Podiatrist – friend or foe?

by David J Wilkinson and Trevor Prior

The Reason ‘Why?’

When one of the authors (DJW) was Honorary Secretary of the Association of Anaesthetists, he received a steady trickle of letters relating to members’ anxiety over their status if they were asked to provide anaesthesia for surgery performed by a podiatrist. This uncertainty continues today.

The other author (TP) has experienced considerable interest, and some hostility, in his work from surgeons, physicians and nursing staff. Through his own investigations and as an elected member of Council for the Society of Chiropodists & Podiatrists, he has been able to provide written assurances for these various groups.

In addition, the opening of a new day surgery centre at St. Bartholomew’s Hospital had provided the two authors with an opportunity to develop an understanding of each other’s speciality. Following further enquiries from surgeons, anaesthetists, nurses and managers, they were able to provide a balanced appraisal of the possible roles each speciality could play for the other.

Because rumours, innuendoes and what appears to be complete ignorance continue to be purveyed by ‘authoritative figures’, this article has been written to try to give clear and unbiased information for anaesthetists. These are personal views and do not necessarily represent the views and or policy of the Association of Anaesthetists.

What is the difference between a chiropodist and a podiatrist?

Chiropodist is the commonly used term in this country although podiatrist is the more universal term. While many practitioners will consider chiropody to describe the conservative management of foot disorders, podiatry is generally considered to represent more advanced treatment and surgical intervention.

In addition, the opening of a new day surgery centre at St. Bartholomew’s Hospital had provided the two authors with an opportunity to develop an understanding of each other’s speciality. Following further enquiries from surgeons, anaesthetists, nurses and managers, they were able to provide a balanced appraisal of the possible roles each speciality could play for the other.
the surgical training programme.

A minimum of two years postgraduate experience is required before the primary fellowship examination can be taken. This examination includes multiple choice and essay questions that are set and marked by podiatrists and Fellows of some of the Royal Colleges such as radiologists and orthopaedic surgeons. Successful completion of the examination enables the candidate to begin surgical training.

The practical training is generally undertaken within a Department of Podiatric Surgery for a minimum of two years and involves both outpatients and theatre sessions. Strict guidelines determine the eligibility of a podiatric surgeon to become a surgical tutor, which are monitored by the Faculty of Podiatric Surgery. During this period of training, the candidate has to sit a further written examination, a surgical clerking examination and is required to publish at least one paper. The training culminates with a final practical examination where the candidate is assessed performing a minimum of three surgical procedures.

Successful completion results in a Fellowship of the Surgical Faculty of the Society of Chiropodists and Podiatrists. Professional indemnity insurance is provided by this organisation to the level of two million pounds and this is included as part of the membership package within the membership fee.

Registration
While the Society of Chiropodists and Podiatrists controls training, the Council for Professions Supplementary to Medicine is responsible for the registration of all chiropodists and podiatrists. This organisation controls the state registration of the Professions Allied to Medicine, the pre-requisite for practising within the NHS. The chiropodists/podiatrists board is responsible for the regulation of these members with the ability to rescind state registration if necessary.

Scope of practice
Podiatrists are trained to treat the foot and this defines the scope of practice. Surgery of more proximal structures, for example the knee and hip, does not fall within the scope of practice, is not covered by the professional indemnity insurance and would be indefensible in a court of law. Rumours that podiatrists are trying to start knee or hip surgery are simply untrue and unfounded.

Podiatrists have a limited access to prescription only medicines. These include local anaesthetics (plain and with adrenaline) and pre-determined doses of ibuprofen and coddyramol. Liaison with the patient’s General Practitioner (GP) for specific postoperative medication is essential.

However, the Crown report, a recently published government commissioned report, states that “extended prescribing might, subject to proper safeguards, lead to better patient care”. More specifically, podiatrists who undertake foot surgery are one of the five examples of professional groups ‘which may wish to consider applying at an early stage for the authority to prescribe medicines’.

While patients may self refer or be referred by other health care workers, many are referred by the GP. Liaison with the GP is essential in all surgical cases although some are performed in conjunction with other hospital disciplines (e.g. rheumatology or diabetology). The issue of patient responsibility has been raised on many occasions with some doctors believing they may retain overall responsibility for patients undergoing podiatric surgery. The General Medical Council (GMC) has clarified the issue in its recent handbook and has specifically responded to communication on this subject. The GMC considers that referrals to podiatrists represent exactly that, referral, not delegation, as podiatrists are independent practitioners. As a result, the podiatrist is responsible for their actions, not the GP.

The majority of procedures are performed under local anaesthesia as day case procedures, with podiatrists administering their own anaesthesia. It is worth stressing that all podiatric surgeons are taught basic life support techniques as part of their initial training and most who are active surgically have extended this to advanced life support training. In our District, trainee doctors attend some of the operating sessions to observe and learn ankle block techniques. If procedures are performed under sedation or general anaesthesia, as may be required for children or very anxious adults, then a consultant anaesthetist will be present. Again, the issue of responsibility has been raised in these circumstances. The GMC has clarified in writing that the same issues apply as relate to referrals by GPs and are covered by the guidelines relating to teamwork. In other words, the consultant anaesthetist is responsible for their (anaesthetist) actions, while the podiatrist is responsible for their (podiatrist) actions.

continued on page 6
A New Beginning?

It is the year 2000 and, some say, the new millennium. New Labour is in, new Britain is where we live and a new deal is probably just around the corner. Change will be inevitable.

Anaesthetists have never feared change. The success of many an operating department depends on the anaesthetists who work there being able to adapt to changing circumstances, rapidly.

When most of us became Consultants, we had a ‘fixed’ job plan which, it was intended, would remain unchanged for the rest of our career. When the last round of change hit us, we were asked to sign up to a new, different job plan which itemised everything we did. No longer were we to be trusted to serve our hospital to the best of our ability but now we had to be accountable.

It was a very large hammer to crack some small nuts, few in number. These latter were the few rogues who left for the private sector, for example, with an unfinished list going on. “My registrar will finish”. Sad to say, some of the offenders were anaesthetists.

When the previous round of job plans was upon us, I attempted to explain to a senior manager how signing up to this would mean that less and not more work would be done by consultants, as opposed to the reverse in the ‘we trust you’ scenario. He was almost persuaded but faltered at the last and we all had to sign.

Now, things are changing again. In his article on page eight, Alastair Chambers discusses flexible working. He shows how consultant contracts can be adapted to give a degree of flexibility to cover colleagues’ absences, both planned and unexpected, as well as giving better cover for extra lists and other duties. Truly flexible sessions where each consultant anaesthetist has varied lists from week to week, would be an effective way of covering absence but, as Dr Chambers points out, would not be universally popular.

Beware the deals! One far sighted practice manager of my acquaintance is dealing with lengthening waiting lists by buying extra operating lists in a smaller hospital, presumably with adequate facilities. How much is the anaesthetist being paid? “Oh, I’ve no idea, the surgeon is handling all that”. Another ploy is to try to persuade colleagues to ‘help out’ by doing extra lists for small reward.

No longer can we expect a trainee doctor to cover because, quite rightly, we concentrate on their education and protect their training time. Nowadays, many non-consultant career grade staff have fixed job plans and there is no flexibility available from them for cover.

All this demands an element of trust. Trust from the surgeons that they will be supplied with an appropriate anaesthetist and trust from the managers that all will be fully employed. In return, of course, we should expect our managers to give us the conditions in which to work with appropriate assistance. Is anybody else’s Trust deliberately downgrading the qualifications of its operating department staff?

Perhaps flexibility and trust could be our watchwords. Let us enter the new era by continuing to be as flexible as before and increasing that flexibility by, say, working with other disciplines (see Podiatrist – Friend or Foe?, first page). Can we be flexible and firm at the same time? I suspect we may have to be. Is flexibility – from us, the surgeons and the managers – the answer?

John Ballance
The GAT Committee Elections 2000

Several current GAT Committee members are leaving us this year, having gained consultant appointments. This will leave at least four places waiting to be filled by new faces with fresh ideas. We are therefore inviting you to stand for election. As a trainee member of the Association of Anaesthetists of Great Britain & Ireland (AAGBI), you are automatically a member of GAT and thus eligible to stand. This is your opportunity to join the GAT Committee – we need you!

GAT Committee Structure
The GAT Committee has nine elected members. There are also co-opted members representing the Council of the Royal College of Anaesthetists (RCA), the Junior Doctors Committee of the BMA, the Anaesthetists in Training in Ireland Committee and the local organising committee for the following year’s Annual GAT Meeting.

Election to the committee is not for a fixed term. Members of the committee remain until they achieve CCST. There is a reasonably fast turnover of committee members – the average duration of service is two to three years. We aim to have representation on the committee from all grades of training. Since it takes a while to settle in, we would particularly like nominations from trainees more than one year away from CCST. I would especially like to encourage SHOs to stand – we need input from your grade and you will, towards the end of your time on the GAT Committee, provide invaluable experience. The overall aim is to have a balance of old experience and new ideas.

We do not have a formal system of regional representation. However, we would like to have a broad geographical spread of committee members. If you feel poorly represented in your area of the UK or Ireland, do please think hard about standing for election.

What does the GAT Committee do?
GAT is the only body which exists to represent trainee anaesthetists at a national level. The objectives of GAT are to represent you – your interests, your training and your practice. We also work to promote communication.

We represent anaesthetic trainees on a large number of councils, committees and working parties of the AAGBI, the RCA and other national medical bodies. The role of our representatives on these various committees is both to provide the views of trainees and to bring back information to the GAT Committee and members. The presence of GAT committee representatives at these meetings is not simply a public relations exercise. Rather, there is genuine interest in the opinion and welfare of trainees, both at the Association and the College.

The GAT Committee meets for a full day, five times per year. At our formal meeting we receive reports from our representatives on the various committees and working parties and discuss current issues for anaesthetic trainees. We formulate our responses and decide whether action is necessary – in doing this we take into account the broad consensus of opinion of GAT members.

At least half the day is dedicated to a ‘brainstorming’ session working on current projects. These include: the Annual Scientific Meeting, GAT Seminars, the GAT Handbook, the GAT page in Anaesthesia News, GAT Surveys and Questionnaires and the GAT Web Pages.

Why Stand?
As a member of the GAT Committee, your contribution will obviously be good for anaesthetic trainees. It will also be good for you! You will find the knowledge and experience gained invaluable in your future consultant career. You will make lifelong friends and, although hard work is involved, you will have tremendous fun. Please think hard about standing – you won’t regret it!

How To Stand for Election
If you would like to nominate either yourself or someone else, we have – this year – introduced nomination forms. These are available either from your departmental linkman, by downloading from the AAGBI Website or direct from the AABGI.

If there are more nominations than vacant places on the committee, election will occur by postal ballot of all trainee members of the Association. The successful candidates will take up their positions on the Committee during the AGM at this year’s GAT Annual Scientific Meeting in Cardiff, 14–16 June, 2000. Please return completed forms to me, Marie Nixon, GAT Committee Chairman, at the Association by Friday 25 February, 2000.

Marie Nixon,
Chairman, GAT Committee
Key Topics in Chronic Pain

Fifth National Crammer Course for the FRCA

The Forte Posthouse Hotel, Lancaster
Friday and Saturday 5 – 6 May 2000
Hosted by Dr AM Severn and Dr KM Grady

An intensive course for the trainee studying for the Final FRCA examination. The course to include lectures, interactive sessions, mcq, short answer and viva practice.

- Concepts of chronic pain
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Course fee £180 to include dinner. Discounted bed and breakfast accommodation is available in a luxury hotel setting.

Details and application forms from S. Severn, c/o Anaesthetic Department, Royal Lancaster Infirmary, Lancaster LA1 4RP, or phone/fax 01524 824044 (email asevern@ageanaesthesia.demon.co.uk)

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Keele University
Stoke-on-Trent School of Anaesthesia

CME Programme
For non-Consultant Career Grade Anaesthetists
22 & 23 May 2000

Course Organiser: Dr Premnan Jayaratnam

Sub-specialty Update
- Day Surgery
- The Long Case
- Intensive Care
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- Recognition & Management of Difficult Airway
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- Airway problems in Recovery
- The LMA

Medicine relevant to Anaesthesia
- Pre-operative optimisation
- Anaesthesia in the Elderly
- Pain medical problems in the Emergency Department
- Allergy & Anaaphylaxis

Professional Development
- A guide to Clinical Governance
- Role & responsibilities of a NCCG Anaesthetist
- Keeping up-to-date

Approved for CME

For further details, please contact:

Mrs Ann Moore
Director of Anaesthesia
City General, North Staffordshire Hospital
Newcastle Road
Stoke-on-Trent
ST4 6QG

Tel: 01782 583024
Fax: 01782 719754

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PANG
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Techniques for regional anaesthesia

Monday 13 March 2000
ICS - Charing Cross Hospital
Fulham, London W6 8RF

Programme:
- Ropivacaine and beyond. R Bannister (Dundee)
- Risk management and safe practice. A Rubin (London)
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- Combined spinal and epidural anaesthesia. R Russell (Oxford)
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- Regional anaesthesia for eye surgery. R Johnson (Bristol)

Registration: £122.50 (inc VAT) Trainees: £88.36 (inc VAT)

Further Information: Mrs S Welham
PANG Administrator
7 Dover Road
Sandwich. Kent CT13 9BL
Tel/Fax: 01304 612620

Announcement in Anaesthesia News

Anaesthesia News reaches over 7000 anaesthetists every month and is a great way of advertising your course, meeting or seminar.

Advertisements are accepted from anaesthetic societies and organisations, courses run by recognised ‘anaesthetic bodies’ and those judged to be of interest to members of the Association of Anaesthetists of Great Britain and Ireland and without obvious commercial intent.

Events will also be listed, free of charge, in the calendar of events on the Association website (www.aagbi.org) and the calendar will also be sent to members four times per year, enclosed with Anaesthesia and Anaesthesia News.

Display advertising can be in two colours and is accepted in camera ready form, by email or on disk. Potential advertisers are invited to discuss their requirements with the Editorial Assistant, Jane Meakin, at the Association. Copy deadline is six weeks prior to the date of issue. Contact Jane for a Rate Card on 020 7631 8804, by fax on 020 7531 4352 or email on anaenews@aagbi.org
there were rumours of a ‘walkabout’ afterwards – he did not appear!

We couldn’t match the dizzy heights of corporate freebies such as a Gaviscon mousemat but I did manage to give away many Association post-it notes publicising the website and email address. I was very disappointed at the quality of biscuits available at coffee time but the penny dropped as I noticed the writing on them and realised they were highly appropriate ‘Nice’ biscuits.

**Jane Meakin, Editorial Assistant**

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**References**


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**Anaesthesia News**  February 2000

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**NICE to see you, to see you NICE**

Clinical Excellence ‘99 Conference, 8 & 9 December 1999, Harrogate International Centre

The Association joined forces with the Royal College of Anaesthetists on two very cold December days in deepest Harrogate. Lenore Craggs (Clinical Effectiveness Co-ordinator at the College) and I ventured north to promote the Association and the College’s pioneering guidelines on good practice (and continued commitment to it) at the NHS National Institute for Clinical Excellence (NICE) 1999 Conference.

We had a stand in the exhibition area and the publications of both the Association and College proved very popular with the delegates – mostly Audit Co-ordinators and Administrators. They were especially interested in the College’s forthcoming Audit Recipe Book – ‘Raising the Standard – A compendium of audit recipes for continuous quality improvement in anaesthesia’.

The President of the Association, Mal Morgan and the Honorary Secretary, Peter Wallace attended the conference alongside College President Leo Strunin who interestingly took advantage of a free demonstration of the ‘De-Stress’ massage chairs adjacent to our stand (as did I).

Health Secretary, Alan Milburn, spoke to the conference and there were reports of a ‘walkabout’ afterwards – he did not appear!

We couldn’t match the dizzy heights of corporate freebies such as a Gaviscon mousemat but I did manage to give away many Association post-it notes publicising the website and email address. I was very disappointed at the quality of biscuits available at coffee time but the penny dropped as I noticed the writing on them and realised they were highly appropriate ‘Nice’ biscuits.

**Jane Meakin, Editorial Assistant**

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Continued from page 2

In addition, the Medical Defence Union has confirmed this situation verbally. The notion that an anaesthetist would be responsible for any complications that might result from the surgical procedure performed by the podiatrist is misleading and incorrect. Naturally, if the anaesthetist felt that the actions of the podiatrist were liable to cause harm to the patient, they would be responsible for taking appropriate action, as they would with any practitioner. Clinical governance is applicable to all areas in the National Health Service (NHS) and in private practice.

On discharge, from what is usually day surgery, patients are provided with emergency contact numbers. Podiatrists generally provide their own on call cover system and review the patients in outpatients. GPs receive a discharge letter and, in many instances, will have provided the postoperative analgesics for the patient through their prescriptions.

**Conclusions**

The establishment of podiatric surgery services within 40 NHS districts and of associated podiatric consultant posts reflect the progress of this speciality. However, as with the development of many new services, some confusion exists regarding the scope of practice and the relationship with traditional medical practitioners. It is hoped that this article clarifies some of these issues.

The right of podiatrists to practise as independent practitioners has been confirmed by the GMC, thus qualifying the relationship that exists between podiatrists and doctors. This should help to establish improved links between the associated disciplines and thus improve patient care.

Anaesthetists should have no anxieties about providing sedation or anaesthesia for patients who require podiatric surgery. Many anaesthetists could learn a great deal about local anaesthesia of the foot by attending a podiatric surgical session.

**David J Wilkinson, Consultant Anaesthetist and Trevor Prior, Consultant Podiatrist.**

Left to right: Jane Meakin, Mal Morgan, Leo Strunin, Lenore Craggs and Peter Wallace
The Vascular Anaesthesia Society of Great Britain and Ireland was formed in September 1997 to provide a forum to promote communication and understanding amongst anaesthetists who have to care for patients having vascular surgery. This is a population of patients that have a high incidence of significant cardiovascular disease and are subjected to elective surgical procedures that carry in-hospital mortality rates of 5–10%.

This society is intended to provide support for both the dedicated vascular anaesthetist who spends a significant proportion of his time working with vascular surgeons and also the anaesthetist who is only sporadically and infrequently faced by a vascular patient of the single-handed general/vascular surgeon. We are especially keen to encourage the increasing number of Specialist Registrars who have expressed interest in joining the Society. We have attempted to provide fair representation of all vascular anaesthetists by constructing the committee in a manner that will ensure equitable membership of anaesthetists from both district general hospitals and teaching/university hospitals.

Annual meetings
The objectives in planning our annual meetings are to provide a programme that is accessible, informative and relevant, in an environment that is conducive to the development of productive professional and personal relationships between practitioners in different vascular surgical units. Therefore, we have hosted our three annual meetings so far in university campus sites so that the scientific programme, accommodation and conference dinner can all be held in close proximity.

We have hosted three annual scientific meetings so far: Durham (1997), Sheffield (1998) and Exeter (1999). The 2000 meeting will be in Edinburgh on Monday 18 and Tuesday 19 September. The venue is limited to 160 delegates so book early once the meeting is advertised in Spring 2000 (no pre-emptive bookings accepted!).

Audit
This sub-group has been formed to promote audit in vascular anaesthesia. In early 1999, the society was able to provide financial support for a national audit of anaesthesia for elective aortic aneurysm surgery. Early results were presented at the society’s meeting in Exeter in September 1999. Hopefully, a major publication should follow once we have applied appropriate validation and analysis. We hope to be able to give moderate financial support for other audit projects and also provide a platform for presentation of worthwhile projects at the annual meetings. As we do not wish to subject our members to ‘questionnaire fatigue’, requests to distribute postal surveys will be subjected to rigorous scrutiny by the audit sub-committee! It is our policy to avoid distribution of the membership database.

Research
The research sub-committee will promote research related to vascular anaesthesia. The Society has funded a multi-centre project which will examine the incidence of peri-operative myocardial infarction in higher risk patients presenting for major vascular surgery. Infarction will be detected by troponin assay and long term survival will be tracked via the NHS central registry. Moderate support in the form of research grants is available to Society members.

Education
The newly formed education/training sub-committee is creating a portfolio of the specialist work of vascular anaesthetists and will also attempt to construct a curriculum for training in vascular anaesthesia.

A register of members with special skills, interests, practices or resources is being compiled and is available through the secretariat in order to be able to facilitate Continuing Medical Education. Moderate assistance with travel grants for visits is available to members.

We have recently approved a generous VASGBI Travel Scholarship which will be available to a member interested in visiting a major international vascular centre with a view to significant service development in their base hospital. Further details can be obtained from the secretariat.

Membership
For information about membership or other matters please contact David Thomas, Department of Anaesthesia, Dryburn Hospital, Durham, DH1 5TW (Tel: 0191 333 2360) or (preferably) via email: vasgbi@dgthomas.demon.co.uk

Website: www.vasgbi.com
Email: vasgbi@dgthomas.demon.co.uk

President: Professor Anthony Cunningham (Dublin)
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Research: Dr Simon Howells (Bristol)
Education: Dr Gita Menon (Thornton Heath)
Working as a Consultant or Consulting as a Worker?

The traditional pattern of consultant work has changed significantly in recent years and, if anything, the pace of change is likely to increase rather than decrease.

The reasons for this are numerous and well known. Less service provision from trainees because of reduced numbers relative to consultants; reduced working hours for trainees and a more explicit educational agenda. There has also been a greater demand for experienced doctors to deal with both emergency and elective cases. Increasing sub-specialisation can result in consultants having to cover colleagues’ absence because the work is unsuitable for trainees without direct supervision. The latest constraint is that required by the European Directive on Working Hours which could have a dramatic effect on the way in which consultants work.

It is essential at this time to consider carefully which aspects of consultant work we wish to preserve and then find ways in which this can be achieved. Terms and conditions of service, financial aspects of out of hours work and the place of non consultant career grade staff are important aspects but I do not wish to address these here. This brief article is concerned with what is the essence of consultant practice in our speciality.

One of the most satisfying aspects of working as a consultant anaesthetist is developing a working relationship with an individual consultant surgeon and the surgical team with whom he or she works. Following appointment as a consultant, many anaesthetists find that lists which they would have considered unattractive as a trainee offer previously unsuspected opportunities to develop professional relationships and contribute in a continuing fashion to the overall care of patients in a surgical unit. I would argue that there are tremendous benefits to anaesthetists, surgeons and other members of the surgical team and not least to patients from this situation. Improvements in the delivery of care whether due to improved staffing levels, better training of staff or better equipment are seldom achieved overnight with a single request, however well argued and presented.

Most of us will remember protracted discussions and negotiations with progress made over many years with a series of small steps – always taking care to ensure that one is not forced backwards. The value of support from those in other disciplines and professions should never be underestimated. This is much easier carried out in a carefully considered manner where the majority of an individual consultant’s weekly programme remains fixed, then this is simply a sensible approach to the problem of covering leave and many consultants, particularly those recently appointed to a new department, find the arrangement convenient as it offers the opportunity to become familiar with a wider variety of specialties within the hospital.

In very small units, considerable cross cover arrangements often work extremely well as all surgeons, anaesthetists and other staff will know each other well. In larger departments, however, this is much less likely and care needs to be taken in devising job plans and departmental rotas so as not to lose continuity.

Increased time off in lieu of out of hours work and the increasing demands of subspeciality work could lead to a situation where individual consultants are frequently unavailable to anaesthetise for specific surgical lists which form part of their job plan. These may then be covered by an individual who is not likely to be present at that specific session on a regular basis and the result is a lack of continuity of senior supervision of that session. This situation is no fault of the consultant who may be required by service constraints of a subspeciality to be elsewhere or rightly be due back time in lieu. It is more a fault of a system which fails to recognise what is most valuable in consultant practice.

If, as seems inevitable, we face a situation of increasing out of hours work for consultants and increasing demands from subspecialities for a consultant run service, then what should our response be? One alternative would be to carry on as we are with an increasing number of theatre lists covered in the absence of the consultant on whose job plan the session appears, by either a trainee, a non consultant career grade or a consultant on a ‘flexible’ session. I contend that it would be much more appropriate to carefully monitor/audit the requirement for time off in lieu and then adjust the basic sessional commitment to allow for this. I would far rather see a consultant having a job plan with fewer fixed sessions which s/he attended on a regular basis than the situation outlined above.

Alastair Chambers, Aberdeen Royal Infirmary elected member of Council
News from the Museum

The ‘Spoonful of Sugar’ exhibition was dismantled in early December, the borrowed exhibits being returned with a sigh of relief to the Science and Royal Pharmaceutical Society’s Museums and the Association’s own items to our store in Woolwich. The Science Museum has very stringent security standards, inspects premises before authorising loans and requires the borrowing authority to insure all the items individually at its own valuation. Since some were ampoules of cocaine more than eighty years old, the responsibility was considerable. If anyone is still wondering about the title of the exhibition, the reference of course was to Barker’s spinal solution, made hyperbaric by the addition of glucose. So when the patient was tipped up, the medicine went down!

It is just two hundred years since the publication of Humphry Davy’s classic description of his researches into nitrous oxide so, inevitably, the exhibition for the year 2000 has to feature the gaseous oxide of which the poet Southey presciently remarked that he supposed the atmosphere of the highest of all possible heavens must be composed of it. Together with carbon dioxide, sulphur dioxide, the higher oxides of nitrogen, the other products of the internal combustion engine and PCBs and CFCs, he wasn’t far wrong! The exhibition has to be selective and will concentrate on the early days in the UK, featuring the contributions of Clover and Hewitt.

It is not often that we can pinpoint the first person to practise or teach one of the absolutely basic everyday manoeuvres of anaesthesia, although careful reading of classic papers may give a hint. For example, more than one hundred years ago, McEwen was the first to realise that the presence of a tube in the trachea made it easy to remove secretions. But, of all our manoeuvres, surely the most basic is to hold the chin up to keep a clear airway and the earliest account we have found of this is by Joseph Clover. So, a small part of the exhibition is devoted to the dispute between Clover and Lister who was addicted to clamping the tongue with Spencer Wells forceps and pulling it forward instead.

Finally, as always, there is the display of new acquisitions. This has been a particularly good year. The Association has been presented with a large collection from Cambridge and, through the kindness of Mrs. Bullough, with a number of pieces of apparatus, books and slides which belonged to her late husband. Dr Alan Gilston, at the October history seminar, presented more items from his personal collection.

The Cambridge collection is substantial and contains several complete machines, for which we have little room in our present accommodation, but a large selection of the smaller items will be displayed. Also, there are two remarkable ‘personal association’ acquisitions. From Dr Cyril Scurr we have the ECG machine which was used to monitor King George VI’s heart during his operation for bronchial carcinoma and from Dr Rex Marrett, via Dr Ian McLellan, who is currently President-elect of the History of Anaesthesia Society, we have received HEG Boyle’s anaesthetic bag.

The exhibition will be open in normal working hours and will run until the end of November. Regular visitors will observe that the Museum was redecorated during the holiday period.

Neil Adams, Geoff Hall-Davies and David Zuck.

3rd South West Thames Anaesthesia Forum

2–5 October, 2000
Da Balaia, The Algarve, Portugal

Open to all Anaesthetists - limited to 100 participants

The Scientific Programme will include lectures, and discussions on:

- Acute and Chronic Pain
- Paediatric Update
- Day Case Anaesthesia
- Obstetric Anaesthesia
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Guest Speakers
Videos on New Equipment, Drugs and Techniques
Anaesthetists in training presenting papers are eligible for prizes.
Deadline for abstracts: August 13th 2000

This Meeting is approved for CME purposes

For further details, please contact:
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Letter to the Editor

About a month ago, I got in the post a newsletter from Newchurch & Company regarding ‘Relative Values review update 2’, entitled ‘Undertaking the Relative Values Review’. As there are, in my view, some rather arbitrary figures in some insurance companies’ fee schedules, this sounded to me like a very worthwhile task in order to get some reasonable relations between various tasks, surgical as well as anaesthetic.

It all sounds rather fine, until you arrive at page three where the basis for the valuations are reported. For procedural interventions the following points are to be considered:
1. Time it takes to perform the service.
2. Technical skill and physical effort involved.
3. Mental effort and judgement.
4. Stress.

Fine, although probably rather a difficult in an inter-speciality comparison. Now, for anaesthetic:

1. Time… full stop.

A comparison between ‘babysitting’ a cataract operation under local anaesthetic and anaesthetising a rigid bronchoscopy with biopsies comes to my mind. And so on.

I don’t often feel very strongly about this sort of thing but this time I really felt rather insulted. I did not expect this sort of downgrading of the anaesthetist’s work in 1999.

It may be that time should be the only consideration. It is probably the only parameter we can reasonably measure but in that case our friends the surgeons should be regarded in the same way. But then, what about the slow versus the quick?

Has the AAGBI been involved in this? If yes, then I think we have to ask for a reconsideration. If no, then I think the AAGBI should take action.

Lars Jakt, Truro

Dr Michael Ward replies

Members will not be surprised to hear that the Association has received a number of letters of concern from members about the output from Newchurch.

I welcome the opportunity to reply to Dr Jakt’s letter and to have the chance to reassure any other concerned members.

The Association of Anaesthetists was invited by Newchurch & Co. to send nominations for a Speciality Advisory Group to help them draw up a new Relative Values Table for a consortium of Private Medical Insurers. Council put forward a number of names of anaesthetists it believed could help with this exercise but declined as an organisation to be the responsible body. Newchurch accepted many of the nominations and added a few names from elsewhere.

The group has met on seven occasions. From the outset it saw its role as acting as individual advisors on behalf of the profession and set as its target the simple aim to improve the financial reward received from Private Medical Insurers to anaesthetists. It also pressed strongly to improve the relative position of anaesthetists against surgeons who spend approximately equal professional time in pursuit of private practice.

The anaesthetic group asked at its first meeting that the insurers consider a system that could be based both on the difficulties encountered because of co-morbidity and time spent in patient care which we knew varied dramatically between practitioners (surgical and anaesthetic). This proposition was not acceptable to the insurers who insisted that such a retrospective system was financially unworkable and that a prospective system, based on average time and complexity, was the only option. The group considered withdrawing at this point but decided that the objectives of improving our professional share of the ‘pot’ was greatest if we remained to argue for a better system than that which is currently in use.

We were also told that the surgeons would use a system based on stress, mental and physical effort and technical skill but we could not see how this could be measured objectively or how it could be applied to our profession. We started from the viewpoint that only fully trained experts in anaesthesia would be involved in private practice and only in areas which were familiar to them. In other words, while we recognised that we all use technical skill, we felt that it was a constant factor throughout our practice and unlikely to vary between practitioners. We believe this to be a wholly professional stance.

Similarly, we are aware that stress, mental and physical effort are also involved but felt these intangible aspects were of less significance in calculating our fees except in exceptional circumstances, unlikely to be covered by the new Relative Values Schedule. As a group, therefore, we offered a time based formula as described in Newchurch’s ‘Update 2’ and tested it against a notional skill/stress/effort calculation. We were pleased that it was found to be sound and comparable.

continued opposite
As this concept was so novel, we also circulated all consultant anaesthetists, with the help of the Association, to ask for their views as to whether to use this system in our negotiations. The result of that survey was overwhelming support for our stance: 80% of respondents were in favour! With such a mandate, we continued with our negotiations and Newchurch has completed a full schedule of Relative Values for Anaesthesia, Sedation and Monitoring across the entire speciality, some 15,000 codes.

The Speciality Group has reviewed this output and is aware of a number of errors and omissions which we have asked to be corrected. We understand that this will be done and the Schedule will be sent to the insurers for pricing. Until we see what value will be placed on the Relative Value units we will not know if our efforts have succeeded. We have reason to believe that there will be significant improvements for most but that some glaring overvaluations in the old schedule when corrected may lead to a fall in income for some. We will not be sure of that until the insurers respond.

We have stressed that, since the values are based on average morbidity and time taken, a system should be developed to enhance the Relative Value of a procedure for anticipated increases in complexity or time taken and have been assured that this will be included in the new schedule.

We know that our system looks too simple but we believe it to be reliable, robust and just. We also know that Newchurch’s newsletter entitled ‘Update 2’ was badly drafted and undermined our deliberations, so we have insisted on a separate ‘Update 3’ that was sent out to the profession just before Christmas. I hope that the position is now clearer.

The Association’s Independent Practice Committee has followed our activities closely and has asked Council to take a more active role in reviewing the scale when it is published and in negotiations in connection with other Private Practice matters. This will be discussed by Council and I hope to be in a position to write to the members again after those deliberations.

Dr Michael Ward, Leader Anaesthetic Speciality Group

SCATA

SOCIETY for COMPUTING and TECHNOLOGY in ANAESTHESIA

SCATA is a society for and of Anaesthetists and any others interested in the application of modern technology to the science, art, and business of Medicine and particularly to the care of patients in the operating theatre and intensive therapy unit. The society holds twice-yearly scientific meetings and its Web site (http://www.scata.org.uk) provides a forum for the dissemination of news and views about technology and information in anaesthesia, pain management and intensive care. Membership information can be found on the Web site or obtained from the society’s Secretary, Dr. Ranjit Verma (rverma@netcomuk.co.uk or c/o the Anaesthetic Department, Derby City General Hospital, Uttoxeter Road, Derby, DE22 3NE).

The society’s next meeting will be in Bristol, on Thursday and Friday, 27 and 28 April, 2000. The scientific sessions will focus on simulation in anaesthesia training and on advances in monitoring in anaesthesia and intensive care. Further details of the meeting can be obtained from the local organiser, Dr. A. P. Madden (ap_madden@madden-33.freeserve.co.uk, or c/o the Department of Anaesthesia, Southmead Hospital, Bristol BS10 5NB).
**Fifth Norwich Awake Fibreoptic Intubation Course**

“Hands on” Training Course
Norfolk & Norwich Hospital

Thursday 16 (1400) to Friday 17 (1500) March 2000

Course delegates will undertake topical local anaesthesia and multiple flexible airway endoscopies on each other, under very close supervision.

Course Fee £250 (participants), £300 (observers).

Approved for 10 CPD points.

Telephone 01603 287086 for an information pack and application form or contact Dr Nick Woodall, Course Organiser, for more information or alternatively visit our website www.publiconline.co.uk/woodall

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**Section of Anaesthesia of the Royal Society of Medicine**

Friday 4 February 2000 (1730)

NEW DRUGS FOR THE NEW CENTURY

Xenon anaesthesia
Dr Thomas Marx
University of Ulm
Germany

Development of new drugs:
how is it done?
Dr Robert Sneyd
Derriford Hospital, Plymouth

Professor David Rowbotham
University of Leicester

Friday 3 March 2000 (1730)

AN EVENING OF DEBATE
The peri-operative physician: is there a role for the anaesthetist?

In favour: Dr. Sheila Willatts, Bristol Royal Infirmary. Against: Professor Nigel Webster, University Department of Anaesthesia, Aberdeen.

Friday 7 April 2000 (1730)

NEW ANGLES ON INTUBATION

Fibreoptic intubation for all
Dr Adrian Pearce
Guy’s and St. Thomas’, London

Masking the larynx
Dr Archie I.J. Brain
Royal Berkshire Hospital, Reading

Airway problems in children
Dr Robert Walker
Manchester Children’s Hospitals, Pendlebury, Manchester

Thursday 27 April 2000 (0930)

AN OVERVIEW OF THE MANAGEMENT OF PAIN ASSOCIATED WITH CANCER
Joint meeting with The Pain Management Centre, University College London Hospitals.

Contact Christine Martin. 1 Wimpole St., London W1M 8EA. Tel: 020 7290 2986
email: Christine.Martin@Roysocmed.ac.uk
We are pleased to acknowledge support from Dräger Medical for the 1999-2000 session.
SAFETY PRIZE 2000

The Association is committed to the promotion of increased patient safety. A prize of £1000 will be awarded for an idea or development in any aspect of patient care which might lead to an increase in patient safety.

The prize is being sponsored by the Medical Protection Society and the Medical and Dental Defence Union of Scotland whose support is gratefully acknowledged.

Further details are available from the Association website www.aagbi.org or The Honorary Secretary, Association of Anaesthetists of Great Britain and Ireland, 9 Bedford Square, London WC1B 3RA.

Closing date for submission 24 March 2000
The Distance Learning project which has been set up and is already running in Zimbabwe seeks to improve the level of training of anaesthetists in district hospitals, by providing them with appropriate learning materials (based on ‘Update in Anaesthesia’), linked with a tutorial and feedback system operated through email links between hospitals. The training materials are provided on CD ROM as well as on paper, as the start of an electronic reference library for each hospital. If the project succeeds, the World Federation of Societies of Anaesthesiology (WFSA) hopes to replicate it in other countries in the future. Thanks to support from WFSA and DfID, Update in Anaesthesia is already available on the world wide web (www.nda.ox.ac.uk/wfsa).

The ‘Glostavent’ project is a field trial of an innovative piece of equipment which can provide safe inhalation anaesthesia, lung ventilation and generation (by means of a concentrator) of its own oxygen supply from room air. Plans are under way to train a group of local technicians in Mozambique, following which a group of machines will be installed, initially in Mozambique and a careful study made of their use and performance.

Before the machines arrive, local technicians will already have been trained to look after them and a reporting system set up to monitor their progress. The Glostavent is manufactured by Penlon Limited, Oxford and has been in use in Gloucester for five years. WFSA is seeking further financial support so that the project can be extended to other countries in the region, beginning with Zambia.

The Association was represented at the meeting by Dr David Wilkinson and the World Federation by its President, Professor Michael Vickers. The photograph shows Clare Short, together with the grant recipients, Mike Dobson and Roger Eltringham and also the Glostavent. She said that she was pleased to see the involvement of British anaesthesia in international development and hoped that further partnership projects with her department will ensue.

Mike Dobson, Consultant Anaesthetist, Oxford

Writing for Anaesthesia News

Anaesthesia News is your newsletter. The Editorial Team is keen that the journal shall represent the views of members. You can get your opinions across or share some experience with 7,000 other members. To write for Anaesthesia News, send a disk in Word format (although other formats can be converted) to the Editor at 9 Bedford Square. You can also send a file as an attachment to an email to anaenews@aagbi.org

Good, old-fashioned typescript is also welcome and can be sent by post or faxed to 020 7631 4352. Photographs are particularly welcome and can be emailed as a jpg file to anaenews@aagbi.org or posted for scanning. They should be of reasonable size and colour is preferable. Articles may be of any length but the Editorial Team reserves the right to edit, if necessary. Copy deadline is six weeks prior to the date of issue.
A couple of weeks ago, a very large crane and a lot of men in hard hats arrived outside our hospital and, in between tea breaks, proceeded to erect our new Anaesthetic Department. A big hole appeared in the corridor next to theatre with a large notice announcing grandly ‘Anaesthetic Department and On-Call Suite’.

A few days later, standing admiring the brickwork and the bumcracks, I was accosted by one of our long-suffering ENT surgeons, close to retirement and in his third ward location in about seven years. “Hello”, he said morosely, “I see you anaesthetists just snapped your fingers and they are building you another new department!” As he shuffled off before I was even able to reply, an orthopaedic surgeon hove into view. “Ahah”, he cried, eyes glinting, “Don’t you lot get too comfortable. How long do you think you are going to be in here? I bet you are on the move again pretty soon!” and he disappeared with a knowing wink.

Now both of these guys had got it completely wrong. They were referring to the fact that we have had two new anaesthetic departments since 1984 and are about to move into another, this time custom built according to the Association glossy with further additions. Both our present accommodation and the previous one were comfortable and pleasant but, like most Departments of Anaesthesia, we have grown like Topsy in the last decade and once more we need more space. We needed to move to our present site about five years ago because they wanted to build the Coronary Care Unit where the anaesthetic department was. They were right, it was the best place for it, between the Intensive Care Unit and Accident and Emergency. We were happy to move and had a great bargaining chip.

There was, however, no cash for a new build at the time and we were determined to stay close to theatre and ITU. We therefore insisted on moving into an area within theatre, uncommissioned but set aside for expansion in the future to two new theatres. As we expected, that time eventually came and once again we had a strong position from which to negotiate. Voila! – a beautiful new department!!

It’s no good trying to explain that to the surgeons though is it? Astute planning and negotiation just isn’t their style. I was just congratulating myself on all of this when one of the workmen popped his head through the hole. “You one of these here Anaesthetists then pet?” he said, “Wot do they do then? D’tthey work for the surgeons in the operating theatre a bit like a nurse then?” Well you can’t win them all can you? Fortunately for him, he still had on his hard hat!!
A heart-rending condition seen only in impoverished artists is shown on page 1. What is it? 

Vineet's Ani}