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FURTHER INFORMATION
CONTACT: +44 (0)20 7631 8805/3
annualcongress@aagbi.org  www.aagbi.org/events
The Association of Anaesthetists of Great Britain and Ireland celebrates the seventy-fifth anniversary of its foundation in 2007. The Association was conceived and founded in 1932 by the Birmingham Consultant Anaesthetist Henry (Harry) Walter Featherstone, M.D. (1894-1967). Before the foundation of the Association in 1932, physician anaesthetists in Great Britain and Ireland did not have a national organisation dedicated to the promotion of their clinical and medico-political aims and aspirations. The first Society of Anaesthetists had been founded in 1893 by J Frederick W. Silk (1848-1943). Its deliberations were mainly clinical but it also promoted some medico-political problems, including emphasizing the need for anaesthetics to be administered by medical practitioners. However, all such political activity ceased when this society amalgamated in 1909 with twenty-two other specialist medical societies and the Royal Medical and Chirurgical Society to form the Royal Society of Medicine (RSM), whose proceedings are confined by Royal Charter to academic discussion.

It is difficult, therefore, to overemphasise the importance of the independent British Journal of Anaesthesia (BJA), first published in 1923, as the mouthpiece of the clinical and medico-political interests of the emergent specialty of anaesthesia prior to the formation of the Association in 1932, and thereafter in recording its proceedings until the publication of its own journal Anaesthesia in 1946. Remarkably the BJA was originally proprietarily owned and edited until 1948 by its first two Editors, Hyman M. Cohen (1875-1929) of Manchester and Joseph Blomfield (1870-1948).
of St Georges Hospital. The political editorials of both Cohen and Bloomfield relating to the promotion of the status and remuneration of physician anaesthetists were robust and forceful. Cohen's very first editorial in 1923 included a plea for the formation of a “British Society of Anaesthetists”.

Henry Featherstone was a remarkable man. He had had a distinguished record as a Regimental Medical Officer in the Great War of 1914-1918, and he was, many years later, decorated for distinguished service in the Second World War (1939-1945) while in command in a hospital ship at the D-Day landings in 1944. In 1932 he was highly respected as a skilful clinician. He was also academically well qualified, having obtained the postgraduate degree of M.D. from the University of Cambridge. In addition, and very importantly, he had an independent income derived from inherited business interests and, consequently, he was not financially dependant on professional medical fees. However, Featherstone was unselfishly determined to improve the lot of the majority of anaesthetists who were less fortunate than himself.

Featherstone had been President of the Section of Anaesthetics of the RSM from 1930 to 1931. There were only about one hundred and fifty specialist physician anaesthetists in the United Kingdom and Ireland in 1932, almost exclusively attached to major hospitals with medical schools. General medical practitioners administered the majority of anaesthetics at other hospitals in the United Kingdom and Ireland as a sideline at that time. Anaesthetists, whether specialists or general practitioners, were poorly regarded by other medical and surgical specialists. This was because they did not have either defined specialist postgraduate training or a diploma of a Royal College to aspire to. They were also very poorly remunerated. Like all other specialists, they gave their services free of charge to public patients in the voluntary hospital system that existed in the United Kingdom in the nineteen thirties and up until the inception of the British National Health Service in 1948. Specialists relied for an income on fees from middle and upper class private patients referred to them by general family practitioners or specialist colleagues. However, unlike other specialists, anaesthetists, including those appointed to university hospitals, were completely dependent on the surgeons for requests to administer anaesthesia for private patients. They were also usually reliant on the surgeons for the collection and payment of fees for the administration of anaesthesia that were, in any case, almost derisory.

Henry Featherstone appreciated that the Section of Anaesthetics of the RSM could not be used to campaign politically to improve the lot of anaesthetists. He therefore called together the one hundred and fifty anaesthetists with appointments at university hospitals. As a consequence the Association of Anaesthetists of Great Britain and Ireland was founded at an inaugural meeting at the house of the Medical Society of London on 1st July 1932, and Featherstone became its first President.

Initially membership of the Association was confined to the university hospital anaesthetists. It was, in fact, not until 1943, with the expansion of the number of designated specialist physician anaesthetists in the armed forces during the Second World War, and especially those who had obtained the Diploma in Anaesthetics introduced in 1935, that all who specialised in the subject became eligible for membership of the Association. This very necessary change was initiated and insisted upon by none other than Lieutenant-Colonel Featherstone.

For the first quarter century of its existence, throughout the Second World War and until the establishment of the British National Health Service in 1948, the Association was the only organisation in the United Kingdom to which the Government and other authorities could turn for advice about the specialty of anaesthesia. Amongst the developments with which the Association was involved in this period were the crucial introduction in 1935 of the original Diploma in Anaesthetics (DA) of the Conjoint Board of the

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First Council minute
The inauguration of the journal *Anaesthesia* came about because the British Journal of Anaesthesia (BJA) was at very low ebb by the end of 1943 and its contents and frequency of publication had become limited and unpredictable. By then its proprietor-editor Joseph Blomfield was a sick man. He had earlier resisted suggestions by Council of the Association should take over the BJA as the official journal of the Association, even though he was Honorary Secretary from 1939-1941 and had asked for and received a grant to support the continued publication of the BJA. The Council of the Association resolved to begin publication of its own quarterly journal *Anaesthesia* "as soon as possible" in February 1944, but wartime paper restrictions and other difficulties deferred the publication of the first issue until October 1946.

Thus began the remarkable twenty year (1946-1966) Editorship of Christopher Langton Hewer of St Bartholomew’s Hospital, London. Langton Hewer had two Assistant editors but did not have secretarial assistance throughout his editorship. He typed all his correspondence on his own rather ancient typewriter. He also wrote seventy-five of the eighty editorials that appeared during his time. These covered every new clinical innovation and political controversy in crisp well written prose, often salted with his quiet and quizzical sense of humour. Langton Hewer’s two successors (Roger Bryce-Smith of Oxford, 1966-1972, and the present writer, 1973-1982,) built upon the sure foundation that he had laid and gradually brought the journal up to twelve issues per year by 1980. All three had to contend with the traditional “hot metal” era of printing in which alterations to the text were costly and preferably had to be the same length as a deletion. They had the task of producing a journal that was at the same time both an international scientific journal reflecting the ever accelerating developments and responsibilities of anaesthetists, as well as the “house magazine” of the Association of anaesthetists of Great Britain and Ireland, reporting on its activities, present and future, as well as those of other organisations world wide. The readership ranged from the no-nonsense practical clinician in a developing country to the abstruse academic in his ivory tower, and from the junior trainee novice to the most senior retired veteran. The art (or was it artfulness?) of producing a successful issue was to provide something of interest for everybody as well as recording and commenting upon the fast moving clinical and medico-political developments of that period.

Bloomfield died in 1948. Cecil Gray, then Reader in Anaesthetics at Liverpool, and his colleague Falkner Hill then took over the BJA as Editors, with a Board consisting of progressive younger anaesthetists from provincial university hospitals, none of whom were, as yet, members of the Council of the Association. They revitalised the BJA on a firm financial basis, from which revolution it has never looked back. For a time there was some coolness between the Board of the BJA and the largely London-based Association Council, and there were even several attempts to amalgamate the two journals, but the outcome of having them exist in parallel rather than as rivals, albeit with a slightly different emphasis in scientific content, has undoubtedly been of great benefit to British and Irish anaesthesia.

The fundamental change for *Anaesthesia* came in 1987 during the editorship of John Lunn, (1982-1990) and the ebullient presidency of Michael Rosen (1986-1988). The circumstance was the decision to publish the separate and successful *Anaesthesia News* to carry the “House magazine” material and include many articles of general interest. This has left John Lunn and succeeding editors of *Anaesthesia* (Maldwyn Morgan, 1990-1998, Michael Harmer, 1999-2004 and, currently, David Bogod) free to firmly establish *Anaesthesia* in the world-renowned position as a leading scientific journal that it now occupies.

*Anaesthesia News* is currently celebrating its twentieth anniversary in a series of editorials and articles. It too has changed its format and expanded over the years but its successive editors are to be congratulated in continuing to produce a journal that is essentially informative as well as interesting and pleasant to read.

The Association of Anaesthetists of Great Britain and Ireland represents the medical and political aspirations of a very considerable majority of the physician anaesthetists in the United Kingdom and the Republic of Ireland (both established and in training), and, through its overseas membership, and not
least through the influence of its journals and other publications, has close contact with many other countries both inside and outside the British Commonwealth, Europe and world wide. Yet it does not have, and has never sought, direct statutory powers, academic, negotiating or co-ordinating. Rather, as it does not operate under a Royal Charter, its broad constitution and relatively informal procedures enable it to promote and encourage other bodies to further the academic and clinical advance of the specialty of anaesthesia and the welfare of individual anaesthetists. It can be truly said that there has not been any major development that has taken in British or Irish anaesthesia since the foundation of the Association seventy-five years ago, that has not been either initiated or promoted under its auspices.

The Association was closely involved in the negotiations that preceded the inception of the British National Health Service in 1948. These resulted in the recognition of anaesthetists as being of equal status to consultants of other specialties in the new service. The Faculty of Anaesthetists of the Royal College of Surgeons of England, which ultimately became the independent Royal College of Anaesthetists in 1992, was founded at the instigation of the Association in 1947. Its remit is to take care of the training, examination and professional standards of anaesthetists under Royal Charter. The Association also gave its support to the foundation of the Faculty (now College) of the Royal College of Surgeons in Ireland in 1959. Patients and anaesthetists alike can be secure in the knowledge that the Association continues to protect their mutual interests.

T B Boulton, Editor of Anaesthesia 1973-1982


All issues of “Anaesthesia” dating back to 1946 are now available online to members and accessed from the “members only” section of the Association website www.aagbi.org

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### Anaesthesia in the 1930s

*From a pamphlet by A. Charles King, dated around 1930.*

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*Applicants who attend the Introductory Meeting but who subsequently choose not to join the Club will be charged £75, which charge will include the cost of Lunch.
Anaesthesia in the 1930s

My first anaesthetic - as a patient - was in 1934 at the age of 8 for a tonsillectomy. That operation was very fashionable at the time. One afternoon I was left by my parents in a ward with three other children of similar age, probably destined for the same operation, and each of us in a cot. Three of these, including mine, had high sides, but in one, the sides were lower towards the foot of the cot and the little girl occupant was very obliging in clambering out of her cot to pick up crayons that others of us had dropped on the floor.

The next morning I was taken to theatre. From memory, coupled with what I saw and smelt when I first joined the Anaesthetics Department in Cardiff 18 years later, I am pretty sure that the anaesthetic was ether on an open mask. I was very relaxed about the whole procedure because I had been assured that I wouldn’t feel anything until it was all over. So I was happy to lie on the operating table and address myself to sleep.

I became a little concerned when, after breathing the ether for about a minute, I still felt wide awake; so I opened my eyes to demonstrate to the anaesthetist - perhaps I should say to the person giving the anaesthetic (possibly the family GP) - that I was still awake for fear that the surgeon might start too soon. I didn’t know then that there are other signs of anaesthesia!

The next thing I knew was that I was back in my cot, with a kidney dish beside my head on the pillow and a raging sore throat. There wasn’t much conversation in the ward for the rest of that day. Recovery, as they say, was uneventful.

Bill Mapleson
Professor Emeritus of the Physics of Anaesthesia
Cardiff University
Some of you may have noticed something strange about *Anaesthesia News* recently. It’s the Sherlock Holmes scenario of the dog that didn’t bark. There has been an elephant in the room all through the spring and summer, and *Anaesthesia News* has sailed serenely on. The elephant is, of course, MTAS.

I have been in an impossible situation – here is an issue occupying the hearts and minds of practically all of us, and yet there was nothing I could usefully print. *Anaesthesia News* has a long lead time, and the situation with MTAS changed so rapidly (and continues to do so) that Channel 4 news, produced daily, could barely keep up. Anything I could publish would be long out of date by the time you received the issue. Instead, the Association has used more immediate methods of communication (the website, the forum) to keep members posted as much as possible.

If you have not followed developments on our website, you may be unaware that the GAT committee has played a blinder. It was incredibly active and organised, sending letters to those in positions of influence, some of which were picked up and reported by national media organisations. One letter was quoted as being a factor in the withdrawal of the North Central Thames School of Anaesthesia from interviews. The GAT committee was able to organise a survey of its membership in the middle of the crisis, so was working from an informed position which many other involved organisations had been unable to match.

Even now, I am hesitant about committing my thoughts to paper, as it may all have changed again by the time you read this. However, we now seem to be reaching a degree of stability (for this year at least).

At the time of writing, (late May) the first round process is reaching completion in Scotland. I have had no official involvement, but as far as I can tell, huge efforts were made by everyone concerned to make it as fair as possible. Those responsible for organising the process for anaesthesia in Scotland made an early decision that everyone eligible would receive an interview, which means both assessors and trainees were spared the backtracking which has occurred in other areas. My colleagues who took part in the interviews thought it was a fair process, and that it was not difficult to identify candidates who shone.

The first round offers have gone out, and the results, in our department at least, are frankly random. We have a pretty good bunch at the moment – there is nobody I would feel dubious about being able to go on and make a jolly good consultant anaesthetist, given the chance. But only about half have been successful in the first round of the MTAS obstacle course, and I certainly could not have picked the winners beforehand. As one of the successful ones said to me when I congratulated him, “I’ve got survivor guilt.” He could not enjoy his success while his colleagues and mates were suffering. We had two superb ST1 applicants, both of whom started anaesthetics in February. Both have extensive experience in A&E and medicine, both have received offers from GP training and/or A&E, but no offer from anaesthesia, their first choice. Here are two well-motivated individuals who gained relevant experience and made a positive, informed decision to choose a career in anaesthesia, and it looks as if they will have to make a compromise – being stuck in a career which is not their choice, possibly for ever. This is not special pleading for our own trainees – I’m sure many consultants will be sharing these emotions.
Interestingly, my enquiries with contacts around Scotland have so far identified no successful SHO applicants at ST1 level – presumably many posts have gone to FY2 applicants. The FY2 doctors have already gone through a similar process – does this make them better at it than existing SHOs?

Do you know what I think is the worst thing? The way offers were made (or not). Candidates received notification that the ST1 post allocations would be made by a particular date, and informed that if they heard nothing, they had been unsuccessful. Our two heard nothing, but since nobody else had, didn’t know for several days if they had been unsuccessful, or whether there had been another delay. How hard is it to send an email saying “We regret you have been unsuccessful at this stage of the process”? What an appalling way to treat these young doctors, already bruised by the system. All that effort, all those hoops to jump through, and not even common courtesy at the end.

One of the misconceptions, I think, was who exactly “junior doctors” are. There was an impression that junior doctors are basically students with knobs on, so they need not be subject to the courtesy expected of any other job application process. The Government gave itself away when it was reported that negotiations had been undertaken with volunteer organisations so that unsuccessful candidates could lose themselves (presumably unpaid) for a year or two. Like students, they would have no ties, and be ready to move anywhere at a moment’s notice. There didn’t seem to be any understanding that these people have partners, mortgages, children, and may be in their late twenties or thirties. Grown-ups, in fact.

The other aspect of this that incenses me (and it’s seemed too trifling a matter to raise in light of what the trainees are dealing with) is the effect on departments. Since time immemorial, trainees have always known which departments they want to work in – there are good ones, and less good ones. This does not happen by accident. Some departments work bloody hard to ensure a good trainee experience, others do not. Under the old system, our department appointed our own SHOs and was never short of quality applicants. This is now set out at naught – we will take who we are given. Why did we all work so hard to give our department a good training reputation?

So where are we now? Well, by the time you read this, events will have moved on further. Scotland declared first, and it is believed a number of trainees from other areas holding offers will subsequently receive an offer nearer home, and release the Scottish offer. Some of our currently unsuccessful trainees may yet complete the obstacle course. Round two is up in the air at the time of writing, although the legal attempt to have the whole process scrapped has failed.

Anaesthesia News can perhaps start noticing the elephant in the room again – I’m planning to run some articles about experiences of the process from various viewpoints. Once the various reviews are complete, the GAT articles will no doubt contain advice for the run-up to the process (whatever form it may take) next year, as it did this.

In this issue, Anaesthesia News celebrates the 75th anniversary of the founding of The Association of Anaesthetists of Great Britain and Ireland, which held its inaugural meeting on Friday 1st July, 1932 at the London Clinic. Tom Boulton has written a special article about the foundation of the Association, and the role of the various publications during those 75 years. There are a series of fillers throughout the magazine this month, recounting memories of anaesthesia in the 1930s – I appealed for help from older readers with this a few months ago and have been overwhelmed by the response. Space does not permit me to print them all, but I hope you find these anecdotes illuminating and entertaining, and I wish to thank all of you who took the trouble to share your memories.

Hilary Aitken
Editor, Anaesthesia News
Not a member? Why not?

Benefits of AAGBI membership:
- Receive: *Anaesthesia* and *Anaesthesia News* every month
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Details at [http://www.aagbi.org/aboutaagbi/membership.htm](http://www.aagbi.org/aboutaagbi/membership.htm)
Enquiries to the membership department on 020 7631 8801 or email members@aagbi.org

Council Election Result

The following candidates were successful in the recent elections to AAGBI Council. They will serve a four-year term of office from September 2007.

Dr Bernie Liban
Dr Ellen O’Sullivan
Dr Steve Yentis

This year there were 22 candidates and a very strong field. Congratulations to those who were successful, and commiserations to those who were not.

Deceased Members

Since January 2007, Council of the Association has been informed of the deaths of the following members:

- Dr PJ Brock  MB ChB FRCA  Reading
- Dr KA George  MB BS MS DA FFARCS  Belfast
- Dr E Hooper  TD MB BS FFARCS DA  Sutton Coldfield
- Dr M Manford  MB BS FFARCS DA  Tunbridge Wells
- Sir JG Robson CBE  London
- Dr GA Sutherland  MB ChB FRCA  Glasgow
- Dr RF Seed  MB BS FRCA FANZCA FFARCSI  Tonbridge
- Dr M Watson  MB CHB FFARCS DA  Bath
- Dr JA Nash  MB ChB  Wirral
- Dr TL Whittton  MB DA DCH DTM+H FRCA  Bristol
- Dr H Buglass  MB ChB DRCOG  Wetherby
- Dr DJ Hughes  MB ChB  Edinburgh

All membership enquiries should be directed to members@aagbi.org

Wanted – retired anaesthetists for active service!

The Anaesthesia Heritage Centre at 21 Portland Place is open Monday to Friday from 9.30am until 5pm. In the past year, the Heritage Centre has become increasingly popular with medical and non-medical groups either on walking tours or on privately arranged visits.

The Heritage Centre can accommodate up to ten people comfortably and it is therefore often necessary to split the groups up. One half of the group is given a guided tour of the museum whilst the other half have a brief talk on the history of anaesthesia and the opportunity to handle some objects from the Museum’s collection.

The presence of anaesthetists who are able to provide some insight and background into the museum and our collections would greatly enhance the service we are able to offer groups. We are therefore looking for volunteers who would be interested in becoming involved with the Anaesthesia Heritage Centre, in particular with providing history of anaesthesia talks and a commentary on the museum objects being passed round. All tours take place during the museum’s normal opening hours, so this would be ideal for retired anaesthetists in the London area with a little time to spare – perhaps a couple of days per month – and introductory training would be given if necessary.

We are also looking for people (retired or otherwise) interested in researching our collections so that full descriptions of them can be added to our database. Images and details can be sent out by email to those too busy or too distant to come to the Association’s headquarters in Portland Place.

All volunteers will receive a warm welcome as well as refreshments. All travel expenses will be reimbursed.

If you are interested in volunteering, please call Trish Willis on 020 7631 8806 for more information.
The future of the NHS has always been hard to predict. Policies come and go, Government bodies are brought to life and extinguished after a short time, and Secretaries of State for Health change on a biennial basis. However, two priorities in healthcare have remained relatively constant throughout the life of the present Government: waiting times and patient choice. Provided there are no cataclysmic political changes, 85% of patients will wait less than 18 weeks from GP referral to the start of definitive treatment by the end of March 2008. By the end of December 2008, the figure will be 100%.

The impact on anaesthesia services has not been quantified, but will produce significant challenges.

First of all, there will be a period during which activity will be markedly increased in order to treat all patients outside the 18 week zone to drive waiting times down towards the target. In my own Trust, this is likely to require an overall increase in surgical activity of 15-20%. This increased activity will not be uniformly spread – our orthopaedic surgical activity will increase by up to 30%, while the gynaecologists should only see a small increase. Providing the facilities and workforce that will allow this substantial increase in workload will be a huge challenge. However, once the waiting list has been managed and the target achieved, there will be an inevitable decrease in activity with implications for Trusts.

Many compounding factors exist within any Trust - the usual complex factors that drive the efficiency and speed of surgical treatment: operating theatre capacity, bed capacity, workforce availability, PCT behaviour and the activity of nearby Trusts and ISTCs. Choice – the opportunity for patients to access their choice of providers for treatment contains a number of caveats which NHS Trusts must abide by. Any services provided under Choice must accept all referrals and cannot turn away work, no matter how many cases are referred!

Given the significant financial pressure that the NHS has experienced in the last financial year and the perceived inability of many PCTs to fund a marked increase in surgical activity, many clinicians assume that the 18 week target may be difficult to achieve. However, the political consequences of a failure to meet such a well-publicised target at a time of leadership change will be of great concern to our political colleagues. It is likely that the target will be pursued vigorously.

What will happen? First of all, life is going to get busier. A 30% increase in orthopaedic activity will place huge strains on Trusts, even those with spare capacity. The question for NHS Trusts is how to get more throughput from the same facilities? Three-sesion days, weekend working, same-day staggered admission and effective pre-assessment would all be good starting points. ISTC and community facilities will be helpful in some areas. However local private hospitals may well find it difficult to help, given that these cases will be paid for at rates dictated by the National Tariff.

How will departments of anaesthesia respond to these demands? In my view, departments that work well together will become stronger, leaner and wealthier than they are at present. Divided or disorganised departments may self destruct. In my experience, senior NHS managers want departments that work, without
having to get embroiled in the micro-politics and administrative minutiae. They do not like being drawn in to disputes between clinicians, preferring clinicians work together in a cooperative and fair way that produces the desired results, and keeps the NHS moving forward. The vast majority of consultant anaesthetists in the UK are fiercely proud of and loyal to the NHS, and see it as a vital structure performing invaluable work. A small minority see it simply as a way of making money, either directly or by generating work be done in the private sector. The potential clash of cultures that these differing opinions can produce may make it harder for some departments to develop a joined up vision for future pressures.

So, most departments of anaesthesia will see a marked increase in workload followed by a downturn once the targets are achieved. Traditionally Trusts have employed more consultants as activity increased. However, in this situation when Trusts know that increased activity will be followed by a decrease, they are unlikely to simply commit themselves to additional permanent staff who may not be able to be retained if their work is not required. Redundancies have occurred already in the NHS.

How will Trusts work out their anaesthesia workforce over the next two years? A range of possibilities exist:

- Appoint full time consultants and SAS grade staff on traditional contracts. Over-recruitment would be a long-term risk with possible redundancies if work leaves the Trust.
- Appoint full time consultants and SAS grade staff on short-term, fixed contracts. Unusual in the NHS at present.
- With a predicted increase of anaesthetic CCT holders, will a more service orientated sub-consultant grade be revisited? Although the profession is against this development, there are a number of specialties with post CCT Fellows currently. The opportunity to have a range of seniority in the department might be perceived to improve flexibility.
- Take on locum staff. As many Trusts now have sufficient substantive consultants to run their on-call rotas and specialist services, locum consultants that work only during the day provide more in-theatre time than permanent staff. Although employment legislation means that Trusts must be careful to terminate locum appointments before they become entitled to job security, the supply of anaesthetists with CCT means that the quality of locums is less of an issue than previously. This appears to be a creeping development within departments.
- Existing consultants take on more work. The overall cost to a Trust of a consultant anaesthetist is about £100K per year. The value of a single additional list is therefore a simple calculation, and many Trusts will prefer to pay their existing staff enhanced rates for flexible, additional sessions to meet the increased workload. This could increase a Trust’s capacity significantly, but will only work if the local department is committed to making sure that the work is done and that additional paid sessions are distributed in a transparent and equitable fashion. If departments take on additional work, there must be a flexible approach to SPA time. This “cooperative” way of meeting additional demand must not only produce the increased work required, but must also be more cost-effective than taking on additional staff. However, overworking existing staff is counterproductive and careful thought needs to be given to the sustainability of this approach. In a Trust working in this way with a vibrant and well-organised department, relationships should stay good, individual income will be enhanced and the anaesthetists will be left to run themselves – an ideal outcome for all.

- Anaesthetic department private groups could be subcontracted to take on additional work. This will work well initially, but the future tendering for anaesthesia provision will see competitors entering the game and the right price, then this will prove very attractive to Trusts. This development could also seriously destabilise NHS departments.

We are living in interesting times of great NHS change, and it is impossible to predict what effects these targets and their resulting pressures will have on our specialty. However, it is time to talk through our options at department level producing a joined-up vision for local anaesthetists.

Departments of anaesthesia that can demonstrate flexibility and teamwork will respond and protect themselves from instability in the employment market. Good local planning is needed and I hope that departments will develop their strategy soon.

As March 2008 approaches, I shall be enormously proud if our team of clinicians and managers can deliver the 18-week target. This will be good for patients and good for the NHS. I think that we can work together to achieve success for the NHS, our profession and ourselves.

Iain Wilson
Assistant Editor

Iain Wilson is the Joint Medical Director of Royal Devon and Exeter NHS Foundation Trust.
Paediatric congenital cardiac surgery in Nairobi

The charity Chain of Hope is an organisation which was founded in 1992 and visits countries in the developing world to perform cardiac operations on children. It started as providing purely service but increasingly aims to build local expertise through a combination of teaching, fund raising and provision of medical equipment. If necessary, children are transferred to London for surgery there.

Chain of Hope is helping the Mater Hospital in Nairobi become a centre of excellence for paediatric cardiac surgery in East Africa. At the present time, work that is too complex for local expertise either has to be sent to South Africa or to Bombay, which are roughly equidistant. The local team has been already doing valve operations and septal defects for some time but has been struggling with Tetralogy of Fallot operations, especially during the postoperative phase, when children who present very late can be particularly difficult to manage. The cardiac programme at the Mater Hospital is also supported by vigorous local fundraising and other charities including the Dutch ‘Terre des Hommes’ (who donated €470,000 while we were there). Chain of Hope has visited the Mater hospital for valvular missions previously, but the March 2007 mission was the first congenital mission. When I had the opportunity to volunteer I did not hesitate to put my name forward. Although Chain of Hope teams consist of consultants, senior nurses and perfusionists, and often world-respected experts in their fields, trainee volunteers with suitable experience are welcomed if they can cover their costs. I was to spend most of the days in theatre with the anaesthetic team, and cover the intensive care for a night shift.

In many ways the demands of complex cardiac surgery meant that this was not the kind of experience that you might immediately think of when imagining a developing world anaesthesia visit.
It was geographically close to, but a world apart from, clinical officers in rural African hospitals who might have to deliver anaesthesia without oxygen supplies or electricity, or from a Zambian teaching hospital that I have visited where even facemasks are so fatigued that their seals will not take any air. We had invasive monitors, echocardiography machines and brand new ventilators on the intensive care unit and all the propofol, remifentanil and milrinone we needed. We also had the benefit of local anaesthetists and perfusionists to show us how they usually did things at the Mater and ODPs who generally knew where things were. Our perfusionists had to cobble together a circuit rather than pull one off the shelf and our surgeon was using old donated instruments but generally equipment was well organised and not a serious problem, although we did lose diathermy at one point during a BT shunt. The senior local anaesthetist Dr Mark Gacii was a pleasure to work with, and while he learned transoesophageal echocardiography from the visiting anaesthesia team, I had plenty to learn from him.

When we were welcomed on the first day the medical director for the mission declared that apart from the obvious satisfaction to be gained from such a mission, it was a joy to escape the bureaucracy of the NHS. This became immediately obvious as everyone was keen to ‘get on with it’ as soon as possible. There was no fear of the European Working Time Directive. Rotas were divided up amicably by those that were doing them, and there was generally more overlapping of roles than I’m used to seeing. I can’t imagine an NHS where the nurses bring you breakfast because you were woken up early to take a child back to theatre, or where an orderly is sent out to buy cigarettes because the surgeon has been kept so busy. Some people (and even a scrub nurse from our team) might think that particularly the last point was undesirable, but it was impossible not to find the no-nonsense, ‘can-do’ atmosphere both charming and efficient.

The first day was tough for our visiting cardiologist, as he worked his way through the list of patients provided by the local team, to determine who could be done on this mission. In the evening before dinner there was a team case conference talking through each child selected. It was a challenging list consisting mostly of late-presenting Fallots, several with significant pulmonary hypertension, some with other serious co-morbidities (table 1). These were the easiest of the 50 or so patients that were presented to us by the local team. The logistics of the week were organised, aiming for a gentle first day to settle in, with sicker patients early after that so that they had more recovery time on the intensive care unit and winding down towards the end of the week.

There were of course some things that were very different from home and took some getting used to. There were the usual issues that you would have at any new hospital, and with any team working together for the first time, especially as the team came from a variety of UK hospitals and also from Munich. At the start of my night on the intensive care unit I was told that platelets could only be available for patients if the team donated blood and that it would take the lab a couple of hours to extract the platelets. Likewise there was no cryoprecipitate, but the blood available was whole blood. The children didn’t seem to bleed as much as they might in the UK, possibly because of a whole blood prime in the bypass pump. Autologous blood donations are checked for HIV, syphilis and hepatitis, but not for malaria and transfusion of parasites was a possibility.

Mosquito nets were essential over patients’ beds on the ward, although of course this is not practical on the ITU. Despite impressive hardware, there was clearly still a shortage of some things we regard as essentials at home, such as proper sharps bins. The usually highly regimented postoperative fluid restrictions in the intensive care had to be relaxed due to the high ambient temperature. An important part of the nurses’ handover on the ITU seemed to be singing hymns impressively loudly at the beginning of the day: it was strangely surreal and after a particularly difficult night it was extremely moving.

The key to anaesthetic practice on the missions, and an exceptional learning experience for me, was fast-tracking patients for rapid extubation. Almost all were extubated on the table at the end of surgery. The method included using little neuromuscular blockade, judicious quantities of fentanyl at induction and a morphine bolus towards the end, intravenous paracetamol and local anaesthetic in the wound and drain sites at the end of surgery. This fast-tracking aims to speed the whole process of recovery, reduce complications of ITU ventilation, and relieve pressure on the visiting nursing team who were working in pairs supervising local nurses for 6 ITU beds and an HDU. The fast-tracking was generally popular and I gather
that several anaesthetists who have been introduced to such methods on these missions have incorporated the practice into selected cases back in the UK.

Every part of our team had an educational role as well as practical duties. For instance, the intensive care nurses often have excellent general ITU skills but little experience with congenital cardiac lesions. Our visiting nurses tried to let the Kenyan nurses do as much of the hands-on work as possible, teaching basic principles and management based around the cases we had. Likewise the intensivists, perfusionists, anaesthetists and surgeon all taught their local counterparts in a hands-on fashion and I think each also gained experience of uncommonly advanced pathology. There was also opportunity for formal teaching by way of an afternoon of lectures delivered by the Chain of Hope team.

In summary, this trip was a fantastic educational experience for me both in terms of learning about new techniques and unusual pathology in cardiac anaesthesia and intensive care and also in seeing how complex anaesthesia and intensive care services can be developed in the third world. I think that the opportunity to contribute to the team as a trainee whilst always being able to call on consultant support was ideal for this high-risk population and I would recommend this experience to any SpR with an interest in paediatric cardiac surgery. I am grateful to the Chain of Hope for letting me have this opportunity.

M Dylan Bould

Links

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<tr>
<th>Age</th>
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<td>3</td>
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<td>8</td>
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<td>8</td>
<td>TOF</td>
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<td>TOF</td>
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<td>Tricuspid atresia, PS</td>
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<td>4</td>
<td>AVSD</td>
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<td>6</td>
<td>AVSD, large PDA</td>
<td>PDA division</td>
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<td>5</td>
<td>TOF</td>
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<td>10 months</td>
<td>DORV</td>
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<td>VSD</td>
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<td>6 weeks</td>
<td>Severe PS with intact ventricular septum</td>
<td>Catheter</td>
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<td>TOF</td>
<td>Full repair</td>
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<td>6</td>
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<tr>
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<td>TOF and AVSD</td>
<td>Full repair</td>
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Table: the case mix from the mission.

TOF (Tetralogy of Fallot), AVSD (atrial-ventricular septal defect), DORV (double outlet right ventricle), PS (pulmonary stenosis), PDA (patent ductus arteriosus), BT (Blalock-Taussig), PA (pulmonary artery).
Education for Anaesthetists is a prime objective of the Association of Anaesthetists. To this end it organises a programme of highly popular seminars.

Seminars are held at the Association of Anaesthetists' headquarters, 21 Portland Place, London, W1B 1PY.

We aim to time seminars so that it is possible for those attending to travel to and from the venue on the day of the meeting, without the need to stay overnight.

A hot lunch and refreshments are included in the cost of the seminar.

**How to book a seminar**

For availability, to look at programmes and download individual application forms please see the website at [www.aagbi.org](http://www.aagbi.org). Alternatively you can complete and send the generic application form enclosed in this section (please photocopy to apply for more than one seminar).

Unfortunately we are unable to reserve places or accept telephone bookings.

**Cancellation Policy**

All cancellations must be received in writing. Written cancellations received more than two weeks before the seminar will be subject to an administration charge of £20. Delegates cancelling after this date will be liable to pay the full seminar price unless the Association considers there to be exceptional circumstances that would warrant a refund.

**Waiting List**

If we receive applications and the seminar is fully subscribed, your payment will not be processed and you will automatically be placed on the waiting list. Should a place become available through cancellation, we will contact those on the waiting list on a first come – first served basis. When a repeat seminar date is fixed, we will write to all members on the waiting list before we advertise the seminar generally.

To be placed on the waiting list, please e-mail David Williams at seminars@aagbi.org

Please note that you cannot attend an Association seminar if you have not applied in advance. Health and Safety codes dictate we are unable to admit anyone who arrives on the day without prior arrangement.
Seminars Calendar

PLEASE NOTE THAT SOME OF THE SEMINARS LISTED BELOW HAVE BEEN PREVIOUSLY ADVERTISED AND MAY ALREADY BE FULLY BOOKED – PLEASE CHECK OUR WEBSITE FOR AVAILABILITY:

www.aagbi.org

GAT: THE CONSULTANT INTERVIEW
Wednesday 11 July 2007
Organisers: Dr M Parris, Northampton & Dr P Johnston, Belfast

- Criteria for a good CV
- Preliminaries to the interview
- Interview orientated communication skills
- Practice interviews - with a selection panel followed by debriefing and analysis
- Interview workshop

ULTRASOUND FOR ANAESTHETISTS VASCULAR ACCESS & ICU
Monday 15 October 2007
Organisers: Dr N Moore & Dr A Gaur, Leicester

- Ultrasound - basics
- Vascular anatomy and techniques
- Sono anatomy and sono techniques re vascular access
- Ultrasound in ICU
- Ultrasound scan on volunteers
- Hands-on experience on phantoms

THE 7 DAY WEEKEND: ENCOURAGING YOU TO PREPARE FOR, AND ENJOY YOUR RETIREMENT
Thursday 19 July 2007
Organiser: Dr M Martin, London

- Maximising your benefit from the NHS pension
- What does a retired anaesthetist do?
- Private pensions – what do I do with them now?
- Understanding investments
- Preparing your assets for retirement
- Simple and effective inheritance tax planning

PAIN, OPIOIDS AND SUBSTANCE MISUSE
Monday 24 September 2007
Organiser: Dr K Simpson, Leeds

- Good practice in pain management
- Good practice in addiction medicine
- Psychological issues in patients with pain and substance abuse
- Liaison with primary care
- Case presentations by all speakers

AAGBI HISTORY OF ANAESTHESIA SEMINAR THEME: MILITARY ANAESTHESIA
Tuesday 16 October 2007
Organisers: Dr A G McKenzie, Edinburgh
Dr C N Adams, Suffolk

- Military anaesthesia before World War I
- Anaesthesia in World War I
- Military anaesthesia in World War II
- Film footage of anaesthetic practice in the two World Wars
- Military anaesthesia in the aftermath of World War II and beyond
- Anaesthesia in the Gulf Wars

MMC UPDATE – LATEST NEWS AND VIEWS
Tuesday 23 October 2007
Organiser: Dr V Bythell, Newcastle upon Tyne

- New structure of training
- Best practice in recruitment and selection
- Practical exercises in recruitment
- Changes to the training curriculum, assessments and examinations
- Who is going to do the work?
- Manpower & discussion

ANAESTHESIA FOR SCOLIOSIS SURGERY
Tuesday 25 September 2007
Organiser: Dr C Mallinson, London

- Scoliosis provision in the UK
- Use of Doppler monitoring of cardiac output in scoliosis surgery
- Patient perspective of surgery
- Acute pain care post scoliosis surgery

NEUROANAESTHESIA & NEUROCRITICAL CARE RECENT ADVANCES
Thursday 25 October 2007
Organisers: Dr E J da Silva & Dr J Sturgess

- Awake craniotomy – anaesthetic input
- Depth of anaesthesia – recent advances
- TIVA – drugs and new equipment
- Interventional neuro-radiology – (Thrombosis in coiling/ Ca2+ blockage infusions)
- Radiology input into neurotrauma and critical care
- Optimising conditions for brain recovery in intensive care

GAT: THE CONSULTANT INTERVIEW
Wednesday 10 October 2007
Organiser: Dr M Parris, London

- Criteria for a good CV
- Preliminaries to the interview
- How to be number one choice at an interview
- Practise interviews - with a selection panel followed by debriefing and analysis
- Hot topics and interview skills workshop
DIFFICULT AIRWAYS  
Wednesday 31 October 2007  
Organisers: Dr M Stacey & Dr T Turley, Penarth  
- Prediction of the difficult airway  
- Anaesthetising the airway  
- Practical awake fibreoptic intubation  
- Management of the difficult airway in children  
- Difficult intubation in adults  
- Failed intubation in obstetrics  
- Extubation

SEMINAR AT THE ROYAL COLLEGE OF PHYSICIANS  
ULTRASOUND GUIDED REGIONAL ANAESTHESIA - INTRODUCTION OF ULTRASOUND INTO CLINICAL PRACTICE  
Monday 12 November 2007  
Organiser: Ultrasound interest group RAGBI / AAGBI  
- Introduction - application and limitation of ultrasound  
- Anatomy - ‘You only see what you know’ – the importance of anatomy in clinical ultrasound  
- The perfect block!! - Upper limb  
- Peripheral nerve stimulation – ‘dead and buried’ or ‘alive and kicking’  
- Ultrasound – the evidence  
- Abdominal blocks – an alternative to epidurals  
- How to introduce ultrasound into clinical practice, training & assessment of competency

AWARENESS AND DEPTH OF ANAESTHESIA  
Wednesday 14 November 2007  
Organiser; Dr J Andrzejowski, Sheffield  
- A sceptic’s guide to depth of anaesthesia  
- KIS(S): The isolated forearm technique  
- Neurophysiology of depth monitoring made simple  
- Bispectral index (BIS) monitoring  
- Learning in your sleep? The psychological impact of awareness  
- Beyond the BIS - best of the rest?  
- Medicolegal aspects of intraoperative awareness

LUNG ISOLATION AND ONE LUNG VENTILATION  
PLEASE NOTE NEW VENUE: ROYAL INSTITUTE OF BRITISH ARCHITECTS  
Tuesday 20 November 2007  
Organiser: Dr D Duthie, Leeds  
Delegates will be divided into two groups for the day. One group will have lectures for the morning whilst the other will take part in practical workshops. In the afternoon the groups will swap so that everyone has a day consisting of 1/2 lectures and 1/2 workshops.

Lectures:  
- Physiology of one-lung ventilation  
- Lung isolation and one-lung ventilation in clinical practice  
- Complications of lung isolation

Workshops:  
1. Robertshaw double lumen tubes and clinical confirmation of lung isolation  
2. Bronchocath double lumen tubes and fibreoptic correct positioning  
3. Arndt and Cohen blockers  
4. Univent tubes  
5. Rigid bronchoscopy

ANAESTHETISTS AND THE LAW  
Wednesday 28 November 2007  
Organiser: Dr S Yentis, London  
Part I – How it works & what it means  
- The courts and their structure  
- The different types of law  
- Lawyers and legal references  
Part II – How you might encounter it:  
- Prosecution under various Acts  
- Assault, battery, negligence, manslaughter & murder  
- The GMC  
- Keeping out of trouble

Directions  

The AAGBI is located in central London, just north of Oxford Street and within easy access of underground stations.  
Great Portland Street is a 4 minute walk. (Circle, Hammersmith and City and Metropolitan Lines)  
Oxford Circus is a 7 minute walk. (Bakerloo, Victoria and Central Lines)  
Please note Regent's Park underground station is closed until Summer 2007 for renovation.

The National Rail stations of Paddington, Euston and King's Cross are all nearby - a few minutes' journey by taxi. All of the other London Termini can be reached by underground or taxi.  
We are situated within a controlled parking area; parking meters are available in the surrounding streets.  
Travel advice can be obtained from www.transportforlondon.gov.uk where you can download underground and bus maps and also view the latest travel updates. To check latest national rail information go to www.railtrack.co.uk
To book a place on a seminar, please complete this form and return to: David Williams, Association of Anaesthetists, 21 Portland Place, London, W1B 1PY or fax to: 020 7631 4352. For availability, see website www.aagbi.org or telephone 020 7631 8862/8834. We regret that we cannot accept telephone bookings.

**Title of seminar** ..................................................................................................................................................

**Date of seminar** ..................................................................................................................................................

Membership no ............................................ Male/Female ............................................ Title

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

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

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

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

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

Email .......................................................... Name of hospital (not trust) ..............................................................

Special dietary requirements ..........................................................................................................................................

Please pay by Sterling cheque drawn on a UK bank and made payable to the Association of Anaesthetists; Credit Card (only Visa/Mastercard/Delta); or Switch. **One cheque per seminar application please.**

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<th>Non-member £240.00</th>
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**Cancellation Policy**

All cancellations must be received in writing. Written cancellations received at least fourteen days before the seminar will be subject to an administration charge of £20. Delegates cancelling after this date will be liable to pay the full seminar price unless the Association considers there to be exceptional circumstances that would warrant a refund.
Cambridge Simulation Courses 2007
Simulation Centre, Addenbrooke’s Hospital, Cambridge
Course Organiser: Dr R Tandon

Cambridge Simulated Advance Airway Course
Tuesday, 16th October 2007
This is a one-day course designed for the Anaesthetist who wishes to develop their skills in managing difficult airways. This course will also act as an introduction to difficult airway equipment

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

Registration Fee: NEW PRICE £100.00

Obstetrics Crisis Resource Management
Patient Safety & Multi Disciplinary Training
26th September 2007; 23rd November 2007; 12th December 2007
This course will aim to prepare candidates to avoid and deal effectively with Anaesthetic emergencies in obstetric practice by developing knowledge in maternal risk; assessing risks and case planning; management of obstetric emergencies and decision-making.

Skills will be developed in the management of the maternal airway, cardiac life support in pregnant women, crisis resource management and the psychological preparation for emergencies in obstetric patients

Registration Fee: NEW PRICE £100.00

Cambridge Final FRCA VIVA Day
December 2007 (Date TBC)

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

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

“A very good course with lots of exposure to all aspects of finals exam”

Registration Fee: £200.00

Cambridge Final FRCA Course
March 2008 (Date TBC)

Interactive Tutorials; VIVA Practice; SAQs & MCQs

“Excellent topic selection, very useful for the exam”

“Very good layout for the exam in terms of anaesthesia goals and pathophysiology”

Registration Fee: £300.00

For further information, please contact: Mr Ashley List, Postgraduate Medical Centre, Box 111, Addenbrooke’s Hospital, Cambridge CB2 2SP; Tel: 01223 217059; Email: al450@medschl.cam.ac.uk
Application forms can also be downloaded from our website www.addenbrookes-pgmc.org.uk
With continued scarcity of consultant posts in anaesthesia (a total of 30 advertised in a recent sample four weeks\(^1\)), there is limited hope that the situation may improve with the Chancellor confirming that spending will be limited to rises of just 2% across the public sector until 2011\(^2\). Add the “disastrous failure” in strategic planning by the Department of Health \(^3\) as noted by Commons Health Select Committee that led to over-recruitment between 1999 and 2005, and the situation looks even bleaker. Currently, post-CCT anaesthetists are facing fierce competition to secure a consultant post and a remarkable CV is desperately needed to do the trick.

But how to make your CV distinctive from your contemporaries is still a dilemma for many trainees close to their CCT dates. With academic anaesthesia in severe crisis,\(^4\) almost non-existent research posts, a sharp decline in clinical academia, and lack of funding for clinical projects\(^5\), it takes a Herculean effort to produce a publication during your training. Trainees are now looking towards alternative options to make their CVs impressive and unique. Popular options include an overseas fellowship in an anaesthetic sub-speciality or a part time postgraduate diploma eg in medical education - but here is a word of caution. For EU graduates the options are diverse but there are restrictions and limitations to be faced by international medical graduates (IMGs) when pursuing these options.

IMGs must check their immigration status before choosing an overseas fellowship. If the fellowship involves staying abroad for 3 consecutive months or more, those on the Highly Skilled Migrant Programme (HSMP) and work permits will lose the cumulative period needed to apply for indefinite leave to remain and worse, if their leave to remain expires while abroad they may have to re-apply. Those in the permit-free training category will know that they have to apply for a work permit once their current leave to remain expires. The solution is to choose a fellowship that involves staying abroad for less than 3 months but there is a catch here also. If the fellowship is unpaid or sponsored, don’t forget to calculate your annual salary correctly for that immigration year because if it fails to meet stringent HSMP criteria your later application for an extension in leave to remain or indefinite leave might be denied by the Home Office. IMGs should get detailed immigration advice before embarking on such a venture or look for a UK-based fellowship.

An IMG thinking of obtaining a PhD, MSc or Diploma in a discipline ancillary to anaesthetics will face discrimination by the UK universities. Most of the UK universities will treat IMGs as an international student irrespective of immigration status and will levy a tuition fee which will be significantly higher than that paid by British or EU students. IMGs are resident and pay UK taxes, and I strongly believe that they should not be treated as international students. I have contacted the Immigration authorities, one university and the Inland Revenue regarding regulations governing this issue but the only useful information I obtained is that the Inland Revenue considers IMGs working in the NHS as ordinary residents and they are not entitled to have access to public funds or to benefit from institutions in receipt of such funds.
My advice to affected IMGs is that they should pursue their case with universities they have applied to. Alternatively, they can apply to various international student sponsoring bodies for financial assistance – some useful website addresses can be found at the end of this article.

For many years IMGs have received unfair treatment from the NHS and are now going through difficult times in their career. The new immigration rules have already restricted their opportunities within the NHS but they are also at disadvantage in achieving their professional and training aspirations elsewhere.

Dr Ifitikhar Ahmed
Specialist Registrar in Anaesthetics
Leicester

References
1. Medical Job Advertisements in BMJ careers. 07/03/07 – 29/03/07.
2. Flinch R. Brown gives NHS last big cash boost. Hospital Doctor. 29/03/07.
3. Gilbert H. Job chaos not our fault, say doctors. Hospital Doctor. 29/03/07.

Useful websites
www.acu.ac.uk
www.gbcc.org.uk
www.somis.dundee.ac.uk/registry/misc/ors.
www.universitiesuk.ac.uk/ors/

Evelyn Baker Medal
An award for clinical competence

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the ‘unsung heroes’ of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement and wisdom and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation.

Dr John Cole (Sheffield) was the first winner of the Evelyn Baker medal in 1998, followed by Dr Meena Choksi (Pontypridd) in 1999, Dr Neil Schofield (Oxford) in 2000, Dr Brian Steer (Eastbourne) in 2001, Dr Mark Crosse (Southampton) in 2002, Dr Paul Monks (London) in 2003, Dr Margo Lewis (Birmingham) in 2004, Dr Douglas Turner (Leicester) in 2005 and Dr Martin Coates (Plymouth) 2006.

Nominations are now invited for the award, to be presented at the WSM in January 2008, and may be made by any member of the Association in respect of any practising anaesthetist who is a member of the Association.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary. Email HonSecretary@aagbi.org by 5 October 2007.

Dundee Anatomical Regional Anaesthesia Course
Tuesday 2nd October 2007

Cuscieri Surgical and Anatomical Skills Centre
Ninewells Hospital & Medical School, Dundee

A comprehensive, one day practical course covering the anatomy and regional anaesthesia of the upper and lower limbs

The course includes:
• Lectures
• Cadaver workshops
• Surface anatomy
• Practical ultrasound training on phantoms and human volunteers

Approved for CEPD and recognised for the ESRA Diploma on Regional Anaesthesia. Course limited to 16 applicants. Course fee £300.

For further information visit the ESRA website at www.ragbi.org or contact
Mrs M Thomson, University Department of Anaesthesia, Ninewells Hospital & Medical School Dundee DD1 9SY; 01382 632427 or e-mail m.a.thomson@dundee.ac.uk
SAS Review Day, the joint annual meeting of SAS Committees of the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists was held on 10th May. It was the Association’s turn to hold the meeting. The programme was designed to reflect topics relevant to the work of SAS doctors.

The meeting opened with a short welcome address from Dr William Harrop Griffiths, Honorary Secretary of the Association. Ramana Alladi, the organiser of the meeting, followed with a short introduction reviewing the activities of the SAS Committee of the AAGBI.

Professor ChrisDodds spoke about anaesthetic considerations in the elderly and highlighted several areas where change has occurred, or is about to, in the management of elderly patients. These include the continuing increase in day case surgery, the new Mental Incapacity Act, and basic science research into ageing as well as the inclusion of pain assessment in hospital discharge policies in the NHS.

He pointed out the implications for anaesthetists particularly with regard to informed consent, and also described how the effects on the microglial system within the nervous system following injury may start to throw some light into the causes of post-operative Cognitive Dysfunction (POCD).

Dr Richard Griffiths spoke about anaesthesia for joint replacement surgery and dealt with preoperative assessment and the role of NSAIDS and when these should be used in elective joint surgery. He had a brief look at tourniquets and how we may be able to reduce the haemodynamic and painful consequences and finally had a look at the role of ketamine.

Dr Angus Crossley explained the current understanding of temperature regulation. He outlined this complex subject in a very clear and concise manner. He explained how it falls to the anaesthetist to attempt to maintain body temperature within the normal range throughout the operative process and how greater attention to thermoregulation should reduce complications and hospital stay.

Dr Rafa Blanco, in his lecture, gave some invaluable practical tips for successful use of ultrasound for effective regional blocks. He stressed the importance of regular practice, accurate documentation and learning from mistakes. He explained how one can avoid complications of regional anaesthetics using ultrasound, for example precise placement may allow reduction of the dose of local anaesthetic agent required for success.

Dr Wim Blancke explained the myths that exist in the management of the airway. He made a convincing argument for the place of LMAs in management of the airway especially in obese patients. He outlined the arsenal of equipment and techniques that are available now and assessed them against current practice, knowledge and evidence. The lecture, I felt, left many delegates thinking hard about their views on LMAs and airway management.

Dr Anthea Mowat explained the details of the proposed new SAS Contract and gave an update on what was happening to the negotiations. I am sure the information will help the members decide what to do when it comes to the ballot.

More importantly it helped SAS doctors to network with their colleagues. All in all the SAS Review Day has been a very useful, educational and interesting meeting. Due to the success of this meeting, which was over-subscribed, it has been decided that an SAS seminar be run in February 2008 – keep your eye on Anaesthesia News for further details.

Ramana Alladi,  
Chairman SAS Committee, AAGBI.
Anaesthesia in the 1930s

In about 1934 when I was aged 19, I was working at Hitchcock Williams in the City. One evening whilst fooling around with my brother, I put my hand through a plate glass window and severed the tendons of the ring and little fingers of my right hand. I was admitted as an emergency to Barts Hospital and prepared for immediate surgery. I cannot recall the pre-med but in those days it was probably morphine and atropine.

I do recall being placed on the operating table and a mask being placed over my nose. I vividly recall reaching a stage when I was unable to speak and oblivious of my body but could hear and see when the anaesthetist lifted up eyelid. I recall the remarks they were making about me which fortunately were not derogatory! I yearned to tell them that I wasn’t under and not to start, but of course I couldn’t. Then I remembered no more until I woke up in my bed in the general ward. I don’t think there were any recovery wards in those days.

Frank Denny
Retired gynaecologist
Perthshire
Dear Editor...

Editor’s Choice letter

Cardioversion by ‘terror’

Much of the enjoyment of anaesthetising for emergency lists stems from having to manage the challenging patient, plan for unusual surgical procedures, witness unpredictable outcomes and generally to expect the unexpected. This case certainly highlights many of these factors.

A 31 year old gentleman presented for an emergency cardioversion following admission 36 hours previously in fast atrial fibrillation unresponsive to aggressive medical management. This had been precipitated by alcohol the previous night. It soon became apparent that this was not a routine alcohol induced supraventricular tachycardia as there was a slightly concerning cardiac history involved, comprising both aortic and pulmonary outflow tracts originating from a univentricular heart, pulmonary valve stenosis and a large atrial septal defect, along with the recent development of pulmonary hypertension.

Surgical correction had been considered as a child but it was felt that the long term benefits were uncertain. This had also been reconsidered more recently, but unfortunately due to the development of pulmonary hypertension during the intervening years, surgery was now not a viable option. Consequently the patient normally tolerated a persistent hypoxia with a PaO$_2$ of about 7kPa with haemoglobin saturations in the mid seventies, had developed a polycythaemia of 23g/dl and had a very limited exercise tolerance.

In the initial period following admission, the atrial fibrillation had been tolerated; however worsening hypotension, hypoxia and evidence of left ventricular failure meant DC cardioversion was now indicated.

A year previously a similar admission had resulted in a successful DC cardioversion. Consultation at this time with our regional cardiac centre had provided advice regarding appropriate anaesthetic management, and this information was available for reference. However, the risks of further cardiac decompensation and subsequent loss of cardiac output during the procedure remained significant. A brief summary of the anaesthetic plan was then discussed with the patient. I was then prompted by the presence of a blank ‘Do Not Resuscitate’ order in the patient’s notes to discuss the consequences of a serious reaction to the anaesthetic or cardioversion and to what lengths the patient would like resuscitation efforts to be continued. Subjectively it was at this stage that his anxiety considerably heightened as the significance of the risks posed by this procedure became apparent. Shortly after this discussion, while waiting for a cardiologist to appear, there was a spontaneous correction of the atrial fibrillation back to a regular sinus rhythm. This was accompanied by considerable drop in my pulse rate too.

This tale arguably justifies that ‘terrorising’ this gentleman with the risks of anaesthesia benefited all involved.

Dr Paul Marval
Derby Hospitals NHS Foundation Trust
(The patient featured gave his consent for details of his case to be published.)

Blackwell gives AAGBI members 20% discount on textbooks ordered online – visit the website www.blackwellpublishing.com/medicine and follow the links. To claim the 20% discount enter the code AAGBI20 when prompted in step 2 of the shopping cart.
Should we keep neostigmine in theatre?

Neostigmine is used in clinical practice for reversal of non-depolarizing muscle relaxants, relief of urinary retention and treatment of myasthenia gravis. It has a number of significant side effects, and to mitigate these the usual anaesthetic practice in the past was to mix neostigmine with either atropine or glycopyrrolate just before administration to overcome the undesirable cholinergic effects of neostigmine such as bradycardia and increased secretions.

Since the introduction of premixed neostigmine and glycopyrrolate ampoules, this practice has changed. Now, the vast majority (if not all) anaesthetists use the premixed neostigmine/glycopyrrolate to reverse the effects of non-depolarizing muscle relaxants.

However, neostigmine ampoules are still available in many anaesthetic rooms and theatres.

Now let us imagine a scenario in which you ask a new SHO to give the patient neostigmine reversal; he may, due to lack of knowledge, give the patient neostigmine without anticholinergic agent causing severe bradycardia or cardiac arrest.

As there is no current indication for sole neostigmine and there is the possibility of a critical incident, I suggest taking neostigmine ampoules off our shelves in anaesthetic rooms and theatres.

Dr Alaa Farag (FRCA, MSc)
SAS anaesthetist
Royal Gwent Hospital

Send Nobel Prize to....

We would like to apply for the Nobel Prize in Medicine as advertised by Dr Bogod in his article on free papers in the May 2007 edition of your magazine. He threw down the gauntlet that there is no easy way to ensure first time insertion of NG tubes in intubated patients. One of the authors was once shown a technique that he has imparted to many over the years and which rarely, if ever fails.

Technique:

1) Insert NG tube into the nostril and advance to the back of the oropharynx.
2) Using a laryngoscope and McGill’s forceps, retrieve the end of the NG tube out of the patient’s mouth and pull approximately 70cm of the NG tube through.
3) Remove the connector from the end of an ETT and cut it longitudinally so that the whole tube will open out flat if required.
4) Insert the ETT blindly into the patient’s mouth. As there is already an ETT between the vocal cords, the new tube can only enter the oesophagus. If any anaesthetist struggles to intubate an oesophagus we would love to learn from them!
5) Feed the end of the NG tube inside the split ETT as far as it will go and then holding the NG tube, withdraw and remove the ETT.
6) Feed the NG tube into the back of the mouth and adjust the length as required.
7) Order an X-ray safe in the knowledge that you probably don’t really need it.

We accept that it’s not the cheapest way of inserting an NG tube but when we’re struggling, it never fails.

Unfortunately, we can’t remember who showed him this technique of using an ETT as a split-introducer so we can’t really claim an eponym. If anyone knows who invented this technique we’d be very happy to credit them.

Frank Swinton, SpR
Rob McCormick, Consultant
Royal Bournemouth Hospital

SEND YOUR LETTERS TO:
The Editor, Anaesthesia News, AAGBI, 21 Portland Place, London W1B 1PY or email: anaenews@aagbi.org The Editor’s Choice letter every month will win a prize.

DUE TO THE VOLUME OF CORRESPONDENCE RECEIVED, LETTERS ARE NOT NORMALLY ACKNOWLEDGED.
Coming soon to a (movie) theatre near you

There is evidence that patients who understand what is happening to them in instances of awareness during anaesthesia, are less likely to have delayed symptoms (e.g. nightmares, anxiety) after the event [1]. In other words: awareness about awareness decreases awareness complications.

Patient education is getting unlikely help later this year from New York to movie theatres near you. The film "Awake", starring Hayden Christensen (Star Wars: Episodes II and III), Jessica Alba (Fantastic Four, Sin City) and Terrence Howard (Crash), deals with the issue of awareness during anaesthesia. Nationwide exposure in cinemas may increase public knowledge.

However, with a plot summary that reads: "a surreal psychological thriller about a man whose failed anaesthetic (sic) leaves him fully conscious during open heart surgery [...] forced to endure intolerable pain, the man retreats into the dark recesses of his mind", this film may increase patients’ preoperative anxiety [2]. I guess we will soon find out if there is any truth in the adage: 'any publicity is good publicity'.

Enjoy the film!

Pierre-Antoine Laloë
Diana Princess of Wales Hospital, Grimsby


Ooops!

I note that your 'Anaesthetists in Literature' editorial (Anaesthesia News, May 2007, pp 6-7) observes, in a roundabout sort of way, that Michael Crichton wrote the book 'Coma'. This is a well-known error.

Michael Crichton directed the film and wrote the screenplay; it was adapted from the bestselling book by Robin Cook.

Dr Tom Neal
Dept of Anaesthesia
Royal Orthopaedic Hospital
Birmingham

Mea culpa – my devotion to Anaesthesia News knows no bounds, but I wasn’t about to source some pulp fiction from 20 years ago for the purposes of research! Editor
“DINGLE 2007”

9th CURRENT CONTROVERSIES IN ANAESTHESIA AND PERI-OPERATIVE MEDICINE, DINGLE, CO. KERRY, IRELAND, OCTOBER 2007

NEW FOR 2007: “Wednesday Workshops”

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Dr Michael Mathay (USA), Dr Danny McAuley (N. Ireland), Dr John Loffey (Ireland), Dr John Myburgh (Australia), Dr John Goldstone, Dr Mark Griffiths, Dr Mark Hamilton, Dr Sheena Hubble, Dr Kathy Rowan, Dr Matthew Ruckledge, Dr Andy Webb (UK) and the Xtreme-Everest Team.

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Full details at www.ucl.ac.uk/anaesthesia/meetings or email SiobhanMythen@btinternet.com

CALL FOR ABSTRACTS

British Society of Orthopaedic Anaesthetists 12th Annual Scientific Congress

London, Friday 9th November 2007

We invite you to submit work for poster presentation. Selected finalists will be invited to give an oral presentation at the Congress on November 9th 2007.

Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 10th September 2007. Abstracts should be emailed in the form of one A4 side of printed text in 'electronic form', Word or PowerPoint, on or before 10th September marked clearly with your name, address, telephone number and email address. Presenters will be required to register for the Congress and selected finalists will be invited to the BSOA Annual Dinner.

Meeting Chair: Dr Roger Cordery
Email: SiobhanMythen@btinternet.com
The Aim of the Weekend is to Suffuse the Candidates with so much Exposure to The Viva Challenge that, on the day, They will be Immune to the Stress & Stupidity that so often & unnecessarily leads to Disaster

MENU
Master Class in the Subtleties of the Viva Encounter
Long Case Booklets
Short Case Booklets
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Six Formal Viva Sessions
(Under as near Examination Conditions as can be mustered)
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University Hospital Aintree, Liverpool.

£250
(Including Breakfast, Lunch & On-Going Refreshments 08.00 – 20.00)

IMPORTANT NOTES

This course will only be of value to those candidates who have earned an invitation to London following the SAQ & MCQ papers.
(Applicants who fail to ‘get a viva’ will not be penalised – Cheques will be destroyed)
Thus candidates will be expected to produce the appropriate evidence.
Interested candidates are asked to consult the Mersey Website (www.msoa.org.uk – Classes & Courses) for Full Feedback & Details of the Administrative Mechanism.

Postscript
Best Viva Result to date – 86%
Worst Viva Result to date – 79%
It must have been towards the end of the 1920s that, in accordance with what was then a rite of passage, I was admitted to the Leeds General Hospital for the removal of my tonsils and adenoids (Ts and As). Who wielded the knife, or who administered the anaesthetic, I haven’t the remotest idea. All I know and, seemingly, will never forget, is the feeling of terror that I experienced as the mask covered my face and the inducing anaesthetic (? ether) began to bite. My conviction was that I was about to die by choking and, instinctively, I fought back with all the strength and with whatever free limbs I had available. But it was all in vain: Goliath defeated David by knock-out!

My first conscious memory of the unfair struggle was of waking in a strange bed with a young, attractive nurse in attendance. She gently sponged my face and helped me to sit up more easily to vomit into a white enamel bowl ready on the bedside table – a routine postoperative procedure at that time.

It took a few days to recover from the postoperative throat discomfort: but the damage to my psyche can be measured by the fact that, on infrequent occasions, when I am particularly stressed, I suffer disturbing nightmares in which I relive the circumstances in which I was convinced that death was imminent.

It might have been otherwise, but the Fates, in cahoots with my revered father, decided that my future lay in the practice of medicine. So, in pursuit of this decision, for the requisite number of years in the 1920s/30s, I was to be seen creeping like a snail unwillingly to school – the Leeds School of Medicine. Then, as a clinical student, I was required to walk the wards of the Leeds General Infirmary. It was inevitable, of course, that at some stage I would cross the threshold of the selfsame ward where the Battle of the Ts and As had been fought and so ignominiously lost. It was just as I remembered it, minus the ministering nurse. For a brief moment I felt faint and nauseated at the sight of the same vomit bowls with the letters LGI emblazoned on the dead-white enamel. What compounded my distress was the realisation that anaesthesia had made no apparent progress since the time I was on its receiving end.

Sad to relate, my experience of the status of anaesthesia at this time, in Leeds at any rate, did nothing to erase this impression. There was no formal teaching. What instruction there was was given by Dr Stanley Sykes – who will be remembered more as an excellent thriller writer than as an anaesthetist – when he demonstrated the antique ‘rag and bottle’ method. Despite the minimal instruction and the primitive method, it sufficed for my needs on the rare occasions I was unlucky enough to be put to the test.

However, the years – more accurately, in my case, decades – have rolled on, in which time, I have to admit with relief, anaesthesia has undergone seismic changes since the stone age practices I experienced as patient and student. I know this to be so because I have benefited from the expertise of the modern anaesthetist on a number of occasions. Now, their art holds no terror for me and – tell it not in Gath- I enjoy it. And what is more - much more - important, the hideous nightmares I used to suffer have evaporated.

Henry R. Rollin
Emeritus consultant psychiatrist, Epsom
Beware Radio Microphones

My finance director attended a large national meeting held by the NHS. On the second day the plenary session was to be addressed by the European president of a large US multinational corporation. The conference was well attended and this session was, in many ways, the highlight of the event.

The VIP speaker arrived 10 – 15 minutes before the start to familiarise himself with the lectern and slide changer. The chairman put on the radio microphone and explained that he would go and look for the second speaker who had not appeared. The speaker asked where the nearest facilities were, which turned out to be just behind the stage.

Apparently the VIP speaker had arrived at the venue the day before and had gone out for the evening to entertain his British team. A lively evening had been enjoyed by all with rather too much alcohol, a curry and a nightclub which had all seemed sensible at the time.

The lecture theatre was about half-full, when the speaker suddenly stood up and made his way back stage through a door at the side. There was a noise through the PA system of a door closing, some groaning and then “Oh, why did I go out last night, don’t I ever learn?” The audience, now filling the lecture theatre, quietened down. The noise of a cubicle being locked and a jacket being taken off were next, and then the unmistakable sound of intestinal hurry accompanied by much groaning and the odd indiscreet comment.

By this time the audience were in stitches, but the zipper being pulled up was clear to hear and then much hand washing and splashing, presumably of the face.

The speaker appeared through the door looking surprised to see the audience laughing. Fortunately the chairman did not explain the source of the laughter until after he had finished his lecture!

Beware the radio microphone - oh – and curries and beer before speaking!

Iain Wilson
I write in response to the request in Anaesthesia News for personal memories of anaesthesia in the 1930's. You state that anyone who has such memories will be a ‘rare beast’, and would now need to be in their mid 80’s. I’m pleased to say that although qualifying for this description I am still (just) on the right side of eighty!

My recollection dates back to the early/mid thirties, probably 1933 or 1934 when I would have been five or six years old. I was taken by my parents for a consultation with an ENT surgeon in Harley Street. I still remember that visit and being fascinated by the array of instruments laid out on a trolley next to the desk. It was decided that I should have my Ts and As removed and the operation was arranged to take place at the London Hospital. This of course was before it became the Royal London Hospital. I also recall travelling on the appointed morning to the hospital and being taken in to the theatre. A mask was held over my face (presumably a Schimmelbusch) and liquid poured on to it. (Little did I know that some twenty or so years later as an anaesthetic registrar, I would be administering exactly the same form of anaesthesia for guillotine tonsillectomy). I vaguely remember trying to resist, and subsequently when in the recovery area with several other children and parents present, making something of an exhibition of myself. I was told afterwards that I screamed the place down and threatened to kill the surgeon. As I spoke only Welsh at the time, the surgeon and theatre staff however were probably unaware of this threat! My emergent behaviour I believe caused some embarrassment to my parents, but a kindly nurse reassured them that it was a good sign indicating that I was fit and healthy, unlike some of the other children who recovered with merely a whimper! An hour or two later, presumably having recovered my composure I was allowed to go home; the present vogue for day-case surgery would therefore appear to be another example of reinventing the wheel. My final and best recollection on leaving the hospital was of being kissed goodbye by a pretty (she must have been mustn’t she?) nurse as I was lifted into a car. On arriving home I was put in my parent’s bed and was soon being subjected to a boisterous visit from two cousins. I believe however that the subsequent recovery from my early surgical experience was uneventful.

Another anecdote about anaesthetic practice during the thirties (1937), may also be of interest. This copy of a letter was written to my father following the acceptance of my grandmother for surgery by the eminent surgeon W. Hamilton Bailey. Colleagues of my generation will be familiar with his name and his authorship of one of the standard surgical text books, as they will be of the practice at that time of making available the odd guinea to the anaesthetist for his contribution, equating this to that of the retractor holder!. At least some progress in that context has been made in the intervening years. It would be interesting to be able to foresee whether or not full parity will have been achieved by the next Association anniversary!

John Francis,
Retired Consultant Anaesthetist,
Exeter.

FROM HAMILTON BAILEY

123 Harley Street
London W1
December 15th 1937

JG Francis Esq.
Seven Kings

Dear Sir,

Thank you for your letter. I have arranged for a semi-private bed for Mrs Francis after Christmas. My House-surgeon will write and let you know as soon as it is vacant.

I quite understand the financial position, and will reduce my operating fee to ten guineas. There will also be a charge of one guinea for the anaesthetist and one guinea for the assistant. I trust this will be convenient for you.

Yours faithfully,

Hamilton Bailey
The Art Exhibition has been a part of the September Congress for so long now that I cannot remember exactly when it began! I can date it to sometime in the 1990s but the precise year has faded into the mists of time. Suffice it to say, the Exhibition is now a tradition. Traditions tend to be venerated and continued. Whether this is from habit or because they have value is sometimes a matter for debate.

As far as the Art Exhibition is concerned, the tradition continues for two reasons only. The first is the support of anaesthetists and their friends and families who unfailingly provide magnificent examples of their artistic talent which they are willing to share with their colleagues. As time has gone by, both the number of exhibitors and the works they contribute have increased. The second reason the tradition continues is the enthusiasm of delegates who flock to admire the exhibits. I do not exaggerate. Every coffee break, the Exhibition is crowded and many people come back for a second and even a third visit. Thus we have an event that is well supported by exhibitors and much appreciated by those who view exhibits.

This said, I still have to work hard to encourage exhibitors. Despite the long tradition of the Exhibition and the obvious enjoyment it provides, some exhibitors remain shy and lack confidence that their work will be appreciated. There are even some individuals who have expressed an interest in showing their work but have not yet found the time or the confidence to do so. I cannot help repeating what I say every year. If you like your work, your colleagues will too. The Exhibition is meant to be a showcase for the talents of anaesthetists and their families. It is meant to give pleasure to all – exhibitors and viewers alike. Above all, it is a fun event, not a chore nor an exam. There isn’t a standard to be met. Nothing is rejected. Nothing is criticised. Quite the contrary. I marvel at the imagination and creativity that our exhibitors have. Perhaps this is an innate talent. Perhaps it is acquired by working in the NHS and channelled into artistic endeavour. Whatever, I am, yet again, asking for your support. I need exhibits!!

The rules are simple. There are none! All items offered for Exhibition are shown. They can be anything that has creative origins and any size – all that is required is that they can be fixed on a wall or stood on a table or the floor. For paintings and photos, they do not need to be mounted or framed. I can offer a basic service providing a simple card mount - if you would like me to mount them for you, I need to receive them by August 20th. Many exhibitors produce beautifully framed work, but you need to organise this yourself. You can bring your exhibits any time up to and including the beginning of the Congress but then they will be shown as you present them. If you cannot attend the Congress, you can ask a friend to bring your exhibits to Dublin or you can send them to me by or to the AAGBI by September 5th and we will take them to Dublin for you. Whichever way you send or bring your exhibits, I would appreciate a communication using either the official entry form or less informal means by August 31st. This is not a proscriptive requirement. I ask to be informed of titles so that I can make labels for each exhibit and a catalogue. I like to think that this
makes the Exhibition more professional but most important of all, it allows your colleagues to see who has created each exhibit.

This year, we are running an additional competition to choose an artwork for the AAGBI Christmas card. The exhibit must not be larger than A4 in format, but otherwise the subject is limited only by your imagination.

I look forward, with your support, to another superb Exhibition in Dublin (September 12th – 14th). If you have any queries or need help with mounting, transport or anything else, please contact me or Julie Gallagher. Our email addresses are: anne.sutcliffe2@btinternet.com and julie.gallagher@aagbi.org. Finally, to those of you who have already promised exhibits, thank you! You are the angels who brighten the dark nights of late winter and give me confidence that eventually there will be an Exhibition. Despite the rhetoric above, many contributors leave it to the last minute to let me know that they will give me work. As spring turns to summer, my nails get shorter and my coronary arteries grow narrower. I worry that there won’t be an Exhibition and a lovely tradition will die. In the interests of my good health, please get in touch sooner rather than later!

A reminder of notable dates:

- **August 20th** – last date for receipt of exhibits which require mounting
- **August 31st** – last date for entry notification (later entries accepted, but will not appear in catalogue)
- **September 5th** – last date for exhibits to be delivered to me or AAGBI if transport to Dublin required
- **September 12th** – start of Congress. Final date for receipt of entries delivered to exhibition hall

Anne Sutcliffe
Goofy management

There is a story that staff of the Disney Corporation arrived at work one day to find an e-mail from management threatening that, in future, anyone found referring to their workplace as Mouswitz would be fired. Almost by return a round-robin appeared using the term Duckau. Sound familiar?

A couple of weeks ago, a brace of managers jack-booted into our operating theatres at 8 o’clock in the morning and announced to shocked staff that, in the interests of efficiency, they must all reapply for their own jobs. The problem, they explained, is that the skill mix is currently too rich; some staff might be down-graded, some might be re-deployed either to other hospitals within the Trust or the wards. They will be replaced in theatre by health-care assistants that they (the theatre staff) are to train up in the space of three to six months. (Well, they might not have said exactly that but that is what the staff heard). Then with an airy salute and an order to go back to work as usual, the pair goose-stepped smartly out of theatre before reality set in and the staff lynched them.

I became aware of this later that morning as I attempted to do a community paediatric dental list accompanied by a weeping anaesthetic assistant. Clearly there are a few questions that need answering here.

Firstly, we have just gone through a long, painful and very costly, Agenda for Change exercise in which skill and responsibility levels were agreed for all the theatre staff. Is this then ‘Hidden Agenda for Change’? If they got it wrong the first time how can we be assured our managers will get it right a second, and why are they not for the high jump for getting it wrong in the first place?

Secondly, and more to the point, why have we spent the last twenty years or so training perfectly competent auxiliary nurses and SENs up to SRN standard, encouraging, and in many cases compelling, them to take university courses, write essays and dissertations, and acquire qualifications, when it now seems that what we really need in theatre are health care assistants?

Could it possibly be something to do with cost? Why use expensive, trained and experienced staff to do a job when you can train someone from the job centre to do it in three months? Why indeed – it’s only critical care and patient safety that we are talking about. I am absolutely sick and tired of this continual attack on professionalism and dumbing down of skill and experience that pervades the NHS at the moment. The assumption (made in many cases by those who have no experience in a clinical setting or last patrolled the wards with a lamp) is that it’s not really all that hard. Health care assistants can do the job of a nurse or ODP; a nurse can do the job of a doctor. They may certainly be able to do the easy bits, but it is not all easy, and mistakes in the NHS are very expensive indeed.

It is time for all true NHS professionals and skilled personnel to rise up and refuse to be pushed around and demoralised like this. To cut costs and truly increase efficiency, I am going to propose a cull of the staff list based on certain criteria. The following staff would have to reapply for their jobs so that we can have a real hard look at what they actually do and decide if they are of any benefit to patient care.

1. Any member of staff with more than three words in their job title e.g. Modern Apprenticeship Care Co-ordinator*.

2. Any member of staff with the words ‘co-ordinator’, ‘project’, ‘CNST’ or ‘team leader’ in their job title. Careful consideration should also be applied to the words ‘deputy’, ‘assistant’, ‘practitioner’, ‘advisor’ and ‘manager’. e.g. Patient Care Advisor Team Leader*. Anyone with more than one of these words, (particularly ‘project’ and ‘manager’ in that order) should just be sacked on the spot.

3. Any job title that is simply ridiculous. e.g. Head of Proposition Development**.

This list is by no means comprehensive and other Trusts may wish to develop their own.

In the case of uncertainty, a simple, two-part test can be applied.

1. Ten patients selected at random are given the job title of the employee in question and asked to write down in one sentence what they think the job entails and how it promotes patient care. e.g. Peripatetic Internal Verifier*. A correct score of more than 2:10 is required. (This may need some development as I fear that in many cases no-one really knows what these posts are for – even the incumbent!)

2. The member of staff should be asked to define ‘tool’. Two correct answers are allowed: An instrument for performing a specific task’ and ‘A foolish person’. If the answer is ‘An electronic or paper programme for allowing a group of people to come to a management decision without using any original thought process’, prompt dismissal is on the cards.

This should really sort the sheep from the goats. We will save so much money we will be able to afford health care assistants to actually assist us and not replace us. Genius!

Ordinary NHS staff who work hard to make a difference and do a good job for patients have had enough. We should rise up and make a stand for skills, experience and professionalism. So I call on all NHS nurses, doctors, ODPs, physiotherapists, lab technicians, secretaries, joiners, pharmacists, dieticians, cooks, cashiers, cleaners, even CEOs to join with me in demanding a critical look at and rooting out of these apparently pointless posts.

And let’s not feel too sorry for those that we have to ‘let go’. Those with no qualifications can all be trained as health care assistants and be back in productive work for the NHS in three months. Those with a degree in knitting or media studies, or a marketing diploma from the University of Scunthorpe might fit in well at Disney.

* All of these are real titles of real jobs in my Trust

** This one might be of use to trainee who find themselves on the dole in August. You can apply for it at the BMA. Salary £60K+. Better join the queue now – starts at Watford.

Gas Flo