article, but there it is – our specialty has been named in a national newspaper as having a significant role in this unpopular decision. It wasn’t us guv, honest... And the old myth that we never speak to patients is perpetuated.

As an anaesthetist, do you ever feel the world has it in for you? How often do you read in your local paper a letter from a patient praising the local hospital and thanking the doctors, nurses and anaesthetists who looked after them? Please send further examples to Anaesthesia News. And if you are in Southampton, where Dr Wilkinson works, the next time you see him, have a word....

Hilary Aitken
AAGBI Awards

The following awards were made at Annual Congress in Aberdeen:

1. Honorary Membership was awarded to:
   Dr Stephanie Greenwell, for services to AAGBI Council. She was elected to Council in 1998, serving as Hon Membership Secretary, editor of Anaesthesia News, and Vice President.

   Prof J Tony Wildsmith, for services to anaesthesia, education and research. Tony has served as an elected Council member of both AAGBI and RCoA. He chaired the Education and Research committee of the Association, and has also served as member of the editorial board of the British Journal of Anaesthesia. He is a past President of the Scottish Society of Anaesthetists.

2. Pask Certificates of Honour were awarded to:
   Dr Sarah Hodges
   Her award is for outstanding services to anaesthesia and medical education in Uganda where she and her husband work. Sarah was unable to attend Congress, and it is hoped she will be able to receive her award at the Winter Scientific Meeting in January

   Mr Clive Bray
   His award is for long and outstanding service to the Association in the form of his being a co-opted member of the Association’s Safety Committee for 23 years. His main job has been with the DHSS and since 2000 he has been a Director with the Medical Devices Agency.

3. Featherstone Award:
   Prof John Sear.
   This award was made for outstanding contribution to British anaesthesia throughout his career, both in teaching and research, as well as having served on Association Council.

Qualifications for those acting as Assistants to an Anaesthetist

The Association advice on the above, which is contained within the document ‘The Anaesthesia Team’, has been modified to:

The Association recommends that all assistants are trained to the level of competency set out in the NHS Education for Scotland Document: Core Competencies for Anaesthetic Assistants

Although the Association is not a statutory body and does not have the authority or the resources to inspect and approve individual courses, our advice and recommendations are widely noted and respected. However, the Association receives many enquiries from individuals who wish to undertake training and also from those who wish to organise training courses about what we consider acceptable.

For many years the Association has recommended that all those assisting an anaesthetist possess a ‘nationally recognised qualification’ but since the demise of ENB 182 and 183 courses, there is no such qualification for nursing staff. The training for Operating Department Practitioners is a nationally recognised qualification and includes appropriate training but would not be suitable for a nurse who wanted to assist in the anaesthetic room.

The document published by NHS Education for Scotland was drawn up in close collaboration with anaesthetists in Scotland and with representation from the AAGBI Scottish Standing Committee. It outlines competencies to be attained by anyone acting as an anaesthetic assistant, either by completion of a training or educational course or by work based learning and experience. In either case, some formal assessment will be necessary to ensure appropriate recognition. This allows the abilities of the many nurses already acting as anaesthetic assistants who have not undertaken a ‘nationally recognised qualification’ to be formally recognised. As far as we are aware, it is the only such document produced in the UK & Ireland that is suitable for our present purpose, and it seemed to Council wholly appropriate simply to affirm that we agree with the recommendations and conclusions of the group who compiled it.

A copy of the document is available on the NHS Education website at www.nes.scot.nhs.uk/documents/publications/classa/NHS_Anaesthetics_final.pdf

William Harrop-Griffiths, Honorary Secretary, AAGBI
Alastair Chambers, Immediate Past Honorary Secretary, AAGBI
WINTER SCIENTIFIC MEETING 2007

QEII Conference Centre, Westminster
10 – 12 January 2007

Celebrating the 75th Anniversary of the founding of the Association

Core topics/Best Practice Sessions
WORKSHOPS: PowerPoint, Critical Appraisal, Resuscitation, Paediatric Emergencies, Difficult Airway

Book your study leave now!

For further information contact the Events Department on:
+44 (0)207 631 8005/8 or meetings@aagbi.org

REGISTRATION FEES

<table>
<thead>
<tr>
<th></th>
<th>Members</th>
<th>Non Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Day</td>
<td>£240</td>
<td>£295</td>
</tr>
<tr>
<td>Two Days</td>
<td>£345</td>
<td>£415</td>
</tr>
<tr>
<td>Three Days</td>
<td>£430</td>
<td>£515</td>
</tr>
</tbody>
</table>
Dr Sarah Rawlinson  
SpR Anaesthetics  
Sheffield Teaching Hospitals

Have you ever wondered what it is that motivates someone to apply for a job in the most hated hospital on the training rotation? Or why one hospital has lots of applications and another very few? Staff at one hospital in my region regularly wonder why female candidates don’t apply for Consultant posts in their department. After several such speculative conversations in which I was involved I agreed to circulate a questionnaire to all recently appointed Consultants (within 5 years) and anaesthetic Specialist Registrars (SpRs) in the region. The aim of the survey was to try and establish what factors were important to SpRs when thinking about where they would like to work as Consultants, and to see if this was mirrored by the feelings of recently appointed Consultants. I was also interested to find out whether gender affected where any SpR might apply for a Consultant post.

The Questionnaire

The questionnaire was anonymous and asked for general data such as gender, year of training or years as a Consultant and number of dependent children. SpRs were asked to rank 10 factors in the order of importance (10 highest, 1 lowest) as to how they felt they would affect their choice of hospital for a Consultant post. The Consultants were asked to rank the same 10 factors, recalling how they had affected their decision to apply for their current appointment. If the Consultants now felt the order of importance should change, after having been in post for a few years, they were given the opportunity to re-order the factors. There was space on the questionnaire for additional comments if either group felt an important factor wasn’t listed. Finally, the Consultants were asked to rate their current job satisfaction giving reasons for their answer.

The results for ranking that appeared on the questionnaire were:

Location of Consultant post / need for relocation  
Partner’s occupation / location  
Access to dependents  
School catchment area  
Available job plan  
Departmental culture / ethos  
On call commitment / structure  
Academic / research opportunities  
Case mix / specialties offered  
Private Practice

The Results

In total, 137 questionnaires were sent out with 64% (36) of consultants and 44% (36) of SpRs returning a completed form. Of the Consultants who replied 70% were male and 30% female; 78% had children. Most Consultants had been in post for 1-5 yrs. The response from the SpRs was split equally, 50% male to female, and 74% had children at the time of the survey. A greater number of male SpRs had children. SpRs from all five years of training were represented among the returned questionnaires.

Both groups ranked the ethos of the department to which they would be applying as the most important factor to consider. The top six choices for each group are shown in figure 1. Five Consultants (14%) stated that they would alter the importance ranking of the factors after having taken up their Consultant post. Of those that made changes departmental ethos was ranked higher and available job plan was ranked lower. The two groups also agreed on the 4 least important factors. In descending order these were access to dependents, school catchment area, academic and research opportunities and lastly private practice.

The main difference between the two groups was that Consultants placed a greater emphasis on case mix and specialties offered, whereas SpRs placed a greater emphasis on their partner’s occupation and location. Figure 2 shows how male and female SpRs ranked the 10 factors. Female SpRs rank their partner’s occupation/location as their first priority and also place a greater emphasis on access to their dependents when compared to the
male SpRs. Factors related specifically to the job itself are ranked lower. Male SpR rankings are closer to that of the Consultants (predominantly male); however they too place a greater emphasis than the Consultants on their partner’s situation, ranking this the 3rd most important factor.

Many respondents cited extra factors that they felt were important and that weren’t listed. These comments are represented by the following statements:

<table>
<thead>
<tr>
<th>Consultants</th>
<th>SpRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential for skills development</td>
<td>Flexibility / development</td>
</tr>
<tr>
<td>Colleague encouragement</td>
<td>opportunity</td>
</tr>
<tr>
<td>Current Consultant opinion</td>
<td>Forward thinking / modern</td>
</tr>
<tr>
<td>Department keen to appoint you</td>
<td>department</td>
</tr>
<tr>
<td>Enjoyment in the department</td>
<td>Attitude of surgical</td>
</tr>
<tr>
<td>as a trainee</td>
<td>colleagues</td>
</tr>
<tr>
<td></td>
<td>Timing of job advert</td>
</tr>
<tr>
<td></td>
<td>Attitude received as a trainee</td>
</tr>
<tr>
<td></td>
<td>Safety / sexism</td>
</tr>
</tbody>
</table>

Of the Consultants who returned their questionnaire 25(69%) commented on their current job satisfaction (figure 3). Of these 9(23%) were very satisfied and 23(65%) were satisfied with their current job. 3(9%) were indifferent and only 1(3%) was very unsatisfied.

The reasons given for being unhappy with or indifferent to their job were as follows:

“It takes years to get the job plan (NHS & PP) that you want”
“Poor hospital senior management”
“Loss of control/autonomy – no longer a professional, just a conveyor belt worker”

The comments made by the satisfied Consultants are represented by:
“Good job plan and working relationship”
“Full and varied job plan with a supportive team”
“Attitude of the department, both trainees and staff”
“Good department with colleagues that listen”
“Professional satisfaction; Professional autonomy”
“stability”

This survey has a number of strengths and weaknesses. The numbers involved are reasonably large and the response rate good for a postal questionnaire. However, we know that non-responders to questionnaires may differ in their attitudes and views which can skew results. The participants in this survey knew that the questionnaire, although anonymised, was being returned to a colleague and this may have biased the answers given. This may account for the low rating given to the importance of private practice and the more socially acceptable greater emphasis placed upon the partner’s situation. The main purpose of the survey was to give an indication of and insight into what motivates us to apply for a particular Consultant post and I believe this was achieved.

So for any departments out there in need of attracting candidates, be careful how you treat your trainees as this is a proxy for departmental ethos! If relocation is likely to be required to undertake a Consultant post it is apparent that this will be unattractive to many candidates. However, a well thought out and attractive relocation package may help to entice the right person.

For all those trainees who are at the point of applying for that all-important Consultant post, give careful consideration to your potential future colleagues; anaesthetic, surgical and support staff. They will become part of your daily life for a very long time. They are less likely to change but your job plan and other factors can!

At the end of the day though, there will always be an element of that old adage “right person, right time, right place”
The Doctors for Doctors Unit was set up nearly three years ago in response to calls for the BMA to provide a more hands-on service for doctors in difficulty. The stigma associated with doctors becoming ill remains all too prevalent, and one of the core purposes was to engender an environment where doctors feel they can seek help earlier rather than later, thereby avoiding potentially drastic consequences. In 1997, the Royal College of Psychiatrists convened a Working Party looking at the stigma of mental health, which led to the Changing Minds campaign in 1998. The chairman of the campaign, Professor Arthur Crisp, said:

"People suffering from mental disorders often attract fear, hostility and disapproval, rather than compassion, support and understanding. Such stigmatisation not only causes people with mental health problems to feel isolated and unhappy, but may also prevent them receiving help and treatment."

Although applicable to all those suffering from mental health problems, this is of particular pertinence to doctors. The stigma of a doctor being ill often prevents appropriate help being sought. Colleagues and management may collude with this with the result that the doctor ultimately only presents when there is a crisis, and treatment and support becomes more problematic. Both the GMC and the NCAS acknowledge that many of their cases concerning health issues could have been averted had the doctor sought help at an earlier stage. A culture change needs to be encouraged within society and within the profession that ‘permits’ doctors to be patients whilst also recognising their particular health needs. This need not compromise patient safety. In fact, a more open environment may encourage doctors to come forward earlier for help which may actually improve patient safety.

Doctors face an inordinate amount of stress and because of this stigma simply push any problems they might be having to the bottom of their pile. They may not want to seek help through the regular channels, preferring an informal corridor consultation instead. Those doctors who perceive they do have a problem also often face the task of having to determine where they can seek help. The worst possible thing for them is to then encounter seemingly insurmountable obstacles, causing them to give up. It is vital that this system is simplified and yet remains robust enough to provide the necessary help. For a doctor to ask for help often takes a lot of courage and if the call is met with an engaged tone or an answering machine message, they might not try again.

For those doctors who have been suspended, there is usually a tangible loss of self, of feeling professionally and personally destroyed. Suspended doctors are often isolated as they will not be allowed any contact with colleagues/friends within the hospital or surgery who might otherwise provide invaluable support.

Whilst much is written about the importance of doctors’ health, the most important point is to ensure doctors give themselves ‘permission’ to make that first call to ask for help. Although the BMA Counselling Service deals with nearly 2,500 calls a year, anecdotal evidence suggests this is still a low uptake compared to employee assistance programmes for other professions.

The Doctors for Doctors Unit provides a ‘one-stop shop’, accessed through BMA Counselling where the caller is given the choice to speak to either a trained telephone counsellor or
being given the details of a doctor-adviser. Sometimes doctors prefer to share a problem with a colleague, especially in areas relating to disciplinary matters or suspension. The doctor adviser provides reflective space for the doctor in difficulty to talk through issues to help gain insight into his or her problem and support and help the doctor move on. A wide range of problems is dealt with, such as drug and alcohol problems, bullying at work and mental health issues, in addition to doctors who have been referred to the GMC or NCAS. The service does not provide diagnosis or treatment, although, inevitably, any talking through of issues is going to have a therapeutic effect. The aim of the Doctor Advisory Service is to help a doctor gain insight into his or her problem and to support and empower them, adopting a holistic approach to care. The reflective space is the most important aspect of this, giving the doctor time to reflect, thereby helping them to clarify and perhaps prioritise their problems.

The service is completely confidential and a doctor can choose to remain anonymous. However, if a doctor-adviser learns that patients may be in danger, he or she has a duty as a doctor, to act to prevent harm. The doctor-adviser will try and encourage the doctor to change whatever presents a risk to the patient. Failure on the doctor’s part to give an undertaking to stop putting patients at risk will mean that the doctor-adviser will have to take advice on how to act, and this may be by contacting the GMC. Spotting a problem early on helps to alleviate potential problems later. It is crucial that doctors recognise the symptoms that might lead to stress, depression, etc. It is also important to ensure doctors have a ‘toolkit’ than enables them to ask for help when they feel the need. The Unit, on its section of the BMA website, has a resource pack, detailing various associations and organisations which are providers of general and specific help for doctors in difficulty.

For every doctor who presents in a crisis there are many others suffering in silence simply not being able to cope with the day-to-day pressures of their job. By beginning to change the culture from both within and outside the profession these doctors will feel able to ask for help at an early stage and this can only be to the benefit of themselves, their families and ultimately their patients.

Michael Peters
Dr Michael Peters is head of the BMA’s Doctors for Doctors Unit and a member of AAGBI’s Welfare Committee.

To access the services mentioned, telephone BMA Counselling on 08459 200169, or visit the web page www.bma.org.uk/doctorsfordoctors

---

CLEVELAND SCHOOL OF ANAESTHESIA

New Intense 3 day OSCE/ Viva Course for Primary Exam

Candidates will attend 9 vivas and 32’ OSCE stations
Intense coaching in OSCE and Viva technique via interactive tutorials

THE JAMES COOK UNIVERSITY HOSPITAL
MIDDLESBROUGH

10th - 12th January, 2007
Course Organiser: Dr Sean Williamson

Non-residential course fee: £375
Includes course dinner plus lunch and refreshments throughout the course

To secure your place please contact:
Mrs Pat McSorley - Course Co-ordinator
School of Anaesthesia, Cheriton 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

Anglia Society of Regional Anaesthesia

Lecture and demonstration course on

Local Anaesthesia and Peripheral Nerve Blocks

Addenbrooke’s Hospital, Cambridge

February 20th – 21st, 2007

Limb block demonstrations
Workshops
Anatomy

Organisers: Dr M J Herrick Dr A M Sardesai

Further information and application form from:

Dr. A M Sardesai
Dept. of Anaesthesia, Box 93
Addenbrooke’s Hospital
Cambridge CB2 2QQ
Tel: 01223 217434
E-mail: anand.sardesai@addenbrookes.nhs.uk

Registration fee: £250 Approved for C.M.E.
THE MERSEY WEEKENDS

Primary FRCA OSCE Weekend
2 pm Friday 5 – Sunday 7 January

Master Classes in
History Taking Skills
Resuscitation Skills
Clinical Equipment Skills

Machine Checking
Basic Radiology
Clinical Examination Skills

Communication Skills
The Simulator OSCE

+ ‘The Shivathon’
(Dr Shiv Singh’s Celebrated Four Hour OSCE Slide Show)

Group Study & Analysis of the Silent OSCE Stations

The Object of the Exercise is, in the time available, to Expose Candidates to as many as possible of the Challenges the College might deliver in the OSCE. The candidates cover as much of the OSCE material as those on the week-long OSCE/Orals course. The Course Faculty is confident that any who attend this course will Pass the imminent RCA Primary OSCE Examination.

As a mark of that confidence, any candidate who subsequently fails will merit a £100 refund of the Course Fee.

Primary FRCA Viva Weekend
2.00 pm Thursday 28th – Saturday 30th December

Intense Presentation Practice
Long Sessions
Unique Modus Operandi
Authentic Ambience

Wide Coverage of Syllabus
Mind-Bending Experience
Replaces Childish Apprehension with Mature Confidence

+ Master Class in Presentation Skills

+ Review of Extensive Catalogue of Examination Vivas

To avoid
Disappointment, Disillusionment and/or Discontent,
it is important that prospective applicants for the Viva Weekend Courses appreciate that there are No External Examiners. Further, there are No Handouts

This is a Mean Courses with a Mean Master and a Mean Discipline
But It Works

(See Website (Classes & Courses) for Feedbacks which will Confirm its Value)

Weekend Course Fee £250
Breakfast / Luncheon / On-Going Refreshments / Water / Sweets / Fruit
University Hospital Aintree
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 included in the cost of 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](http://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 more than two weeks 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.

SCOTTISH SEMINAR
To be held at Scone Palace, Perth
CLINICAL EPIDURAL ANAESTHESIA
Thursday 8 March 2007
Organiser: Dr M Stoneham, Oxford

Sponsored by:

- Anatomy of the epidural space
- Awake and asleep issues and consent
- Epidurals and anticoagulation
- Epidurals and outcome studies
- Why epidurals fail

Local co-ordinator: Dr C Connolly, Dundee

THE ‘CATEGORY 1’ CAESAREAN SECTION:
DELIVERING SAFETY FROM CHAOS
Wednesday 14 March 2007
Organiser: Dr M Kinsella, Bristol

- Acute fetal compromise – assessment and obstetric decision making
- Intrauterine resuscitation
- Anaesthetic decision making
- Emergency anaesthesia for the high risk woman
- Teamwork, communication, lessons from critical incidents
- Multiprofessional training and drills in obstetrics

FIBROOPTIC ENDOSCOPY AND INTUBATION
Thursday 15 March 2007
Organiser: Dr S Benham, Oxford

- Airway training
- Fibreoptic equipment and airway aids
- Difficult fibreoptic intubation
- Other uses of the fibrescope
- Awake fibreoptic intubation: Preparing the patient
- Awake fibreoptic intubation – Videos
- Demonstration of equipment and practice on Oxford box

SCOTTISH SEMINAR
To be held at Scone Palace, Perth
ANAESTHESIA AND THE ELDERLY
Friday 9 March 2007
Organisers: Prof C Kumar, Middlesbrough
& Prof C Dodds, Middlesbrough

Sponsored by:

- Do physiological changes make a difference during anaesthesia in the elderly?
- Assessment of elderly patients for anaesthesia
- Day case anaesthesia in the elderly
- Anaesthesia for colorectal surgery in the elderly
- Anaesthesia for gynaecological cancer in the elderly

Local co-ordinator: Dr C Connolly, Dundee

CARDIOTHORACIC INTENSIVE CARE
– UNIQUE PROBLEMS II
Thursday 29 March 2007
Organiser: Dr T Strang, Manchester

- Pulmonary hypertension and its impact on CICU
- Right Heart Failure – therapeutic options in the CICU
- Heart failure – selection for transplant and ideal CICU discharge strategy
- The problem thoracic patient – re ventilation and resuscitation
- Airway stents - anaesthetic considerations and implications for CICU
- Alternative anticoagulants for external circulation
- The ICS care bundle – does the evidence apply to us?
Seminars Calendar

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

ULTRASOUND FOR ANAESTHETISTS
Tuesday 5 December 2006

BLEEDING, CLOTTING AND HAEMORRHAGE – AN UPDATE
Tuesday 12 December 2006
Supported by an unrestricted educational grant from Novo Nordisk

SKIING – BEGINNER OR SEASONAIRE?
POST A-DAY PENSIONS, INVESTMENTS AND SKIING (SPENDING THE KIDS’ INHERITANCE)
Wednesday 24 January 2007

COMMUNICATION FOR ANAESTHETISTS
Thursday 25 January 2007

STANDARDS AND EQUIPMENT SEMINAR
Monday 29 January 2007

CARE OF HEAD-INJURED PATIENTS IN NON-NEUROSURGICAL CENTRES
Joint meeting with NASGBI
Thursday 22 February 2007

MANAGEMENT OF MAJOR TRAUMA
Monday 26 February 2007

PERIOPERATIVE MYOCARDIAL INJURY: IMPLICATIONS, DIAGNOSIS AND MANAGEMENT
Wednesday 28 February 2007

GAT: PAIN SEMINAR
Tuesday 6 March 2007

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)

Please note Regent’s Park underground station is closed until June 2007 for renovation.

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
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 ..............

Surname ..................................................................................................................................................

First name ................................................................................................................................................

Address .....................................................................................................................................................

Postcode ....................................................................................................................................................

Daytime phone ............................................ Post held ...................................................................................

Email .............................................................. 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.**

<table>
<thead>
<tr>
<th>Please debit my credit card (Visa/MasterCard/Delta) or Switch Card:</th>
<th>Member</th>
<th>Non-member</th>
<th>Retired Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£120.00</td>
<td>£240.00</td>
<td>£60.00</td>
</tr>
</tbody>
</table>

Card/Switch Number ......................................................................................................................................

Card Security Code ................. (The last 3 numbers printed on the signature strip on the back of your card)

Expiry date ................................................................. Start date/Issue no (Switch only) ..............................

Cardholder’s name ........................................................................................................................................

Cardholder’s signature ................................................................. Date ..............................................................

**Cancellation Policy**

All cancellations must be received in writing. Written cancellations received at least fourteen days 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.
Limited Edition Prints
– a special offer for members of AAGBI

Julie Brixey-Williams’ year as the AAGBI’s first ever Artist-in-Residence (supported by a grant from the Leverhulme Trust) ended in 2004 with an exhibition at Portland Place entitled ‘Traces of the Invisible’. Featuring art inspired by Julie’s direct involvement with anaesthetists and anaesthetic technology, the show was a sell out and many pieces now grace the walls of anaesthetic homes, offices and departments around the country. And, of course, the downstairs corridor at Portland Place, for those of you who’ve eaten there recently.

One of the most popular series was the Flow Loop Calligraphies; translations in Chinese ink and shellac of images from the anaesthetic machine, themselves in turn visual representations of anaesthetic phraseology spoken into the machine by the artist.

Four of these hand-drawn images have now been reproduced as giclee prints, each signed and authenticated by the artist. These are high quality digital prints on museum quality archival paper, limited to fifty of each image.

Julie would like to offer these attractive works to AAGBI members at a discount to the open market price. With Christmas coming and departmental budgets still in credit (!) here’s an opportunity to own a unique artwork inspired by the work you do. Each image measures 20” x 24” and the prints are priced at either £190 unframed or £230 framed in a plain black frame with an off-white mount. Postage and packing is extra, but there’s no VAT. £10 from each print sold will be donated to the Association’s Overseas Anaesthesia Fund.

If you would like to make a purchase please contact Julie on 07950 931796 or by email at juliebw@hotmail.com.
Looking across from the Welsh side of Offa’s Dyke at the NHS reforms in England and the mayhem that has resulted one might feel a little smug. NHS Wales has gone a very different route to that of England. The increasing involvement of the private sector, global marketisation and the spectre of medical redundancies seem very far away from the Welsh hospital corridors. This may prove a temporary respite though as other pressures build up in Wales. There is no doubt that Wales has a different type of NHS model, both structure and ethos. Westminster politicians have been known to refer rather disparagingly to Wales as the control arm of the great NHS experiment. The amazing thing is that the changes happened so quickly.

THE EARLY STORY

The story started in July 1997 when the UK Government published a White Paper “A Voice of Wales” which outlined its proposals for devolution in Wales. These proposals were endorsed in the referendum of 18th September 1997. A staggering majority of 0.6% in a 50.1% turnout voted in devolution for Wales! The indifference of the Welsh population to the Welsh Assembly continues to this day. But the powers of the Welsh Assembly Government (WAG) continue to grow; just passed by Parliament is the Government of Wales Bill. Once implemented, the Bill will give AMs (assembly members) new powers to recast the Welsh healthcare scene. Just seven years after passing authority down to Cardiff Bay, Parliament has given healthcare law making powers to the WAG.

THE STRATEGY

The saving grace in this potentially powerful Assembly is that it has been mostly a power sharing government with no big majority to drive forward radical changes. Despite this power vacuum, policies have been generated which have led to the divergence of NHS Wales. Some of these differences are:

- Local Health Boards instead of PCT’s, the LHBs act as Commissioners. The 22 LHBs are coterminous with Local Authorities.
- A holistic approach to healthcare to provide seamless care with social services.
- No Health Authorities, but three Regional Offices to keep Trusts at arm’s length from WAG.
- No payment by Results
- No Foundation Trusts
- No Independent Sector Treatment Centres (ISTCs)
- A different Consultant Contract
- No anaesthesia practitioners.

These are some of the obvious differences but other subtle changes have a dramatic effect on some specialities – for instance, Welsh ITUs contributed to the data which informed “Comprehensive Critical Care Review”, but the monies poured into Critical Care following the review has never reached Wales. Some of the differences listed have a distinct benefit and it could be said that the dramatic events in England have not occurred in Wales because of this.

The seamlessness with social services has not materialised and the original holistic approach has been replaced with hardened
and time framed targets. Following enormous pressures from Welsh MPs in Westminster, waiting times are now the top priority. As in England, ministers are offering Welsh patients the choice of where to be treated if they have had an excessive delay. The unfortunately named “Second Offer Scheme” has produced some small reductions in waiting times. Now there has been a further policy change; in 2005 Designed for Life was published, which was the blueprint of reform of the NHS in Wales.

The good old-fashioned DGH could become a relic of the past if WAG has their way, as they try to win over support for a drastic redesign of the NHS in Wales. The drastic redesign has not come out of the blue. Three years ago Derek Wanless’s report, “The Review of Health and Social Care in Wales”, warned that the current pattern of hospital delivery, established in the 1960s, was simply not sustainable. In his report in 2003, Mr Wanless emphasised there would be no gain without pain. Tough decisions on hospital provision would have to be made. The response of this dire warning was the Designed for Life document.

Designed for Life has set ambitious targets - 700 more doctors by 2010 and 6,000 more nurses. The strategy is built on keeping people out of hospital by treatments at local centres or at home. GP services are to be expanded and networks are to be formed to provide diagnostic work and a wide range of services. Meanwhile specialist services will be centralised in a bid to streamline the existing provision and to reallocate budgets. Unpopular decisions will therefore have to be made.

THE REALITY

Already the proposals are hitting public opposition! Local plans to modernise hospital services have been out to consultation. The loss of some local hospitals has been accompanied by large public protests. The Local Development Plan monies arrive at the Trust at the same time as cuts are made because of the financial deficits—almost a schizophrenic situation! Already the time line is slipping; beds are being lost due to financial cut backs; services will be affected by the 2009 EWTD hours reduction; the public are not engaged to the changes being made --- disaster fast approaches! Professor Mike Harmer predicted the arrival of “Armageddon” in his Anaesthesia News editorial in May 2006, perhaps his adopted home will experience the reality of this!

What do anaesthetists in Wales feel about the current situation?

A straw poll carried out at several meetings around Wales found some common difficulties which concern Welsh anaesthetists. The most feared is the changes produced by MMC and therefore is shared with the rest of the UK. The fear of the unknown generated by the radical changes in training can be felt in all institutions in Wales. No doubt August 2007 will prove to be an interesting month!

The Consultant Contract on the whole has been reasonably well received by the profession although there are pockets of unrest. Just as in England, politicians and managers failed to appreciate how much work consultants were doing for nothing under the old contract. WAG attempted to deliver the contract with a hands-off approach, allowing individual trusts to implement the contract as they saw fit. The failure of the Assembly to fully fund the sessions identified by trusts led to a BMA Welsh Council resolution of no confidence in the ability of the Assembly to implement the Consultant Contract, which remains in place at the time of writing. Welsh BMA and WAG have not officially communicated since that resolution was passed. The initial fanfare of a significant improvement over the English contract has given way to a view that an opportunity was lost by poor implementation. The mechanism to maintain a professional contract; sessions of 3 to 4 hours each with an average working week of 37.5 hours, rather than increasing the professional nature of the contract resulted in some trusts arguing over 10 minutes here or there and whether lunchtime was working or not. An overhaul of the discretionary points system produced commitment awards available to all but the most poorly performing doctors whilst continuing with national clinical excellence awards scheme. The ‘typical’ 3 SPAs has been eroded by local negotiations to an average of 2.2 across Wales. Average paid working week has reduced by about 2 hours per week and the recruitment of additional consultants has been helped by measures within the contract such as the escalator payments that encourages trusts to recruit rather than flog their current workforce.

Clinical Engagement is another common cause for concern within the profession. At national level the advisory mechanism in Wales is undergoing review. The conduit to WAG is the Welsh Medical Committee, which acts as an executive committee overseeing Specialty Advisory Groups (SAGs). This has tended to be reactive mechanism. The Anaesthetic SAG meets only twice a year. There is no Standing Committee in Anaesthesia for Wales unlike in Scotland and Ireland. Clinicians often complain that their voice is not being heard. ‘Modernisation’ methods are being adopted from England without adequate consultation, finances invested without benefit of worth, and performance management introduced. The Clinical Directorate structure remains similar to that of England, but slow relentless drive towards a management culture continues unabated.

CONCLUSION

Better or not? The patients increasingly are getting a better deal—free prescriptions being very popular. The medical profession’s deal --- OKish at present, when an eye is cast across to England. The future—hard times to come!

Dr. Les Gemmell Council Member AAGBI
Dr. Stefan Coghlan Consultant Anaesthetist,
Chairman Welsh BMA Consultant Committee
Cambridge Final FRCA Courses 2007  
Addenbrooke’s Hospital, Cambridge  
Course Organiser: Dr R Tandon

**Final FRCA Course**  
28th - 30th March 2007

Interactive Tutorials; VIVA Practice; SAQs & MCQs  
“Excellent topic selection, very useful for the exam”  
“Very good layout for the exam in terms of anaesthesia goals and pathophysiology”

Registration Fee: £300.00

**Final FRCA VIVA Day**  
Saturday, 16th June 2007

Consultant led, intensive VIVA preparation course giving trainees extensive VIVA practice for the exam

The aim of the day is to provide candidates with at least 8 hours VIVA practice to give the required preparation and confidence to pass the exams.  
91.7% pass rate of delegates attending.

Registration Fee: £200.00 – Date TBC

**Simulated Advance Airway Course**

Monday, 14th May 2007  
Tuesday, October 16th 2007

Simulation Centre,  
Addenbrooke’s Hospital, Cambridge  
Course Organiser: Dr R Tandon

This is a one-day course designed for the Anaesthetist who wishes to develop their skills in managing difficult airways. This course will also act as an introduction to difficult airway equipment

Aims:
- Effective management of airways  
- Appropriate use of airway technology  
- Emergency airway  
- Use and handling FOI

Registration Fee: £125.00

**Obstetrics Crisis Resource Management & Multi Disciplinary Training**

5th February, 25th April & 26th September 2007  
Simulation Centre,  
Addenbrooke’s Hospital, Cambridge

Aim: To prepare candidates to avoid and deal effectively with Anaesthetic emergencies in obstetric practice. Objectives include:

**Knowledge**
- Maternal risk  
- Assessing risks and case planning  
- Management of obstetric emergencies  
- Decision Making

**Skills**
- Management of the maternal airway  
- Cardiac life support in pregnant women  
- Crisis Resource Management

**Attitudes and Practice**
- Psychological preparation for emergencies in obstetric patients

Registration Fee: £150.00

For further information, please contact: Mr Ashley List, Postgraduate Medical Centre, Box 111, Addenbrooke’s Hospital, Cambridge CB2 2SP; Tel: 01223 217059; Email: al450@medschl.cam.ac.uk
In 1979 an article appeared in Anaesthesia entitled ‘Chloroform at Christmas’ by K Bryn Thomas who served as Honorary Curator of the Anaesthesia Museum from 1965 until 1978. Bryn Thomas wrote extensively on the history of anaesthesia and his publications included The Development of Anaesthetic Apparatus: A history based on the Charles King Collection of the Association of Anaesthetists of Great Britain and Ireland.

Bryn Thomas’s article in Anaesthesia concerned a playbill he had acquired for a harlequinade performed at the Theatre-Royal in Edinburgh in December 1847. At this time the Theatre-Royal was at its most successful and was visited by almost all of the important stars of the day. This particular performance caught Bryn Thomas’s attention because it featured scenes set in “Doctor Chloroform’s Establishment, and Pawnbroker’s Shop”.

The Harlequinade was a short series of comic scenes and had developed from the Commedia dell’arte. The chief characters were Harlequin, the hero and suitor of Columbine. Columbine’s father, Pantaloon and his servant, the clown, also featured strongly. The clown’s role was transformed by Joseph Grimaldi (1779-1837) who became one of the most successful performers of harlequinades. As a result, by the time this harlequinade was performed the role of clown had upstaged that of Harlequin. It is significant, therefore, that the clown takes the lead role in the chloroform sequence in the playbill.

Part of the entertainment of 1847 was the performance of a pantomime. Pantomime had been performed for many centuries but part of its ongoing appeal was, and still is, to enact a popular folk tale or folk legend and to incorporate modern trends to make the entertainment topical. These days, pantomimes can feature everything from genetic engineering to council tax. Bryn Thomas’s argument therefore that the playbill illustrates the impact of the introduction of chloroform is clearly borne out.

James Young Simpson, Professor of Obstetrics in Edinburgh (pictured) was at the forefront of the use of analgesia during labour. He was the first to use ether to ease the pangs of childbirth when he administered it on 19 January 1847. However, he wanted to find a better, more pleasant agent and his research led him to self-experiment with chloroform early in November 1847. He then administered it to relieve the pain of childbirth and reported his work in mid-
### The Association of Paediatric Anaesthetists of Great Britain and Ireland

**Annual Scientific Meeting in conjunction with**

The European Society for Regional Anaesthesia (ESRA)

**G-MEX Convention Centre, Manchester 8th - 10th March 2007**

**Thursday 8th March**

**Regional Analgesia in Children**
- ESRA –APA Specialist meeting
- Lectures from A Bosenberg, B Dalens, PA Lonnqvist & M Johr on novel techniques in regional anaesthesia

**Rotating Workshops (10 stations)**
- Videos, demonstrations
- Interactive discussion

**ASM 9-10th March**
- The extremely pre-term infant
- Debate: TIVA vs. Inhalational
- Technology in Paediatric Anaesthesia
- Evidence based review of vomiting
- Free Papers and Posters
- Trainee prizes

**Jackson Rees Lecture**
- Professor Baroness Greenfield ~ “What is Consciousness?”

---

**For further information contact:**

APA 2007 (Delegate Registration) 21 Portland Place London W1B 1PY. Tel 02076314352

E-mail: apamanchester2007@hotmail.co.uk or consult the APA website: www.apagbi.org.uk
Dear Editor...

Needle Nightmare!
Is this how kids view anaesthesia?

We need your help!
A new project has been set up jointly by the Royal College of Anaesthetists and the Association of Paediatric Anaesthetists of Great Britain and Ireland, to consult with, and design information for, children undergoing anaesthesia. This follows on from the recent success of the RCoA / AAGBI Patient Information Project.

We are aware that many hospitals will already use excellent locally designed and produced sources of information specifically aimed at children rather than their parents. We would like to see as many examples of these as possible. They may take the form of booklets, leaflets, puzzle books, videos, DVDs, access to a local website, Saturday clubs, etc.

We would be most grateful if any examples of information for children used in your hospital could be sent to the project team. We would also value information about the author of the information and the process by which it was produced (e.g. individual author, working group, focus group consultation). The samples we collect will be invaluable in helping to design further information resources after consultation with children having surgery.

The address for the team is:
Anaesthesia Information for Children Project Team
c/o Dr Judith A Short,
Consultant Paediatric Anaesthetist
Sheffield Children’s NHS Foundation Trust, Western Bank, Sheffield, S0 2TH

Sense and Sensibility

From a book on the history of anaesthesia - wild theatre sisters wouldn’t drag the title out of me - I learn that by the end of the nineteenth century, in relation to patients, the anaesthetist’s ‘skill lay in suspending their sensibilities during surgery, and successfully integrating them as a whole at the end of the process.’

Leaving aside the question of whether one can successfully integrate things not as a whole, no one could quarrel with the first part of the sentence, but I had no idea that when I turned patients into the ‘safe’ position at the end of an operation, and handed them over to the recovery room staff, I was successfully integrating their sensibilities as a whole.

Of course it is much too late for me to benefit from this information, but ever mindful of the welfare of our younger colleagues, I suggest that it could be very useful in private practice. ‘Do you wish your sensibilities to be successfully integrated as a whole at the end of the operation? Because that’s extra.’

David Zuck
History of Anaesthesia Society

On call can be a real pain in the neck

I recently went away for a weekend which involved some very amateur surfing. The battle between a rather poor excuse for a surfer and Mother Nature was easily won by the latter. I returned home having been dumped by a wave onto the sandy bottom which caused a ‘bit’ of a sore neck. Having decided I would ignore my wife’s requests to see a doctor (“I am one”, I reminded her), I went to do my on call on Neuro ICU three days later. I was advised by colleagues (to whom I obviously listen more than my wife) to have an x-ray. An A&E visit, x-ray, CT neck and neurosurgical review later I was on my way home with a confirmed fracture of the spinous process of C4, becoming a real pain in the neck for my colleagues and rota writers.

Simon Webster
Specialist Registrar, Frenchay Hospital, Bristol

And I thought I was being brave working on my broken little toe…! Ed

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.
I have been a Staff Grade or equivalent since 1992. All my training had been at SHO level, so I was pretty green when I started. As I acquired regular lists of my own, mainly with Consultant Surgeons operating, I realised I had a lot to learn to provide the surgeons and their patients with the service they required. Study leave was available but funding was not. I was getting pretty good with difficult airways on regular ENT lists populated with, amongst other things, Pierre-Robin babies and adults with upper airway tumours. However, I was not competent with the fibreoptic scope and I didn’t have the money to self-fund one of those very expensive courses. One of our Consultants kindly took me under his wing and taught me the basics over a few lists. I taught myself the rest by reading and practising (two maxillofacial and four ENT lists a week gave me plenty of opportunity to hone my skills!). The satisfaction of learning a new skill to a high level of competence relevant to my day-to-day practice was immense. Dr Iftikhar Parvez went further than this and reported his experience of organising and running a fibreoptic course.

I’m an insomniac and, because journals have fewer side effects than benzodiazepines, I read them to help me get off to sleep (Health Trends was the best – oh how I mourn its passing!). I’d read a lot about something called desflurane and it sounded awfully good. When it came to our hospital it turned out to be every bit as good as all those clever papers said it was and it changed my practice. I got so interested that I ended up co-hosting two European meetings and giving lectures in the UK, Europe and Israel on desflurane and low flow anaesthesia.

Other things followed. In the late 90s I introduced remifentanil to the Trust. It was a lot of work, but the sense of achievement was immense. This awoke my latent interest in total intravenous anaesthesia, leading eventually to more lectures and workshops. Teaching is wonderful – it is satisfying in its own right, but it also forces one to keep up to date.

I have had lots of other opportunities for professional and service development. One of the most rewarding was introducing s-ketamine into the Trust for use in paediatric caudals. The process was time-consuming and frustrating because s-ketamine is not a licensed drug in the UK and for some reason my application would not be accepted without a consultant signature on it even though I’d done all the work! Getting a consultant signature was not straightforward – the first few I approached were quite rightly unwilling to sign the form as they were unfamiliar with the technique, but I succeeded eventually. The rewards were great because the drug has greatly improved the analgesia my paediatric plastic surgery patients receive.

Professional development has kept me interested in my work – what I do now is not good enough; I can always improve. I gave a talk on Job Satisfaction at the College in the 1990s and the thrust of it was to keep learning and improving to stay happy and interested. Dr Ramana Alladi has encouraged us with similar sentiments more than once. (2,3).

So why do I still get frustrated? I’ve spent a lot of evenings and weekends doing the background work for all this development and I hope it is fair to say that I offer my patients and surgical colleagues expertise rather than competence these days. I’ve done it because I have a professional obligation to do so and because it gives me great personal satisfaction, but I also hope that my Trust will acknowledge it fully. I successfully worked my way up through most of the optional points until the
Trust stopped awarding them. This sent out a very negative message to many of the Staff Grades – bottom of the heap and all that. Optional points were recently reintroduced and I was delighted and rather overwhelmed to be awarded two. I then received a letter saying I was already on the penultimate increment and would, therefore, receive one point. How quickly I deflated! I’ve felt like I’ve been doing more of an Associate Specialist’s job for the past few years but have been told repeatedly that it’s not a good time to apply for regrading – the new Consultant contract, Foundation status, financial crises etc. etc. always take priority. Bottom of the pile again. That’s the problem – we are always the last item on the agenda; there are other, higher priorities. Career development opportunities exist in theory, but so often not in practice, and I am by no means alone in my experience. That is why I, and many others, sometimes feel frustrated and helpless.

This article isn’t just a whinge – I’ve thought a lot about what makes me and many others happy or otherwise at work. I was hoping that the new contract would address artificial barriers to legitimate career progression, but the early signs are that it won’t. By career progression I’m not talking about a free ticket to a consultant job (that’s the last thing I want!) but the opportunity to progress, by merit, to the top of the SAS grade, and not to be blocked because other things in other departments take priority. Dr Athur Siddique (4) thinks that the SAS group need recognition and investment and that we are an untapped resource. I agree – we can offer so much, given the opportunity. We are limited in what we can do from within the grades as we have little voice where the decisions are made. The NHS and its Trusts needs to rise to the challenge – we can offer so much more but we need the opportunities or the executive power to create the opportunities ourselves.

Christopher Rowlands
Staff Grade in Anaesthesia, Bradford Royal Infirmary

References
2. Developing an interest as an SAS Doctor. R Alladi, Anaesthesia News, January 2005
The Mersey Selective

Lectures, Tutorials & MCQ Practice & Analysis
Designed to Address those more Esoteric Areas of the Syllabus not covered well in the textbooks and thus considered to require Special Attention & Elucidation, the aim being to Explain & Simplify

2 pm Sunday 18th – 4 pm Friday 23rd February
Liverpool Medical Institution

Sample Subjects from Course Menu

<table>
<thead>
<tr>
<th>Physiology</th>
<th>Pharmacology</th>
<th>Physics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal</td>
<td>Pharmacokinetics</td>
<td>Electricity</td>
</tr>
<tr>
<td>Muscle</td>
<td>Pharmacodynamics</td>
<td>Pure Physics</td>
</tr>
<tr>
<td>Exercise</td>
<td>CVS Pharmacology</td>
<td>Damping</td>
</tr>
<tr>
<td>Altitude &amp; Depth</td>
<td>Isomers</td>
<td>Mechanics</td>
</tr>
<tr>
<td>Acid &amp; Base</td>
<td>Statistics</td>
<td>Measurements</td>
</tr>
</tbody>
</table>

Sample Assessments of the The Mersey Selective September 2006
NB. Only one Comment per Lecturer/Lecture Quoted

‘Well explained, clarified many points that confused me …..Great lecture’
‘Clear concise explanations, engaging speaker …..Very good, easy to understand’
‘Covered such a poorly understood topic with sparse information in books with excellent presentation. Brilliant’
‘Blistering performance! Absolutely top class lectures, so good you don’t realise you’ve been lead into understanding complex physiology’
‘Dr N’s lectures were fantastic. He has a real talent for explaining important + difficult concepts. Thank you.’
‘Nobody does this like him almost makes it seem easy’
‘Good, clear slides, liked the MCQs mid-lecture …..Content clear and to the point’
‘Fantastic lecture, made the whole topic very easy to understand with special emphasis on what to expect in the exams – really helpful’
‘Very basic with excellent emphasis on what to expect and some top tips’
‘Very informative/thought-provoking … Scary as ever but very useful tips’
‘Absolutely excellent ….. Fantastic analogies’
‘Excellent teacher. Very exam focused, explanations were clear and to the point’
‘Superb graphics and use of powerpoint, well delivered’
‘And the best slides of the week’
‘Excellent …..Slick …..Very well presented – Made the topic appear very manageable’
‘Excellent …..Very interesting lecturer’
‘Excellent …..Very enjoyable, nice end to the course’

General Universal Generic Comment
‘Food (at the Everyman Bistro - www.everyman.co.uk) was excellent’

£300
For further Assessments & Application Forms
WWW.MSOA.ORG.UK
Improving practice in regional anaesthesia: The risks, the options, the future

How can we improve practice in regional anaesthesia?
You are invited to attend a symposium to discuss with leaders in the field the risks, the options and the future of regional anaesthesia.

London
Thursday 9th November 2006 from 10.30-4.30

Manchester
Wednesday 29th November 2006 from 10.30-4.30

We will also be holding meetings in early 2007 in central and northern England. For further up to date information contact your Abbott representative.
‘Tis the season to be jolly – but not if you happen to be on call all over Christmas. Bah! Humbug! With a bit of luck this Christmas may be my last one on call. My retirement is not imminent, but with eight consultants on the ICU rota, even if previous form is not taken into account, I may just get away with it.

When I was first appointed there were only four of us on the rota, and as a party animal, always wanting New Year off, I seemed to do an awful lot of Christmases. I have tried to explain to my current colleagues that as I had already done more than my share of Christmases, I should not have to do any more, but I am told that this argument is flawed. Using this same logic I have already been on call for far more weekends than they will ever be required to do. Should I stop doing weekends as well? I recommend the idea to the house!

Since I started as a consultant, Christmas in the hospital has changed greatly. Alcohol was not only available, but so freely imbibed by some staff, including doctors and nurses, that we said (only partly in jest) that patients well enough should be sent home for their own safety! Now, of course, there is no alcohol – and quite rightly so. The consultant in times gone by, lord and master of his own ward, would come in wearing his new tie and jolly sweater (obviously Christmas presents from the family, never to see the light of day again after Boxing Day) to carve the turkey for Christmas lunch to be served on each ward. Now that consultants have lost ‘ownership’ of their patients to Trust managers, perhaps the managers should take over this function. Perhaps some manager is busy formulating a turkey-carving protocol at this very moment. The wards used to be decorated lavishly with no trace of MRSA on the baubles or paper chains. Protocol at this very moment. The wards used to be decorated lavishly with no trace of MRSA on the baubles or paper chains.

Perhaps some manager is busy formulating a turkey-carving protocol at this very moment. The wards used to be decorated lavishly with no trace of MRSA on the baubles or paper chains. Perhaps some manager is busy formulating a turkey-carving protocol at this very moment. The wards used to be decorated lavishly with no trace of MRSA on the baubles or paper chains.

In the interests of increased productivity (screwing doctors down even further?) it has been suggested that the Christmas period should be taken by all as annual leave. But what about Intensive Care, Obstetrics, Acute Pain, trauma and ‘NCEPOD’ type lists which are independent of elective work? Covering these commitments and providing an ‘on call’ service would mean that relatively few anaesthetists could be given annual leave. Our Trust, like many others, is currently reviewing the whole business of leave for medical staff. As part of this, for some reason known only to itself, it is attempting to make everybody’s leave year finish at the end of March. As there is usually a flurry of leave-taking as one’s end-of-leave-year approaches, it would seem to make sense to continue to stagger leave throughout the year. No doubt there is a plan to make all consultant appointments and retirements fixed on April 1st to tie them all nicely into the tax year and April Fool’s day. (“What do you mean you are starting here today as a consultant? – April Fool!”)

Earlier this week it took me under ten seconds to insert a cannula into a vein on the back of a patient’s hand, tape it in place and give a relaxing shot of Midazolam. The ward nurse then spent as long as it took me to anaesthetise, intubate the patient, wheel him through to the operating table and re-connect him as long as it took me to anaesthetise, intubate the patient, wheel him through to the operating table and re-connect him to monitoring and a ventilator, to complete a new 3 page form which I had never seen before, entitled ‘The Peripheral Cannulae Care Plan’. All this was apparently required for a cannula that would be removed in recovery an hour later! In my impetuous youth I would have torn the form up as soon as it was filled in and thrown it away. Alas, the fire in my belly has gone out (well, not quite, but that’s another story!), and I realise with resignation that the paper-free NHS that was promised to us by 2002 by Mr Blair now is further away than ever. I think I shall try to do my bit for a paper free NHS by not filling in any forms, including anaesthetic charts, fluid charts etc. and make all my orders ‘verbal orders’ from now on, and see how that goes.

We recently had a well-known television personality admitted to one of our local hospitals, and as I drove in through the waiting press cordon who peered into my car in case I was...
someone important enough to feature on their next news item (ie another television personality come to pay a visit), I was reminded of a previous occasion at the same hospital. On that occasion, in the interest of security, the identity of the patient was not disclosed to the hospital in advance only that top level security would be necessary. Instead of a press cordon, a police cordon complete with police marksmen and dog teams was to be put in place. The hospital manager put two and two together and, bearing in mind the relative proximity of the hospital to various Royal residences, suspected that the proposed patient may be of blue blood.

In preparation for such an important, high profile patient, the hospital management leapt into unprecedented action. A new carpet was hurriedly laid, silk sheets and a bone china tea service were placed in the best private room, and staff were instructed on the correct protocol for the administration of injections to royalty. What a let down! The VIP turned out not to be a member of the Royal Family, but a less illustrious personage who had had threats made against him. I always wondered what he thought of the new silk sheets. The final twist in the tail with this story was that the Resident Medical Officer on call that night was a nice doctor from the very nation which had made the threats!

This also reminds me of the experience of a friend of mine who had the honour of anaesthetising a Royal prince who had sustained an injury. Realising that, although Royal, his patient was likely to be as nervous as any other about to undergo an emergency operation and, as part of his usual anaesthetic room patter, he asked “What would like me to call you when I am wakening you up?” The prompt response was “Your Royal Highness of course!” No knighthood for him – and no point in studying the New Year’s Honours list! Whether you expect to see your name there or not, I wish you a Happy New Year.

Invitation to develop your ideas in Anaesthesia

Indigo-Orb is a medical device company based both in England and California. We have devised a new syringe for Epidurals namely the “Autodetect / Episure”. This was launched in 2005 across Europe and has received extremely favourable feedback. The continuing trials being conducted by Stanford University and the multi-centre trials across Europe are a success and in 2006 the product is being launched within the USA. Our mission is to achieve better health care at an affordable price.

Dr Riley at Stanford University has successfully carried out initial trials. We have received great reviews from BWH, Harvard, Duke University, and the Mayo Clinic in the USA.

We are well aware of how often practising clinicians harbour an idea for an improvement to an existing clinical device, or nurture an idea for a brand new development. The journey from concept to market is long and hard but with the right help, it can be made easier.

Indigo-Orb would like to offer the same opportunity to British and Irish Anaesthetists who have ideas and wish to take them forward. With your idea, together we can:

- Design, engineer, and produce a prototype
- Develop an Intellectual Property file
- Apply for a CE Mark and FDA approval
- Organise the clinical trials
- Explore the Market
- Sell Globally

You will be involved every step of the way.

With the help of our team, your product can be sold globally just like our Autodetect/Episure LOR Syringe.

Remember 99% of people have ideas but only 1% implement them.

Should you be interested, please do not hesitate to contact me on:

Bobby S Shah
Vice President Of Sales & Marketing
indigo-orb inc.

email: bshah@indigo-orb.com
website: www.indigo-orb.com
Tel: +44 7973 722 302
Fax: +44 870 134 0410
1st AINTREE DIFFICULT AIRWAY MANAGEMENT COURSE (ADAM)

“What you really need to know about airway problems but have never been taught”.

A new philosophy for anticipated difficult airway management. A systematic methodology based upon:

Knowledge Experience Dexterity

We deliberately bring together airway enthusiasts of all abilities

We teach a problem-centered, hands on approach to learning the skills needed for any and every situation based upon patient assessment, plan formulation, execution and postoperative care.

Places are limited to guarantee groups of 5 delegates to an instructor with manikins and simulators.

Resuscitation Training Department
University Hospital Aintree
Liverpool L9 7AL

Friday 9th – Saturday 10th February, 2007.

£375 (includes lunch and evening course dinner).
Closing date for entry is 15th January 2007. Full prospectus on receipt of application.

For further information and booking please contact:
Mrs. Denise Morgan – O’Neill, Office and Information Manager
Email: adam.aintree@nhs.net  0151-529-5153
CONFERENCES & EVENTS
Centre for Anaesthesia, UCL and associated groups
on-line booking link and further details for all events can be found at:
www.ucl.ac.uk/anaesthesia/meetings


4th Paediatric Sedation: How to do it Safely
IET/Savoy Place, London, 7th & 8th June 2007, Chair: Dr Mike Sury, GOS, London
CALL FOR ABSTRACTS
We invite you to submit abstracts of audits in relation to Paediatric Sedation, either prospective or retrospective, in particular those featuring new care plans, treatment protocols and the use of Ketamine vs. other sedation agents vs. no sedation! Any work is acceptable which has not been accepted for publication in peer review journal by the abstract deadline of 31st January 2007. Submission should be a maximum one A4 page and emailed to SiobhanMythen@btinternet.com by 31st January 2007. A number will be accepted for poster presentation and finalists will be asked to present at the Paediatric Sedation Conference 2007

6th EBPOEM: Evidence Based Peri-Operative Medicine Conference
- Professor Lee Fleisher, Assessment and reduction of cardiac risk in non-cardiac surgery
- Professor George Hall, Anaesthesia and modulation of the stress response
- Mr Alan Horgan, Colorectal surgery: Improving care through optimising and auditing my practice.
- Professor Gavin Kenny, Remifentanil: The perfect peri-operative opioid
- Dr Ross Kerridge, Implementation of peri-operative systems: an international perspective
- Professor Henrik Khelet, Enhanced surgical recovery: simple steps to improve surgical outcome
- Dr David Lubarsky, Pharmacological protection for AAA surgery
- Professor Mervyn Maze, Anaesthesia: A molecular conundrum
- Professor Don Poldermans, Peri-operative medication
- Dr Andy Rhodes, Anaesthesia for bariatric surgery
- Dr Neil Soni, An ideal peri-operative fluid
- Professor Matt Thompson, Vascular surgery: improving outcomes and changing practice
- Professor Jean-Louis Vincent, Epidemiology and prognosis of organ dysfunction after major surgery

Provisional agenda, venue and booking details available at www.ucl.ac.uk/anaesthesia/meetings
(Did you know 2007 Tour de France is scheduled to start from London on the morning of Saturday 7th July?)

“Dingle 2007”: 9th Current Controversies in Anaesthesia and Peri-Operative Medicine
10th-14th October 2007, Dingle, Co. Kerry, Ireland
CALL FOR ABSTRACTS: £1000 in prizes
We invite you to submit work for poster presentation. Selected finalists will be invited to give an oral presentation in Dingle on Friday 12th October 2007. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 30th June 2007. Abstracts should emailed in the form of one A4 side of printed text and in word or PowerPoint on or before 30th June 2007 marked clearly with your name, address, telephone number and email address.

Contact: Siobhan Mythen, Event Administrator on behalf of Centre for Anaesthesia, UCL
E-mail: SiobhanMythen@btinternet.com
Today was the start of a complete ban on smoking in my Trust. We are forbidden to smoke in any part of the buildings or grounds, including in vehicles parked in the car parks. Although it was very pleasant not to run the smoke and fag-end gauntlet on entering the premises this morning, the day has proved taxing as, one by one, the few members of theatre staff who still smoke reached the end of their tether. Actually, it has been such a bad day I have seriously considered taking up the weed myself.

One of the nurses has solved the problem by taking advantage of the free nicotine gum on offer but is still looking pretty murderous. Fortunately he is not assisting me today. A most ingenious solution has been found by the desperate orthopaedic surgeon with whom I am working this afternoon. Three or four times he has driven off site and round the block in his Mercedes, blissfully puffing away on his pipe. He tells me he intends to put in travelling expenses for the mileage! I believe him.

We are all wondering what is to happen to the now empty smokers’ shelters scattered all around the site – perhaps they can be converted to bike sheds when we are not allowed to drive to work because it’s bad for you.

This is just another in a long string of intrusions on personal choice instigated by the Trust over the last ten years. As a life-long non-smoker I am relieved not to have to breathe smoke in my workplace but have some sympathy with the addicted. Also where will it all end? Will pop and crisps be banned next from the cafeteria and shop? Will we all have to wear sensible lace-up shoes? What about caffeine, the only thing (apart from Sleek adhesive tape) that keeps the NHS from collapsing?

And what about the approaching festive season? There was a time when consultants and their respective families came in on Christmas morning, wished everyone a Merry Christmas, gave sister a bottle of sherry and a box of chocolates and went home for their own lunch. The hospital would be decorated in cheerful bad taste and carol singers would go round the wards entertaining the patients. Elderly long-waiters with no family would be offered surgery on Christmas Eve so they could be in over the holiday period. Everyone had a good time.

A complete alcohol ban on the Trust premises, and last year a ban on decorations in clinical areas for fear of MRSA infection (or is it CRAP, Cheer Resistant Active Pathogen?) have put paid to good spirits on the wards at Christmas time. The latest cost-saving measure, to close half of the surgical and the gynaec wards at week-ends, will even stop those ladies who in the past would choose to treat themselves to a Christmas hysterectomy as a punishment to their family for all the turkeys and puds slaved over while the kids were growing up.

I’m just wondering what Scrooge management will think up this year. Perhaps a ban on the nurses wearing twinkly festive earrings or the porters sporting Santa hats because it is unprofessional. I am pretty sure that quite soon we will not even be allowed to call it Christmas in the interest of political correctness and diversity, and will have to resort to the awful, American ‘Happy Holidays’.

Anyway, to cheer myself up (and entertain me during the trauma list) I have composed a little musical parody to help me through the run-up to Christmas. Based on fact, it more or less describes and is inspired by a day in the life of the trauma anaesthetist.

Sung in reverse order:

On the twelfth day of Christmas my true love sent to me
Twelve patients waiting
Eleven in the day-room
Ten notes a-missing
Nine F1’s effing
Eight porters prancing
Seven sisters dancing
Six surgeons stressing
Five old dears
Four falling drunks
Three greensticks
Two trauma lists
And a Twix with a nice cup of tea!

Happy Holidays!

Gas Flo