Medical Error in Scotland

No! not a confession, nor cause for another inquiry but the theme of the 2003 Open Meeting of the Scottish Standing Committee. Following the success of the inaugural meeting last year, it was an obvious choice to return to the same venue at Stirling Conference Centre. As on the previous occasion, a committee meeting was held prior to the main event, to which members of the Association Executive were welcomed.

An addition to the agenda was a presentation by Dr Andrew Hothersall (Western Isles General Hospital) on anaesthetic issues relating to the more remote hospitals in Scotland. Andrew had recently been appointed as anaesthetic educational facilitator to RARARI (Remote and Rural Areas Resource Initiative) and highlighted the problems of working in remote areas, such as recruitment and retention of staff, deskillling, and heavy on-call commitment, as well as all the benefits of living in such beautiful locations. The committee offered its full support to him in his new appointment.

It is testament to the success of last year that the Open Meeting was almost fully subscribed. Unlike its predecessor, however, instead of covering a variety of topics, both political and clinical, the speakers followed a main theme throughout, ‘medical error: causes, consequences and curtailment’. The fact that there was minimal overlap or repetition from the speakers gives evidence of the scale of the problem.

Professor Alan Aitkenhead began the proceedings by reassuring us all that anaesthesia is relatively safe and deaths related to anaesthesia have, since the 1930s, continued to fall with the increase in scientific knowledge and improved training and medical records. Errors by anaesthetists, however, can have disastrous consequences for the patient and we are more likely than other specialities to have our practice scrutinised. He categorised errors into two main groups; active ones which usually precede the incident and may be technical, knowledge, rule or skill
based and latent ones which are within the system and may affect our actions.

Dr Bill Mathewson (MDDUS) continued with the theme discussing the epidemiology of medical errors, the roles of the medical defence organisations and the importance of joining one, and the prevention of complaints. Clear and accurate records, good doctor/patient relationships and agreed systems of working with colleagues will do much to reduce these. He highlighted the fact that ‘Bristol’ was the first occasion in which a Medical Director was found guilty of serious professional misconduct on behalf of his colleagues.

Ms Tracey Turnbull (an unfamiliar face to most anaesthetists) from the Scottish Central Legal Office then gave a very clear and interesting presentation on the format and function of the CLO, the ‘litigation pathway’ and the effects of Legal Aid on the advice given to Trusts. Claims against anaesthetists are, thankfully, very low in number but awards are high.

The morning session concluded with Dr. Alexandra Campbell of the SEHD, discussing the Adults With Incapacity (Scotland) Act, 2000. In Scotland, people under the age of 16 cannot be overruled by an adult, with regard to consent to medical treatment, if they are considered to be capable of understanding the nature and consequences of the procedure. The AWI Act concerns those over 16 whose disability causes them difficulties with personal decisions or consent to medical care.

A lively Open Forum then followed, where the usual topics of study leave, travelling costs to meetings and nationwide ‘travelling roadshow’ seminar programmes were revisited. Manpower was, again, an area of concern and Dr Peter Wallace gave a short résumé on the recent discussions over ‘non-physician’ anaesthetists and the planned pilot studies in England.

The afternoon session started with a double act from Edinburgh. Dr ‘Arnie’ Arnstein proposed that, following the successful improvement in safety in high risk industries, by investing in a safety culture, errors can be reduced in healthcare by analysing the whole process and implementing systems which will highlight them and reduce the risk factors. Poorly performing individuals can be assisted by having them work within a safe environment. As usual, the principal obstruction is that of resource! Conversely, Dr. David Scott illustrated his morbidly hilarious talk with examples of errors with equipment – both design faults and equipment used inappropriately. He expressed his dismay at the inefficacy of notification systems and how hazard warning notices may have the opposite effect to that desired, by promoting dangerous techniques. The solution is to design the faults out of the equipment.

Many of the delegates were disappointed that our main speaker, Dr. Mac Armstrong, had been forced to withdraw, at short notice, due to commitments elsewhere but we were grateful to Brian Kennedy of Willis Ltd. who nobly agreed to stand in and skilfully led us, in determined fashion, through the quagmire of Patient Safety Regulatory Bodies and Systems in Scotland. Thanks were given to all the speakers and, in particular, to the chairman of the session, Pete Alston, who so splendidly organised the meeting. We hope to see you all again (and, perhaps, the CMO Scotland as well) in 2004 for what promises to be another excellent meeting!

Ian G. Johnston

Scottish Standing Committee Meeting minutes can now be found on the Association website.

ANYONE FOR ECT?

The Royal College of Psychiatrists is keen to establish an ECT accreditation service and wishes to involve anaesthetists in the process. If you are a senior anaesthetist with an interest in and, ideally, sessional time dedicated to ECT, you are invited to contact either Helen Caird of the Royal College of Psychiatrists at helen.caird@virgin.net or Dr John Bowley FRCA at j.bowley@virgin.net, to register an expression of interest, with no obligation.
Editorial

We will keep writing

On your journey to work or wherever you have gone to read your copy of Anaesthesia News, you may have encountered some stress. Something that may have irritated you and which you will have to put behind you before you encounter your first patient.

Like GasFlo, you may be seriously annoyed by one of the patients, presenting with a string of so-called ‘allergies’. Like her, you may have to change your well-worn technique, thereby possibly slightly increasing the risk to your patient.

None of these minor irritations can surely compare to what others must put up with. In my time as Editor of this organ, I have been privileged to receive many Letters from Zimbabwe, written under various conditions of hardship. Computer chaos reigned once and a telephone line was misappropriated on another occasion! At the moment, we can turn on our radios to find out what is going on in that country, although long distance reports are often unreliable, especially when reporters are not allowed into the country.

Incredibly, with “a huge police and army presence” and “even tanks in town”, our correspondents in Zimbabwe continue to provide informative copy for Anaesthesia News. Spare a thought for our colleagues getting to work (assuming they can) past all these problems and, as Laurie Marks comments on page 20, once there, facing the problems of diminishing numbers of staff because of ‘exports’. Amazingly, despite all of this, with one exception when the computer died, copy has arrived, usually well ahead of the due date.

All of the problems faced by our colleagues overseas must put ours into perspective. We have time to consider our pensions, as outlined on page nine, and rid ourselves of the minor hassles that work in the modern Health Service throws at us. Increasingly, a better informed population dictates what we do (or, often, what we don’t do for lack of beds, time, staff…). The news recently has been full of the increased Caesarian section rate in this country and how doctors are being blamed for the rise. No mention of the mothers, then, and the ‘too posh to push’ brigade? What about these people as a pressure group to make us change the way we do things?

Some change must surely be for the good. Increasing patient safety by ensuring that our syringes are correctly labelled and the introduction of a safer, newer, system of labels must be applauded. However, as pointed out on page five by our colleagues from Northampton, we must not allow this to be an excuse for lack of vigilance.

As GasFlo states, we should only change our usual techniques with care. Patient satisfaction is all very well but no excuse for increased risk. If the general public wants an increasingly ‘Americanised’ system, with increased Caesarian section rates and lengthier operations, amongst other things, then so be it but the inherent increase in risk must be explained.

And back in Zimbabwe life goes on. Our correspondents there have time to wish us well and say that, whatever happens, they will keep writing. So will we and so, I hope, will you.

John Ballance

COMPROMISED AIRWAY COURSE

NHS

COMPROMISED AIRWAY COURSE

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Mrs Tina Craig, Course Co-ordinator, Clinical Skills Centre, Leicester Royal Infirmary, Leicester LE1 5WW.
Tel 0116 2586123 or email Tina.Craig@uhl-tr.nhs.uk

University Hospitals of Leicester NHS Trust

Anaesthesia News July 2003
Letters to the Editor

A surgeon’s impression of anaesthesia – chloroform and ether

No doubt you will have received some well phrased comments on the above article published in your April issue. Ms Florence cites Sir William Banks, who is hardly an illustrious figure in anaesthesia history, certainly not of the stature of surgeons William Halsted or August Bier. However, he was obviously a man of wide interest. Sir William’s conclusion that “the most important factor in the safe administration of anaesthesia is the experience of the anaesthetist” is right on the mark.

Why on earth, then, would Ms Florence suggest that today’s surgeons, whose experience in anaesthesia amounts to a few weeks’ exposure as a medical student, plus a quick perusal of Anaesthesia for the Uninterested, should be “masters over the management of the anaesthetic”(sic)? The metaphor of the General, the Brigadier and death as the enemy is so archaic as to be downright corny. Many of us anaesthetists will go through an entire career without seeing a single death in theatre. Improved drugs, drug delivery systems, standards of practice etc. have made the operating theatre as safe as a modern jet aircraft. On the rare occasions that a death occurs, it is often in the circumstance of heroic efforts on a moribund patient. Many of those are salvaged as well with good teamwork.

In fact, experienced anaesthetists today can anaesthetise just about any BODY for any THING, with full expectation of a good result. As for “disgrace falls on the surgeon”(sic), Ms Coleman must know that in law she shares co-responsibility with her anaesthetist. Anaesthetic mishaps are glaringly obvious and often quite dramatic. The surgeon would be immediately exonerated of blame and the ‘disgrace’ would land squarely on the anaesthetist. I am left wondering in fact if Ms Coleman is serious or if this is just an attempt to ‘wind up’ her anaesthesia colleagues. To her final question I would answer, yes!!! Things have changed... thank God.

Happy Birthday, Cecil!

It was back in the mid-sixties that I first visited the Liverpool University Department of Anaesthesia and stayed on to work, study and complete their course culminating in the FFARCS. The Department, established under Professor Gray, was world renowned and attracted postgraduate students and qualified specialists from all over the world. Another icon there was Dr Jackson Rees, now no longer with us, and others too numerous to mention in this letter.

Professor Gray (the’Guru’) was famous for the ‘Liverpool Technique’ which spread beyond Liverpool and was practised quite diligently in most quarters of the Commonwealth. His Department added lustre to a city which was fairly ‘jumping’, boasting two cathedrals, one yet to be completed and the other, I gather, now falling down slowly in bits; two excellent football teams – Liverpool and Liverpool Reserves (a la Bill Shankley!), the Beatles – where are they now? – pop culture: the Liverpool 8 poets and pop fashion... cry your heart out Carnaby Street! Those were the days!

I have fond memories of my association with Professor Gray and all his colleagues in the Department and the hospitals there and will always have a soft spot for the place because that was where I met my wife too!

We would like to wish both Professor Gray and his wife all the best and many more secure years in comfort and happiness.

Drs Nanda and Alexandra MENON

A Footnote to Ray Towey’s Letter from Uganda

Ray mentions Brother Elio, who gives “a decent burial to any fatal rebel casualty”. What a character! I met him when examining at St.Mary’s, Lacor, in October 2000. There had been an attack by the Lord’s Resistance Army on a night club in Gulu. Without introduction he came up to me and blasted the British for manufacturing and exporting weapons. Two days later I was apprehensive on hearing he was to drive me back to Kampala. The yet undiagnosed ebola epidemic had just started and I went to the requiem mass for the second nurse who died, while waiting to be picked up. I sat next to him but soon gave up any attempt at conversation. He just grunted in reply. We were waved through one or two police blocks.

When we reached the Nile he asked quite kindly if I would like him to pull in so that I could look at the Falls. “You don’t get ambushed the other side of the river” he said. I did not admit that I had not realised there might be an ambush. Once we got on our way again he chatted about himself. He was an Italian from a village near Selva in the Dolomites and always took his holiday in the winter. His passion was skiing. I have skied in the area three or four times so we were off skiing the runs; doing the Sela Ronda right there just north of the Equator. It was an unforgettable two hours. We had to stop before we got to Kampala while he said the Hail Mary with a student in the back of the vehicle. Then before dropping me at my guest house he pulled in at an Italian shop. “The only place you can get proper pasta in Uganda. The local stuff is rubbish.” he said. I brought him a bottle of Chianti. Thank God he survived the ebola epidemic.

Ruth Hutchinson, Zimbabwe

Thomas O’Leary, Consultant anaesthetist
Mohammed bin Khalifa bin Salman al Khalifa Cardiac Centre, Bahrain

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

Well we knew it was coming, the change to colour coded syringe labels, we knew it was a risk, a veritable critical incident waiting to happen and we won’t be surprised to read of harm to patients and possibly even the odd death or two in the coming year from misidentification of drugs around the country.

We accept that this change has to happen, but what we really find disappointing is the published intent of the College and Association to provide absolutely no guidance on how to minimise the risk, apart from the top tip of suggesting increased vigilance! It is of course the fashion to devolve decision making to local level and also to avoid being involved in taking responsibility.

Here in Northampton we have what we believe is a well run risk management department and, after the problem of changing labels was highlighted, we (in conjunction with a psychologist) came up with the idea of binning all the coloured labels and changing to white labels only. Advice received was that we should use these for six months to ‘unremember’ the old colours and then introduce the new scheme. We are sure there will be problems with this approach but it is our best guess that the risk will be lower than just changing straight off from one colour scheme to another.

Some of our anaesthetists believe that, in their professional practice, using the new colour scheme immediately will minimise their risk of error. Stocks of the new coloured labels will be available for their use.

We’d like to make it clear that if any other departments decide to use this as advice on a plan (in the absence of any other advice) and it works well, we thought of it first. However if it all goes horribly wrong then, as usual, “You’re on your own”.

Dr Chris Frerk and Dr Rae Webster
Consultants in Anaesthesia and Critical Care,
Northampton General Hospital

1. Syringe labelling in critical care areas, Royal College of Anaesthetists Bulletin 19, May 2003, p953

The Fentolator

I very much support the idea which has been expressed by Paul Fenton, Anaesthesia News, April 2003, that it may be possible to produce an anaesthetic gas delivery system suitable for either third world or developed country use. I also agree that this may be of benefit in both situations. My own best efforts in this regard relied on pressurised oxygen as a driving gas and to power a pneumatic logic circuit and would not therefore be appropriate for the very poorest countries.

It is regrettable, therefore, that the system which he proposes, which is essentially a combination of an enclosed afferent and a circle system, has a number of deficiencies, the most important of which is as follows. In the event that the pressurised fresh gas supply should fail, Dr Fenton envisages that room air is entrained into his circle system. Unfortunately, air will only be entrained at a rate equal to the patient’s oxygen consumption and, if fresh gas is only available at this rate, then it must be 100% oxygen. This situation could be remedied if the reservoir bag was removed from the circuit, but I see no suggestion that this should be done.

Dr J Russell, consultant anaesthetist, Abergavenny

Paul Fenton replies....

I thank Dr Russell for his supportive and critical comments. It is an advantage that one can discuss developments in a less formal way in Anaesthesia News than would be the case in a more academic journal but I hope with the same results. The most important thing is to promote interest in the problems of anaesthesia in Africa and elsewhere in the developing world. His input is therefore invaluable.

He mentions “a number of deficiencies” but specifies only one which I can respond to. He is right to point out that, in the event of a failure of the oxygen supply, the recirculating function of the circle system must cease and all the patient’s inhaled gas must come from room air, ie air must be entrained in preference to gas coming round the system.

This can be simply achieved in a number of ways. Two that I favour would employ a valve or a constriction operated by the failure of pressure of the fresh gas flow - a sort of ‘fail-safe’ device. When flow ceases (and therefore pressure drops in the pipe to the rotameter), either a valve opens in the expiratory limb to vent the patient’s expired gas to the room or a constriction directs gas out of the NPRV or the air inlet opens in the inspiratory limb in response to the same falling pressure.

As a further refinement, a coloured knob could show when this valve or constriction was operational. It would be obliterated at start up, as a safety check.

Anaesthesia News
July 2003

Letters to the Editor

Chest examination

Recently, I had cause to call out the vet to look at my horse. In the course of his visit we chatted about anaesthesia, during which he volunteered that he had had a recent knee arthroscopy. “And do you know” he said “the anaesthetist gave me only the most perfunctory going-over beforehand and he didn’t even listen to my chest! I wouldn’t dream of anaesthetising an animal without listening to its heart and lungs”. I remembered this when reading the recent correspondence regarding pre-op examination initiated by Dr Lanigan (March 2003). Surely we are at least capable of delivering similar standards to veterinary practice?

Pamela Laurie, Banbury
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“Gill provides the main link between the jungle and the anaesthetist, for one of his specimens of Chondodendron tomentosum provided the source of the first extract to be used clinically.”

Richard Gill and curare

Richard Gill, 1901 – 1958, was an independently minded son of a Washington physician, who dropped out of the medical course at Cornell, spent two years in the Southern Ocean, returned home, obtained a BA, married, and moved to Lima.

Wanting a permanent expeditionary base in the jungle, he built a tropical paradise, the Hacienda Rio Negro, at 5,000 ft on the eastern slopes of the Andes, just inside the ‘cool’ jungle in the Pastaza Valley of Ecuador. Here he grew tropical fruit, coffee and castor beans for export to the United States. His interest in the local Indian medicines and customs made him a very skilled self-taught ethno botanist, and he was made a local Brujo, (medicine man/witch doctor). Eventually the Indians agreed to teach him the secret of making arrow poison, which contained curare and many other ingredients.

In 1932, just before returning to the States for a holiday, his horse Chugo reared, and he slid off backwards hard, onto his heels. He rapidly developed neurological symptoms, culminating in a spastic quadriplegia. His physician, Walter Freeman, diagnosed multiple sclerosis, a diagnosis never accepted by Gill. While he was in bed, paralysed, Freeman told him that the only drug that might reduce his spasticity, was curare, unfortunately unavailable outside South America. This must have been a particularly frustrating event for one of very few men in the world capable of producing it.

Over several years Gill recovered sufficiently to contemplate returning to his hacienda, and mounting a wide-ranging ethno botanical expedition to the jungle. This became known as the Gill Merrill expedition and, although Gill’s aim was to bridge the gap between jungle and laboratory for many drugs, the most important objective was to bring back supplies of curare. This expedition was undoubtedly the catalyst that got curare into clinical use. Financial help was supplied by the businessman, Sayre Merrill. They brought back the largest consignment yet produced of samples of the raw materials and the plants for the production of curare, from which Professor McIntyre of Nebraska prepared an extract of standard potency, which they labelled ‘Intocostrin’. Other drugs Gill brought back were not so well received. This was the early days of cine film, and he produced a filmed record of the trip.

Some Intocostrin from Gill’s samples was given to a neurologist, Dr A E Bennett, who used it in convulsive therapy for depression, reducing the fracture rate dramatically. It was then given to Harry Griffith to try it in anaesthesia, which he did in January 1942, and it rapidly became part of a standard anaesthetic technique.

Gill’s other contribution was to show that the Indians used the nearest appropriate vessel, calabash, tube, pot or tobacco tin for their arrow poison, and that this did not indicate what plant, or from which area it had come.

In her book, Green Medicine, Margaret Kreig is very dismissive of Gill’s achievements, but his cine film of the expedition proves many of her statements to be wrong.

He died in 1958 and multiple sclerosis was confirmed at post-mortem. He would have been pleased to hear Cecil Gray:

“We are all convinced that this had the same significance for our speciality as Listerian antisepsis had to surgery”.


Dr Ann Ferguson FRCA, DHMSA

Writing for Anaesthesia News

Anaesthesia News is always happy to receive copy of articles, reports, travel stories and opinions. Most will be accepted although some editorial revision or abbreviation may be necessary. Letters to the Editor are particularly welcome. There are several ways of sending your work to your Newsletter and it should arrive at least four weeks before the intended publication date. A Word file, posted on a disk or sent attached to an email is best, although typescript may be scanned. Please send photographs, of reasonable size and in colour, either as a jpg file attached to an email, or as ‘hard copy’.

Our contact details are: 21 Portland Place, London W1B 1PY. Telephone 020 7631 1650. Fax 020 7631 4352. Email anaenews@aagbi.org
Some thoughts on anaesthesia in developing countries

The World Federation of Societies of Anaesthesiologists (WFSA) was founded in 1955. Its aim is to provide a high standard of anaesthesia for everyone. Of the more than 100 member societies of the WFSA, the majority is from developing countries. The educational activities of this organisation include distribution of anaesthesia literature, regional refresher courses and the support of specific anaesthetic training programmes. World Anaesthesia in conjunction with the WFSA produces two publications: World Anaesthesia News and Update in Anaesthesia which are also available online at www.nda.ox.ac.uk/wfsa

In 2002 WFSA/AAGBI activities included lecturer visits to Cameroon, Uganda and Tanzania and Refresher/CME courses in Zambia, Kenya, Mozambique, Mauritius and Nigeria.

Primary Trauma Care (PTC) is a course run by the PTC Foundation. It is aimed at training doctors and other health workers in less affluent countries and emphasises basic trauma care with minimal resources. Participants will be trained locally to run subsequent courses. The courses have been run in East Africa, India, Indonesia and the South Pacific. The manual is available online at www.nda.ox.ac.uk/ptc

Educational CD ROMs
E Talc (CD Rom) is a project of TALC (teaching aid at low cost, a UK based Charity), which provides free access to up-to-date health and development information and training materials for health workers. www.e-talc.org

Further CD ROMs are planned, as a joint project between World Anaesthesia and the AAGBI, in order to make educational CDs available to colleagues in the developing world.

What might be of interest for you
There is a great demand for anaesthetic textbooks and journals. It can be very difficult for colleagues in the developing world to obtain anaesthetic literature. Please donate unwanted/unused books and journals. Contact Dr Eltringham to receive names and addresses of keen recipients.
Email: reltringham@clara.co.uk

Instructors course for Primary Trauma Care.
Information from ptc@nda.ox.ac.uk

If you wish to undertake visits, which include teaching, research or study, you can apply to the Association of Anaesthetists for a travel grant. Further info under www.aagbi.org/grants_awards.html

The WFSA is grateful for any donation, which could be made with the annual AAGBI subscription (under covenant to the Education and Research Trust of the AAGBI, so increasing the value).

More information about WFSA can be found at www.anaesthesiologists.org

Barbara Bahlmann,
GAT committee

Some thoughts on anaesthesia in developing countries

Visit the trainee website on www.aagbi.org/trainee.
PENSIONS FOR ANAESTHETISTS MADE SIMPLE

Pensions have been in the news continuously over the past few years, both because of numerous legislative changes, mis-selling and, most recently, the significant falls in the stockmarket. For most anaesthetists, their pension provision will be made up of two funds, one based on NHS income and one based on private practice income.

NHS Income
The NHS Superannuation scheme offers an excellent, secure basis for retirement provision, especially in today’s volatile climate. 6% of salary is deducted monthly from your salary and the employer adds a further 4%. This results in 1/80th of your final salary as a pension for every year worked in the NHS. For example, 20 years service will produce 20/80ths i.e. 25% of final salary as a pension. Additionally, a tax-free lump sum of three times the annual pension is paid at retirement. To achieve full benefits, 40 years service by the age of 60 are needed. This is impossible for anaesthetists to achieve so consideration to buying extra benefits should be considered. There are two options.

1. The purchase of ‘Added Years’
This is achieved by paying an extra fixed percentage of salary monthly. The major advantage is certainty i.e. you know what extra benefits you are buying at retirement. The major disadvantage is a lack of flexibility, both in terms of varying contribution levels during your working life and choosing how you take your benefits at retirement.

2. The purchase of Additional Voluntary Contributions (AVCs)
With this method, a contribution amount is chosen which builds up a pot of money in parallel to the superannuation scheme. It is difficult to predict the exact level of benefits that will result, but you can easily vary contribution levels and at retirement take a form of pension which most suits the individual and their dependents.

Private Practice Income
It is not unusual for consultant anaesthetists to top up their NHS income through private practice. If no pension provision is made on these earnings the drop in income on retirement can be dramatic. While other vehicles, such as property, have been promoted in the press, the most appropriate, tax efficient and commonly used method of incorporating private practice income to bolster retirement provision for most anaesthetists is by way of a personal pension. In simple terms, for every £100 contributed to a pension the government will add £66.67 to that figure representing a ‘guaranteed’ growth of over 66% before any investment return is taken into account. Many accountants offer the advice to maximise pension contributions because of the dramatic reduction in tax liability achieved.

The Government has recently introduced a new personal pension called ‘Stakeholder’ which is cheap (charges capped at 1%) and extremely flexible. If you are contributing to a personal pension and it is not a Stakeholder, there is a high chance you would be better off by transferring to a Stakeholder pension. The Financial Services Authority, which regulates pensions, estimates that two million people with personal pensions should consider transferring to Stakeholder. If you are not contributing to a pension on your private practice income, you should seriously consider doing so.

In summary, the key to maximising your retirement income is careful research and planning at the earliest stage possible. With the new Government Stakeholder pensions, the costs have been reduced dramatically but the tax relief still remains extremely attractive. Our advice is to act now and fully review your pension provision. The time spent will be an extremely wise investment.

Dr Mark Martin and Mr Robert Jones, Pension Specialists, 20Twenty Independent Limited

If you would like more information please call Dr Mark Martin on 020 7400 8613.
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For Further Information and booking please contact Karen Grigg or Joanne Barnes on Telephone: 020 7631 8803/8802 or email: meetings@aagbi.org.
ANAESTHESIA FOR LASER SURGERY 2003
IN CONJUNCTION WITH THE 20TH CLEVELAND (UK)
INTERNATIONAL HANDS-ON LASER COURSE

ONE DAY COURSE – 23 October 2003

Departments of Anaesthesia and Otolaryngology
and H and N Surgery, James Cook University Hospital,
Middlesbrough, UK.

This course will cover
• Laser physics
• Laser safety
• Anaesthesia for laser airway surgery
• Paediatric airway surgery
• Guest speaker Dr Ian Barker, Children’s Hospital, Sheffield

Educational approval applied for: 5 CME points

The Cleveland Laser course is recognised by the European Laser
Association, the British Medical Laser Association and the
International Society for Lasers in Medical Science.

Course Fee £150

Further Information and application form from:
Mrs A Ellis, Course Co-ordinator
Dr S Williamson, Course Organiser
Head and Neck Office, Department of ENT, James Cook
University Hospital, Marton Road, Middlesbrough TS4 3BW, UK
Tel 01642 854023, Fax 01642 854070.
e-mail:angela.ellis@stees.nhs.uk

To advertise in Anaesthesia News,
see the details on page 16
or contact Claire Elliott on
020 7631 8817,
by fax on 020 7631 4352,
or email claireelliott@aagbi.org

BRISTOL MEDICAL SIMULATION CENTRE
FORTHCOMING COURSES

8 and 9 July, 2 Day Paediatric Anaesthesia Critical Incident Day
(GRL), for occasional paediatric anaesthetists (£275)
5 September, Medical Emergencies Course, for SpRs and
consultants in Emergency Medicine, ITU and Anaesthesia (£200)
9 October Low-Flow Anaesthesia Course, for anaesthetists
(£150)
14 October, NCCG Critical Incidents Day, for non-consultant
career grade anaesthetists (£150)
16 and 17 October, Transport for the Critically Ill Course, for all
grades (£275)
21 October, Paediatric Anaesthesia Critical Incident Day (GRL),
for occasional paediatric anaesthetists (£160)
22 and 23 October, Team Training for Critical Incidents, for
nurses and clinicians (£270)
30 and 31 October, Obstetrics and Gynae Course, for obstetric
anaesthetists
3 November, Simulated Airway and Ventilation Emergency
Course, for SpRs and consultants in Emergency Med, ITU and
Anaesthesia (£150)
13 November, Mature Consultants Course, for mature consult-
ants in Anaesthesia (£150)
14 November, Medical Emergencies Course, for SpRs and con-
sultants in Emergency Medicine, ITU and Anaesthesia (£200)

Specific departmental courses can be arranged
upon request (fee negotiable)
Includes coffee, tea, biscuits and lunch. CEPD points approved;
five points (for one day) and eight points (for two day courses)

For bookings please contact Jane Southway, Secretary on Tel
(0117) 927 7120 or Alan Jones, Centre Manager, The Bristol
Medical Simulation Centre, UBHT Education Centre, Level 5,
Upper Maudlin Street, Bristol BS2 8AE. Tel (0117) 342 0108,
e-mail alan@simulationuk.com ; and/or visit the website at
http://simulationuk.com (this contains course details).
MEETINGS & CONFERENCES, CENTRE FOR ANAESTHESIA, UCL
Fax: 020 7580 6423 / Tel: 020 7323 9911 / uch.acru@btinternet.com
Professor Monty Mythen, Portex Professor of Anaesthesia and Critical Care, UCL
www.ucl.ac.uk/anaesthesia/meetings

“DINGLE 2003”
5th Current Controversies in Anaesthesia & Peri-Operative Medicine

Dingle, Co. Kerry, Ireland 8th-12th October 2003
Call for Abstracts - £1000 in Prizes
Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline EXTENDED TO, 31st July 2003. 1 A4 page abstract submissions to: Dr Denny Levet c/o uch.acru@btinternet.com
Applications forms now available

OESOPHAGEAL DOPPLER TRAINING ~ CME APPROVED
Places available for Brighton 19th September 2003 Coming soon dates for London ~ Birmingham ~ Exeter
Contact: Dr Mark Hamilton c/o uch.acru@btinternet.com

Lectures and Practical Sessions on:-
- Validation and comparison
- Physiology of cardiac output
- Waveform interpretation
- Critical review of the literature
- Cost effectiveness and outcomes
- Clinical application

PAEDIATRIC SEDATION: DEVELOPING SAFE PRACTICE
Institute of Electrical Engineers, London, 16th & 17th October 2003
A conference for doctors, dentists, nurses, psychologists and all health professionals involved in paediatric sedation. The content is targeted to improve the quality and safety of paediatric sedation services by disseminating knowledge, philosophy and skills about both the practical and the organisational aspects of sedation.

Invited Speakers include: Dr Neil Morton (Glasgow) | Dr Eileen Bradbury (Manchester) | Dr Monica Stokes (Birmingham) | Dr Mark Thomas (London) | Mrs Eileen Eastman (Bristol)

Meeting Chair: Dr Mike Sury, GOSH, Department of Anaesthesia, Great Ormond Street Hospital for Children NHS Trust
AGENDA & APPLICATION FORM NOW AVAILABLE www.ucl.ac.uk/anaesthesia/meetings

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8th Annual Congress of the British Society of Orthopaedic Anaesthetists, London, 14th November 2003
PROVISIONAL ANNOUNCEMENT AND CALL FOR ABSTRACTS

For abstract submission forms and full congress details contact:
Meeting Chair: Dr Mike Hetreed (RNOH, Stanmore)
c/o bsoa@btopenworld.com / Telephone: 020 7323 9911
AGENDA & APPLICATION FORMS NOW AVAILABLE
WWW.UCL.AC.UK/ANAESTHESIA/MEETINGS
**FIFTY YEARS AGO**

‘ANAESTHESIA’, JULY 1953

**MODERN ANAESTHESIA?**

Having retired from anaesthetic practice some years ago, I was interested when a surgical colleague invited me to an operation, to see the modern anaesthetist at work. The patient was a man of over 80, so far as I could judge from his appearance, reasonably fit. The anaesthetist appeared on the scene with a loaded 20 c.cm. syringe containing, as he informed me, 1g. of pentothal. This was injected into a vein much quicker than it takes me to describe it. The anaesthetist then disappeared: also, the patient's respirations. I was wondering which would re-appear first, but the anaesthetist won, with a second syringe, containing, as he explained, 80mg. of flaxedil. This was injected as quickly as the piston of the syringe could be persuaded to descend. The patient, whose colour had changed through some interesting and picturesque shades of blue into purple and grey, was quickly revived by a few vigorous pumps with the handle of a Mushin absorber, and, still apnoeic but now pink, was taken into the theatre.

Here, cyclopropane was added to the mixture, and a diathermy pad applied to a thigh. The anaesthetist must have noticed that I was now getting interested in the other theatre, for he called me back and was good enough to explain that, as the diathermy machine was at the foot of the table, and we were at the head, “it was quite safe”. I was about to protest, when the anaesthetist disappeared again (the patient was still apnoeic) but he re-appeared a few moments later with yet another syringe, which was injected as quickly as the other two. This, I was told, was 50 mg. of pentamethonium. Having heard something of the properties of this drug, I felt a little anxious, particularly when I could no longer feel the radial pulse. My anxiety must have been apparent for the anaesthetist said, “Why, he’s got a beautiful pulse” (that is not how I would have described it, but then, I am not a modern anaesthetist). The anaesthetist again did his disappearing act, to re-appear later with a sphygmomanometer, with which he attempted to measure the blood pressure. “That’s very satisfactory, the systolic is just below 60”...

Some 90 minutes later, the surgeon asked me over coffee whether I did not think that was a wonderful anaesthetic. My reply I am afraid, was couched in such terms as I am sure you, Mr Editor, would consider unprintable. I wonder what would have been the reply of your readers?

Yours, &c. AN OUT-OF-DATE ANAESTHETIST?

Ref. Anaesthesia 8.3, 200

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**COURSES OFFERED IN 2003 FOR CONSULTANT ANAESTHETISTS**

**ACRM (Anaesthesia Crisis Resource Management)**
The integration of technical training and non-technical skills (human behaviour) to facilitate teamwork and situation awareness. (£250)
25 July; 10 Sept; 5 November.

**ACRM and Obstetric Anaesthesia** The principals of ACRM, as above, with an obstetric theme. (£250) 11 July; 30 July; 8 October.

**Instructors Course** (2 days) For multi-professional generic instructors concentrating on the logistics of running courses, and the art of debriefing. (£400) 30 and 31 October.

CEPD points approved – 5 CME points per day.

**Paediatric Critical Care** Aimed at Paediatricians / Consultants at DGH, dealing with children regularly or occasionally. (£250)
17 September.

Other courses: **Conscious Sedation** Aimed at doctors and nurses involved in sedation practice (Doctors £250: Nurses £125) 22 July; 23 July (Paed); 3 September (Paed).

CEPD points applied for.
Specific departmental courses can be arranged upon request.
Includes coffee, tea, and lunch.

For registration and other details please contact:
Scott Carter, Administrator, Simulation Centre, Chelsea & Westminster Hospital, 369 Fulham Road, London, SW10 9NH.
Email: scott.carter@chelwest.nhs.uk
Website: www.chelwestsimcentre.co.uk
Tel: 020 8746 8632, Fax: 020 8746 8155.

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To advertise in *Anaesthesia News*, see the details on page 16 or contact Claire Elliott on 020 7631 8817, by fax on 020 7631 4352, or email claireelliott@aagbi.org
Regional Anaesthesia Study Day
Thursday 18 September 2003,

This one day course will be held at the research and teaching centre of the Royal Orthopaedic Hospital in Birmingham. The course is aimed at all grades of anaesthetists who would like to further their knowledge of regional anaesthetic techniques.

Areas covered include:
- Local anaesthetic drugs
- Complications
- Equipment
- Advantages and disadvantages of regional anaesthesia
- Catheter techniques
- Upper and lower limb blocks

For details please contact the course organiser:
Dr Guy Shinner FRCA, c/o Anaesthetic Department,
The Royal Orthopaedic Hospital NHS Trust, Bristol Road West,
Northfield, Birmingham B31 2AP.
or email guyshinner@barclays.net
or Tel: 0121 685 4000 ext 55570.

Cost £100
CME approval applied for.

PAIN INTERVENTION INTEREST GROUP
OFFICIAL SPECIAL INTEREST GROUP OF THE PAIN SOCIETY OF GREAT BRITAIN AND IRELAND

ANNUAL SCIENTIFIC MEETING
Friday 12 September 2003
The Gleeson Lecture Theatre, Lift Bank C, Lower Ground Floor,
Chelsea & Westminster Hospital, London SW10 9NH

PROVISONAL PROGRAMME
- New Technologies – The View from NICE
- Introducing New Techniques
- IDET – Current Status
- Neuro destructive Procedures – Old Techniques for Current Problems
- SCS for Peripheral Vascular Disease – Does it Work and How to do it
- Lesioning Lumbar Facet Joints – How to do it
- Lumbar Facet Joint Injections – A Beginners Guide
- What is the Evidence for RF Lesioning?
- Meet the Experts Panel – A panel to discuss questions from the floor.

CME applied for

Further information from:
Simone Seychell, Department of Anaesthetics, Chelsea & Westminster Hospital, Fulham Road, London SW10 9NH.
(email: simone.seychell@chelwest.nhs.uk)

‘Everything you wanted to know about being a Consultant but were afraid to ask’
Establishing and Developing as a Consultant
20–21 November 2003
The National Liberal Club, 1 Whitehall Place, SW1

This is a two-day seminar intended for Consultants and Senior SpRs, and is based on the format of previous successful meetings. The topics addressed cover much of the non-medical knowledge useful for consultant life, and often difficult to find. Subjects covered include contracts and negotiation, NHS and hospital politics, medical protection and dealing with complaints, discretionary points, and an extensive guide to starting in and developing private practice. Within a unique venue the faculty has been chosen for its expertise and quality of presentation. There will be ample opportunity for questions, debate and one to one discussion.

For the full programme and on-line booking visit:
www.everythingyouwantedtoknow.co.uk

Registration fee (includes all refreshments, post meeting drinks reception and flight on The London Eye):
20 and 21 November: £300
One day £250
25% reduction for doctors in training
(PGEA Approved) 9 CEPD points

For further information, please contact: TowMed Courses,
c/o Simone Seychell, Department of Anaesthesia, Chelsea and Westminster Hospital, London tel 020 8237 2763 fax 020 8746 8801 email simone.seychell@chelwest.nhs.uk
www.everythingyouwantedtoknow.co.uk

Society for Education in Anaesthesia (UK)

Annual National Conference
Monday 13 and Tuesday 14 October 2003
The Orange Studio, Birmingham

To receive further details, please email Seauk2003@pmde.org
www.seauk.org
Advertising in Anaesthesia News

Anaesthesia News reaches over 8,000 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.

Details of events and meetings will also be listed, free of charge, in the Calendar of Events which is sent out to all members four times per year, enclosed with Anaesthesia and Anaesthesia News. Display advertising is accepted in camera ready form, by email or on disk. Potential advertisers are invited to discuss their requirements with the Editorial Assistant, Claire Elliott, at the Association of Anaesthetists. Copy deadline is four weeks prior to the date of issue.

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All prices shown below are exclusive of VAT

The prices are exclusive of VAT which is charged at the standard rate unless a valid VAT Exemption Certificate can be submitted.

Contact Claire Elliott on 020 7631 8817, by fax on 020 7631 4352, or email claireelliott@aagbi.org

Association of Anaesthetic Golfers of Britain and Ireland

Inaugural meeting at NOTTS GOLF CLUB (Hollinwell)

Monday, September 22 2003

Programme

9.30am – 13.00pm Academic Meeting
Soup and Sandwiches
2.00pm 18 holes Golf
Dinner

Registration Fee £105

CME Applied for

For further details and application form please contact:
Dr D J Layfield, Dept Anaesthesia, Queens Medical Centre,
Nottingham NG7 2UH
Tel 01159 709195 Fax 01159783891
Email davidlayfieldl@yahoo.co.uk
Mersey School of Anaesthesia and Peri-operative Medicine

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

Mersey Selective Course
A Five Day course of lectures and tutorials designed to cover some of the more esoteric aspects of the Primary Basic Sciences not adequately explained in the standard texts
29 September – 3 October
16 – 20 February
(Trainees are advised to consider this course two to three months ahead of the MCQ paper)

Basic Obstetric Anaesthesia Course
An One Day Course on the Practice and Theory of Obstetric Anaesthesia specifically designed for SHOs as an introduction to Maternity Unit responsibilities
11 November

Primary Prep Course (MCQ)
A Six Day course of intensive MCQ analysis intended only for candidates within weeks of sitting the Primary FRCA Examination
17 August (1 pm) – 22 August (Waiting List Only)
23 November (1 pm) – 28 November
28 March (1 pm) – 2 April

Primary Prep Course – (OSCE/Orals)
A Seven Day course of Master Classes, OSCE and Viva Practice, available only to trainees who have been successful in the preceding MCQ paper.
(Failure to ‘get a viva’ will guarantee a place on the following course if required)
19 September (6 pm) – 26 September (Waiting List Only)
16 January (6 pm) – 23 January
7 May (6 pm) – 14 May

Final FRCA (Booker) Course
Two Weeks of SAQ Practice and Analysis, MCQ Practice and Analysis and Lectures/Tutorials
Candidates may register for both weeks or for either one of the two weeks
6–10 October and 13 –17 October
19–23 April and 26–30 April

S.A.Q. Weekend Course
6pm Friday 12 September – 4 pm Sunday 14 September
Master Classes In Style and Technique
Supervised Practice and Analysis

For Details and Application Forms
WWW.MSOA.ORG.UK
Notes from a Small Hospital
An Everyday Tale of Folk in the North

There seems to be a new syndrome sweeping through the wards. Seemingly unrelated to any recognised microbe and almost certainly incurable; thankfully it is rarely fatal for the patient, merely extremely irritating for the anaesthetist. I shall call it FARS (Flo’s Allergy to Report Syndrome).

The FARS patient, typically female and between 20 and 40 years old, will report one or more allergies, none of them medically proven, ranging from the mundane (penicillin) to the completely bizarre (kapok). There will be no clinically recognisable symptoms normally associated with allergies e.g. rash, bronchospasm, cardiorespiratory collapse, but elusive swellings or discoloration of odd parts of the body or vague gastro-intestinal chaos. Indeed, many of these allergies will not yet actually have been experienced but the patient will be determined to defend herself against the potentially offending agent. She will be intelligent, well read (Woman’s Own, Cosmopolitan) and may have one or more of the following associated signs and symptoms; food allergies (gluten, ‘dairy’); trendy diet; regular consumption of industrial quantities of vitamins and food supplements; an interest in aromatherapy; have brought her own linen to hospital.

In the last six months I have had various such patients allergic to water (‘I can only drink the filtered kind doctor or I bloat’); oxygen (‘I get a red mark round my face’), and the wonderfully snookering “adrenaline, doctor, it makes my heart go very fast.” A recent ‘heart-sink’, about to undergo laparoscopic cholecystectomy, declared life-threatening allergies to opiates (nausea), codeine (constipation), non-steroidals (“the chemist told me they’d upset my asthma”) and local anaesthetics (felt awful after a trip to the dentist and an extraction). “So will it be very painful after, Doctor?” Well, there’s always acupuncture and paracetamol to fall back on, I thought, not very confidently!

It’s the smug, self-important way that this information is delivered to you that really gets up my nose. It’s almost as if these patients enjoy being knowledgably different or special in some way that will make you take extra care of them. And, to some extent, this does work as you really cannot afford to doubt them and are impelled to take avoiding action. What they fail to realise, however, is that forcing the anaesthetist to use unfamiliar drugs and equipment can put them at risk. At the very least, it causes delay. I recently had a maternity patient with a ‘latex allergy’ to report, in agony and wanting an epidural. It took me over half an hour to hunt down the latex-free box in delivery suite and determine that the epidural catheters we use are indeed free from latex. As I was establishing the epidural, I asked her when and how she had been diagnosed with the allergy. Panting heavily, between contractions, she told me through gritted teeth that it had been the f***ing condoms that had first alerted her to the problem and that was why she was in the f***ing mess she was in now!

A very common misconception is that having a little black line after removing an adhesive dressing means an Elastoplast sensitivity. How many asthmatics deny themselves really effective non-steroidals in favour of useless paracetamol? And how many patients, do you suppose, are actually sensitive to penicillin? Years ago, my (then) baby daughter developed a spectacular rash while taking a course of amoxicillin for a chest infection. Our GP immediately labelled her as being allergic to penicillin (FARS by Proxy). Fortunately for my daughter, who might have been condemned to erythromycin and other nasty antibiotics for the rest of her life, a few years later my husband (locum parent) took her in my absence to see a locum GP. Both failed to spot the so-called allergy. Three doses of amoxycillin later she was absolutely fine and her earache was much better!

According to women’s magazines, day time television and the Internet, any minor health problem has got to be explained by a food allergy. Any skin condition must be latex or soap powder. Behavioural disorders in children must be due to junk food (anything which tastes nice) and not poor discipline, and the humble peanut has become a potential killer! I actually saw a woman studying a packet of salted cashews in the supermarket last week. “Hmm”, she said to her partner, thoughtfully, “It says this product may contain nut products!” Gingerly, she replaced the pack on the shelf as if it was an unexploded grenade.

Allergy, it would seem, has become a national obsession. My mother has always said that a little bit of what you fancy does you good. Unfortunately, for many of our patients a little bit of what they fancy they know is doing them no good at all – or their anaesthetist!

Gas Flo
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Or alternatively visit our website at: www.intersurgical.com
Families

A good nursing friend of mine recently buried her husband and as always it was a very sad time. The tragedy is that his death was preventable. He died of AIDS. This Zimbabwean trained nursing sister is good at her job. A dedicated individual, with a good track record, will easily find employment in Europe. Once established in a hospital she will recruit from home to fill the needs in her adopted hospital which many Zimbabwean nurses have already done. It is simply the law of supply and demand in action. For these nurses, there are significant benefits to be gained. These benefits are used as a trade off against the losses of family support, friendship and life style.

The nurses leaving Zimbabwe categorically say that it is NOT just about pay. The other issues include job satisfaction, working conditions, respect and acknowledgement. Often, they have simply reached their breakpoint. There is no doubt that the improved pay and buying power of their wage will benefit the family back home. However, this means leaving her husband, and her children and it is up to the granny or younger sister to care for the children. For the family, this care does seem to work, but not for the husband. Another lady comes onto the scene and the family unit is broken! The natural consequence of this pattern of life is that the husband is infected with HIV, while the wife overseas is often working double shifts to earn ‘forex’ (foreign exchange, i.e. hard currency).

We live in a shrinking world with easier movement of individuals and families from country to country. Unless the efforts made to keep the family unit together are significant there will be an increase in failed families. The stability of a society and country is based on the strength of the family unit. For a child, a home environment of unconditional love and emotional support outweighs any benefit from the better schooling procured by a bigger income. The EQ (emotional intelligence) is increasingly recognised as more important than IQ in the growth and development of our children. EQ blossoms in the protective environment of a stable, affirming family. The breakdown in the family unit is felt now in the workplaces but increasingly it will be felt in the bigger picture of society. It will be the children who could ultimately suffer, probably only seen many years later. Zimbabwe has been, and will continue to be, affected by this breakdown of the family unit.

Movement of people from the poorer underdeveloped countries to the affluent, successful, developed countries will always continue. Historically, people were forcefully moved (the slave trade), now force, visas and deportation have to be applied to halt the movement. What a change! The factors affecting migration are complex but will often include money, opportunity, happiness and security. Many surveys the world over emphasise that happiness has more to do with family, friends and health than money. In addition, a lasting marriage is of more value than lots of money. So, is the best solution to move with the family? The Australian nurse recruiting agencies recruit nurses for limited short-term contracts of two to three years but also include a move of the family, making attempts to find employment for the spouse and schools for the children. This is an expensive way of doing things but, in the long term, may well be the best method for the family and society. This is the way forward and should be used when recruiting nurses from abroad. But most recruiting countries just want the work done and the waiting lists reduced. The long-term consequences for the imported labour are not significant.

Uganda has an enviable record of halving the HIV rate of infection. The drive to change people’s behaviour improved moral standards with the appreciation of the risks of multiple partners and the risks of free sex. An openness and willingness to be involved in change has resulted in a reduction in the HIV rate. There was a national ‘buy-in’ to the whole process. The people identified themselves with the problem and saw that they could be part of the solution. Here, too, we need to ‘buy-in’ to the preservation of the family unit to improve the EQ of the children, and reduce the HIV spread through casual relationships.

But how many hospitals recruiting Zimbabwean nurses are interested?

Laurie Marks
marksman@zol.co.zw