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“Namaste! Welcome to Simikot, Nepal” said Uwe, an Austrian member of the Nepal Trust Health Team, grinning enthusiastically. We had just landed on a dirt airstrip situated on a spur above a meandering valley high up in the predominantly inaccessible “Hidden Himalayas”. Some members of the team hugged each other and we had all cheered once we had taxied to a stop, as the landing had been spectacularly bouncy. A wrecked twin prop plane by the side of the airstrip indicated that our relief was justified!

Simikot, the principal town of the Humla region in Nepal was where the Nepal Trust (www.nepaltrust.org) was holding its annual health camp. Humla, with a population of only 40000, is situated in north-western Nepal in a remote and mountainous region. Economically and socially it is the poorest region within Nepal and our only point of entry was by plane into Simikot as the nearest road is over 70 kilometres away. Despite the recent unstable political situation in Nepal the series of health camps has continued to be run successfully and without serious incident over the last three years.

The camp drew together volunteer professional staff from Nepal, Austria, Scotland and Gibraltar. I was led to believe my job would be to administer spinal anaesthetics only to patients – in previous years it had not been thought possible to give general anaesthetics safely due to the cold temperatures and
the altitude (over 3000 metres). However a volunteer theatre team from southern Nepal had brought up some basic equipment for administering general anaesthesia. The general anaesthetic equipment used was an Indian Shree machine with nitrous oxide, oxygen and an on/off halothane drawover vapouriser with a Bain circuit. A crash course in the functioning of the Shree machine, a check I had to hand all my basic resuscitation equipment, and we were away. A list of 20 patients appeared, with each operation noted carefully and a history which always included “no previous anaesthetic”! With no quick access to blood results in Simikot and many patients having chronic respiratory disorders my days were kept very busy until well into the night on some occasions.

The Nepalese in this region are very superstitious and do not have chimneys on their dwellings. The reason is to prevent evil spirits entering down the chimneys and therefore the majority of the population suffer some degree of chronic smoke inhalation. The conditions and altitude also provided many trying problems such as low initial oxygen saturations, temperature control, and the minimal monitoring which consisted of a saturation probe and a manual blood pressure cuff, with ventilation taking place by hand only. No modern safety features existed so a great deal of clinical observation was required. Flitting thoughts from my FRCA examinations many years ago of splitting ratios to calculate concentrations of halothane gas were overridden by clinical skills in assessing the partial pressure of halothane in my patients (which should be the same as at sea level). At least we had halothane!

The camp administered medical, surgical, dental, paediatric and ophthalmic care to over 9000 patients in nine days. Almost 300 major, minor and family planning operations were carried out successfully. Operations included emergency laparotomies on a septic shock patient, hysterectomies, hernia repairs, release of burn contractures, removal of meningocoeles, and vasectomies! The theatre had been set up as well as possible with conditions similar to those in a war zone but certainly not comparable to any facility in the western world. The term “sterility” takes on a completely different meaning when in a remote Himalayan camp many miles from the nearest road. Part of the building had been used as a donkey shed just weeks before!

The camp administered medical, surgical, dental, paediatric and ophthalmic care to over 9000 patients in nine days. Almost 300 major, minor and family planning operations were carried out successfully. Operations included emergency laparotomies on a septic shock patient, hysterectomies, hernia repairs, release of burn contractures, removal of meningocoeles, and vasectomies! The theatre had been set up as well as possible with conditions similar to those in a war zone but certainly not comparable to any facility in the western world. The term “sterility” takes on a completely different meaning when in a remote Himalayan camp many miles from the nearest road. Part of the building had been used as a donkey shed just weeks before!
Ketamine was used liberally; muscle paralysis only if necessary. The endotracheal tubes were all reusable and spinal anaesthesia was used whenever possible. Postoperative care would often mean 3 patients to a bed, and we constructed a makeshift ward outside on a concrete base with a tarpaulin as protection against the elements as the beds became full.

Finer issues of clinical governance recede quickly in the rarefied air and a consideration of risk/benefit ratio overrides all others. My interview and registration with the Nepal Medical Council seemed a distant memory in the metropolis of Katmandu! Being a once-a-year camp and the only contact with medical staff the population has, over 9000 of the population attended in 9 days - 1 in 5 of the region’s population. Difficult decisions would often have to be taken - the nearest hospital is over a week’s hard trekking away, and no local can afford the airfare down to Nepalganj. Therefore if interventions are not undertaken it will almost certainly be a year till another medical doctor is able to see them, and explains why patients are carried by relatives over rough mountainous tracks for up to five days to be seen.

Anaesthetising a critically ill patient with septic shock provided several firsts for the region: the first use of inotropes; dopamine via a drip in drops per minute. Postoperatively the relatives thought this was the elixir of life and proceeded to open it up fully at every opportunity, providing an interesting set of blood pressure readings on the charts. On enquiring if any blood could be made available, 40 minutes later I was both surprised and delighted to receive a bag of type-specific blood, a first for Simikot. This was not really the time or the place to question its origin so after checking its compatibility with the patient, she became the first recipient in the Humla region of a blood transfusion. The laparotomy revealed a perforation of her small bowel from ascaris worm infestation which the surgeon had to pull from the perforation: not my most pleasant viewing experience in an operating theatre!

Our lasting thoughts as the plane soared up over the Himalayas were of how vulnerable the population are and the isolation all the staff felt dealing with so many complications in such isolated circumstances. The work had been memorable, the scenery spectacular and the people friendly and hospitable. We all hoped some continuity could be established by providing a permanent medical presence in Simikot. We left fatigued, dirty, yet euphoric in the knowledge we had at the least contributed to the philosophy of improving healthcare to the population of Humla region, Nepal. And memories to last a lifetime! Namaste!

Richard Roberts
Consultant in Anaesthetics and Critical Care,
Gibraltar
The Scottish Standing Committee is now six years old and it was a pleasure to attend their annual Open Meeting in Stirling in February. It was the usual successful mix of clinical and political topics and Professor Alison Pollock, author of the fascinating insight into the health care reforms ‘NHS Plc’ gave a guest lecture on the subject. A most revealing slide detailed the true costs of a PFI scheme from figures eventually provided to her by the government under the Freedom of Information Act; it was about four times the non-PFI cost.

Despite Scottish MPs voting for the reforms in the English NHS, Scotland has yet to follow suit, having only one independent sector treatment centre newly opened by the Minister the same weekend as our meeting. All NHS patients treated there will be covered by the Scottish NHS indemnity scheme CNORIS. This is a welcome change, as when SSC Convenor Neil Mackenzie raised this issue two years ago with the Scottish Executive they said the NHS would not provide indemnity cover for these NHS patients.

Unfortunately in England, Health Minister Andy Burnham has confirmed that NHS indemnity is not currently available for locally contracted arrangements and recommends that independent organisations arrange their own clinical negligence insurance. He does say "This is under review and that proposed changes in legislation when Parliamentary time allows and subject to Parliamentary approval will enable the Secretary of State to extend CNST cover to all providers of NHS services". In the meantime individuals must decide for themselves. In our December statement AAGBI recommended that no consultant considers signing up to the BUPA Hospital Panel or any similar arrangement unless 100% CNST cover is guaranteed for all NHS patients involved. BUPA hospitals themselves are now apparently up for sale as the BUPA organisation restructures itself; perhaps the expected influx of NHS work is not going to materialise.

The National Patient Safety Agency has recently published two Patient Safety Alerts (PSAs) of particular interest to anaesthetists (www.npsa.nhs.uk). ‘Promoting Safer use of Injectable Medicines’ (PSA 20) notably includes a recommendation that trusts implement a ‘purchasing for safety’ policy to promote the procurement of injectable medicines with inherent safety features. They recommend that ready-to-administer and ready-to-use injectable medicines are purchased and believe that the additional cost should be offset against preparation in the clinical area, which incorporates the cost of component materials, staff time, wastage and associated risk. ‘Smart’ infusion pumps incorporating dose checking software can cost more than other pumps, but Trusts should consider the benefit of these additional safety features when planning pump replacement programmes.

PSA 21 ‘Safe Practice with Epidural Injections and Infusions’ is also of interest to anaesthetists and should help members persuade their Trusts to implement any of the recommendations not currently in place. The safety of epidurals is also currently being audited by the Royal College of Anaesthetists National Anaesthesia Audit entitled ‘Major Complications of Spinal and Epidural Anaesthesia’. The initial snapshot audit has already shown that over 700,000 such procedures take place in the NHS each year, and the reporting period for all major complications is now underway. The specialty has long had an ambition to determine the prevalence and incidence of these events and I would encourage every member to take part in this important audit. E-mail tcook@rcoa.ac.uk for further details.

As I write, the Medical Training Application Service (MTAS), set up for Modernising Medical Careers (MMC) appears to have unravelled. The extent of the disaster was marked by the speed with which the Department of Health has set up a group to review the process as a matter of urgency. It was pleasing to see the President of the Royal College of Anaesthetists, Judith Hulf, at the table although surprising to also see some of the architects of the flawed system there reviewing their own process. The statement by the Department of Health which stated that they had operated a wide consultation process beforehand was correct; they failed to add however that none of the suggestions was taken on board - for example, the Colleges who have long experience and a successful track record in training appointments had suggested appointing one third of the posts in the first year, spreading the process over a longer period of time and staggering the appointments.
An unprecedented march by trainees and some consultants took place in London from the Royal College of Physicians in Regents Park to the Royal College of Surgeons in Lincoln’s Inn. It was pleasing to note they also chose (or perhaps the police did) to include the Royal College of Anaesthetists in Red Lion Square: recognition indeed. The GAT Committee has worked very hard on this issue, warning of problems before and throughout the recent MTAS debacle. They have made the voice of anaesthesia trainees heard and their latest MTAS survey showed that considerable problems still exist. Just after one of the GAT press releases the resignations started and it is not clear if they have finished yet. A further independent review body is to be set up to look at the wider picture of MMC as well as the MTAS catastrophe and it is to be hoped that improvements such as more flexibility and specialty-specific elements could be introduced.

Significant developments have occurred in connection with parity of pay for NHS work in the Independent Sector. A case was made that after 59 years of equal pay between the specialties, discrimination was being introduced for NHS work with surgeons being paid far more than anaesthetists. This was indirect discrimination on grounds of gender because a far higher proportion of anaesthetists are female than surgeons.

During discussions between AAGBI and the Department of Health in 2005 they stated that whilst they agreed with parity they maintained they were not in a position to guarantee that independent contractors complied because “their relationship existed within a framework of clearly delineated divisions of legal responsibility” This relationship has now changed because under the Equality Act of 2006 NHS organisations will have a legal requirement to pro-actively promote gender equality. The overriding principle is that public money should only fund activity taking place in line with public policy.

This is all explained in the Department of Health’s own document “Creating a Gender Equality Scheme. A practical guide to the NHS” (Published Feb 2007, Gateway Ref. 7559). When referring to NHS services outsourced to private contractors (page 35) it says that NHS organisations procuring these should now ensure that the private contractor has measures in place to meet the gender equality duty. This duty became a legal requirement on April 6, 2007 and so any anaesthetist invited to do NHS work for non parity rates should refuse, draw this new legal requirement to the organisation’s attention and insist that they comply. Anyone requiring further information please contact the Honorary Secretary.

Another area of even longer standing concern has been the relatively low number of clinical excellence awards (CEAs) received by anaesthetists at all levels. This is very important as the Doctors and Dentists Review Body (DDRB) sees to increasingly see CEAs as part of Consultants’ overall remuneration package. Since the new CEA system started in 2003 there appear to have been even fewer awards for anaesthetists. The Association has had several meetings with the ACCEA Chairman Professor Jonathan Montgomery and the Medical Director Professor Hamid Ghodse to clarify the issue and Professor Montgomery kindly agreed to speak and answer questions at our AAGBI Linkman Conference. I would encourage everyone to discuss this with their Linkman and make sure that all members start to prepare their CEA application form for the next round of their Trust Employer Based Award Scheme or the National Scheme NOW. If you are new to the process ask a senior colleague for guidance and read the previous articles in Anaesthesia News. (July and September 2004, October 2006)

One thing is guaranteed - if you don't fill a form in you certainly won't get one!

David Whitaker
President AAGBI
14TH ANNUAL PAEDIATRIC ANAESTHESIA UPDATE  
Friday 22nd June 2007  
The Manchester Conference Centre  
Organiser: Dr D Patel  
Manchester Children's University Hospitals  
Department of Anaesthesia  

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Dr Gordon Gladman, Liverpool  

Postoperative fluid management for Children  
Mr Anthony Landers, Birmingham  

Debate: General Anaesthesia is preferable to Sedation for radiological procedures in children  
For: Dr Jonathan Smith, London  
Against: Dr Oliver Dearlove, Manchester  

Paediatric resuscitation guidelines: what’s new?  
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Email: christine.taylor@cmcc.nhs.uk  

Association of Cardiothoracic Anaesthetists / British Society of Echocardiography  

There will be one sitting of the Transoesophageal Echocardiography Proficiency Examination in 2007  

Thursday 11th October 2007  
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Have you performed any research or audit, or do you have an interesting case report that you would be interested in presenting?  
This would also be an ideal opportunity for your trainees to get involved.  
There is a prize of £200 for the best verbal presentation and £100 for the best poster presentation.  

For further information please contact:-  
Dr Andy Lumb, Chairman of the Education Committee, Consultant Anaesthetist, St James University Hospital, Beckett Street, Leeds, LS9 7TF  
Tel: 0113 2065789  
E-mail: Andrew.Lumb@leedsth.nhs.uk  

Closing Date: 7th July 2007
I sit writing this as one of my last jobs as Chairman of GAT: my term comes to an end on 28th June this year when I formally hand over to Dr Chris Meadows.

Over the past two years the face of medicine has changed dramatically and although I could fill the entire volume of *Anaesthesia News* with MTAS and MMC, I am not going to! At the time of writing, the review body still hadn’t issued its final statement and by the time you read this everything will have changed again no doubt. Suffice to say GAT wrote to the panel on your behalf stating our concerns with the process to date and urging for fair review. The statement was met with a positive response from our members and was cited as one of the reasons why the interview panel in the North Thames deanery withdrew from the first round of interviews. GAT has voiced its opinion on the failings of the new system since it began and continues to do so. We have persistently felt our concerns were overlooked, and it is a tragedy that we have reached this point. I hope by the time you read this the issue has been successfully resolved.

To make matters worse the Government introduced new legislation regarding the employment of overseas medical graduates, which rightly caused much anguish and concern amongst the medical community. This issue has also yet to be fully resolved.

We have continued to be involved in the Anaesthesia Practitioner project, to ensure that the standard of training of our doctors is not compromised. There is now a national curriculum and an examination, both of which have had considerable input from the RCA, ensuring APs are of a high standard. The government funding for the initial phase of the project in England and Wales has come to an end and funding for further APs will be at local level.

GAT continues to organise and run in-house seminars, but we have recently noticed that trainees are finding it increasingly difficult to attend. I suspect this is both due to shift pattern working and tightening of the purse strings within Trusts. Our aim is to run seminars directly addressing trainee issues and needs and I would urge any of you with bright ideas for a seminar to get in touch with us at gat@aagbi.org

We also run a successful Annual Scientific Meeting, which we hope incorporates a varied and interesting scientific programme as well as a lively social programme. This year’s ASM will be held in sunny Brighton a couple of weeks after you receive this issue of *Anaesthesia News*, so if you haven’t booked- do it now!

I would like to take this opportunity to thank the Committee for all their hard work during my time in office and also to thank Council and the in-house staff for their advice and support. I wish my successor well and hope GAT continues to stand up for anaesthetic trainees, in what I expect will be turbulent times ahead.

**Sara Hunt**
GAT Chairman 2005-07
Val Bythell joins the Anaesthesia News team

Dr Val Bythell has been appointed Assistant Editor for Anaesthesia News. She was elected to Council in 2006. She has been in charge of organising MTAS in anaesthesia in the Northern deanery, and has promised to write an insider’s view of the process once the dust settles! We are delighted to welcome her to the team, and look forward to her contributions.

Peter Wallace unveiled!

It is customary for Past Presidents of the Association to have a portrait painted to grace the walls of AAGBI headquarters. Council was delighted to welcome back Peter Wallace (President 2002 – 04) to unveil his recently completed portrait by Mark Roscoe. As with many portraits, the Association Presidents often have an item of significance included in the picture – for instance Leo Strunin’s portrait features one of his beloved whippets. Readers will note that Dr Wallace is holding a glass of red wine.

AAGBI Christmas Card Competition

The Association is pleased to announce that a competition to produce an image for the Association Christmas card will be held in conjunction with the art exhibition at Annual Congress in Dublin, 12th-14th September 2007. Entrants must hold copyright of any photograph or artwork submitted and entries must be no larger than A4 in size. The winner will be decided by delegate vote, and members will be able to purchase the cards in November and December. Further details will appear in Anaesthesia News soon, or contact anne.sutcliffe2@btinternet.com or juliegallagher@aagbi.org. See notice on P21

Prize for “Editor’s Choice” letter

Anaesthesia News is delighted to announce that each month the best letter, as chosen by the editor, will win a prize of a textbook donated by Oxford University Press or Blackwell Publishers. See p22 for details of this month’s winner.
The Mersey Weeks

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

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Introduction

One small syringe, one big syringe, eyes roll back and he or she is unconscious. Our daily bread, our domain we guard so closely, the art we are so proud of. But at the heart of our art there is the mystery of consciousness, which has eluded centuries of enquiry by scientists and philosophers alike. Blinded by the utilitarian approach to our work we fail to ponder this elusive problem, believing it to be the domain of religion or philosophy. Surely anaesthesia has nothing to do with those, or does it? We have to realise that increasingly the issue of consciousness is coming to the forefront of both lay news and academic enquiry. And we should be in a position to add to the debate.

Personal perspective

Neurocritical care is not what you call an ordinary start to an anaesthetic rotation. The world of quiet infusion pumps, monitors and fascinating pathophysiology was absorbing and thought provoking. The patients arrived unconscious or anaesthetised and I had more often watched them wake up than anaesthetised them. It did occur to me to question the difference between the blow to the head and the effects of general anaesthetic, but I failed to find any definitions of consciousness at the time. The issue arose again, a year or so later when during preparations for the Primary, a patient at a pre-assessment, exclaimed with a grin on his face: “You don’t know how it works!” I agreed with him and proceeded to explain the theories concerning general anaesthesia I’d read in a book the night before. In spite of that a lingering unease remained. More recently browsing through the journals I came across yet another paper on awareness monitors (and awareness in spite of unconsciousness!), and I thought to myself: how does awareness relate to consciousness, for they do not seem to be the same thing…

Mind Games

Many of us would equate consciousness with awareness without much thought. However a closer look at the phenomenon of awareness would reveal that it is very basic in nature. A thermostat is “aware” of temperature and thus able to respond. One can easily imagine artificial intelligence constructs that are “aware” of the world around. A crab on the beach is aware of the dangers and the available food, but is that creature capable of experience? Can it feel the fright or enjoy a meal? Some philosophers would label such experience as qualia and add that they are subjective and therefore unique. Awareness may be the reflection of sensory perception directed towards the outside world. Experience on the other hand consists very much not just of the sensory perception, which maybe very similar for members of one species, but also of certain conditioned meanings attached to that perception. Those are very individual in nature and linked to a capacity for memory formation. To me, for instance, the smell of betadine in a surgical scrub often brings a memory of my grandma, who used the stuff on all the cuts, grazes and bites I suffered as a child many years ago. It is therefore a pleasant if somewhat nostalgic smell. To another person however, the sensory perception of betadine, which is likely to induce
similar electrochemical process in the central nervous system, will have a different quality. The above example also raises an issue of “me” or “self”. It is “my” experience (qualia) and “my” memories and they are unavailable to another being. And thus we arrive at the epistemological problem, which has remained both a nightmare and a delight to many philosophers over the centuries. For if, as believed by Kant, we base our knowledge of the world on perceptions and those are tainted by the “self” we cannot appreciate the truth about the world. In other words I cannot be sure that the way you see colour green is the way I see colour green. The extreme but valuable example of this has been provided by Thomas Nagel in his essay on “What is it like to be a bat?”(1). While we may learn everything about bat biology and its ability to navigate by means of ultrasound, we will never be able to experience that no matter how imaginative we are. This issue of subjective experience as a hallmark of conscious process or consciousness has been dubbed the hard problem of consciousness by contemporary philosopher David Chalmers. Of course if there is a hard problem, there ought to be the easy one as well. But the truth is that nobody has yet been able to crack the easy one.

The easy problem

While the hard problem remains mostly a philosophical issue, the easy problem of consciousness has caught the attention of scientists. The easy problem refers to the way we process thoughts. What makes a brain process a conscious experience as opposed to the many neuronal activities that go on unnoticed? Here in many respects materialists rule. For if the brain is a physical entity then we should be able to measure, observe and experiment on it, arriving at an answer as to the nature of consciousness. So the search is under way for so-called neuronal correlates of consciousness. Examples of the techniques employed include modalities such as functional MRI (fMRI), functional electrical impedance tomography or charge coupled device cameras (2). However with billions of neurons and even more neuronal connections, the most powerful fMRI studies lack resolution. Other techniques are subject to other limitations. Many studies provide fascinating insights, but the world is still searching for an appropriate methodology. Without much hard data to analyse, many theories are created, some leading deep into the world of quantum physics; others into Buddhist meditation. Firmly stating that consciousness is the product of the brain takes us back to philosophy and the deterministic world that so dominates the scientific realm. According to the deterministic view, consciousness and the way we interact with the world is predetermined by the workings of our brain, which in turn is created to our genetic blueprints. One may therefore conclude that our actions, reactions and experiences are very much predetermined, abolishing concepts such as free will or moral responsibility and making a mockery of law.

Enter the anaesthetist

The mystery of consciousness seems fascinating and I have barely scratched the surface of this subject. Books are published on it, although they do not appear in our curriculum. So why exactly should we bother? Why consider something so vague and difficult to grasp? Terry Wallis is a man that has woken up suddenly after 18 years in so-called minimally conscious state (3). His recovery may well contribute some answers about the easy problem, but on the other hand it will create many questions about the life-and-death decisions made in places such as neurocritical care. The nature of brain death and situations such as persistent vegetative state might be called into question. Equally when considering the subjectivity of our experiences or qualia, we cannot help but to consider perception of pain. How about perceptions that should not occur e.g. phantoms? Isn’t dealing with that too, our daily bread? Finally, there is the issue of consciousness and awareness under anaesthesia. I have mentioned that consciousness is linked very much to the ability to form episodic memory. One may therefore bravely, put forward a proposal that in fact many operations do not require the unconscious state we tend to provide, but simply the abolition of memory and adequate analgesia. This has been hinted at in a recent editorial in the BJA (4).

Conclusion

Having read some books and articles on the subject I am nowhere near the definition of consciousness. My quest continues and more books and papers await my attention. Yet I know that while they will provide more food for thought, it is unlikely that I shall find the solution to the enigma of consciousness. And if a patient asks me again: “How does this work?”, I might tell them: “It’s a kind of magic…”

Dr P Szawarski
SpR Anaesthetics
Queen Elizabeth Hospital
Woolwich, London

References:
2. Greenfield SA and Collins TF. A neuroscientific approach to consciousness. Prog Brain Res 2005;150:11-23
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 (Pontypidd) 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.
Making device purchases – who decides, and does it matter anyway?

The purpose of a Trade Association such as Barema is to speak on behalf of its members when there are issues which could have a major impact not only on our members but perhaps more importantly on users and patients. There is one such issue at the present time - namely device purchasing, as our research points to wrong items going into operating theatres. When there is apparently more money than ever going into the NHS, and yet there are cuts being made at the coal face, we believe theatre consultants, technicians, nurses and managers need to insist on getting the correct products to use in their units. The likely consequence for not doing so will be less choice coupled with a deterioration of quality.

In our daily living we all visit shops, supermarkets and showrooms and select the products we want to buy – and if they are not available, we either go somewhere they can be bought, or we choose an alternative. Judging from conversations with theatre staff at all levels, it would seem that increasingly this principle does not apply when it comes to purchasing medical devices. Does it matter?

Speaking from an industry perspective, Barema would say ‘Yes, it definitely does’, and here’s why. In a free market economy, companies exist in order to supply products which are called-for by users – a statement of the obvious. But… a product bought today will more than likely be superseded at a future date, and therefore in order to survive, companies must continually update their products. Sometimes these will incorporate relatively minor improvements, whilst on other occasions they could be major innovations. For example, there have been considerable developments in ventilators and airway devices in the last ten years.

The funding for developing tomorrow’s new devices usually comes from the income stream of today’s sales – an exception may be from a start-up company with funding from grants or business backers. The healthcare device market is not huge when compared to, say, the car industry, but is more diverse and therefore a higher number of smaller companies operate in the healthcare marketplace. For long term survival, these relatively smaller device companies must price their products at a level to generate sufficient income to allow for investment. At the same time they must remain competitive. In an increasingly regulated and cost driven healthcare environment, this is not easy!

The power to make a purchase should lie with your Hospital, or Trust. There is nobody outside of your own Hospital/Trust structure who has the right to select products. However, once a purchasing decision has been made at department level, the actual purchasing process can vary from one Trust to another, e.g. in financial approval requirements. For equipment, orders above £5,000 may be subjected to three competitive quotations, whilst those over £20,000 are put out to tender – but there are no hard and fast figures, and actual limits will be set out in Trust Standing Orders. Final selection is not dependent on price alone, and it may be necessary to argue for the benefits of your preferred choice. For consumables, where high volumes are used, it is usual practice for a user group (made up of clinical and procurement representatives) to make the product choice after all the pricing information has been assimilated. It is essential that there is clinical participation in these user groups, otherwise there will be a tendency to go for the cheapest, with the result that ‘inappropriate’ products are purchased.

Once the choice of product has been established there is a further decision for the Trust to make – how should it be delivered into the hospital? There are three possibilities:

• direct from the manufacturer
• via an approved distributor or wholesaler
• via NHS Supply Chain [the recently outsourced logistics arm of the NHS].

If either of the latter two options is the most cost effective, it is important to emphasise that no product substitution should be permissible without the prior consent of the Trust.

The purpose of this article is to emphasise that theatre consultants, technicians, nurses and managers need to be sufficiently engaged in the procurement process to ensure that sound, safe and innovative products arrive in their hands for the continued benefit of patients. Barema is asking that you make sure you obtain the products you want, and not those that ‘appear’ in theatre without your agreement.

Harrie Cook
Secretary, Barema
www.barema.org.uk
CONFERENCES & EVENTS

Centre for Anaesthesia, UCL and associated groups
on-line booking link and further details for all events can be found at:
www.ucl.ac.uk/anaesthesia/meetings


4th Paediatric Sedation: How to do it Safely
IET/Savoy Place, London, 7th & 8th June 2007, Chair: Dr Mike Sury, GOS, London

CALL FOR ABSTRACTS
We invite you to submit abstracts of audits in relation to Paediatric Sedation, either prospective or retrospective, in particular those featuring new care plans, treatment protocols and the use of Ketamine vs. other sedation agents vs. no sedation! Any work is acceptable which has not been accepted for publication in peer review journal by the abstract deadline of 31st January 2007. Submission should be a maximum one A4 page and emailed to SiobhanMythen@btinternet.com by 31st January 2007. A number will be accepted for poster presentation and finalists will be asked to present at the Paediatric Sedation Conference 2007.

6th EBPOM: Evidence Based Peri-Operative Medicine Conference

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

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

“Dingle 2007”: 9th Current Controversies in Anaesthesia and Peri-Operative Medicine
10th–14th October 2007, Dingle, Co. Kerry, Ireland

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

Contact: Siobhan Mythen, Event Administrator on behalf of Centre for Anaesthesia, UCL
E-mail: SiobhanMythen@btinternet.com
Seminars at 21 Portland Place

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. 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**

<table>
<thead>
<tr>
<th>Seminar</th>
<th>Date</th>
<th>Organisers</th>
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<tr>
<td><strong>ULTRASOUND IN ANAESTHESIA AND CRITICAL CARE</strong></td>
<td>Monday 4 June 2007</td>
<td>Dr B Nicholls, Taunton &amp; Dr O Weldon, Newcastle upon Tyne</td>
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<tr>
<td><strong>SAFE TRANSFER OF CRITICALLY ILL PATIENTS</strong></td>
<td>Wednesday 6 June 2007</td>
<td>Dr P Farling, Belfast</td>
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<tr>
<td><strong>ANAESthesIA FOR MAJOR SURGERY – AN UPDATE</strong></td>
<td>Tuesday 12 June 2007</td>
<td>Dr R Rao Baikady, London &amp; Dr P Farquhar-Smith, London</td>
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<tr>
<td><strong>AIM Seminar EFFECTIVE LEADERSHIP</strong></td>
<td>Tuesday 19 June 2007</td>
<td>Dr M Jones, Bridgend</td>
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<tr>
<td><strong>PERIOPERATIVE BLOOD MANAGEMENT</strong></td>
<td>Thursday 28 June 2007</td>
<td>Dr V Brown, London</td>
</tr>
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<td><strong>PLYMOUTH SEMINAR TO BE HELD AT THE ROBBINS CENTRE, UNIVERSITY OF PLYMOUTH</strong></td>
<td>Wednesday 4 July 2007</td>
<td>Professor J Hunter, Liverpool &amp; Dr M Coates, Plymouth</td>
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#### ULTRASOUND IN ANAESTHESIA AND CRITICAL CARE

- Physics of ultrasound
- Machines / optimising image / needling techniques
- Vascular access
- Ultrasound in critical care
- Ultrasound guided regional anaesthesia
- Focused echocardiography
- Ultrasound training – assessment / competency lessons. Emergency medicine

#### SAFE TRANSFER OF CRITICALLY ILL PATIENTS

- Safe transfer of patients with brain injury
- NICCaTS - A centrally based transfer service
- Transfer and the ambulance service
- Paediatric transfer
- Air transfer

#### ANAESthesIA FOR MAJOR SURGERY – AN UPDATE

- Preoperative assessment for major surgery
- Perioperative fluid management and monitoring
- Perioperative pain management after major surgery
- Anaesthetic dilemmas: Choice of anaesthetic/monitoring / temperature control
- Management of massive haemorrhage
- Postoperative optimisation of high risk surgical patients and surgical intensive care

#### AIM Seminar EFFECTIVE LEADERSHIP

- Negotiating skills
- Dealing with complaints
- Conflict resolution
- Success in committees
- Your role in a team
- What the clinical director expects
- Leading a clinical team
- Developing the business case
- Understanding change in the NHS

#### PERIOPERATIVE BLOOD MANAGEMENT

- The state of the UK blood supply. SHOT report
- Physiology of blood components and clotting
- Clinical aspects of coagulation, transfusion triggers and anaemia
- Monitoring of coagulation and platelet function, TEG – the present and the future
- Blood conservation techniques
- Pharmacological methods - the debate continues
- Autotransfusion, cell salvage, factor VIIA and surgical outcome

#### PLYMOUTH SEMINAR TO BE HELD AT THE ROBBINS CENTRE, UNIVERSITY OF PLYMOUTH

- Anaesthesia for patients with diabetes mellitus
- Anaesthesia for patients with thyroid disorders
- Anaesthesia for patients with disorders of the parathyroid glands
- Anaesthesia for patients with a phaeochromocytoma
- Anaesthesia for patients with endocrine disorders of the pituitary gland
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

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

ANAESTHETISTS AND THE LAW
Wednesday 28 November 2007
Organiser: Dr S Yentis, London

Pt I – How it works & what it means
- The courts and their structure
- The different types of law
- Lawyers and legal references
Pt II – How you might encounter it:
- Prosecution under various Acts
- Assault, battery, negligence, manslaughter & murder
- The GMC
- Keeping out of trouble

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 use of 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, CUSUM

ANAESTHETISTS AND THE LAW
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Directions

The AAGBI is located in central London, just north of Oxford Street and within easy access of underground stations. Great Portland Street is a 4 minute walk. (Circle, Hammersmith and City and Metropolitan Lines) Oxford Circus is a 7 minute walk. (Bakerloo, Victoria and Central Lines)

Please note Regent’s Park underground station is closed until June 2007 for renovation. The National Rail stations of Paddington, Euston and King's Cross are all nearby - a few minutes’ journey by taxi. All of the other London Termini can be reached by underground or taxi.

We are situated within a controlled parking area; parking meters are available in the surrounding streets.

Travel advice can be obtained from www.transportforlondon.gov.uk where you can download underground and bus maps and also view the latest travel updates. To check latest national rail information go to www.railtrack.co.uk
Booking a Seminar

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

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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>Please debit my credit card (Visa/MasterCard/Delta) or Switch Card:</th>
<th>Member £120.00</th>
<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.
DON’T FORGET to enter the Art Exhibition
Annual Congress, Dublin, September 12th – 14th

All work offered is accepted and shown. Entries can be in any media. There is no limit on number, type or size of works accepted. The goal of the exhibition is to showcase the talents of all anaesthetists and their families and friends.

This year there is also a NEW COMPETITION being organised alongside the Annual Congress Art Exhibition. We are looking for a picture by an AAGBI member or their family that will be chosen by a popular vote to be used for the AAGBI Christmas Card. Entries can be in any media but must not exceed A4 in size.

For further information about the Art Exhibition or the Christmas Card competition, please contact Julie Gallagher on +44 (0)20 7631 1650 juliegallagher@aagbi.org or Dr Anne Sutcliffe on +44 (0)121 704 2925 anne.sutcliffe2@btinternet.com

17th National Acute Pain Symposium

Thurs 6th & Fri 7th September, 2007
Crowne Plaza Hotel, Chester

For details & bookings contact:
Georgina Hall
Tel : 07901717380
E-mail : medsymp@btinternet.com

Registration:
Doctors £ 345
Nurses £ 195

Obstetric Anaesthetists’ Association

Refresher Day on Obstetric Anaesthesia and Analgesia
17 October 2007, RCOG, London

A one-day course aimed at Consultants, Staff Grades and Associate Specialists who cover obstetrics on-call but who do not do any elective daytime obstetric work. This popular course will concentrate on practical aspects of current obstetric anaesthetic practice, including various emergencies one may have to face when on-call. 5 CPD points

Three-day Course on Obstetric Anaesthesia and Analgesia
5-7 November 2007, Church House London

The OAA’s well-known annual course, popular with anaesthetists from both the UK and overseas, covers a wide range of core and relevant topics in obstetric anaesthesia and analgesia, including aspects of maternal medicine, fetal wellbeing and areas of current clinical controversy.

Leading specialists will be joined this year by Lawrence Tsen and Scott Segal, both young, dynamic, internationally acclaimed speakers from the world-renowned Brigham and Womens Hospital in Boston, US. Their lectures promise to both educational and exciting, bringing together new ideas and a wealth of experience from North America.

Suitable for anaesthetists of all grades, this intensive course will also be of interest to midwives and obstetricians. Others who just cover obstetrics on-call may also find this a useful way of being brought “up to speed” with current practice and opinion. 15 CPD points

for further details see www.oaameetings.info

t: +44 (0) 20 8741 1311
Dear Editor...

Editor’s Choice letter

Too much fun?

These are uncertain and concerning times for many anaesthetists. NHS finances are in disarray and MTAS is a weight around the neck of many trainees and consultants. People are craving guidance and leadership from our national organisations. I was therefore disappointed to see quite so many light-hearted articles on these subjects in April’s Anaesthesia News. I believe the role of the official newsletter of the Association should be to publicise what the Association is doing for us in these worrying times. The football coach Alan Durban famously told fans of his team bemoaning lack of action “I’m here to win, if you want entertainment go and see clowns”. I feel similarly that Anaesthesia News should tell us what the Association is doing to help us and leave the humour to Private Eye.

Matthew Thomas
SpR, Bath

Editor’s reply: Anaesthesia News exists to inform and entertain its readers, and we strive to get the balance right. While the April issue, as is traditional, contained a number of spoofs, it also had serious articles about run-through training, the work of the research committee, and avoidance of wrong-site surgery, among others. Because of the lead-in times, Anaesthesia News is unable to deliver up-to-date information about rapidly changing situations, such as the MTAS debacle – information of this nature is generally posted on the Association website or forum. I continue to defend the use of humour as one of the ingredients to raise morale at difficult times. What do other readers think?

Not sweet enough?

The anaesthetic nurses here in Brechin are extremely thoughtful and have kindly added an emergency chocolate supply to the wee tray of drugs on our anaesthetic machines. They have proved very useful to cheer yourself up during longer, mind-numbing cases. As we also keep a couple of extra propofol ampoules handy, you could say we now have a choice of Milky Ways.

Charles Allison,
Stracathro Hospital,
Brechin

Pre-Operative Confusional State

I had a terrible day recently. I stood in the anaesthetic room with an elderly patient who had suffered a fractured neck of femur. I started to interview her but as I did she screwed her eyes up and interrupted me.

“Anaesthetist?” she sneered. “That’s a funny job. Is it like being on the way to being a surgeon?”

Andrew Baldock
SpR in Anaesthetics
Southampton

This month’s Editor’s Choice letter wins a copy of Emergencies in Anaesthesia, (RRP £19.95) donated by Oxford University Press.

OUP gives AAGBI members 20% discount on many textbooks ordered online – visit the website at www.oup.co.uk/promotions/medicine/websoaagbi

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.
**Climate Maths (1)**

Today I showed three garden boys from our street how to look after the shoots from the stump of a big tree to maximise its chance of regenerating. When fully grown, it will take 5kg of carbon dioxide (CO2) out of the atmosphere every year. None of these young men had heard of global warming, but they were interested. Trees produce wood which is a highly saleable product in our society, where the electricity supply is unreliable, and the cost of gas and paraffin exorbitant.

A British Medical Journal 'filler' (1) by Professor Julian Crane of the Department of Medicine, Otago University, New Zealand, calculates the cost in CO2 of his journey to the 16th annual congress of the European Respiratory Society in Munich. It came to 3700 kg of CO2. There were 17,239 other delegates from various countries. Assuming 170g of CO2/km for travel by air, 140g/km for travel by road, and 52g/km for travel by train he calculates the carbon footprint for the Congress travel to be 3.92g X 106. He calculates that this could be absorbed by 784,000 trees or 784 hectares at 1000 trees per hectare in a year. He then goes on to estimate the cost in trees of the documentation used at his Congress.

The British Medical Journal has now followed up with an editorial entitled 'Reducing the carbon footprint of medical conferences' (2) The forthcoming Congress of our World Society is being held next year in Cape Town. It will be a stunning event I am sure. But in the interests of combating Global Warming do we owe it to the next generation to give it up - except perhaps of those of us who can reach Cape Town by train?

Ruth Hutchinson  
Zimbabwe

2. Roberts I, Godlee F. BMJ 2007; 334:324

**Climate Maths (2)**

In the April 2007 edition of Anaesthesia News, there was an interesting article about "How your Anaesthesia News reaches you." In it I read: "In Singapore....the two publications are packaged and sent direct to subscribers. So by the time you read the masterpiece you have submitted in a published edition, it has travelled many miles."

I don’t think this is a boast that we should be proud of. I imagine that a large proportion of the recipients of the two journals are in the UK. A further smaller proportion will be in Europe and there will be fewer subscribers from outside Europe. Why can't the two journals be printed in the UK and sent via surface mail, where possible?

I weighed Anaesthesia and Anaesthesia News on my kitchen scales. They weighed 425g. There are 9000 members of the AAGBI. There are 12 issues of Anaesthesia and Anaesthesia News per year. The total weight of journals, per year, therefore is 46 tonnes.

With tongue very much in cheek, I have used shaky maths, some dodgy values for fuel consumption of jet aircraft and family cars and made a generous assumption that the average weight of a member of the AAGBI is 70kg.

For the same climate impact, the AAGBI could send 330 lucky members on a return trip to exotic Singapore. Not fair for the other 8,700 members? OK, for the same climate impact, 9,000 members of the AAGBI could drive from London to Brighton and back for a day at the seaside. If a few anaesthetists cycled to Brighton, some took the train and a few more car shared, then there'd be plenty of room in the other cars for family and friends. What a good day out! All for the climate-cost of mailing our journal from Singapore!

It may make financial sense to print journals in Singapore but I bet the climate calculations stink.

Joe Mellor  

*Editor’s reply – we printed a previous letter on this topic in September 2006, and the editor- in- chief of Anaesthesia, David Bogod outlined the reasons for the move then. However, we are so impressed with Dr Mellor’s calculations, we felt that they deserved a wider audience.*
**Who ensures the correct operation?**

I read with interest Dr Bengeri’s “letter from Uncle Sam” with regard to Correct site surgery and the US implementation of a universal protocol incorporating a “Time Out” procedure (1). The contribution of the Anaesthesia Reference Group to the UK NPSA Correct Site Surgery Alert (2) was also mentioned in the March 2007 Royal College of Anaesthetists Safety Bulletin (3), in particular the multidisciplinary “cockpit check” prior to surgery.

Anaesthetists should be central to these checks, alongside the surgeon. The RCoA and AAGBI failed to endorse the NPSA alert because it did not specify that the operating surgeon should be the signatory confirming that the checks have been done(4)(5). Whilst undoubtedly the surgeon retains the ultimate responsibility for ensuring “correct site surgery” a final “Time out” procedure involving all theatre staff takes at most minutes.

I believe the anaesthetist is best placed to co-ordinate this and sign the form as a representative of the theatre multi-disciplinary team, and in doing so acknowledging the shared responsibility taken to ensure correct site surgery. This was the accepted practice when I worked in Queensland following their mandatory implementation of “Ensuring intended procedure” policy, based on the US Veterans Health directive (6).

By failing to endorse the alert, I feel we have given credence to those surgeons who still feel it is another form filling exercise, despite the RCS endorsement.

Dr Hilary Eason, SHO Anaesthetics, Stepping Hill NHS Trust


Reply: I agree with Dr Eason that appropriate measures should be taken to ensure correct site surgery and I can assure her that the decision by the Councils of both the AAGBI and the RCoA not to endorse the NPSA Correct Site Surgery Alert was not taken lightly. As a member of the NPSA working group on Wrong Site Surgery I can confirm that there was considerable discussion on which member of the theatre team should be the signatory confirming that appropriate checks had been done. The guidelines in the NPSA Alert state that the surgeon is responsible for marking the patient on the ward and seeing the patient immediately before induction of anaesthesia to confirm the patient’s identity, that the correct site has been marked and that any relevant imaging is present. It also recognised that the surgeon has the ultimate responsibility of ensuring that the correct patient receives the correct operation. It seems illogical then to devolve the final responsibility to a different member of the theatre team, especially to the one team member (the anaesthetist) who is likely to be the busiest at the time between induction and surgery.

The “Time Out” check involving all theatre staff is the final opportunity for all members of the theatre team to participate in confirming patient identity and intended operation. I would not wish a harassed anaesthetist, who has already confirmed, before induction, that he is anaesthetising the correct patient, to be distracted at a critical stage by having to oversee the check and complete a form.

Once again the inevitable similarity with airline pilots has been alluded to. Let us remember that the pilot’s cockpit check is performed before take-off, not while the airplane is still trying to achieve cruising altitude!

Dr John Carter
Vice-President AAGBI

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**Default alarm settings**

In the 4th Edition of the Association’s Standards of Monitoring “glossy” it is stated that, “The default alarm settings incorporated by the manufacturer are often inappropriate ...”. Nowhere is this more dangerous than with the factory default low-limit setting for oxygen, which is often set at less than 2%. Though the ability to change the setting to a low limit is necessary when expired oxygen is being monitored, surely - recognising that the alarm limits often are applied to the inspired gas - the failsafe default should be a factory setting of no less than 21%? Is the Association able to exert its considerable influence to get manufacturers to change their practices? Meanwhile, I recommend that all purchasers of new monitors should check this and save more appropriate limits before the equipment is first used.

Stephen Millar
Consultant Anaesthetist, Burton upon Trent

Reply: The Safety Committee is aware of this problem, but we would like to thank Dr Millar for highlighting it again. It is on the agenda for discussion at the next meeting between the Safety Committee and Barema.

Les Gemmell, Chairman, Safety Committee, AAGBI
The Mersey Weekends

Primary Viva Weekend
Intense Viva Preparation & Practice
14.00 Friday 31st August – 16.00 Sunday 2nd September

Primary OSCE Weekend
Intense OSCE Preparation & Practice
14.00 Friday 7th – 16.00 Sunday 9th September

Final SAQ Weekend
Intense SAQ Preparation & Practice
14.00 Friday 14th - 16.00 Sunday 16th September

Final Viva Weekend
Intense Viva Preparation & Practice
14.00 Friday 30th November – 16.00 Sunday 2nd December

By Request – A New Course
Physics, Anatomy & Regional Anaesthesia Revision Weekend
Suitable for Candidates of both Primary & Final Examinations
14.00 Friday 20th – 16.00 Sunday 22nd July

Daily Programme
Friday 14.00 – 20.30
Saturday 08.00 – 20.30
Sunday 08.00 – 16.00

Course Fee £250
Breakfast, Lunch & On-Going Refreshments

Details
Assessments
Application Forms

WWW.MSOA.ORG.UK
So ends a piece of doggerel by an unknown author, and to many readers it might feel a little familiar! In this article I would like to cover some of the facts and figures about Inheritance tax (IHT) and how legitimately to avoid it. According to research (www.unbiased.co.uk, Oct 30th 2006) we gave away about £1.3 billion in unnecessary IHT in 2006. This was apparently a fall of around £300m on 2005, so we’re improving – slowly. That’s £1.3bn that didn’t get handed down to the next generation, mostly due to failure to take action to mitigate the tax.

Often dubbed ‘the optional tax’, IHT is the final fiscal extraction from beyond the grave. Known formerly as Death Duties, it was generally considered the problem of the aristocracy and independently wealthy, not the man or woman in the street. Not so these days, as the seemingly unstoppable rise in house prices has outstripped the increase in the IHT threshold over recent years, making IHT a concern for a large percentage of homeowners.

So what can be done? First, know the rules. Each individual has a ‘nil rate band’ which is currently set at £300,000. The value of most assets above this threshold will, on death, attract a flat rate tax of 40%, payable before the estate is distributed.

The first rather obvious possibility is to reduce the value of your estate before death. The less you own, the less the tax. This can be done by giving it away, or by a technique known in the trade as ‘SKI-ing’ (Sporing the kids’ Inheritance). You can SKI to your heart’s content, a good guide being the FT’s ‘How to Spend It’ supplement, which illustrates myriad ways to dissipate your hard earned cash in an entirely pleasurable fashion. You can also give unlimited amounts to charities or political parties without any IHT consequences.

Gifting is another matter. Each individual can gift up to £3,000 per year without consequence, plus unlimited small gifts of up to £250 per beneficiary (but not to recipients of the £3,000 allowance). You can also give as much as you like away from income as long as doing so doesn’t affect your standard of living. If your child is getting married or entering a civil partnership you can gift up to £5,000, and grandparents can gift up to £2,500. You can gift as much as you like to your spouse or civil partner, as long as he or she is domiciled in the UK. If not, then you need to take specialist advice as certain restrictions might apply. Go beyond these limits, though, and gifts will generally count as Potentially Exempt Transfers. Such gifts fall out of the IHT net after seven years, with the tax payable tapering down from year four.

“…And when he’s gone we won’t relax
They’ll still be after the Inheritance Tax!”
So now you have whittled down your estate through profligate ski-ing and using your gift allowances, what next if the estate is still way above the IHT threshold?

First, make a will, or review the existing one. There are a plethora of urban myths about wills – that 70% of the population don’t have one, that 75% of solicitors who died last year died without one. I can’t find any hard evidence but in dealing with hundreds of clients over the years there does appear to be some truth in these assertions.

A will allows you to direct your assets to those whom you would like to inherit them, as we all know, but can also be used as an IHT mitigation tool, and especially for couples. A typical scenario is this:

Dr Smith dies, leaving his entire estate to his wife, Mrs Smith. This is an exempt transfer, so no IHT is payable and Dr Smith’s IHT allowance is not taken into account. Having inherited everything, Mrs Smith dies a few years later, leaving everything to the children in her will. Assuming the current IHT threshold, £300,000 of this inheritance is free of IHT, the rest is taxable at 40%. But of course, her husband’s IHT allowance was never used, so the result is an additional tax liability of 40% on his unused allowance, or £120,000 in this example. This is part of the £1.3bn of unnecessary IHT referred to above.

By using nil rate band discretionary trusts in their wills it could have been possible to avoid this extra liability without lessening Mrs Smith’s security.

Another action for members of the NHS pension scheme to consider is to make a form of election on the death in service benefit, particularly if there is no spouse or civil partner. Doing this removes this benefit (normally two years’ salary) from the estate, and therefore from the IHT calculation.

If you have a reasonably clear idea of your likely IHT liability it is possible to insure against the eventual tax. Typically, a life policy is written in joint names with the benefit being paid out only on the second death. If calculated correctly the life assurance benefit pays for the tax, leaving the estate intact. When death occurs at a relatively young age, this can represent extremely good value for money, although in most cases the premiums paid would be a fraction of the tax due even if they were payable for a longer duration.

There are also investment options to reduce IHT. As an example, shares in unlisted companies (which includes shares held on the Alternative Investment Market) fall out of the IHT net once they have been held for two years and providing they are still held on death. These are classed as ‘business assets’ and as such are eligible for ‘business property relief’. There are now a number of portfolio services that allow individuals to hold a diversified selection of such shares for the purpose of IHT planning. You would need to consider the risks involved, but unlisted shares do not necessarily equate to ultra-high-risk start-ups, as some might believe. Other assets that can be IHT exempt in a similar way include forestry and woodlands.

In summary, a number of quite legitimate options are open to you to avoid your estate becoming liable to IHT. Legislation changes constantly, and so you need to review your options from time to time. But if you take no action you are likely to form part of the annual £1bn + voluntary donation to Her Majesty’s Revenue and Customs.

If you have any questions about any of the issues raised in this article please feel free to email me at mark.martin@cavendishmedical.com

Dr Mark Martin is a Director of Cavendish Medical Ltd. This information is provided as a service to readers of Anaesthesia News.
A Personal View

Many doctors of all grades think an SAS job is a dead-end. I beg to differ and think the same could be said about many Consultant jobs. An SAS career need not be dead-end; it is how you look at it and how you do it which makes it dead-end. Unfortunately some SAS doctors think that they should get everything on a platter and do not want to make any extra effort. The NHS is changing and so must our approach to the job. It takes a lot of effort to change people’s view but goal-directed effort will slowly and surely win you friends. I know that there have been obstacles and there always will be. It is YOU who has to decide how best you can make your job worthwhile and more interesting to give you maximum satisfaction. Along with Consultants, we should have annual job appraisals when we can discuss how we can develop our career. This article suggests some avenues which will help you achieve this.

Teaching and Training: I cannot emphasise enough the importance of teaching and training. This is one single skill that will earn you respect and you will be regarded in a completely different light by your colleagues. Teaching and training works both ways. On one hand, it gives you the opportunity to improve your own knowledge of the subject and on the other hand when you teach, you help the juniors improve their knowledge and skill. The vast amount of experience that SAS doctors have can make teaching and training a valuable exercise. No matter how qualified we are and no matter what our field of expertise, we all have enough knowledge and experience to teach and train. Simple practical tips will go a long way in our trainees’ career and they will not only remember it but may also thank you forever.

Although, in the past, possession of the Fellowship was a mandatory requirement for teaching and supervision of trainees, this is no longer the case if you have the relevant experience and competence.

You can choose who to teach, what to teach, where to teach and how to teach. You can also teach medical students and I know a few SAS doctors who are involved with this. PBL facilitation has opened up new horizons for undergraduate teaching. There is a PBL tutor course run by most Universities which you can attend, and thus enrol yourself as PBL tutor. You can also attend a ‘how to teach’ course run by The Royal College of Anaesthetists and get yourself on the Royal College approved panel of teachers. This will enable you to teach SHOs and SpRs in small group teaching and also in theatre. If you want you can offer your skills to Paramedic training centres, the School of Nursing, ALS, APLS, … the list is endless. The same can be said about teaching specific skills from simple eye blocks to percutaneous tracheostomies.

Sub-speciality interest: Choose a sub-speciality or an area where you think you can excel and before long, people would be coming to you for advice. For instance, you can become expert in ENT anaesthesia. I know someone who does special needs dental lists which are quite challenging and he takes a lot of pride and job satisfaction in doing it. You don’t have to stick to it all your life. You can change your interest as and when you want. Life keeps changing and so does one’s interest.

Examining: Universities are often looking for examiners for their Undergraduate OSCE Exams. By attending an OSCE Examiners course, you can become involved in another aspect of academic life.

Audit and Research: People think that research is only the remit of SpRs and Consultants. That isn’t the case. Yes, you will have to put in extra effort, and research has become more difficult (for everyone) in the last few years. However, research and publications establish you in a different league and improve your CV significantly. Audit should be an integral part of our working life and its importance cannot be stressed enough. You ought to do one audit per year. This also gives you a platform to make an impression, as well as showing your interest in a particular field. Audit your own performance which will open your eyes and help you with revalidation. Presenting your audit to the department will help brush up your Powerpoint and presentation skills.

Journal Club: A journal club is a valuable teaching aid for any department. Being a permanent member of the department, an SAS doctor is an ideal person to organise and run a Journal Club.

Management/Rota: You can approach your department head to become involved in some management responsibility. For instance, preparing the weekly rota is a big responsibility for which the department will be eternally grateful!
New Technique for Inhalational Induction Described

From our correspondent Scoop O’Lamine

Members of the Gas Induction Techniques Society attending this year’s annual meeting were delighted to hear about an innovative idea described by Dr Ivan O’Brain which dramatically improves the efficiency of inhalational induction in male adults.

The technique is based on the recently reported genito-diaphragmatic reflex (GDR), which describes the respiratory reflex associated with stimulation of the genito-femoral nerve.

“Most of us (well, half of us) have experienced strong stimulation in this area at one time or another” explained Dr O’Brain. “My own clinical observations have been based on a randomised study of televised sportsmen who received a sudden blow to the testicular region during a number of sports. The reflex I observed is the same regardless of the nature of the blow. Normally a deep inspiration, followed by breath-holding for an average of 20 seconds then a rapid respiratory rate settling over around 60 seconds.”

In his practice, Dr O’Brain prefers to use the single vital-capacity breath induction of anaesthesia. The technique is often limited by the inability of the patient to understand how to maximise their inspiratory effort and then hold the breath effectively. “I have found that by combining the single breath technique with Firm-Grip Testicular GDR, the technique of induction is transformed. There are training requirements for the FGT technique but when mastered, the trained Gripper is often able to control the depth and apnoea very accurately, resulting in a speedy, safe induction.”

Dr Isle Killim, Clinical Director at Dr O’Brain’s Trust appeared uncertain of the place of the new advance in clinical practice. “As far as I know this technique is not widely used in our trust, although from a number of complaints I am dealing with, I can certainly confirm it has been attempted.”

Acknowledgment: My thanks to Dr Steve Laurence, Consultant Anaesthetist, Royal Preston Hospital.
Working less than full time is an option up to 70% of trainees will consider at some point, particularly if starting a family. Access to Less Than Full Time (LTFT) training has been portrayed as a formality but the reality is that LTFT is not such a readily available option. If working LTFT is on your future agenda I would urge you to read on.

LTFT training is fully supported by the Royal College of Anaesthetists, the Deaneries and the BMA. It is recognised that there will be a substantial increase in the number of trainee doctors seeking to work fewer hours over the coming years. Some predict that over the next 3-5 years the number of juniors training flexibly will double. There is an initiative to increase numbers over the next 5 years so that 20% of all trainees with an educational contract are LTFT.

Anaesthesia has a higher number of LTFT SpRs than any other hospital speciality. In 2006, 9% of Anaesthetic SpRs were training flexibly, with 50% of female SpRs in some regions working less than full time.

All junior doctors in training posts are eligible to apply for LTFT posts. A training post must be obtained first, but it is not necessary to declare your intent to work LTFT until offered the training post. All that is required is a well-founded individual reason that fulfils the category requirement (see table). In order to prioritise those wishing to train flexibly, the reasons for application are divided into two categories.

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<th>Category 2</th>
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<td>Disability or ill health (this may include IVF)</td>
<td>Unique opportunities for their own personal professional development, e.g. training for national/international sporting events, or short term extraordinary responsibility e.g. a national committee</td>
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<tr>
<td>Responsibility for caring for children (men and women are equally eligible to apply)</td>
<td>Religious commitment i.e. involving training for a particular religious role which requires a specific amount of time commitment</td>
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<tr>
<td>Responsibility for caring for ill/disabled partner, relative or dependant</td>
<td>Non medical professional development such as management courses, law courses, fine arts courses or diploma in complementary therapies</td>
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All applicants who fulfil the criteria of Category 1 are treated as ‘priority’ applicants and will be supported by the deanery. Category 2 applicants are considered on their individual merits and the availability of funding. Applications may also be considered for other reasons.
Trainees are required to undertake at least 50% of a normal working week. Day time work, on call and out of hours duties are calculated on a pro rata basis equivalent to full time trainees in the same grade or speciality. Flexible training hours will normally be 50% - 80% of full time. LTFT trainees are not permitted to engage in any other paid employment, including locum work.

All programmes are arranged through the regional Postgraduate Deans. There are three ways of training LTFT:

1. **Supernumerary** – an individual post is created for a named person, who is placed as an additional trainee within a department.

2. **Slot-sharing** – where more than one individual working LTFT is placed within a training “slot” in a department. Two LTFT trainees in a slot share would be employed as individuals and work together. They share an educational post but not a contract and often overlap sessions.

3. **Job share** - two individuals are recruited to share one full time post including the salary. The Junior Doctors’ Committee does not support job share arrangements.

Traditionally, flexible trainees held supernumerary posts. In this way trainees could meet their 60% commitment, yet arrange programmes which best met their needs, both at work and domestically. This proved very popular with trainees but was not so favourable for anaesthetic departments or finance officers.

The situation is changing. Supernumerary trainees are expensive and do not fulfil any service commitment to anaesthetic departments. The funding from the postgraduate deanery is finite, and with more trainees presenting with well-founded reasons for training on a LTFT basis, money is becoming a limiting factor in some deaneries. There may be delays in commencing training, which vary according to geographical region.

The theoretical situation of choosing what percentage of work an individual wants to undertake on a supernumerary basis is often impossible. At the BMA flexible training forum Anne Hastie, the London Deanery director of postgraduate general practice education, revealed that resources earmarked for LTFT training had been diverted in 2006/07 to plug deficits elsewhere. Trainees in some regions are being placed on waiting lists for flexible training; other regions ask individuals to find another trainee to slot share. If you are lucky you will be offered LTFT training on a 50% basis in a slot share. If you wish to work at more than 50%, the implications financially and in terms of future CCT date are huge but as one trainee was told by her postgraduate deanery ‘You cannot have your cake and eat it’.

It is always worth liaising with your flexible training Regional Advisor to negotiate the possibility of adding (for instance) an extra 10% on a short term basis where funding allows. It may be possible to train for one year at 60% and then return to 50%.

Furthermore, if it is your intention to return to full time training let your Deanery know early. Those in a LTFT post need to be aware that returning to a full time post is not an immediate process - it can take up to a year to return to full time work.

Access to flexible training is therefore dictated by budgets. Perhaps some encouraging and positive news was presented at the recent BMA flexible training forum in London where Anne Hastie stated “we believe that funding is likely to be restored to its full amount”. She then went on to say that this turnaround would enable deaneries to progress towards their 2010 target of filling 20 per cent of training posts with flexible trainees. But she emphasised that flexible trainees could not expect to work exclusively in supernumerary posts. ‘Slot shares’ would become the norm.

In summary, be warned, be prepared and be hopeful that in the future, funding will allow a little more flexibility when attempting to juggle a demanding and fulfilling career with a demanding and fulfilling personal life.

Susan Williams
GAT committee member

**Useful sources of information**

- [www.bma.org.uk](http://www.bma.org.uk) British Medical Association
- [www.copmed.org.uk](http://www.copmed.org.uk) COPMeD
- [www.nhsemployers.org.uk](http://www.nhsemployers.org.uk) NHS Employers

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Low Flying Anaesthetist

Well, I was away from the country for two weeks on my annual pilgrimage to the home of the brave, land of the free where I propel myself on short planks down slopes where the buffalo used to roam; and although, on my return, nothing seemed to have happened in the Archers and Tony Blair was still PM, there suddenly appeared to be a disaster looming in medical unemployment. "8,000 Junior Doctors to Leave Country or Medicine in NHS Job Crisis" ran the first headline in a broadsheet newspaper to catch my eye when I arrived back in the home of the disenchanted, land of the oppressed. How can we possibly have gone, in a few short years, from desperately needing to increase medical student intake in order to meet projected requirements for more consultants, to wasting the expensive training of such a large number of doctors? A few years ago we apparently were going to be so short of anaesthetists that it was foreseen that we would have to stop providing epidural services and even train and employ a new work force of Anaesthetic Practitioners. In fact we are now going to have 3200 more consultants than we need (or should that read “can afford”). Despite this we are still going to have fewer doctors per head than most other European countries as well as North America. But then, when this government is paying GPs so much, it has to make savings somewhere! As ever, the wheel will turn full circle. Within 0 years medical unemployment will be a thing of the past, and we will be back to too few doctors for available posts. One third of final year medical students in one of our major medical schools have declared no intention of ever practising medicine.

One of the disposable weekly medical publications ran an article a few months ago on the future of medical cover for Intensive Care. This is close to my heart, as any reduction in trainee cover is likely to mean that yours truly will be one of the muggins having to provide the gaps in cover (pity we did not remove the on-call element of our contracts like the GPs!). The loss of posts subsequent to the introduction of Mangled Medical Careers seriously threatens Intensive Care trainee numbers. These currently provide 24 hour resident cover in shifts which are both labour intensive and generally unpopular as they screw up twice as many weekends for twice as many trainees than before the European Working Time Directive was introduced. (Strange that my European colleagues tell me that most European hospitals take the EWD nowhere near as seriously as we do.) A suggestion to cope with this problem has been to appoint doctors to provide resident cover as a long term career; and the way manpower planning and MMC are developing there will be plenty of unemployed medical graduates to choose from. Anyway, what caught my eye was the quote from the current President of the Intensive Care Society that an ICU post to provide resident cover as a career would be “preferable to nothing or a career in histopathology”. Well! Perhaps histopathologists do not read Hospital Doctor. There has not been a plethora of letters from offended histopathologists fighting their corner as a popular, fulfilling specialty. Straplines such as “meet interesting people…and dissect them” or “we are all the same under the microscope” come to mind!

Which reminds me of a letter in the Times some years ago, defining anaesthetists as “not the high-fliers of the medical profession”. Immediately there was a predictable and articulate response from a number of eminent, and not so eminent, anaesthetists, and some letters were actually published. A local department of Anaesthesia in my part of the country promptly formed the “Low Flying Anaesthetist’s Society” (LoFA for short), complete with a society tie (pictured) with a ‘smiley’ on it - fast asleep of course. The Society’s motto (I suppose it would be a “strapline” now) was Per lofa ad somnum, and I do not intend to offer a translation to the well educated, high-flying readers of this publication.

Of course, one of the reasons for forming a new Society is that founder members can make themselves officers of the society, which looks good on clinical exuberance award applications. (Even my son did this for his University application – he and two friends formed a Geographical Exploration Society whose only function seemed to be to meet in various pubs, and they took it in turns to be president – I don’t know where he got that idea from!) Anyway, true to the thinking behind this new society of alleged low flying anaesthetists, not only was there no requirement for official application to belong and no membership fee, there were also no officers - no president, secretary or treasurer! Such exalted positions belong to the high flyers of life.
Talking of application forms, I was looking over the new MTAS application forms the other day out of interest. I used to be closely involved in shortlisting for our regional SpR rotation, and it was always possible to recognise the applicant who might not have excelled at every step, but none the less would be the sort of person you would like as your own anaesthetist, and who you could imagine would be an excellent colleague to boot. My usual inclination on hearing of an SpR applicant who had 5 grade A+s, MBBS (Hons), BSc (Hons) and MRCP, is why is someone so intelligent doing medicine? There is very little room these days for individual thought; we are not encouraged to be innovative – our CD is trying to restrict our use of newer and better drugs purely on cost. Never mind the fact that as a teaching hospital we should be evaluating these new drugs and techniques to the full. Strange how as soon as we all got used to management jargon, such as blue-sky thinking, extending the envelope and thinking outside of the box, we are told to get back in our box and use the cheapest possible methods of achieving artificial targets imposed by our ill-informed masters. We even have Trust prescribing directives for oral as opposed to intravenous paracetamol, and metoclopramide as the anti-emetic of choice!

It is no better for our surgical colleagues – they have lost control of their lists to target-driven non-clinical managers, whose glib response to the surgeons’ complaints are that the patients are no longer ‘theirs’ (the surgeons), but belong to the Trust. One of my surgeons almost came to blows recently with a manager who was insisting that he cancelled a patient with an intracranial tumour in favour of a patient needing a nerve stimulator who had been on the waiting list for a long time, and was about to breach the latest target time, incurring penalties for the Trust. Another surgeon I work with has a waiting list of major reconstructive work and the local PCTs will only allow the cases to be done when they are about to breach in order to spread their budget across a number of months. Obviously if the surgeon takes holiday, or has more urgent cases, these ‘breachers’ may turn up on a different surgeon’s waiting list initiative – one of our surgeons was even stopped from going on annual leave because some of the patients on his waiting list were about to breach. Yet another surgeon had his all-day vascular list replaced at 24 hours notice with half a dozen patients with ‘breaching hernias’. The most noticeable effect of all this is that many of the surgeons I work with are no longer prepared to work all the hours they used to, especially on non-clinically urgent ‘breachers’, just to ensure the Trust managers are on schedule to secure their jobs or to receive their bonuses. Reminds me of a particular typo or bloomer on an SpR job application form where the candidate had to give an account of his experience in different areas of the NHS. One candidate had simply typed “I have had experience with all prats of the NHS”. I know just how he feels.

Every issue of Anaesthesia now available online

To celebrate the 75th Anniversary of the Association, the Editorial Board of Anaesthesia is pleased to announce the completion of the Legacy Project.

Blackwell, our publisher, first proposed two years ago that the entire back archive of Anaesthesia be scanned into an electronic format and made available to the membership. As well as being a valuable scientific resource, simple, web-based access to all issues of the journal back to Volume 1 in 1946 provides a fascinating insight into the world of anaesthesia 60 years ago, and allows the reader to encounter some of the great writers, researchers and innovators of that prolific period. Hale Enderby, Macintosh, Mushin, Alfred Lee and many others can be found in these pages, and their insight and humanity - as well as their spare and measured use of language - is still an inspiration.

Digitising the entire archive was a more difficult task than might be imagined. Great care had to be taken to protect rare and fragile paper copies, and several issues could only be sourced with the diligent help of AAGBI members. We are particularly grateful to Tom Boulton, Anna Maria Rollin and Peter Morris, along with the librarians of Manchester Royal Infirmary and Epsom Hospital. The Heritage team at the AAGBI, Trish Willis and Iris Millis, were invaluable in their enthusiastic and expert supervision, and thanks must go to the team at Blackwell, who not only provided expertise and facilities, but also the funding for the project.

The release of the Legacy Project coincides with the launch of a direct link to the journal from the Association website. One click from the 'members only' area will take you to Blackwell Synergy and full electronic access to Anaesthesia from 1946 to the present day.

"The past is a foreign country“ wrote L P Hartley. Enjoy your travel.

David Bogod
Editor-in-chief, Anaesthesia
Gordon Jackson Rees, known to all his friends as “Jack”, was born 8th December 1918 in Oswestry and educated at Oswestry School. He was the second son of a marine engineer who had served in the Royal Naval Reserve in both World Wars. His mother's maiden name was Jackson and his first Christian name derived from his mother’s admiration for General Gordon of Khartoum. Whilst travelling with his father, he assisted in the maintenance of mechanical devices and became familiar with the measurement of pressure-volume loops, later of value in his professional career. Despite his father’s hope that he would follow in his profession, Jack was determined to study medicine. Apart from excelling at cross-country running, his scholastic achievements were modest and gave little hint of his later brilliance and practical innovative ability. His school leaving grades were satisfactory to study medicine at the University of Liverpool in September 1937. During his second year he met a fellow medical student, Miss Elisabeth Schofield, and after qualifying in late 1942, they married and enjoyed an extremely successful partnership for 58 years.

Early in 1943, Jack was called up into the Royal Air Force medical branch and in 1945 he was offered a postgraduate course in anaesthetics. He was sent to the Radcliffe Infirmary to study under Macintosh and Mushin, finally being posted to RAF Hospital, Cosford. There Dr Douglas Howat coached him for the Diploma in Anaesthetics, easily passed in 1946. He was demobilised later that year and returned to Liverpool, obtaining posts in anaesthesia at the Royal Southern Hospital and other Liverpool hospitals and was appointed a Consultant Anaesthetist to the Royal Liverpool Hospitals in 1949. Here, he met two people who dramatically influenced his subsequent career. Dr, later Professor, Cecil Gray, a Consultant Anaesthetist in the United Liverpool Hospitals, and Miss Isabella Forshall, a Consultant Paediatric Surgeon at the Royal Liverpool and Alder Hey Children’s Hospitals, described by Jack as a "a formidable lady". With both he developed life long friendships. Cecil Gray, as newly appointed Reader in Anaesthesia in the new University Department of Anaesthesia, recognised his tremendous potential and invited him to become a part-time demonstrator. Together, they introduced the revolutionary concept of the "triad of anaesthesia", using different specific agents to produce a desired effect, a far cry from the conventional method using a single anaesthetic agent. Shortly afterwards, Miss Forshall persuaded Professor Gray to second Jack to the Royal Liverpool and Alder Hey Children’s hospitals to develop paediatric anaesthesia. He continued to hold Consultant posts in five adult hospitals and because of his conscientiousness and expertise, was constantly in demand for difficult emergency cases and carried a heavy clinical workload. Gradually, however, he devoted his professional activities solely to the care of infants and children.

The Jackson Rees technique initially developed as a result of his experiences in adult anaesthesia, and an intense desire to humanise the management of children undergoing anaesthesia. He introduced a number of radical changes. These consisted of heavy premedication, intravenous induction with thiopentone and routine use of muscle relaxants, either tubocurarine or succinylcholine, with tracheal intubation and a high rate of...
controlled ventilation using only nitrous oxide and oxygen by adaptation of the Ayre’s T-piece: the simple addition of an open ended bag on the expiratory limb. The effects of the muscle relaxant were routinely reversed with a standard dose of prostigmine. In 1950, within a year of being appointed to the Liverpool Children’s hospitals, he published a seminal paper in the British Medical Journal on neonatal anaesthesia. His technique became the yardstick of safe and successful paediatric anaesthesia. It produced great improvements in the results for infants and children undergoing surgery, which allowed the development of more complicated operations. Further innovations followed, particularly prolonged nasal intubation for intensive care using an adapted polyethylene tracheal tube. Jack’s technique soon became known throughout other paediatric centres and resulted in the operating theatres at the Liverpool children’s units being packed with distinguished paediatric anaesthetists from around the world. He was invited to lecture and demonstrate at many national and international meetings. He travelled widely to paediatric centres as a visiting Professor and invited lecturer. He was made an Honorary member of a large number of learned societies and presented with many prestigious awards in this country and abroad. He inspired a large following of trainees, who came from departments both within the United Kingdom and abroad to learn the technique he had perfected. He received visits from many colleagues during his years of practice and remained in contact with many long after he retired.

Dr Jackson Rees was awarded the John Snow Medal of the Association of Anaesthetists of Great Britain and Ireland, the Medal of the Faculty of Anaesthetists of the Royal College of Surgeons of England, the Frederick Hewitt Medal of the Royal College of Surgeons of England, the Henry Hill Hickman Medal of the Royal Society of Medicine, London, and the Robert M. Smith Award of the American Academy of Pediatrics. He was extremely popular and became well known as a superb speaker, a witty panellist and a persuasive debater. His writings are a model of lucidity and a pleasure to read, though he confessed that he was “a reluctant writer”. It has been said that anyone who got a letter from him should frame it!

His flair for appreciating the clarity of issues made him eminently qualified for membership of numerous examining bodies and a natural President and Chairman of many committees, both locally and nationally. He was particularly proud to be a founder member and later President of the Association of Paediatric Anaesthetists of Great Britain and Ireland and attended nearly every annual meeting following its inception in 1973, particularly enjoying the gossip at the bar after the annual dinner. His influence on the development of the specialty was recognised by his appointment as the first President of the Federation of European Associations of Paediatric Anaesthesia in 1986.

In recognition of his contribution to the welfare of children, the Liverpool branch of the Athenaeum club, which celebrated its bicentenary in 1998, chose him as one of only five distinguished citizens from the whole of Merseyside, who had contributed locally, nationally and internationally to the advancement of knowledge and humanity; a unique award for a unique man.

Dr Rees retired from clinical anaesthetic practice in 1983 but was invited to be guest Professor of Paediatric Anaesthesia at the Erasmus University, Rotterdam for a year. Fortunately for his admirers and for posterity, his achievements were recorded on 4 hours of videotape in 1997-8 now held by AAGBI. The revolutionary improvements that Dr Rees initiated laid the foundation for the practice of anaesthesia for infants and children, which could not have been envisaged 50 years ago. Dr Jackson Rees died in January 2001.
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*The Editor-in-Chief reserves the right to refuse publication.

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