Extremes of Age

by Stuart Ingram

Contents
1-2 NCEPOD 1999
3 Guest Editorial
4-5 Gat Page: Gat Annual Scientific Meeting 2000 in Cardiff
7 Specialist Society Page: Plastic Surgery and Burns Anaesthetists
9 History Page: Referential Recognition for John Snow
10 Letter to the Editor
12-13 Joint Committee on Good Practice
14-15 Irish Page: 11th Annual Open Meeting and Seminar of the Irish Standing Committee
16 Tales from another back line Cartoon

November saw the launch of a new National CEPPOD Report, ‘Extremes of Age’. The planning of this report began back in the autumn of 1996 when it was decided to carry out a re-audit of the original 1989 NCEPOD sample that looked at children. However, it was recognised that, in examining deaths in children occurring in hospital within 30 days of a surgical procedure, this would be a small sample. Paediatric deaths account for less than one per cent of the 20,000 deaths reported to NCEPOD each year. It was therefore agreed that, as well as looking at children under 16 years, we should also look at the very old, patients over the age of 90 years.

Careful consideration was given as to the questions that should be included in the questionnaires for each sample. For paediatrics, it was important that we gathered data from anaesthetists, surgeons, ward sisters, nurses and district nurses. However, for the very old, we were advised to ask the patients, carers and families what had happened.

Dr Stuart Ingram

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The copy deadline for the March 2000 edition of Anaesthesia News is 18 January
From these and other discussions, the co-ordinators began to draw out the various opinions that might result in recommendations and identified cases to illustrate these points. Initial drafts were then written. The steering group, under the guidance of Dr Stuart Ingram, had put the data from the questionnaires into the computer and had carried out an analysis that formed the basis for the various tables in the Report. Drafts were commented on by the advisers and then, during the summer, they went to the Steering Group. This large and august body has representation from the various Colleges and Associations that support the work of NCEPOD. Its members read the drafts, corrected spelling and grammar and commented on the conclusions that were being drawn. Bit by bit an agreed text was established. The Chief Executive, Fiona Whinster, talked to printers about presentation and layout, as well as combing the text and tables for inconsistencies. Finally, in August, all was finalised and sent off to the printers.

When the first NCEPOD Report was produced, John Lunn, the anaesthetist who set up the Enquiry, described how they decided to launch it at a press conference. Expecting modest interest, they prepared carefully but were astonished at the media interest. The message went out on television and in the newspapers with sensational headlines that raised public interest but infuriated much of the profession. Since then we have learnt to use expert help. For the press release and press conference we have professional guidance. As the Report is paid for by public money and is in the public domain, this is thought to be the best way to launch its contents.

So, on the morning of 17 November, we found ourselves at the Royal College of Pathologists overlooking the Mall, as the Queen made her way past in a horse drawn coach to open Parliament and we waited for the press.

We started with the Chairman welcoming those present and explaining what we had been doing. Then there was a presentation of the main findings and recommendations relating to the two groups of patients. In general, the paediatric aspects were positive as many of the recommendations from 1989 had been acted upon and care for these very sick children invariably lay with senior staff. For the elderly there were more issues to be addressed, peri-operative fluid management, delays prior to operation and availability of HDU beds. The Chairman invited questions. There was little interest in the children as good news does not make headlines but the elderly elicited more comment.

We had been warned that the Mail would be interested, its target readership being women in their 40s, the mothers of children and carers of the elderly. So it was to be. The...
11th Annual Open Meeting and Seminar of the Irish Standing Committee

Saturday 20 November 1999 saw the 11th Annual Open Meeting and Seminar of the Irish Standing Committee in the Westbury Hotel, Dublin.

Dr Sean McDevitt, the Convenor, opened the meeting and invited the President, Dr Mal Morgan, to speak. Dr Morgan stated that he was delighted to be back in Dublin and gave a summary of current Association activity. First, he discussed revalidation and mentioned that the GMC in London had agreed to devolve responsibility for revalidation to the Royal College of Anaesthetists; a joint committee has been formed with the Royal College to address this issue. The President stated that he would reach a situation where everyone would have to be appraised every year and mentioned the difficulties of assessing an anaesthetist’s performance. He said that the general view was against an examination. In addition to a system of personal portfolios, each Department would have its own portfolio, based on the principle that an individual must be able to develop his or her profession in the right environment.

Dr Morgan mentioned several other working parties of the AAGBI. The working party on Substance Abuse has sent out a confidential questionnaire to each Anaesthetic Department in the United Kingdom and Ireland. So far, there has been a 63% response rate.

The President added that working parties were being set up to revise various ‘glossy’ publications of the Association. Dr Morgan also mentioned another working party on infection control. He stressed that each patient is entitled to breathe from an uncontaminated breathing system. He added that the UK Department of Health had issued a directive that items intended for single use were not to be re-used. Finally, Dr Morgan mentioned insurance for members engaged in patient transfer, or travelling to an accident site. Membership would entitle members to up to £1 million insurance cover.

Dr McDevitt thanked Dr. Morgan and mentioned a few topical Irish matters. He expressed his thanks to PJ Breen and Aidan Synnott, the outgoing Convenor and Deputy Convenor, respectively. He said that everyone was greatly appreciative of the difficult work they had performed while on the Committee, especially in VHI negotiations. He then welcomed two new members of the Committee, Ann-Elizabeth Bourke and Dermot Kelly.

Dr McDevitt then mentioned some issues affecting the specific Irish matters. He expressed his thanks to PJ Breen and Aidan Synnott, the outgoing Convenor and Deputy Convenor, respectively. He said that everyone was greatly appreciative of the difficult work they had performed while on the Committee, especially in VHI negotiations. He then welcomed two new members of the Committee, Ann-Elizabeth Bourke and Dermot Kelly.

He and other authors who were responsible for this patient’s management are to be congratulated on their dedication and the successful outcome. One cannot however be but very conscious of the monumental expense involved in this particular enterprise. The patient, who had refused transfusion even though she would otherwise die, was in hospital for 114 days, of which 38 were in ICU; followed by one week in the HDU, before transfer to a general ward. Daily transfer by ambulance (with full ICU support and a consultant intensivist in attendance), to the Hyperbaric Oxygen Unit, occurred during the first sixteen days. In addition, medications, investigations, parental nutrition and staff salaries all contributed to the cost.

The Association of Anaesthetists’ recent booklet ‘Management of Anaesthesia for Jehovah’s Witnesses’ considers comprehensively, from the anaesthetist’s viewpoint, the legal and practical issues of management of such cases, but carefully (probably deliberately) avoids associated issues. Although described as an advisory document, anaesthetists who chose not to follow this advice would be hard pressed to justify their actions in the event of a subsequent dispute.

One of the unequivocal recommendations is that ‘In an emergency, an anaesthetist is obliged to care for a patient in accordance with the patient’s wishes and irrespective of the anaesthetist’s own views’. (my italics). It is a traumatic enough experience whenever a patient dies in our care, even when everything possible has been done. How much more so when it happens for want of simple measures one has been obligated to withhold? Having been thus constrained in our own choice of management, we obviously cannot stand by but must do whatever else is possible to save the patient’s life.

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I pose the following questions as Devil’s Advocate: irrespective of strongly held beliefs and convictions, is it not selfish in the extreme for a mother with an existing family to refuse ‘standard’ treatment when this refusal could result in her own children being orphaned? If a choice has to be made, is not the commandment (from the same Good Book) to ‘love one another’, equally if not more compelling than that prohibiting the acceptance of blood?

By refusing to allow generally recognised life-saving treatment, does this not in effect, change the condition to one of ‘self-infliction’ and, if so, should the patient be required to bear the cost of alternative treatment, especially in the present climate of so called NHS Rationing?

Can it be justified for a patient who refuses conventional treatment to ‘block’ sparse ICU resources from other deserving patients, in this case for 38 days, when it is not unreasonable to postulate that a much more rapidly successful outcome would have occurred had this patient been given a blood transfusion at the outset?

While the personnel caring for this patient must have derived great personal satisfaction and fulfillment at achieving the eventual happy outcome, this will have been preceded by many continuing hours of great anxiety, no doubt also shared to some extent by their own families and that of the patient. Is it right, when NHS staff are increasingly suffering from low morale and overwork, that additional unnecessary stress of this nature should be an added burden?

John Francis, Exeter

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.
The Annual Scientific Meeting of the Group of Anaesthetists in Training will be hosted by the Cardiff Anaesthetic Department, between June 21 and 23. GAT meetings are always extremely popular with trainees, with a tradition of combining education with enthusiastic participation in social activities. We anticipate that this year’s meeting should be no exception. The planned scientific programme incorporates issues currently topical in anaesthesia, while the social programme offers an opportunity to visit the best of old and impressive buildings in Cardiff with events planned at both Cardiff City Hall and the magnificent Millennium Stadium.

Scientific Programme

The content of this year’s scientific programme reflects the nature of work and interests of the host department and considers the expanding role of the anaesthetist, highlighting that anaesthetists are now involved in nearly all stages of hospital patient care. We believe that it will be both stimulating and interesting to delegates. The sessions are detailed below:

- thoracic anaesthesia;
- emergency medicine;
- critical care of the surgical patient;
- equipment evaluation and standard setting;
- transfusion medicine;
- current controversies in anaesthesia – an open debate on aspects of obstetric anaesthesia, managing the difficult airway and airway management in ICU.

Following tradition, the hotly contested Registrar’s prize competition is an integral part of the scientific programme. The closing date for entries this year is March 10. Short-listed entrants are asked to make an oral presentation of their project of not more than ten minutes, followed by a brief discussion. The winner receives a cash prize and the President’s Medal. Further information is available on the Association website or from the Honorary Secretary of the Association.

The Annual General Meeting and Trainee Conference will take place on the second day. The GAT Chair will present the work of the GAT Committee over the previous year. This will be followed by the Trainee Conference when issues currently affecting our training are presented and discussed. This is a good opportunity for you to have your say. The Association sees its trainee members as the future of the profession and our opinions are warmly welcomed.

In addition, there will be a short report from this year’s Baxter Healthcare Travelling Fellowship and, as a reminder, a presentation from the winner of the Abbott History of Anaesthesia essay prize. The closing date for essay entries is January 31.

Pinkerton Lecture

The Pinkerton Lecture is always a highlight and this year we are delighted that Dr David Whittaker, a Consultant Dental Surgeon and Reader in Oral Biology and Forensic Dentistry from Cardiff has agreed to speak. Dr Whittaker is renowned for his work in the identification of the deceased from their teeth or following facial reconstructive work. He will demonstrate the techniques used in his work and illustrate his lecture based on the infamous criminal cases he has investigated.

As events progressed it became clear that this exercise was going to be a long-term challenge and to meet it, the AAGBI and the RCA established the Joint Committee on Good Practice (JCGP). This Committee was charged with outlining how the process could be taken forward, the quality agenda kept under review and active steps taken to equip individual anaesthetists and departments of anaesthesia in their preparations to meet the changing scene.

Joint Committee on Good Practice

The JCGP has accepted that there is an urgency to give guidance to all anaesthetists so that they will be in a position to counter any criticism of their professionalism and at the same time meet the challenges which will be inherent in revalidation.

The JCGP is working in four areas to bring forward recommendations and advice to equip individual anaesthetists and departments of anaesthesia to produce objective evidence of good practice and prepare for appraisal and assessment of their work as outlined in clinical governance. They are:

1. The personal portfolio
2. The departmental portfolio
3. The basis of appraisal
4. The basis of assessment

The GMC and most specialties see the need for every individual to prepare and maintain a personal portfolio although the GMC has not as yet clearly defined where this fits with revalidation. The emphasis on which data should be included in a personal portfolio is more likely to vary with specialty. The JCGP sees good practice in anaesthesia as having distinctive characteristics and so is pressing ahead to produce a template of a personal portfolio for anaesthetists. At the same time the Committee sees the need for the development of a departmental portfolio. Anaesthetists tend to work in teams and to organise their work in association with their other colleagues. Many anaesthetic problems are not inherent in the individual but reflect departmental problems and will only be resolved at this level. The data as to how well this is being achieved must be clearly demonstrated at a local level and correlated at a national level.

The personal portfolio and departmental portfolio have been presented to a Focus Group for comment and are now, after modifications, released nationwide for pilot studies to test their usefulness and acceptability.

Appraisal and assessment are part of clinical governance and the JCGP is finalising advisory documents in these areas. They will be ready for pilot studies early in 2000 and should meet the timetable for Clinical Governance.

Joint Liaison Committee

Running parallel with these activities, the RCA and AAGBI established a Joint Liaison Committee to give advice and assistance to Trusts about the organisation, personnel, working patterns and relationships of anaesthetists within a Trust. It is designed to help the Trust to deal with difficult problems involving anaesthesia when the other methods available at Trust level have failed. It is too early to judge the eventual demand for the services of this committee nor indeed whether its contribution has been successful but, in its work so far, it has tackled this very difficult area with resolution and sensitivity.

Conclusion

The JCGP is convinced that, once these measures are in place, anaesthetists and departments of anaesthesia will have the objective evidence to be able to reassure the public that they are providing the best service which can be expected within the system in which they work.

The JCGP also feels that, with such measures in place, individual anaesthetists within departments who satisfactorily meet the agreed criteria will then qualify to have their names retained on the medical register. The best group to lay down such criteria has to be the profession and the specialties within it. The standards must be national so that they are acceptable nationwide and no doctor gets locked into one particular Trust or institution and is unable to move therefrom. The GMC and the specialty have a slightly different agenda and the marrying of the two aspirations of best practice on the one hand and what is acceptable on the other will be challenging.

A further area of concern in all these moves is remedial treatment for the dysfunctional doctor, retraining and other alternative measures.

The JCGP feels that, once they achieve their immediate objectives, anaesthetists will be able, with the co-operation of the public, to continue to develop the specialty, maintaining and improving the high standards which have always characterised it.

Morrell Lyons is Chairman of the Joint Committee on Good Practice

‘Old Journals’

What happens to your old journals once they have been read? Do they lie around the house irritating your spouse? Now’s the time to do something about it.

One of the aims of Anaesthesia News is the donation of their own journals, once they have finished reading them, to colleagues who are unable to obtain them for themselves.

A form of practical help which is well within the reach of many readers is to supply a single copy of your old, perhaps in demand, journal to the recipient. The content of this year’s scientific programme reflects the nature of work and interests of the host department and considers the expanding role of the anaesthetist, highlighting that anaesthetists are now involved in nearly all stages of hospital patient care. We believe that it will be both stimulating and interesting to delegates. The sessions are detailed below:

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Joint Committee on Good Practice

By Morrell Lyons

The right of the Medical Profession to self regulation in governing its conduct and practice can no longer be taken for granted. Serious doubts have arisen as to how effective the profession is at this task. Recent events have encouraged the perception that doctors are more interested in the preservation of their own status and right to practise than they are about the welfare of the patients whose care has been entrusted to them.

Self Regulation

Despite the criticism the medical profession is still convinced that self regulation is both a desirable goal and one that the profession is capable of effectively continuing to carry out. The nature of the practice of medicine is such that the medical profession itself is still the only logical body with the background and understanding to enable the administration of the necessary regulatory duties. The profession realises that it will have to make strenuous efforts to confirm that it is indeed capable of fulfilling the self regulatory role while at the same time working with patients to preserve their interests. To this end, the General Medical Council (GMC) has proposed that revalidation should become mandatory for all doctors. Such an exercise, they believe, would both reassure the public as to the maintenance of expertise and also demonstrate that the medical profession is capable of self regulation.

Revalidation

Medicine in the United Kingdom has arrived somewhat late at a decision for revalidation, the process in different forms being in place in countries such as the USA, Canada, the Netherlands, Australia and New Zealand. There is now an acceptance that revalidation is a necessary part of the discipline of good practice. There is still controversy about its ability to achieve this goal and, incidentally, contribute to the preservation of self regulation. There is still controversy about its ability to achieve this goal and, incidentally, contribute to the preservation of self regulation in the discipline of good practice. There is still controversy about its ability to achieve this goal and, incidentally, contribute to the preservation of self regulation. Meanwhile, the Department of Health (DH) published its own solution to the quality agenda by proposing a system of Clinical Governance, Appraisal and Assessment with guidelines to support clinical governance. Clinical Governance not only affects all health care professionals but also the systems and processes in which they work.

Medical Specialties

In their particular specialty the individual medical specialties are without doubt in the best position to set and assess standards and they need to give consideration to the problems inherent in revalidation. It is abundantly clear that, in the present circumstances, the GMC cannot accept unconditionally the word of bodies such as the Royal Colleges that their members are worthy of revalidation. Agreed objective data are necessary and will have to demonstrate the status of each individual doctor. Anaesthesia

Anaesthesia is not new to audit and, since the introduction of anaesthesia, anaesthetists have looked critically at their practice. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Royal College of Anaesthetists (RCA) have put these endeavours onto a national footing with the initiation of CEPOD and NCEPOD and, in the light of experience, the setting of guidelines and standards. In 1997, the AAGBI and the RCA were presented with the challenge from the Chief Medical Officer, England, to try to define good practice in anaesthesia. They set up a Joint Working Party for this purpose and their deliberations culminated in the publication of ‘GOOD PRACTICE – a guide to Departments of Anaesthesia’. The booklet laid down the principles of good practice and, while much of the advice contained in the document was already available from the AAGBI and the RCA in a more disparate form, the working party took the opportunity to bring it together in one document of advice and guidance.

Meanwhile, the Department of Health (DH) published its own solution to the quality agenda by proposing a system of Clinical Governance, Appraisal and Assessment with guidelines to support clinical governance (NICE) and the monitoring role undertaken by the Commission for Health Improvement (CHIimp). By these means the DH is endeavouring to give guidance to the health care professionals about the need for adequate standards of care and how these might be monitored and eventually improved. Clinical Governance not only affects all health care professionals but also the systems and processes in which they work.

Social Programme

The 33rd Annual Dinner of GAT will be held at Cardiff City Hall. This is a spectacular civic building close to the city centre. Included in the evening will be a champagne reception and five-course dinner, followed by a live band and late bar. No after dinner speaker is expected!

The Wednesday evening event will be held in the Millennium Stadium, home of Rugby World Cup 1999. An evening of food, wine and entertainment following a local theme is anticipated. The venues of all this year’s academic and social events are within Cardiff city centre. Accommodation for delegates will be based at Cardiff Hall of Residence. Cardiff is emerging as one of the most vibrant and cosmopolitan cities in Europe, combining a rich cultural heritage with a wealth of restaurants, bars and other attractions. All these will be within easy walking distance.

Don’t Miss It!

Attendance at recent GAT meetings has been disappointing. Limits on study leave expenses have been introduced which may be one reason for this. However, for the GAT 2000 meeting we have introduced a new dimension with practical workshops but still maintaining our traditional format. We believe this offers good value for money. Anaesthesia is a progressive, forward thinking specialty but we need your help to keep it there. We look forward to meeting you in June.

Workshops

New for this GAT meeting are two workshops which will run concurrently with the lecture sessions. The first will be a workshop on difficult airway management with skill stations for practicing the use of the fibrescope, percutaneous tracheotomy and other advanced airway techniques. The second will be an anesthetic simulator where critical incident scenarios may be practiced.

In addition, in between sessions, there will be an opportunity to advance your IT skills with computer stations manned by our local computing experts. They are prepared to answer your questions on any aspect of IT and demonstrate how you can get the most out of currently available software and the Internet.

Biannual Workshops on the techniques and practical application of peripheral nerve blocks for upper and lower limb surgery

March 6, 7, 8, 2000

Numbers to be restricted to 8 to allow hands-on experience. Suitable for Consultants, Staff Grade, 4th & 5th year SpRs. Workshops include: dissections of the relevant anatomy. Use of nerve stimulators as an aid to performing peripheral nerve blocks. Demonstrations and hands on experience of nerve blocks and catheter techniques.

For further information contact Joanne Barnes, Datex Ohmeda Educational Co-ordinator, at the Association or at meetings@aagbi.org

Look out for the full programme and registration booklet coming soon with Anaesthesia News.
COURSES AT THE SCOTTISH SIMULATION CENTRE

DEVELOP YOUR TEACHING IN THE OPERATING THEATRE

Wednesday & Thursday 2 & 3 February 2000

This two day practical course addresses the important aspects of effective teaching in the operating theatre. Participants will also be given the opportunity of conducting teaching sessions in the simulator theatre. Faculty includes Mr David Greaves, Director of the Northern School of Anaesthesia. Only ten places available. CEPD points applied for. Course fee £200.

ANAESTHESIA AND UNUSUAL CONDITIONS

Thursday & Friday 10 & 11 February, 1999
Thursday & Friday 16 & 17 March, 1999

We all read about these conditions and hope that we never have to deal with them in reality. This two day course, for anaesthetists and non-consultant career grade staff, will help you prepare for the unexpected. CEPD points applied for. Course fee £150.

For bookings please contact Scottish Clinical Simulation Centre, Stirling Royal Infirmary, Stirling FK8 2AU. Tel 01786 434480, Fax 01786 446026. E-mail simulator@scsc.co.uk

CHARITY COMMISSION NOTICE

Charity: East Grinstead Anaesthesia Research Trust (231254)

A copy of the draft Scheme can be seen at:
Anaesthetic Department
Queen Victoria Hospital NHS Trust
Hollyt Road
East Grinstead
West Sussex RH19 3DZ

or can be obtained by sending a stamped address envelope to the Charity Commission, Harmsworth House, 13-15 Bouverie Street, London EC4Y 8DP quoting the above reference. Comments or representations can be made within one month from today (by 1 February 2000).

The Honorary Secretary, Association of Anaesthetists of Great Britain and Ireland
9 Bedford Street, London WC1B 3RA

Association of Anaesthetists of Great Britain and Ireland

BAXTER HEALTHCARE TRAVELLING FELLOWSHIP OF UP TO £2,500

Opportunity: to travel anywhere in the world to undertake a hospital-based study to examine current problems and fresh applications of fluid therapy, with particular emphasis on resuscitation, trauma, parenteral nutrition, intravenous infusions of drugs and blood transfusion.

Financial support: up to £2,500 sponsored by Baxter Healthcare.

Eligibility: open to all members of the Association of Anaesthetists of Great Britain and Ireland.

Closing date for applications: Friday 14 January 2000

Further details are available from the Association website www.aagbi.org

Association of Anaesthetists of Great Britain and Ireland

THE WYLIE MEDAL UNDERGRADUATE PRIZE 2000

The Wylie Medal will be awarded to the most meritorious essay concerning anaesthesia or associated clinical practice written by an undergraduate medical student at a university in Great Britain or Ireland.

Prizes of £300, £150 and £50 will be awarded to the best submissions. The overall winner will receive the Wylie Medal.

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 11 February 2000

LOCAL ANAESTHESIA FOR OPHTHALMIC SURGERY

8th Video Conference Meeting, Friday 28 January 2000, Middlesbrough

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in the North Riding Infirmary, Middlesbrough on 28 January 2000. The meeting will include lectures and live demonstration of orbital blocks. Attendance is limited to 50 participants.

Application form and information from Mrs Pat McSorley (Course Administrator 01642 854601). Registration fee is £200 (BOAS Members £175), inclusive of catering. Cheques payable to Cleveland School of Anaesthesia.

Programme

9:00–9:30 Registration & Coffee
Chairman: Dr Chris Dodds, Middlesbrough.

9:30–10:15 Anatomy Relevant to Orbital Blocks, Dr Jonathan Dutton, North Carolina, USA.
10:15–11:00 Complications of Orbital Blocks, Dr Anthony P Rubin, London.
11:00–11:30 Coffee Break
Chairman: Mr Tim Dowd, Middlesbrough.

11:30–12:15 Review of Orbital Blocks, Dr Jonathan Dutton, North Carolina, USA.
12:15–12:45 Teaching and Training in Orbital Anaesthesia, Dr David Greenaw, Newcastle.
12:45–12:50 Discussion
Chairman: Mr David Smerdon, Middlesbrough.

12:50–13:45 Lunch

13:45–17:00 Live Demonstration of Orbital Blocks
Chairman: Mr David Smerdon, Middlesbrough.

Comments: Drs Anthony P Rubin & Chandra Kumar.

Retro and or peribulbar: Hustead Technique
Dr Chandra Kumar, Middlesbrough.

Hamilton Technique
Dr Chandra Kumar, Middlesbrough.

Other Needle Blocks
Dr Narinder Dhariwal, Sunderland;
Mr Bartley J McNeela, Middlesbrough;
Dr A P Rubin, London;
Dr Dave Ryall, Middlesbrough.

Sub-Tenon: Stevens’ Technique
Dr Clovis Dodds, Middlesbrough;
Dr Caroline Carr, London.

Greenbaum’s Technique (modified)
Dr Chandra Kumar, Middlesbrough.

17:00 Closing remarks
Dr Clovis Dodds, Middlesbrough.

Meeting Organiser: Dr Chandra Kumar, Consultant Anaesthetist, Cleveland School of Anaesthesia, South Cleveland Hospital, Middlesbrough TS4 3BW Tel: 01642 854601, email: ckmkumar@globalnet.co.uk

For bookings please contact Scottish Clinical Simulation Centre, Stirling Royal Infirmary, Stirling FK8 2AU. Tel 01786 434480, Fax 01786 446026. E-mail simulator@scsc.co.uk
MEMBERSHIP
Membership has shown a slow but steady increase and now stands at 178.

ANNUAL MEETING
The annual meeting for 1999 took place on 16 October at St Andrews Centre for Plastic Surgery and Burns, Broomfield Hospital, Chelmsford. Professor Hatch gave a talk on organising paediatric services for plastic surgery and burns, including some of the political dilemmas in relation to surgery for cleft lip and palate, the relationship of paediatric burns units to PICUs, self-regulation and quality issues. This was followed by a talk by Dr Ingram on Hypotensive Anaesthesia - how low can you go? In it he reviewed the history of hypotensive anaesthesia and how the technique related to the physiological changes associated with hypotension. This theme was continued by a talk from Professor Aitkenhead entitled the Medicolegal Implications of Specialised Anaesthetic Services. Dr Emerson’s paper was a thought provoking one, discussing the relationship of the legal implications to the techniques of anaesthesia and ended with a discussion on the Society’s response to the RCA in relation to standard setting.

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President: Dr Frank Walters, Frenchay Hospital, Bristol
Secretary: Dr Eulie Beese, Morriston Hospital, Swansea
Treasurer: Dr Michael Steyn, St Andrews Centre for Plastic Surgery & Burns, Broomfield Hospital, Chelmsford.

OTHER ACTIVITIES
Members of the group have taken part in training or lecture visits to Russia and the RCA update session on plastic surgery and burns.

WEB PAGE
A web page will be established to include the major centres for burns and plastic surgery, together with contact numbers.

STANDARDS IN ANAESTHESIA FOR PLASTIC SURGERY AND BURNS
The Society is actively looking at ways in which standards for good practice may be implemented. A document suggesting some of the changes is being drawn up with the current office holders of the Society and includes Dr Colin Ince and Dr Diana Swallow.

OTHER ACTIVITIES
The Russell Davies – Stuart Laird Prize
This prize, sponsored by Abbott Laboratories, was awarded this year to Dr M Stafford who presented a paper on ‘Arterial and venous serum concentrations of ropivacaine and bupivacaine after axillary brachial plexus block’.

The Editor replies...
The Anaesthesia News team appreciates Dr Birkinshaw’s vigilance but not his accuracy. Some of the replies to the recent survey of members indicated that the views in his letter were shared. The Editorial Assistant has been careful to temper the Editor’s enthusiasm with the digital camera on social occasions. The Editor (a working peripheral Consultant) has long known that he is keen to photograph all who will stand still long enough, is grateful to receive any congratulations and kudos and wonders just who is broken down by age and sex.

PS. Please don’t ‘bin’ your newsletter before showing it to non-members who will want to learn of the many benefits of joining the Association!

Keith Birkinshaw, Dunfermline
Anesthesia Fellowships

Applications are invited immediately for the following fellowship positions for:

September 2000:
1. Neuroanaesthesia
2. Clinical Anaesthesia
3. Ambulatory Anaesthesia.

and January 2001:
1. Neuroanaesthesia
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4. Regional/Pain Management

The Toronto Western Hospital is a major teaching hospital at the University of Toronto. All fellowships provide strong research experience. Applicants must hold the FRCA or FFARCSI to be eligible. Applicants: send CV and three reference names to Dr Frances Chung, Director, Department of Anaesthesia, Toronto Western Hospital. Edith Cavell 2-046, 399 Bathurst Street, Toronto, Ontario, Canada M5T 2S8. Fax (416) 603-6494.

Three Day Intensive Care Course

Queen’s Medical Centre, Nottingham
5 – 7 April 2000

On theoretical and practical aspects of Critical Care Medicine

Aimed at candidates sitting Final Postgraduate Examinations in Medicine, Surgery and Anaesthesia. Includes Lectures, Workshops, Ward Round, informal discussions and Course Handbook.

Fee £275

Accommodation available at an additional cost.

Enquiries to:
Irene Bostock, Adult Intensive Care, Telephone 0115 924 9924 ext. 43339

5th 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), £80 (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

HISTORY Page

Referential Recognition for John Snow

O

ver a dozen years ago, when I rejoined the Folio Society, one of the ‘free’ books was Chambers Biographical Dictionary, the 1984 revised edition. As a sort of test, my ten year old daughter read out some of the names and questioned me about them! I asked her to look up Snow and was perturbed to discover that the only Snow mentioned was CP Snow of ‘Two Cultures’ fame who occupied nearly a column. He was a third rate novelist who had one good idea and I think is overrated.

Crawford Long, WTG Morton, Horace Wells and Sir James Young Simpson all had entries. The one about Simpson referred to his championing of chloroform for childbirth against religious and medical opposition but ambiguously stated that “its employment at the birth of Prince Leopold signalled general acceptance”. Was this why, in an after dinner speech in Sheffield a few years ago, the then President of the RCOG was adamant that it was Simpson who gave chloroform to Queen Victoria? (Subsequently, I sent him photocopies of the entries in John Snow’s Casebook; didn’t get a reply!)

I wrote to Chambers in Edinburgh, pointing out the omission of John Snow both as a pioneer of scientific anaesthesia and as father of British epidemiology but got only a noncommittal anodyne reply.

For some reason, I got another freebie in 1995 – the Hutchinson Encyclopaedia. It (and the 1999 edition) include Simpson and CP Snow but none of the others. My daughter gave me Microsoft Encarta on CDROM as a birthday present in 1997. Naturally, I looked up Snow but only CP was listed. Encarta ‘97 includes Crawford Long, Davy, Morton and Simpson but no other anaesthetists like Clover or Wells. Last year, I bought the Encyclopaedia Britannica (EB) CD ‘98. There is no biographical note about John Snow but he is named in articles about anaesthesia and chloroform and also medical geography and the history of London. There are biographical entries for Colton, Davy, Jackson, Long, Morton, Simpson, Wells and, of course, CP Snow. I e-mailed EB who eventually replied saying the Board of Editors or some such is considering the idea. The Wood Library/Museum of Anesthesiology supports my appeal to EB.

That’s the bad news as far as I’ve checked. The good news is that recently I thumbed through the latest edition of Chambers in a bookshop and found quite a decent entry for John Snow. So, did my letter all those years ago have an effect? At the time, I tried encouraging some of the great and good in anaesthesia, including the Professor in Edinburgh, to write to Chambers. I found an entry for John Snow in the Cambridge Biographical Encyclopaedia and, of course, he’s in the Dictionary of National Biography, as are several other British anaesthetists (there should be more). I may spend a little more time in bookshops looking in reference works but, really, I’ve got better things to do. I hope this piece may encourage others to check reference books and then write or e-mail all who omit our heroes.

Adrian Padfield, History of Anaesthesia Society

Advertising in Anaesthesia News

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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

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Future meetings

The 2000 annual meeting in will be held in Oxford on 7 October 2000, with Morriston Hospital Swansea being the hosts ... Surgeons and in order to strengthen relationships with other Societies, further meetings of a similar nature are planned.

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Web Page

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Standards in anaesthesia for plastic surgery and burns

The Society is actively looking at ways in which standards for good practice may be implemented. A document suggesting the standard of knowledge required for specialist units, district general hospitals and trainees was debated and the response will be presented to the Royal College in due course. The PSBA has set up a Competencies and Standards Group specifically to look at these issues and it has already met three times. The group consists of the current officers of the Society, together with Dr Colin Ince and Dr Diana Swallow.

The Editor replies...

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The Sherry Glass Count

T

he tabloid newspapers have been criticised for showing too many women’s breasts in the past. This has been meas- ured, using the ‘nipple count’. Anaesthesia News is in grave danger of overdoing the number of photographs, nowadays in colour, of the ‘great and good’ with wine glasses in their hands and vacuous smiles on their faces. The count has been rising in recent editions.

It does not give the working peripheral Consultant joy to see vast coverage under ‘news’ of the leaders receiving yet more congratulations and kudos. Most of us deliberately forsook all idea of joining that crowd when we took posts at smaller more peripheral hospitals. It does however accentuate a feeling of ‘them and us’.

I shall be monitoring the sherry glass count (broken down by age and sex of course) in Anaesthesia News before putting them in the bin.

Keith Birkinshaw, Dunfermline

Superior Carrier Service

William Harrop- Griffiths, Assistant Editor at Anaesthesia, takes an urgent despatch to 9 Bedford Square.
Anaesthesia News
January 2000

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The Honorary Secretary, Association of Anaesthetists of Great Britain and Ireland, 9 Bedford Square, London WC1B 3RA.

Closing date 11 February 2000

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BAXTER HEALTHCARE TRAVELLING FELLOWSHIP OF UP TO £2,500

Opportunity: to travel anywhere in the world to undertake a hospital-based study to examine current problems and fresh applications of fluid therapy, with particular emphasis on resuscitation, trauma, parenteral nutrition, intravenous infusions of drugs and blood transfusion.

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• Eligibility: open to all members of the Association of Anaesthetists of Great Britain and Ireland.

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Charity Commission Notice
Charity: East Grinstead Anaesthesia Research Trust (231254)
Scheme to affect the trusts of the charity.
Reference: VB-126853-CD(Ldn)
The Commission proposes to make a Scheme for this charity.

A copy of the draft Scheme can be seen at:
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Queen Victoria Hospital NHS Trust
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East Grinstead
West Sussex RH19 3DZ

or can be obtained by sending a stamped address envelope to the Charity Commission, Harmsworth House, 13–15 Bouverie Street, London EC4Y 8DP quoting the above reference. Comments or representations can be made within one month from today (by 1 February 2000).

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Joint Committee on Good Practice

By Morrell Lyons

The Right of the Medical Profession to self regulation in governing its conduct and practice can no longer be taken for granted. Serious doubts have arisen as to how effective the profession is at this task. Recent events have encouraged the perception that doctors are more interested in the preservation of their own status and right to practise than they are about the welfare of the patients whose care has been entrusted to them.

Self Regulation

Despite the criticism the medical profession is still convinced that self regulation is both a desirable goal and one that the profession is capable of effectively continuing to carry out. The nature of the practice of medicine is such that the medical profession itself is still the only logical body with the background and understanding to enable the administration of the necessary regulatory duties. The profession realises that it will have to make strenuous efforts to confirm that it is indeed capable of fulfilling the self regulatory role while at the same time working with patients to preserve their interests. To this end, the General Medical Council (GMC) has proposed that self regulation should become mandatory for all doctors. Such an exercise, they believe, would both reassure the public as to the maintenance of expertise and also demonstrate that the medical profession is capable of self regulation.

Revalidation

Medicine in the United Kingdom has arrived somewhat late at a decision for revalidation. The process in different forms being in place in countries such as the USA, Canada, the Netherlands, Australia and New Zealand.

There is now an acceptance that revalidation is a necessary part of the discipline of good practice. There is still controversy about its ability to achieve this goal and, incidentally, contribute to the preservation of self regulation by the medical profession.

In their particular specialty the individual medical specialties are without doubt in the best position to set and assess standards and they need to give consideration to the problems inherent in revalidation. It is abundantly clear that, in the present circumstances, the GMC cannot accept unconditionally the word of bodies such as the Royal Colleges that their members are worthy of revalidation. Agreed objective data are necessary and will have to demonstrate the status of each individual doctor.

Anesthesia

Anesthesia is not new to audit and, since the introduction of anesthesiologists, anaesthetists have looked critically at their practice. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Royal College of Anaesthetists (RCA) have put these endeavours onto a national footing with the institution of CEPOD and NCEPOD and, in the light of experience, the setting of guidelines and standards. In 1997, the AAGBI and the RCA were presented with the challenge from the Chief Medical Officer, England, to try to define good practice in anaesthesia. They set up a Joint Working Party for this purpose and their deliberations culminated in the publication of ‘GOOD PRACTICE – a guide to Departments of Anaesthesia’. The booklet laid down the principles of good practice and, while much of the advice contained in the document was already available from the AAGBI and the RCA in a more disparate form, the working party took the opportunity to bring it together in one document of advice and guidance.

Meanwhile, the Department of Health (DH) published its own solution to the quality agenda by proposing a system of Clinical Governance, Appraisal and Assessment with guidelines. Clinical Governance not only affects all health care professionals but also the systems and processes in which they work.

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Anesthesia

Anesthesia is not new to audit and, since the introduction of anesthesiologists, anaesthetists have looked critically at their practice. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Royal College of Anaesthetists (RCA) have put these endeavours onto a national footing with the institution of CEPOD and NCEPOD and, in the light of experience, the setting of guidelines and standards. In 1997, the AAGBI and the RCA were presented with the challenge from the Chief Medical Officer, England, to try to define good practice in anaesthesia. They set up a Joint Working Party for this purpose and their deliberations culminated in the publication of ‘GOOD PRACTICE – a guide to Departments of Anaesthesia’. The booklet laid down the principles of good practice and, while much of the advice contained in the document was already available from the AAGBI and the RCA in a more disparate form, the working party took the opportunity to bring it together in one document of advice and guidance.

Meanwhile, the Department of Health (DH) published its own solution to the quality agenda by proposing a system of Clinical Governance, Appraisal and Assessment with guidelines. Clinical Governance not only affects all health care professionals but also the systems and processes in which they work.

Workshops

New for this GAT meeting are two workshops which will run concurrently with the lecture sessions. The first will be a workshop on difficult airway management with skill stations for practicing the use of the fibrescope, percutaneous tracheotomy and other advanced airway techniques. The second will be an anesthetic simulator where critical incident scenarios may be practiced.

In addition, in between sessions, there will be an opportunity to advance your IT skills with computer stations manned by our local computing experts. They are prepared to answer your questions on any aspect of IT and demonstrate how you can get the most out of currently available software and the Internet.

Social Programme

The 33rd Annual Dinner of GAT will be held at Cardiff City Hall. This is a spectacular civic building close to the city centre. Included in the evening will be a champagne reception and five course dinner, followed by a live band and late bar. No dinner speaker is expected!

The Wednesday evening event will be held in the Millennium Stadium, home of Rugby World Cup 1999. An evening of food, wine and entertainment following a local theme is anticipated.

The venues of all this year’s academic and social events are within Cardiff city centre. Accommodation for delegates will be based at Cardiff Hall of Residence. Cardiff has a diverse array of restaurants, bars and other attractions. All these will be within easy walking distance.

Don’t Miss It!

Attendance at recent GAT meetings has been disappointing. Limits on study leave expenses have been introduced which may be one reason for this. However, for the GAT 2000 meeting we have introduced a new dimension with practical workshops but still maintaining our traditional format. We believe this offers good value for money. Anesthesia is a progressive, forward thinking specialty but we need your help to keep it there. We look forward to meeting you in June.

Dr. Sarah Harries, Co-opted local representative for GAT ASM 2000 Cardiff Dr Ian Bowler, GAT Committee Member

For further information contact Joanne Barnes, Datex Ohmeda Educational Co-ordinator, at the Association or at meetings@aagbi.org

Look out for the full programme and registration booklet coming soon with Anaesthesia News.
The Annual Scientific Meeting of the Group of Anaesthetists in Training will be held in the Cardiff Anaesthetic Department, between June 21 and 23. GAT meetings are always extremely popular with trainees, with a tradition of combining education with enthusiastic participation in social activities. We anticipate that this year’s meeting should be no exception. The planned scientific programme incorporates issues currently topical in anaesthesia, while the social programme offers an opportunity to visit the best of old and impressive buildings in Cardiff with events planned at both Cardiff City Hall and the magnificent Millennium Stadium.

Scientific Programme

The content of this year’s scientific programme reflects the nature of work and interests of the host department and considers the expanding role of the anaesthetist, highlighting that anaesthetists are now involved in nearly all stages of hospital patient care. We believe that it will be both stimulating and interesting to delegates. The sessions are detailed below:

- thoracic anaesthesia;
- emergency medicine;
- critical care of the surgical patient;
- equipment evaluation and standard setting;
- transfusion medicine;
- current controversies in anaesthesia – an open debate on aspects of obstetric anaesthesia, managing the difficult airway and airway management in ICU.

Following tradition, the hotly contested Registrar’s prize competition is an integral part of the scientific programme. The closing date for entries this year is March 10. Short-listed entrants are asked to make an oral presentation of their project of not more than ten minutes, followed by a brief discussion. The winner receives a cash prize and the President’s Medal. Further information is available on the Association website or from the Honorary Secretary of the Association.

The Annual General Meeting and Trainee Conference will take place on the second day. The GA T Chairman will present the work of the GA T Committee over the previous year. This will be followed by the Trainee Conference, with issues currently affecting our training are presented and discussed. This is an opportunity for you to have your say. The Association sees its trainee members as the future of the profession and our opinions are warmly welcomed.

In addition, there will be a short report from this year’s Baxter Healthcare Travelling Fellow and, at this meeting, a presentation from the winner of the Abbott History of Anaesthesia essay prize. The closing date for essay entries is January 31.

Pinkerton Lecture

The Pinkerton Lecture is always a highlight and this year we are delighted that Dr David Whittaker, a Consultant Dental Surgeon and Reader in Oral Biology and Forensic Dentistry from Cardiff has agreed to speak. Dr Whittaker is renowned for his work in the identification of the deceased from their teeth or following facial reconstructive work. He will demonstrate the techniques used in his work and illustrate his lecture based on the infamous criminal cases he has investigated.

As events progressed it became clear that this exercise was going to be a long-term challenge and to meet it the AAGBI and the RCA established the Joint Committee on Good Practice (JCGP) in 1997. This Joint Committee was charged with outlining how the process could be taken forward, the quality agenda kept under review and active steps taken to equip individual anaesthetists and departments of anaesthesia in their preparations to meet the changing scene.

Joint Committee on Good Practice

The JCGP has accepted that there is an urgency to give guidance to all anaesthetists so that they will be in a position to counter any criticism of their professionalism and at the same time meet the challenges which will be inherent in revalidation.

The JCGP is working in four areas to bring forward recommendations and advice to equip individual anaesthetists and departments of anaesthesia to produce objective evidence of good practice and prepare for appraisal and assessment of their work as outlined in clinical governance. They are:

1. The personal portfolio
2. The departmental portfolio
3. The basis of appraisal
4. The basis of assessment

The GMC and most specialties see the need for every individual doctor to prepare and maintain a personal portfolio although the GMC has not as yet clearly defined where this fits with revalidation. The emphasis on which data should be included in a personal portfolio is therefore likely to vary with specialty. The JCGP sees good practice in anaesthesia as having distinctive characteristics and so is pressing ahead to produce a template of a personal portfolio for anaesthetists. At the same time the Committee sees the need for the development of a departmental portfolio. Anaesthetists tend to work in teams and to organise their work in association with their other colleagues. Many appraisal problems are not inherent in the individual but reflect departmental problems and will only be resolved at this level. The data as to how well this is being achieved must be clearly demonstrated at a local level and correlated at a national level.

The personal portfolio and departmental portfolio have been presented to a Focus Group for comment and are now, after modifications, released nationwide for pilot studies to test their usefulness and acceptability.

Appraisal and assessment are part of clinical governance and the JCGP is finalising advisory documents in these areas. They will be ready for pilot studies early in 2000 and should meet the timetable for Clinical Governance.

Joint Liaison Committee

Running parallel with these activities, the RCA and AAGBI established a Joint Liaison Committee to give advice and assistance to Trusts about the organisation, personnel, working patterns and relationships of anaesthetists within a Trust. It is designed to help the Trust to deal with difficult problems involving anaesthesia when the other methods available at Trust level have failed. It is too early to judge the eventual demand for the services of this committee nor indeed whether its contribution has been successful but, in its work so far, it has tackled this very difficult area with resolution and sensitivity.

Conclusion

The JCGP is convinced that, once these measures are in place, anaesthetists and departments of anaesthesia will have the objective evidence to be able to reassure the public that they are providing the best service which can be expected within the system in which they work.

The JCGP also feels that, with such measures in place, individual anaesthetists within departments who satisfactorily meet the agreed criteria will then qualify to have their names retained on the medical register. The best group to lay down such criteria has to be the profession and the specialties within it. The standards must be national so that they are acceptable nationwide and no doctor gets locked into one particular Trust or institution and is unable to move therefrom. The GMC and the specialty have a slightly different agenda and the marrying of the two aspirations of best practice on the one hand and what is acceptable on the other will be challenging.

A further area of concern in all these moves is remedial treatment for the dysfunctional doctor, retraining and other alternative measures.

The JCGP feels that, once they achieve their immediate objectives, anaesthetists will be able, with the co-operation of the public, to continue to develop the specialty, maintaining and improving the high standards which have always characterised it.

Morrell Lyons is Chairman of the Joint Committee on Good Practice

‘Old Journals’

What happens to your old journals once they have been read? Do they lie around the house irritating your spouse? Now’s the time to do something about that! Old Journals gives you the opportunity to have your old journals read by a worthy recipient. The JCGP is finalising advisory documents in these areas. They will be ready for pilot studies early in 2000 and should meet the timetable for Clinical Governance.

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11th Annual Open Meeting and Seminar of the Irish Standing Committee

Saturday 20 November 1999 saw the 11th Annual Open Meeting and Seminar of the Irish Standing Committee in the Westbury Hotel, Dublin.

Dr Sean McDevitt, the Convenor, opened the meeting and invited the President, Dr Mal Morgan, to speak. Dr Morgan stated that he was delighted to be back in Dublin and gave a summary of current Association activity.

First, he discussed revalidation and mentioned that the GMC in London had agreed to devolve responsibility for revalidation to the Royal College of Anaesthetists; a joint committee has been formed with the Royal College to address this issue. The President stated that he would reach a situation where everyone would have to be appraised every year and mentioned the difficulties of assessing an anaesthetist’s performance. He said that the general view was against an examination. In addition to a system of personal portfolios, each Department would have its own portfolio, based on the principle that an individual must be able to develop his or her profession in the right environment.

Dr McDevitt mentioned several other working parties of the AAGBI. The working party on Substance Abuse has sent out a confidential questionnaire to each Anaesthetic Department in the United Kingdom and Ireland. So far, there has been a 63% response rate.

The President added that this meeting provided an opportunity to revise various ‘glossy’ publications of the Association. Dr Morgan also mentioned another working party on infection control. He stressed that each patient is entitled to breathe from an uncontaminated breathing system. He added that the UK Department of Health had issued a directive that items intended for single use were not to be re-used. Finally, Dr Morgan mentioned insurance for members engaged in patient transfer, or travelling to an accident site. Membership would entitle members to up to £1 million insurance cover.

Dr McDevitt thanked Dr. Morgan and mentioned a few topical Irish matters. He expressed his thanks to PJ Breen and Aidan Synnott, the outgoing Convenor and Deputy Convenor, respectively. He said that everyone was greatly appreciative of the difficult work they had performed while on the Committee, especially in VH1 negotiations. He then welcomed two new members of the Committee, Ann-Elizabeth Bourke and Dermot Kelly.

Dr McDevitt then mentioned some issues affecting the specialty in Ireland, specifically clinical governance and the medical manpower debate, including the proposed new category 3 consultant. This grade, proposed by the Department of Health, would be a fully trained specialist with clinical independence but on a different contract from existing consultants and this is something the authorities and other staff who were responsible for this patient’s management are to be congratulated on their dedication and the successful outcome. One cannot however be too conscious of the monumental expense involved in this particular enterprise. The patient, who had refused transfusion even though she would otherwise die, was in hospital for 114 days, of which 38 were in ICU, followed by one week in the HDU, before transfer to a general ward. Daily transfer by ambulance (with full ICU support and a consultant intensivist in attendance), to the Hyperbaric Oxygen Unit, occurred during the first sixteen days. In addition, medications, investigations, parenteral nutrition and staff salaries all contributed to the cost.

The Association of Anaesthetists’ recent booklet ‘Management of Anaesthesia for Jehovah’s Witnesses’ considers comprehensively, from the anaesthetist’s viewpoint, the legal and practical issues of management of such cases, but carefully (probably deliberately) avoids associated issues. Although described as an advisory document, anaesthetists who chose not to follow this advice would be hard pressed to justify their actions in the event of a subsequent dispute. One of the unequivocal recommendations is that ‘In an emergency, an anaesthetist is obliged to care for a patient in accordance with the patient’s wishes and irrespective of the anaesthetist’s own views’. (my italics). It is a traumatic enough experience whenever a patient dies in our care, even when everything possible has been done. How much more so when it happens for want of simple measures one has been obliged to withhold? Having been thus constrained in our own choice of management, we obviously cannot stand by but must do whatever else is possible to save the patient’s life.

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I pose the following questions as Devil’s Advocate: irrespective of strongly held beliefs and convictions, is it not selfish in the extreme for a mother with an existing family to refuse ‘standard’ treatment when this refusal could result in her own children being orphaned? If a choice has to be made, is not the commandment (from the same Good Book) to ‘love one another’, equally if not more compelling than that prohibiting the acceptance of blood?

By refusing to allow generally recognised life-saving treatment, does this not in effect, change the condition to one of ‘self-infliction’ and, if so, should the patient be required to bear the cost of alternative treatment, especially in the present climate of so called NHS Rationing?

Can it be justified for a patient who refuses conventional treatment to ‘block’ spare ICU resources from other deserving patients, in this case for 38 days, when it is not unreasonable to postulate that a much more rapidly successful outcome would have occurred had this patient been given a blood transfusion at the outset?

While the personnel caring for this patient must have derived great personal satisfaction and fulfilment at achieving the eventual happy outcome, this will have been preceded by many continuing hours of great anxiety, no doubt also shared to some extent by their own families and that of the patient. Is it right, when NHS staff are increasingly suffering from low morale and overwork, that additional unnecessary stress of this nature should be an added burden?

John Francis, Exeter
From these and other discussions, the co-ordinators began to draw out the various opinions that might result in recommenda-
tions and identified cases to illustrate these points. Initial drafts
were then written. By midsummer, the administrative assistant
had put the data from the questionnaires into the computers and
had carried out an analysis that formed the basis for the various ta-
bles in the Report. Drafts were commented on by the advisers and
then, during the summer, they went to the Steering Group.
This large and august body has representation from the various
Colleges and Associations that support the work of NCEPOD.
Its members read the drafts, corrected spelling and grammar and
commented on the conclusions that were being drawn. Bit by
bit an agreed text was established. The Chief Executive, Fiona
Whimster, talked to printers about presentation and layout, as
well as combing the text and tables for inconsistencies. Finally,
in August, all was finalised and sent off to the printers.

When the first NCEPOD Report was produced, John Lunn,
the anaesthetist who set up the Enquiry, described how they
decided to launch it at a press conference. Expecting some-
thing modest, they prepared carefully but were astonished at
the media interest. The message went out on television and in the
ewspapers with sensational headlines that raised public inter-
est but infuriated much of the profession. Since then we have
learnt to use expert help. For the press release and press confer-
ence we have professional guidance. As the Report is paid for
by public money and is in the public domain, this is thought to
be the best way to launch its contents.

So, on the morning of 17 November, we found ourselves at
the Royal College of Pathologists overlooking the Mall, as the
Queen made her way past in a horse drawn coach to open Par-
liament and we waited for the press.

We started with the Chairman welcoming those present and
explaining what we had been doing. Then there was a presenta-
tion of the main findings and recommendations relating to...

Keep up to date

One simple way of curing the hospital bed crisis is illustrated here. What is it? Answer on page 12.

The Pain Society

The British and Irish Chapter of the
International Association for the Study of Pain

Annual Scientific Meeting

3 – 5 April 2000
University of Warwick

Plenary sessions include:

- An overview of current pharmaceutical developments
- Fear processes in chronic pain
- Visceral pain mechanisms
- Nursing issues: group protocols and dispensing
- Sensation from the heart and chest
- Adrenergic mechanisms and analgesia
- Neuropathic pain: mechanisms and treatment
- Meta-analyses – have they helped?
- Cognitive behavioural therapies for pain

In addition, there will be a total of 33 parallel mini-symposia and workshops catering for all interests.

The meeting is open to doctors and other health care profession-
als with an interest in pain management. Registration forms and
full conference details will be sent to all Pain Society members
automatically and to others on request, in December.

The Pain Society, 9 Bedford Square, London WC1B 3RA
Tel 020 7636 2790, Fax 020 7323 2015.
email painsoc@compuserve.com
NCEPOD 1999
Extremes of Age

November saw the launch of a new National CEPPOD Report, ‘Extremes of Age’. The planning of this report began back in the autumn of 1996 when it was decided to carry out a re-audit of the original 1989 NCEPOD sample that looked at children. However, it was recognised that, in examining deaths in children occurring in hospital within 30 days of a surgical procedure, this would be a small sample. Paediatric deaths account for less than one per cent of the 20,000 deaths reported to NCEPOD each year. It was therefore agreed that, as well as looking at children under 16 years, we should also look at the very old, patients over the age of 90 years.

Careful consideration was given as to the questions that should be included in the questionnaires for each sample. For paediatrics, it was important that a variety of questions be asked so that the results could be compared with those from other units. For the elderly group, it was important that questions relating to possible confounding factors be included.

Kathy Sherry and Anthony Gray, the anaesthetic co-ordinators, took responsibility for organising the anaesthetic aspects of the elderly group and the same was done for the children. As the cases were looked at and discussion took place, aspects were identified where it was felt that improvements could be made. In a similar way the surgeons also began to formulate their views and a point was reached when joint discussion seemed sensible. Almost half of the over 90’s were orthopaedic patients and, of the remainder, general surgery was the greater portion. Postoperative care was often not satisfactory, fluid balance confused and anaesthesia less than ideal. The general surgeons were adamant that these were their patients and that they and their teams would look after them but the orthopaedic surgeons were equally clear that they would be delighted if anybody would take over the care of their patients!