Scottish Standing Committee: Stirling Open Meeting Report

Anaesthesia Practitioners: Interim Joint Statement RCOA and AAGBI

Forget Apocalypse, Prepare for Armageddon: President Mike Harmer Reports
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We are aware that in recent weeks the support of both the Royal College of Anaesthetists (RCOA) and the Association of Anaesthetists (AAGBI) for the Anaesthesia Practitioner (AP) project has been called into question on several occasions. We believe that a clear explanation of the current situation and our future plans is necessary to allay some of the fears which appear to be prevalent at the present time.

Where are we at present?

The New Ways of Working in Anaesthesia (NWWA) project has been running for three years and has reached a stage where the initial five pilot site projects are nearing completion. A great deal of progress has been made to date in the development of a national curriculum and establishment of a second round of pilot sites; still more work is needed both in these and also over the issues of registration and regulation.

Assessment of the pilot sites and evaluation of the roles that Anaesthesia Practitioners (APs) might play within the anaesthesia team have always been integral parts of the project. To date there have been no formal assessments of the pilots, nor will this be practical for at least another year. The RCOA and AAGBI agree on the importance of continuing to support the AP project until the information from the pilot sites has been fully evaluated.

It is appropriate at this stage of the project to reflect on the progress to date and to check that the assertions under which the project was developed still hold.

Background to the Project

The original premise under which the AP project was developed was of a predicted and unavoidable workforce shortage of anaesthetists in the next decade. The NWWA programme started in 2002 as a joint project between the Royal College of Anaesthetists and the NHS Modernisation Agency within the English Department of Health (DH) to investigate a potential role for non-medical practitioners in the UK. In order to undertake a feasibility evaluation, a Stakeholder Board was established to include all with a direct or indirect interest in the project.

In 2003, five Trusts started as pilot sites for the programme, and in 2005, an additional 21 Trusts joined, with 34 trainees organised in seven training clusters. The NHS University commissioned an AP training curriculum from the University of Birmingham, and arrangements were proposed by which the RCOA would undertake a final assessment of APs before their registration. Currently, arrangements to establish a voluntary register of APs are under discussion. At present, there are no qualified APs in UK. Five students should qualify in October 2006, and 34 more should complete their training in 2007.

Recent Changes

Since 2002, the NHS has seen substantial changes in training and service delivery. It is important to ensure that the continuing development of Anaesthesia Practitioners is appropriate for the future NHS.

We believe that the pilot project must continue to be clearly and unambiguously supported, to ensure that all the questions about the suitability and practicability of APs working in the UK are properly answered, whatever the ultimate outcome. Those opposed to the project believe that if the College and the Association simply withdrew their support, the project and APs would
Anaesthesia Practitioners cont…

cease to exist, but this is simply not the case and certainly should not be allowed to happen. If we withdraw our support now, the project will still continue, but the national bodies representing anaesthesia will have lost control. The project will fragment, but then rebuild outside our current structures and processes. In order to prevent this, the RCOA is seeking to take the administration, accreditation and registration of the project into the College to ensure that we retain control.

Workforce Concerns

Nevertheless we acknowledge a serious concern over the future workforce need for APs, which centres around doubts over the accuracy of the College’s workforce predictions for the future. How do we know we will really need APs? Firstly, the current situation of trainees delivering service is unsustainable in the long term for two reasons:

• If we continue to use the same number of trainees to deliver service work, but don’t create consultant posts for them to take up, based on our current numbers we will overproduce by about 240 CCT holders each year

• If on the other hand, service work which trainees undertake is transferred to career grade posts, once we have a full complement of career grade staff delivering the service, trainee numbers will inevitably need to fall to a number sufficient to replace retirements

The second area of concern is over career grade posts. There is already competition for consultant posts in some parts of the UK and with the increased intake into medical school, such competition will only increase. In short, the fear is that APs will take away jobs from fully-trained medical anaesthetists by being a cheap option. There is nothing suggest that this will actually happen.

In order to address these concerns, the College is undertaking a review of its workforce predictions in the next few months by renewed examination of the available data and by departmental questionnaires. We will make every effort to make realistic and sensible predictions for the future and this should help us estimate the need for all grades of anaesthetists as well as APs.

The key issue is what role APs will play as part of the anaesthesia team of the future? We must stress yet again that they are not a cheap substitute for anaesthetists and they are not there simply to address a shortfall in medical anaesthetic recruitment. The plain truth is that whatever our study of workforce numbers shows, the way in which anaesthetic departments deliver their service responsibilities will change and APs will provide an additional option for departments to consider in developing an anaesthetic team and department which will work in the 21st century

Current Position

1. Any significant change in practice from the 2000 workforce projections is likely to challenge the premise upon which the AP project was established. In order to verify the continuing validity of the predicted workforce data, an urgent review needs to be conducted.

2. While the RCOA and AAGBI will continue to support existing pilot sites, they have maintained the consistent position that the existing pilot programme needs robust assessment to evaluate its true potential for UK anaesthesia before the project can be fully ‘rolled out’.

3. Only when these reviews of workforce and the AP pilot sites are available will the Department of Health and the profession be able to assess the need, practicability, safety, cost effectiveness and desirability of APs

4. The importance of proper assessment and evaluation of the existing sites, and the need to allow time for such, must not lead to the development of ‘alternative’ AP projects.

5. The RCOA’s formal review should include consideration of the extra anaesthesia capacity created by APs, a review of their impact on the training of anaesthetists, anaesthesia safety and how the role actually evolves in the workplace, which may be different from those anticipated.

6. The RCOA and AAGBI do not support significant expansion in the numbers of trainee APs until results from the planned workforce review and from an evaluation of the existing pilots have been properly assessed.

The College and Association are both committed to supporting the project in the expectation that it will be properly evaluated to ensure its applicability for the future and the quality and safety of patient care. It is entirely possible that APs will find an important and successful role in some NHS Trusts, but it is also possible that they may not. This is why the initial project has always been considered and conducted as a pilot and this is how it must continue to be viewed. Different hospitals, in different situations and with different needs will require a variety of options to deliver service and APs may help in some models of service provision.

Anaesthesia practitioners are potential new members of the anaesthesia team, who will work with us and support us in the future, but are not substitute anaesthetists. We hope that we may be able to recruit and train sufficient anaesthetists, but it is the need to replace the inevitable reduction in trainee numbers which will provide the biggest challenge.

David Greaves Mike Harmer Peter Simpson
Project Lead President AAGBI President RCOA

This is an abridged version of the original document that can be found on both websites.
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*This figure is derived from the list of successful candidates as published on the RCA Website. However, those candidates on the course who did not sit the examination for whatever reason (e.g. Dublin) are not accounted for and thus it is likely that the definitive figure is greater than 67%.

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Forget Apocalypse, Prepare for Armageddon!

There can be little denying that we currently face the greatest period of change in healthcare provision since the inception of the NHS. The changes come thick and fast and there is hardly time to catch breath between them. The curse implicit in the Chinese blessing of ‘May you live in interesting times’ is for many ringing true. We are certainly living in interesting times and they are far from pleasant. It seems only a month or so back that I was last reflecting on the issues that were impacting upon our specialty and healthcare as a whole, yet month on month even more developments occur that are likely to change the very foundations upon which the NHS was founded and has functioned.

As I pen this article, it has just been announced that Sir Nigel Crisp has stood down as head of the NHS. The dire state of the NHS’s finances would certainly have been a factor in that decision, even though it remains to be seen if it was a matter of jump before being pushed. We hear that spending on the NHS has never been greater, yet more and more Trusts are unable to live within budget. A large part of the blame for this situation has been laid on the salary increases of healthcare workers. The new consultant contract and the implications of ‘Agenda for Change’ have placed major financial burdens on the Trusts and the NHS as a whole; but it cannot all be laid at the feet of the ‘greedy consultants’ as some at the DoH would have the public believe.

For almost as long as I can remember, there have been mumblings about a new consultant contract that would put an end to those who have abused their position. There was a perception that many consultants did not give fully of their time to the NHS and did not fulfil their contracted hours. A good friend of mine who happened to be head of our Personnel Department (now of course called HR) could easily see what would happen to Trusts if the DoH demanded a new contract that was time sensitive. He thought it would be better to acknowledge the huge contributions made by the vast majority of consultants with a base increase of say 15%. However, those factions of the DoH (or perhaps the No 10 think-tank) that had been suitably indoctrinated insisted on opening ‘Pandora’s Box’; the outcome was bleating from healthcare officials such as the fact that in Scotland the new contract had added 40% to the salary bill. So is it really the ‘greedy consultants’ or the ill-informed politicians/civil servants who are to blame?

On the same day as Sir Nigel Crisp’s departure came the long-awaited news that the Health Secretary has agreed to the redevelopment of the Barts and London sites. This £1 billion venture has been on hold for some months as concerns rose over the true cost of such PFI projects. One would expect unbridled joy from all involved but like so many things in healthcare, there is always a sting in the tail. In this case, it is the mothballing of 250-odd of the beds in the new development, along with threats (published in Hospital Doctor) of a necessity to reduce staff costs (i.e. numbers!). This whole debacle was reported in the Evening Standard of 8th March as a DoH success because the restructuring of the project was going to save £20 million per annum on rental payments (a reduction down to £97 million per annum for the 32 years of the agreement). Admittedly, over the period of the rental, that would amount to a saving of over £0.6 billion, but the cost to the taxpayer would still be more than £3 billion for what is said to be a £1 billion project. Is that saving really the case? The plan to mothball 20% of the beds might imply a similar diminution in all activity and thus account for the approximately 20% in rental charges.

So there seem to be major problems for healthcare in general, but what about anaesthesia specifically? Some years ago, David Saunders predicted a massive workforce shortage that would have its impact from 2009 onwards. This apocalyptic prediction required urgent action and several alternatives were considered. There was an increase in training numbers allocated to anaesthesia and we would be able theoretically to produce sufficient trained anaesthetists to replace retirements and allow an expansion of about 200 consultants per year. At the same time, the DoH was exploring other workforce possibilities, in particular the possible role of non-medical providers of key services. Anaesthesia was considered alongside other specialties and possible working patterns were proposed. At about this time, the College became involved in an attempt to control a situation that could have rapidly got out of hand as unbridled enthusiasts and paramedical healthcare groups looked at how to run our
specialty. The outcome of the College’s involvement was the development of the Anaesthesia Practitioner (AP) project. The Association joined the College and others to set up a Stakeholder Board to oversee the project. To date, only pilot sites have been involved with a total of some 35 students, and there is yet to be formal assessment of the students, far less agreement as to the precise role that they will play. However, there has been a very vocal lobby against any involvement in such a project and it is tempting to assume that everyone might think the same.

At recent meetings and debates on the topic, there have been outspoken supporters of both sides of the argument and a fairly large silent majority who seem prepared to see how things develop. By the time this article appears in print, I hope that all full AAGBI members will have received (and, I hope, completed) a questionnaire on this and other topics that are effecting our specialty. In the meantime, there has been criticism levelled by members/fellows that they are not clear on how the two bodies currently stand on the issue. A joint statement has been prepared that I hope will help to clarify matters and appears in this issue of Anaesthesia News.

In reviewing the AP programme, it has raised questions over the validity of the workforce predictions mentioned earlier. Clearly, if those original predictions are no longer valid, it could dramatically change the threats that face us in the forthcoming years. These figures are currently being reviewed but on initial inspection, they would appear to be about right. However, one has to introduce a caveat to any calculation of workforce and that is the transition of theory into practice. Whilst a huge number of consultants would be needed to provide a 24-hour service with trainees purely supernumerary, such is highly unlikely to actually happen as finances will not allow, and an alternative will have to be considered. In addition, workforce predictions may change with changing patterns of work and a shift to less invasive procedures and better medical treatments.

In the face of a huge mismatch between numbers, workload and finance, there is even talk of rationalising services to reduce the acute load on a hospital; though it has to be admitted that they are not clear on how the two bodies currently stand on the issue. A joint statement has been prepared that I hope will help to clarify matters and appears in this issue of Anaesthesia News.

Assuming that we do reduce the number of trainees, there must be a change in how and where we train them. The traditional ‘every hospital must have trainees’ philosophy is likely to disappear to be replaced with trainees being placed in centres that can supply all their training needs. For many hospitals, this would have a major impact as the on-call cover would no longer be provided by trainees. As well as the on-call issues, who will help you during a long free-flap operation – perhaps there is an essential role for an AP. Thus, even if the initial assertion that APs will be needed to provide anaesthesia proves not to be the case, it is highly likely that they would have a valuable role in supporting a consultant and help to provide high quality care.

It does seem a topsy-turvy world where with one breath we seem to be saying that we may need all the workforce that we can get and in the next breath we are discussing reducing the numbers of trainees – but then nobody ever said that workforce prediction was a precise science!

So, if we are thinking about training, what about Modernising Medical Careers (MMC)? There has already been so much written about this and many thoughts on its feasibility. If there is a ray of hope for us, it is that of all the specialties, anaesthesia is the best prepared and therefore most able to institute run-through training (spies on the inside of PMETB suggest that some specialties are struggling with the concept of competency-based training itself and certainly haven’t thought of numbers). So, a great honour, you might think, if we are invited to lead the way, but before we rush into it, let us just reflect on what happened with Calman. Again, we were ahead of the game and tried to embrace the proposals with a reduced duration of registrar training, only to see others holding on to their prolonged training
with the implication that their specialty was more highly trained than ours. It took a rearguard action then to redress the situation and revert to a 5-year registrar period. So, perhaps we should not be too eager in coming forward and perhaps keep a watching brief on how things go before taking the plunge. There is clear pressure to get this started but if I was a betting man (which I am not), I would put a few pounds on it not getting started in August 2007.

What of the concept of MMC though? Is there anything fundamentally wrong with a training system that gives security for trainees and a structure for trainers? The many versions of the ‘training diagrams’ now seem to have come down to an accepted final one. There remain many unanswered (or perhaps, unanswerable) questions such as where will existing SHOs, SAS doctors and overseas doctors fit in? Unlike when Calman was introduced, there does not seem to be an obvious plan for assimilation for existing trainees. Rumours abound as to who will enter the ‘little blue box’ (Fixed-term Specialty Training). Will it be a ‘ sampler’ box where it will be possible to ‘try before you buy”? Will it be a possible place for overseas doctors? How many of these posts will one person be allowed to do? Will the arrows showing possible two-way traffic really have ‘No Entry’ at one end?

To me, perhaps the most interesting and important aspect of the whole MMC matter is the absence of the word ‘consultant’. There is certainly recognition of attainment of specialist registration but only the term ‘senior medical appointment’. So does this mean that the objective of training is no longer to produce consultants but to produce specialists – just as in most other European countries? Some surgical subspecialties have already suggested different levels of specialisation that would tend towards a hierarchical structure amongst trained clinicians. Is this the DoH way of introducing a sub-consultant grade by another name?

Unthinkable not to have all trainees ending up as consultants some might think, but my guess would be almost inevitable given a number of factors. Firstly, it is debatable whether the NHS can afford consultants any more (the whole pay issue explored earlier). Secondly, the increasing alignment with Europe and the availability of trained specialists who in the past may not have ‘ticked all the boxes’ for a consultant post but would certainly fulfil a specialist role at a sub-consultant salary scale that was acceptable to them. Lastly, if we do get into a situation of overproduction in training, there will be an ideal opportunity for Trusts (presumably all Foundation by then and free agents) to introduce market forces. Are we really far away from a situation of a Trust deciding what it is prepared to pay for services and dictating terms to those available to provide the services. Again, unthinkable as nobody would agree to it, but just remember the number tempted by the low-fee, high-volume offers from ISTCs. It could become a ‘dog-eat-dog’ situation.

The last major change announced recently that will have an impact of healthcare is the change in immigration legislation. On the surface, it would seem that doctors would easily fulfil the requirements and score sufficient points, but there is a snag. The current permit-free training agreement will cease with almost immediate effect. For non-EU doctors to work in the UK, they will need a work permit. That will only be granted if they have a recognised post. However, they can only be considered for a post if the employer (Trust) cannot fill that post with a UK or EU graduate. There does not appear to be any protection for those already working in the UK when their current post finishes. Many will argue that this is nothing but a slap in the face to the countries that have over the years underpinned the NHS. The exact impact of these changes is yet to be fully understood, but in the current climate of ill-thought out change, it is likely to be detrimental.

When David Saunders warned us of the impending workforce apocalypse, it triggered major concern. Unless the powers that be decide on some joined-up thinking, and look at how to prevent the many current changes from driving the NHS into a deregulated free-for-all, it is Armageddon that we face – the end of our working world as we know it!

Mike Harmer
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5th Evidence Based Peri-Operative Medicine

- Professor David Bennett (London, UK), Goal directed therapy
- Professor Henrik Kehlet (Hvidovre, Denmark), Enhanced surgical recovery
- Professor Monty Mythen (London, UK), Is there a problem with UK surgical practice
- Professor Don Poldermans (Rotterdam, Netherlands), Beta Blockade and surgical patients
- Professor John Sear (Oxford, UK), Anaesthesia and hypertension
- Professor Mervyn Singer (London, UK), Glycaemic control
- Professor J.A.W Wildsmith (Dundee, UK), General vs Regional anaesthesia

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Acute Trust Chief Executives are busy calculating the impact of the tariff changes for 2006-7. An initial increase of 6.5% has been reduced by a 2.5% efficiency saving and other requirements resulting in a further 2.5% reduction, bringing the total increase to a less than impressive 1.5%. This figure is to take account of inflation, pay rises, staffing, pension contributions, CNST, administration, facilities and drug costs before any investment in services can be made. Since many Trusts struggled to break even at the end of 2005-6, the outlook is not one of an expanding acute sector.

The NHS is a publicly funded service run by a democratically elected government. We elected them. Politicians have a responsibility to deliver healthcare within a budget raised from taxation, along with education, security and all other public services. Trusts have to remain within budget, deliver NICE recommendations and meet all political targets - an enormous challenge.

Even the 1.5% uplift is not as simple as it first appears, and not all Trusts will be affected equally. A detailed read reveals an even more difficult scenario for some hospitals. In elective surgery the tariff remains reasonably stable, as it must do to continue to attract ISTC investment. In medicine however, Trusts will only receive the full tariff for the equivalent number of emergency admissions that were admitted in 2004-5 + 3%. If we admit more patients, we will only receive 50% of the tariff. With changes to out-of-hours provision in primary care, Trusts will find emergency patients difficult to sort financially. Yet, in reality, emergency medicine is the service that many acute Trusts need to urgently invest in, in terms of facilities, staffing, management and training.

The requirements for good management in the NHS are now more important than ever. Running the acute sector will prove increasingly difficult within the allocated budget. In a typical acute Trust, many believe the cuts in budget will reduce income by around 5% in 2006-7. The difficulty for all of us is how to cope with this, whilst maintaining quality services for patients and continuing to invest in good clinical care.

Unfortunately, many clinicians are reluctant to engage in management and view the opportunity to become a clinical director negatively. Certainly, clinical management is stressful, as working ‘for the dark side’ leaves one exposed to difficult decision making in a system which cannot please everyone all the time, yet is supposed to provide everything to everyone (not even politicians believe this). This results in the need to back one piece of the service in preference to another, exposing us to some difficult interpersonal issues.

However, full time NHS managers need support from effective clinical and medical directors to deliver appropriate care. Along with other senior healthcare professionals, we are the only people in position to assist Chief Executives and Finance Directors faced with difficult choices not only this year, but increasingly in the future, as the ability of medical care to outstrip its budgets increases exponentially.

Although the normal cliché ‘get rid of a few pen-pushers and there would be plenty of money’ is an amusing and popular comment from medics, changes within the NHS to manage targets, waiting lists, personnel, appointments, tariff, payroll and expenses all need people and expertise. I believe the NHS is
probably short of expert senior managers, and their posts are challenging and vulnerable. We often forget that many of these colleagues joined the NHS with a vision not too different from our own.

As clinicians we have a stark choice – engage with managing the NHS in the acute sector, or accept we cannot simply blame others when it goes wrong. This next decade will bring about enormous change in the NHS, increasing ‘competition’, pressures to perform and political decisions made for electioneering rather than healthcare (that is a politician’s profession). We need to influence things – both for our patients for whom we care, and for our younger colleagues who in turn will care for us. Let’s not let the NHS slip away as we engage in superficial debate about the minutiae of clinical life. The complexity of our organisations is much greater than a simple treatment centre – what about the education of our next generation for example?

Anaesthetists often make good managers; we tend to take the broader view, enjoy solving problems and are often able to get co-operation between different individuals and departments for the common good. In my opinion a willingness to learn, vision, integrity, insight into people and flexibility are the most important attributes, and not the number of management courses attended.

Start by meeting your own management – many are as dedicated to patients and the NHS as we are, but their arenas and priorities are different. Consider shadowing one for a day, and then offer to reciprocate. We need to recognise that the targets and changes that vex us all are centrally driven and not the result of some dreamt-up local initiative. Trust Executives do not have our security, or the opportunities we have of directly caring for patients, but their roles are important and in my Trust they are decent, hardworking, loyal people who every day face the impossible task of making a service work without the resources we demand from them. Other Trusts may have different experiences but most of us should be able to communicate, given that we are all there for the same person – the patient. Get involved or at least support the colleague who does. In anaesthesia, critical care, and the NHS, we shall all regret it if we don’t!

Iain Wilson
Joint Medical Director &
Honorary Treasurer Elect
The fifth open meeting of the Scottish Standing Committee took place on February 24th at Stirling Royal Infirmary Conference Centre. Over 100 delegates from all over Scotland attended, plus a few renegades from across the border. Pete Alston was the organising maestro this year, and had arranged a packed and varied programme of the now traditional mix of the clinical and political, with the addition this year of the philosophical.

The morning kicked off with a presentation from Harry Burns, Scotland’s new-ish Chief Medical Officer, on The Future of Acute Medicine in Scotland. In a previous incarnation, Harry was a surgeon, so not unknown to many of the audience. Much of what he had to say was fairly reassuring, but left us in no doubt (as if we were anyway) about the problems facing the Health Service over the next few years. Our visitors from elsewhere in the UK would have been interested in the differing emphasis in the Scottish NHS – more of the original socialist model and less of the free market developments found elsewhere in the United Kingdom.

Next was some cutting edge stuff from Dr John Dingley about Xenon anaesthesia, a technique currently restricted by the high cost and lack of suitable apparatus. John demonstrated some of the ingenious equipment he has been developing (including one for rats) – suffice to say, if you’re stuck with your Ikea furniture build, he might be the man to contact!

After coffee, Alistair MacFie highlighted his work in developing SIGN guidelines for non-coronary surgery in patients with stable angina. It was interesting to hear about the process each guideline goes through in development - and the length of time it all takes!

Just before lunch was the ideal time for Professor Ian Greaves who introduced a “Ready Steady Cook” element to the proceedings by producing a Tupperware box with some liver – plus an onion. He was speaking on the new theories of partial resuscitation in trauma, and the shift in emphasis to stopping blood loss rather than the traditional ATLS approach of flushing in fluids. The liver was used to demonstrate one of the new topical agents which can be useful in arresting haemorrhage in blunt trauma. The onion was a red herring.
We were left rather wishing we’d hung on to the liver, as there was the, now traditional, failure of the lunch to arrive on time. This year’s excuse was a malfunctioning hot servery trolley. Still, it was a nice day, so your correspondent took the opportunity to have a stroll outside – I was a resident in Stirling longer ago than I care to remember and it was nice to see the old place hadn’t changed too much, if you ignore the big new building out the back which dwarfs the building I worked in.

A short open forum followed lunch, with questions about anaesthesia practitioners well to the fore as usual. It is clearly a source of considerable anxiety to the profession and Peter Wallace was on hand to give the latest update on progress in Scotland. The next formal session was an update on pensions by Linda McAllister, the Scottish BMA’s lead pensions officer. So much is changing all at once on several fronts, it’s hard to keep up. The good news for those of us who are already enrolled is that at the moment it looks as if we are protected from the major changes to the NHS scheme, which will apply to new joiners only. However (and I write as someone with a cross-border NHS career) at present, moving from Scotland to England or vice versa means leaving one scheme and joining another, and it’s unclear whether this would mean automatic transfer to the new rules. Similar concerns exist around doing a university based research post, a year abroad etc.

Mike Wee spoke about dealing with the aftermath of a death on the table – we will all have had one of these at some point, and even when it’s anticipated, it can still have a significant impact. At the very least the paperwork and dealing with the practicalities mean continuing the list is awkward, leaving aside the emotional impact. Mike chaired the Association working party which produced a glossy on the topic last year.

And finally, Dr Margaret Branthwaite spoke about Hastening Death – a subject which has been debated in the press recently. Margaret explored various arguments for and against physician assisted suicide (largely destroying those against) using examples of practice from around the world. As usual her arguments were incisive, and her signature delivery, speaking for 45 minutes without notes or visual aids, impressed us all. Reassuringly, both government bills for England and Wales, and Scotland have been carefully worded so that there is no compulsion on any individual to collude.

So a very full, but enjoyable day – if only we could sort the lunches!

At this time of year the personnel on the Scottish Standing committee change round – Gavin Gordon from Glasgow and Kathleen Ferguson from Aberdeen were successful in the recent election, which means we say goodbye to Harry McFarlane and Ken Barker, both of whom have contributed much in the last few years. Harry has been secretary to the Standing Committee in the last year, and Ken has been involved in organising the meeting in the last couple of years. We look forward to welcoming the new members.

Hilary Aitken
The Mersey Weekend Series

FINAL FRCA VIVA WEEKEND # 5

2.00pm Friday 16th - 4pm Sunday 18th June

Important Notice
To avoid Disappointment, Disillusionment and/or Discontent, it is important that prospective applicants appreciate that there are No External Examiners contributing to this course
All the examining is done by the candidates themselves
Further, there are No Handouts
It is a Mean Course with a Mean Master with a Mean Discipline
But
It Works

Feedbacks from Course # 4 December 2005
There were 64 candidates registered. Feedbacks were submitted by 55 candidates
On a scale of 1 – 5
1 = Waste of Time & Money
5 = All Promises & Objectives Achieved
28 candidates scored the course (5) & 27 candidates scored the course (4)

Sample comments
“As realistic as I think it could be. Well organised and thought through.”
“This course is no doubt a five in every aspect”
“Excellent organisation & a fantastic course”
“Very broad exposure”
“It is for practice but I have also gained knowledge ++”
“Very well structured. Very intensive”
“Excellent organisation! Thank you very much!”
“Superb. Very worthwhile experience. Encouraging reflection and development of technique”
“Thoroughly enjoyed the course and the “exam conditions” experience”
“I was a bit sceptical when I was told there would be no examiners. I must admit now the set up is great – give a chance to experience “exam conditions” and learn at the same time”
“Reduced inhibition & fear of vivas”
“Excellent practice although exhausting”
“Benefited from role of examiner highly”
“Gave me excellent insight & (the) sheer volume has been fantastic”
“Good fun.- very good value for money”
“When I started on Friday, I thought this was not good. However, I soon started enjoying. Very soon had plenty of practice”
“Good bank of questions. Good to have opportunity to read through them all”
“Definitely gained confidence and improved my performance”
“Should be more than weekend”

Venue: University Hospital Aintree, Liverpool.
Course Fee: £250 (Including Breakfasts & Lunches)
Application: www.msoa.org.uk
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2006
Aberdeen
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New! Three streams of didactic lecture sessions

update
- Liver disease and anaesthesia
- Morbid obesity
- Difficult airways
- Education in anaesthesia
- Avoiding errors in anaesthetic practice
- Case presentations of clinical problems

scientific
- Cardiorespiratory reserve assessment
- Depth of anaesthesia
- Free papers
- Acute and chronic pain
- Intensive care
- Psychology in the workplace

current issues
- The ageing anaesthetist on call
- Fatigue and anaesthesia
- Diversity in anaesthesia
- Retirement, pensions and financial planning
- ISTCs and NHS
- Disciplinary action
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workshops
Regional Anaesthesia, Advanced PowerPoint, Difficult Airways, Sedation, Pain Therapy, Personal Finance, Private Practice and many more!

free papers
- Abstracts are invited for oral or poster presentation
- Accepted papers published in Anaesthesia
- Prizes awarded to the best free papers
- Closing date for submission: 2 June 2006

entertainment
Tour the bustling city centre with its many elegant granite buildings; visit the picturesque villages with historic gardens and castles. Experience traditional Scottish entertainment, including a Ceilidh band at the Annual Dinner!

AAGBI Members! Apply before the 21 July 2006 and take advantage of the discounted fee!

<table>
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<th>Attendance</th>
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<td></td>
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<td>Tuesday 19 &amp; Wednesday 20 September only</td>
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<td>Thursday 21 &amp; Friday 22 September only</td>
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Book your study leave now!

For further information contact the Events Department on: +44 (0) 20 7631 8805/8 or meetings@aagbi.org www.aagbi.org
Dr AP Rubin Consultant Anaesthetist

The purpose of this short article is to record, for the benefit of posterity, the facts concerning the growth of this branch of medicine at Charing Cross Hospital during the years up to the establishment of a separate division of anaesthesia within the Medical School in 1956, and of a separate department of anaesthesia within its own premises in 1957.

The fifty year anniversary of this development occurs this year and will be commemorated by a clinical meeting and dinner that will take place in London on Monday the 9th October 2006.

Charing Cross Hospital (CXH) was founded in 1818, and until the introduction of ether anaesthesia in 1846, surgery was performed, as elsewhere, without the benefit of any anaesthetic. It is difficult nearly two hundred years later to imagine the great pain, suffering and misery that the patients endured. The pain relieving properties of opiates had been known for many years but they did little to alleviate the acute pain of surgical incisions. Partial asphyxiation by strangulation with a ligature around the neck, or partial concussion by repeated blows with a mallet on a closely fitting wooden skullcap were among bizarre methods of achieving unconsciousness. At a much later date mesmerism or hypnosis were used but with limited success.

The usual was for the patient to be given large quantities of alcohol. When stuporous he would be carried to the operating theatre, strapped to the table, and manually restrained. Surgery had to be very fast and was limited to operations such as amputation, lithotomy, and the removal of superficial tumours.

The introduction of anaesthetic agents from 1846 gave the surgeon the one thing that he had always needed – time, and coupled with the introduction of antisepsis and asepsis, added an element of safety. Anaesthetists increased in numbers and improved in skill. Operations of much greater complexity could be performed, safe in the knowledge that the patient could be kept unconscious and free from psychological shock for the necessary time.

The first anaesthetist to be appointed to the staff of CXH was Peter Marshall MRCS who was appointed ‘chloroformist’ in 1868. Before this time, anaesthetics had been given by occasional practitioners with an interest or by house physicians. At that time there were very few doctors with an interest in anaesthetics, but among them was John Snow who was for some years associated with the hospital.

An interesting idea of anaesthetic practices in the 1870s can be found by examining the answers to a questionnaire published in the British Medical Journal in 1875. The following questions were asked:

1. What anaesthetics are now in use? For what cases are ether or chloroform preferred?
2. What methods of administration are employed?

3. Has any change been made in the last four years in the anaesthetic used, or its mode of administration, and if so, what reasons are given for the change?
4. Can any suggestion be made by the adoption of which the safety of the anaesthetised patient can be more completely secured, or any improvement in the production of anaesthesia for surgical operations be effected?

The reply from CXH came from Woodhouse Braine, ‘chlorformist to the hospital’ who stated:

“Nitrous oxide is given to render the patient insensible, and the anaesthesia is kept up by means of ether. Clover’s combined apparatus was not used. Nitrous oxide was first administered from an ordinary type of apparatus, and ether was then given from a felt cone.”

C Carter Braine analysed 1856 cases done in the operating theatre from 1895 to 1900 using information from the ‘anaesthetic registers’. This data excludes anaesthetics given in the gynaecological, casualty, out-patients or other departments. This analysis showed that ether was used in 64% of cases while chloroform was used in only 21%. In 1899, when the use of chloroform was at its peak (24%), the number of anaesthetic deaths was also at its highest. During these years, there was a gradual increase in the use of A.C.E (alcohol, chloroform, ether) mixtures and also mixtures of ether and chloroform in other proportions, such as the one part chloroform two part ether mixture introduced by Bellamy Gardner (Assistant Anaesthetist to the hospital 1896-1898, and Full Anaesthetist 1899-1904).

Amongst the most famous of the early anaesthetists at CXH was Frederick Hewitt. He was born in 1857, and studied at Cambridge and St George’s Hospital, qualifying in 1883. He decided to specialise in anaesthesia, and was appointed Anaesthetist to CXH in 1884, the Royal Dental Hospital in 1885 and the London Hospital in 1886. In 1888, he relinquished all these appointments to return to his alma mater, St George’s. Hewitt was the author of a popular textbook entitled “Anaesthetics and their administration” published in 1893. In all, five editions appeared; the last in 1922. He administered an anaesthetic to King Edward VII on the eve of his coronation in 1902 for surgery for acute appendicitis, and was knighted in 1911. He is justly remembered for his pioneer work on the use of nitrous oxide,
emphasising that its use was possible without concomitant asphyxia. He taught that chloroform was especially dangerous during the induction period, and introduced ethyl chloride as an induction agent into this country. He designed or modified many pieces of equipment, including Junker’s chloroform inhaler and Clover’s ether inhaler (which he altered by enlarging the diameter of the central tube and allowing it to be rotated within the ether container). He died in 1916.

A name continually appearing in the list of staff anaesthetists is that of Braine. Woodhouse Braine was on the staff from 1874 to 1890. His stepson C. Carter Braine started his career as a surgeon, qualifying FRCS, but decided to specialise in anaesthesia and was appointed Assistant Anaesthetist to CXH in 1890, and full anaesthetist in 1891. In 1905 when he became the senior anaesthetist, a special position of Surgeon-Anaesthetist was created for him, a post he held until 1919 when he retired, after which he was ‘Consulting Anaesthetist’ until his death nearly twenty years later. The title of Surgeon-Anaesthetist was given to the Senior Anaesthetist until 1962 (the last holder being HK Ashworth), when the post was renamed Senior Consultant Anaesthetist or Chairman of the Division of Anaesthesia.

H. Bellamy Gardner, who was Assistant Anaesthetist to the Hospital from 1896 to 1898 and full Anaesthetist from 1899 to 1904, did much work on the scientific basis of anaesthesia. He was particularly interested in the use of mixtures of chloroform and ether in different proportions, and published many articles on this topic. Apart from his abilities as an anaesthetist, he had a reputation as a gifted literary person who led a wide social life. In addition to a textbook of anaesthetics, he contributed many articles to the Charing Cross Hospital Gazette on a variety of subjects such as stage and travel. During the 1914-1918 war when the staff of the hospital was greatly depleted by the calls of the armed services, he came out of retirement to return to the hospital to help make up the grave shortage of qualified and able anaesthetists at that time.

We are not sure whether there were junior anaesthetic staff, as up to 1903 it was the duty of the RMO and RSO to assist in the administration of anaesthetics, and indeed many anaesthetics were given by house physicians and surgeons. Most of these were later to become physicians or surgeons, and many were recorded as ‘assistant anaesthetists’. The first Assistant Anaesthetist whose duties were wholly confined to the administration of anaesthetics was Bernard E Potter, appointed in 1904. The last Assistant anaesthetist was Sidney Fouracre and the post was discontinued in 1919. Resident Anaesthetists were unknown in this hospital, as in most others until 1926, when the first, a Mrs DG Parsons, was appointed. In 1928 a post of Second House Anaesthetist was established, the first person to hold the post being a Miss Probyn. Anaesthetic registrars were not appointed until after World War II.

From 1867 to 1874, the anaesthetic staff consisted of one anaesthetist and by 1956 there were six. Until 1956, the Consultants were members of the Division of Surgery, and had therefore no means of independent approach to the Academic Board of the Medical School. Largely due to the efforts of HK Ashworth (‘The Brigadier’), the School Council approved the formation of a separate Division of Anaesthesia in June 1956; exactly fourteen days after Dr Ashworth had succeeded to the post of Surgeon-Anaesthetist. The first meeting of the division took place in October 1956. The next logical step was to obtain from the Medical School suitable accommodation for the Department, and premises were allocated in 1957 at 17-18 Henrietta Street W.C.2 together with the sum of £150 per annum for maintenance. The Department was formally opened by Sir Robert Macintosh, First Nuffield Professor of Anaesthetics in Oxford on October 8th 1957. Regular monthly meetings were held in the Department, which all members of the Department, both senior and junior, attended.

In April 1959, when CXH amalgamated with the West London and Fulham Hospitals as a preliminary step to the rebuilding of Charing Cross at Fulham, the membership of both the Division and Department of Anaesthesia was increased by the addition of one Consultant Anaesthetist from each of the constituent hospitals.

Acknowledgement

I would like to acknowledge the fact that much of this material was collated many years ago by the late Professor Cyril Conway.
This article was originally planned to cover the changes to the NHS Pension had the NHS Confederation proposals been finalised. As they haven’t at the time of writing this, I am (to mix my metaphors) going slightly off-piste and aiming to upset a whole load of apple carts, widely held beliefs and sacred cows. What follows applies not only to pensions but, to be frank, the investment world at large. If you own a pension where the outcome is dependent on how well the funds grow (e.g a SIPP or Personal Pension), this is essential reading.

Here’s the basic premiss. ‘Active’ fund managers (highly paid, very bright and on a billboard near you now), aim to beat the market. They see the market as a vast car-boot sale with bargains everywhere they look. By exploiting these ‘mispricings’ in the value of shares, rather like a car-boot punter finding an original Rubens on a stall for £0, they can achieve growth above the market rate of return. Because only they, as star fund managers, can do this, they can charge you a premium for being an investor in their funds. Their whole raison d’etre is based on the belief that markets are ‘inefficient’.

However, all the research seems to prove entirely the opposite. First, it only takes two people to create an efficient market. In my example above, you might get lucky and pay for the £0 Rubens before anyone notices. Chances are, though, that the local antique dealer would also be sniffing around the same stall, a bidding war would begin and this would continue until the intrinsic value of the Rubens was paid. Compare this to the capital markets, where millions of people participate in a globally connected network.

So, are markets totally efficient? Probably not, but even if there are some mispricings, research shows that few, if any, fund managers can exploit them consistently. An extreme view holds that 100 fund managers in one room would have about as much luck spotting mispriced securities as 100 orang-utans next door throwing darts at the FT. The Sandler Report, a Government driven survey of retail investments in 2002, suggested that the average UK Unit Trust underperformed the market by 2.5%, due to a combination of high charges and unsuccessful active fund management. It stated that the correlation between higher charges and better investment performance for UK Unit Trusts was at best weak. It further pointed out that a greater percentage of retail investment funds are actively managed than in the institutional market, despite the fact that institutional investors are better equipped to identify superior active investment managers.

So, if markets are to all extents and purposes ‘efficient’, what does this mean? First, it means that the markets assimilate all historical, present and predicted information about the price of shares, and thus by and large shares are correctly priced. The car-boot sale analogy having just fallen over, what does this mean for you as an investor? Firstly you have to redefine what ‘investment’ means. Many people see investment as a game (‘playing’ the stockmarket), or a bet (‘gambling’ on shares), or a war (‘beating’ the market). In reality, investment is a simple process of lending money to companies who make or do something with it and then pay you the market rate of return, which is yours for the taking. In pension terms it should be a successful investment experience leading to a well-funded retirement. There’s nothing
wrong with a bit of speculation on the side, but it shouldn’t be the main dish, unless you’re a complete investment-adrenaline junkie.

You need to realise you don’t have to pay a premium for active fund managers, given that it seems most appear to destroy rather than create value for investors. By using passive, asset-class funds that aim to capture the market rate of return, you can hugely reduce your fund costs. An Exchange Traded Fund (ETF) in corporate bonds, for example, will set you back about 0.2% per annum in running costs. A lower risk active ‘fund of funds’ from a well-known investment house will cost you, in comparison, 2.72% each year – nearly 50% of a typical 6% yield! They do have nice bill-boards, though.

The problem is partly that there is a long-standing symbiotic relationship between the vast majority of investment advisers and the fund management industry. Active funds are generally commission-loaded, both up-front and ongoing. Commission-based IFAs depend for their income on perpetrating the belief that they can pick the fund manager most likely to uncover the best bargains at the global car-boot sale.

A paradigm shift to fee-based financial advice means that this symbiosis is dissolved. Rather than listening to industry and press ‘noise’, advisers can work in a scientific, evidence-based way to create low-cost, massively diversified passive portfolios that aim to deliver market returns. As William Sharpe, the Nobel Prize winning economist wrote on Index Funds:

“In the long run this boring approach can give you more time for more interesting activities such as music, art, literature, sports and so on. And it very well may leave you with more money as well”

Conclusion

Asset class investing (not the same as index tracking, but related) is the best kept secret in the business. If it ever got out, people like me would write articles like this and the entire active fund management industry would fall over. Well, perhaps not, but if you want a successful investment experience you need to accept that there are no car-boot bargains, that IFAs and their clients are notoriously bad at picking the winners, and you shouldn’t listen to ‘noise’. After all, what was the biggest noise is recent history? Technology funds, surely. IFAs recommended them, the press enthused about them, and investors duly lost their shirts. Nice call.

Surveying a harbour full of beautiful boats owned by star fund managers, someone once asked the question “Where are the clients’ yachts?” Where indeed!

For more information contact Dr Mark Martin at markmartin@doctors.org.uk

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BRISTOL MEDICAL SIMULATION CENTRE
FORTHCOMING COURSES FOR 2006

- 30th & 31st March 2006, Transport of the Critically Ill Patient, for anaesthetists and EM staff (£275)
- 11th May 2006, NCCG Core Critical Incidents Course, for anaesthetists (£150)
- 12th May 2006, OSCE, for primary FRCA (£125)
- 24th/25th May 2006, Team Training for Critical Incidents, for all grades of anaesthetists (£275)
- 27th & 28th July 2006, Transport of the Critically Ill Patient, for anaesthetists and EM staff (£275)
- 8th September 2006, OSCE, for primary FRCA (£125)
- 7th & 8th December 2006, Transport of the Critically Ill Patient, for anaesthetists and EM staff (£275)
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All course fees are subject to VAT except where stated

Specific Departmental Courses can be arranged upon request (fee negotiable)

Includes coffee, tea, biscuits and lunch or afternoon tea. CEPD points approved; 5 pts (for 1 day) & 8 to 10pts (for 2 day courses)

For bookings please contact Gerri Whitrow, Centre Administrator, The Bristol Medical Simulation Centre, UHB Education Centre, Level 5, Upper Maudlin Street, Bristol BS2 8AE Tel (0117) 3420108, e-mail: gerri.whitrow@ubht.swest.nhs.uk or visit the website at http://simulationuk.com (This contains course details)
20th ANNUAL SCIENTIFIC MEETING

28th-29th JUNE 2006

THE BURLINGTON HOTEL
BIRMINGHAM

Programme to include:
General Anaesthesia in Ophthalmic Surgery
Back to Basics Guest Lecture – Occulopressure
Subspecialty Ophthalmic Surgery
Topics in Continuing Education Free Paper Prize
Topical Anaesthesia Debate Case Scenarios

Organising Committee:
Mr Ken Barber
Dr Monica Hardwick
Dr KL Kong

For more details e-mail: boas06@aol.com
Or Visit the BOAS Website : www.boas.org

Association of Cardiothoracic Anaesthetists / British Society of Echocardiography

There will be one sitting of the
Transoesophageal Echocardiography Proficiency Examination in 2006

Thursday 26th October 2006
(prior to the BSE Bournemouth meeting)

The 2006 Accreditation Pack can be downloaded from www.bsecho.org

Registration forms for the exam will be available to download in July and should be posted to:

The BSE Administrator
10 Greycoat Place, London Victoria, SW1P 1SB

Practical and Comprehensive Update for the General Anaesthetist

An intensive, practical and stimulating two-day national conference for busy, hands-on Consultant and Career Grade Anaesthetists

organised by Infomed Research and Training, on Monday 8 and Tuesday 9 May 2006
at The Radisson Edwardian Marlborough Hotel, 9-13 Bloomsbury Street, London WC1

About the conference:
A practical focus to maintain state-of-the-art knowledge of both the speciality and related disciplines that impact on it
Practical, hands-on sessions for delegates
Opportunities to discuss clinical problems with Consultants in a congenial atmosphere

Faculty includes:
* Dr Terry Hankin, Consultant in Anaesthesia and Intensive Care Medicine, Whiston Hospital, Merseyside
* Dr Mike Makris, Reader in Haematology and Honorary Consultant Haematologist, Royal Hallamshire Hospital, Sheffield
* Dr Anthony Wolff, Consultant Anaesthetist, ITU, Barnet Hospital
* Dr Daniel Lutman, Consultant Anaesthetist, Children’s Acute Transport Service, Great Ormond Street Children’s Hospital, London
* plus ten other leading, hands-on Consultants who are committed to and have a proven track record in the dissemination of Anaesthetic know-how to front-line Clinicians

Delegiate Rate
£550 for the two days.
£350 daily rate.

Topics include:
How to become famous in the NHS

From our correspondent Scoop O’Lamine

NHS Consultant lifestyle coach Dr R Slikker recently held a one day development workshop to explain his approach to becoming famous in the NHS, including how to radically improve the chances of receiving a Platinum award. During this workshop he launched in his new book “A Slikker route to fame!”

“Anyone can make it in the NHS, but by following my easy step by step advice, you will radically improve your chances!” Dr Slikker detailed his 10 year NHS fame framework:

Key recommendations

1. Get to know the NHS system – forget the NHS exists primarily for patients; it can be an excellent platform to further your career. Learn how to take advantage of the system.

2. Communicate graciously with all seniors, but in particular those on the CEA committees. The rest don’t really matter.

3. Get your name known. Find an aspect of your daily job in which no-one is interested. Ideally, this should be something that can be construed as involving Patient Safety* and that has never received high prominence in the medical press. Get together with 3 or 4 Multidisciplinary* colleagues and start a Specialist Society*, ensuring you are President. (Top tip – ensuring your other Executive members are not ambitious is vital here).

4. Register the Society with your Royal College or Association.

5. Release a statement to the Press about the Serious Risks* posed by your chosen area. Sign it as President of your own National Specialist Society. Copy this to the different Colleges, NPSA, MDUs, meeting organisers, other specialist societies. The wider the better.

6. Increase the membership of the society – this will cost a few drinks, but providing there is no registration fee people will join. Take anyone (i.e. multiprofessional*).

7. Produce a constitution, headed notepaper, website, 2 page newsletter and organise a meeting (ensure it is small).

8. Develop National Guidelines* and Good Practice* at your meeting and circulate as before. Place on website.

9. Write to neighbouring Trust (or any other) and let them know that you will be inspecting their service with reference to the National Standards*. Repeat this a few times, reporting findings to the SHA, Colleges etc.

10. Register your society with ACCEA as a nominating body and have yourself proposed for a higher award.

Repeat steps 5 – 10.

* Key words and phrases, guaranteed to impress the right people.

Many successful case studies were presented at the meeting, an example of which is shown below:

Case study

Mr Rodney Slyme has been following the Slikker principles for 12 years, and is the life President of BRACES – (British Rugby-Associated Cauliflower Ear Society). Mr Slyme explains “Before BRACES started, the management of this serious injury was non-standardised and haphazard. Now, thanks to my efforts, we have protocols in place for prevention, treatment and rehabilitation.” The NHS has now adopted BRACES guidelines nationally, thanks to the selfless effort of Mr Slyme.

When asked his secret for such rapid success in the NHS Mr Slyme said, “Get the book, and adopt a Slikker approach!”
Association of Anaesthetists of Great Britain and Ireland Guidelines – truly representing opinion?

Guidelines produced by committees with access to expert opinion should contain up to date and balanced advice. The AAGBI continues to produce multiple new and updated guidelines. Although broadly welcomed, perhaps inevitably these documents frequently produce debate, sometimes heated, amongst my colleagues. This is not necessarily to be viewed as a bad thing! However, it is recognised that committees may, by virtue of their authority, fail to reach a measured consensus with views polarising. In psychology, examples of this are ‘group think’ and ‘risky shift’; described following the Bay of Pigs/Cuban missile crises. The former may result in a committee recommending a particular course in order to preserve the integrity of the group. The latter phenomenon may result in the committee taking an extreme view; beyond that which any individual committee member would have taken alone. The presence of these influences may not be immediately apparent to the committee members. Although the AAGBI offers an opportunity for the membership (but not others) to discuss the guidelines after publication through the ‘doctors net’ organisation, I wonder whether with modern computer based communication the time has arrived for each working party to canvas opinion prior to issuing definitive guidance.

Dr F E Arnstein FRCA DAvMed
Consultant Anaesthetist
Western General Hospital
Edinburgh

Reply from Honorary Secretary

Dr Arnstein raises valid concerns and makes a useful suggestion regarding ‘canvassing’ opinion before an AAGBI guideline is published. AAGBI guidelines very seldom address direct clinical judgement – for example which drug or technique to use in a particular situation, and many are concerned with statements of what is considered current best practice in terms of staffing, equipment and organisation. What is not acceptable is often either explicit or implicit. Although there is often a considerable amount of time and effort spent by individuals looking at the literature, this is seldom in the manner of a systematic review as there is often little evidence from RCTs in the area chosen. The outcome of a working party’s deliberations may therefore be subject to the sort of bias mentioned. However, the final report from the working party is presented to Council of the Association who must formally approve the document before publication. This process can and often does result in significant changes being made.

This matter was mentioned in the ‘open forum’ at the Winter Scientific Meeting and one of the comments made was that the final draft of a guideline could be published on the website for (say) a month before being presented to Council for final approval. This would allow for critical comment to be taken into account. It was also suggested that the existence and remit of current working parties should be published on the website so that interested parties, whether members of the Association or not, could make comment and suggestions during the process. The Association website is currently being re-constructed and I anticipate that the above changes will take place in the near future.

Alastair Chambers

Syringe labels

In the March issue of Anaesthesia News, Professor Mike Vickers thought that an International Standard for Syringe labels was “as far away as ever”. He is too pessimistic; The International Standards Organization (ISO) accepted USER-APPLIED LABELS FOR SYRINGES CONTAINING DRUGS USED IN ANAESTHESIA as a new work item in 2005. The Australian Standard AS/NZS4375:1996 will probably serve as the base document.

The European Standardization Committee CEN/TC215 will consider whether this work item should be adopted in Europe as a Vienna Agreement/ISO lead project i.e. The ensuing ISO Standard will be adopted in Europe and published as an ISO.EN Standard. This is the likely outcome.

Ronald Greenbaum
Chairman ISO/TC121
**Compostable Packaging**

Barrie Phypers’ letter on Journal Wrapping has prompted a response. Brown paper envelopes are actually a very high energy, labour intensive resource, involving chopping down a tree, pulping it and bleaching it. Recycling of course will reduce the impact on the environment but it does not prevent the first tree from being chopped.

What would be much better would be to use compostable packaging – a starch based biopolymer which is in fact a by-product of the potato industry. The materials produced vary from cardboard like trays used for fruit/veg to what looks like your every day cellophane wrapping. The difference is that it can be put on your compost heap and 12 weeks later it has broken down and can be used in the garden. The down side of course is that it is more expensive to purchase but with less cost and negative impact on the environment. Recycling, whilst commendable, is also expensive and still contributes to global warming. Compostable packaging is produced by ‘Compak’ in Leominster.

Jane Bellamy
SpR Derriford Hospital, Plymouth.

**Midwives - a stereotype?**

Is the David Bogod who ridicules Dr de Quincy for putting back the cause of midwife-anaesthetist co-operation by about 15 years (letters March 2006), the same David Bogod who sends up the Royal College of Midwives by writing the following in the Daily Telegraph (24 Feb 2006): ‘It is not easy to come up with a single suggestion that falls foul of both patient autonomy and equal access, the holy grails of modern healthcare, but the Royal College of Midwives seems to have beaten the odds with its proposal to charge labouring women £500 for “unnecessary” epidural pain relief?’

From my perspective, Dr de Quincy and the D Bogod of the Daily Telegraph are the ones who have midwives rightly assessed.

Name withheld in the interests of fostering local midwife-anaesthetist co-operation!

**Journals of Ivan Ezegas**

*I just thought I would let you know how much I enjoyed the pennings of Ivan Ezegas in the March 2006 issue of Anaesthesia News.*

Don’t let him go off to Moldania. And do pay him a bit - so that he can supplement his locums.

Shreekar Yadthore
Research SHO - Anaesthetics
Cardiff

Alas Ivan is going home to Moldania for the summer. However, there is a good chance he will be tempted to return later this year. Ed.

**We all need a midwife at least once in our lifetime**

I was surprised by Dr de Quincy’s article ‘Midwives – what is it about them?’ (No.222 January 2006 Newsletter of the Association of Anaesthetists). I was surprised by its harsh unprofessional tone, and surprised too that the Association should appear to be endorsing such derisory stereotyping of a fellow professional group. I appreciate the article was intended to be humorous (at any rate, I hope this was its intention) but we should not forget that we all need the help of a midwife at least once in our lifetime. Unlike the author, obstetric anaesthetists have been pivotal over the years in developing a multidisciplinary approach to care during pregnancy. Articles such as this are not at all helpful, in fact they are embarrassing.

Dr R Marjot.
Consultant Anaesthetist
Royal United Hospital
Bath

SEND YOUR LETTERS TO:
The Editor, Anaesthesia News,
AAGBI,
21 Portland Place,
London W1B 1PY
or email: anaenews@aagbi.org
As a follow-up to last year’s telephone survey of overnight on-call room facilities for anaesthetic trainees in hospitals across England, Wales and Northern Ireland [1], GAT has, over the last few months, once again collected this data. The results are shown here by region with last year’s figures included alongside for comparison:

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<th>Region</th>
<th>Percentage of total (2005/6)</th>
<th>Percentage of total (2004/5)</th>
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<tbody>
<tr>
<td>North Thames</td>
<td>16.2%</td>
<td>12.5%</td>
</tr>
<tr>
<td>South Thames</td>
<td>21.9%</td>
<td>18.8%</td>
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<tr>
<td>Eastern (East Anglia &amp; Trent)</td>
<td>21.9%</td>
<td>11.1%</td>
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<tr>
<td>Thames Valley &amp; Hampshire</td>
<td>7.6%</td>
<td>0%</td>
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<tr>
<td>South West &amp; Wessex</td>
<td>9.1%</td>
<td>16.6%</td>
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<tr>
<td>Midlands</td>
<td>9.1%</td>
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<td>Wales</td>
<td>18.8%</td>
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<tr>
<td>North West</td>
<td>7.5%</td>
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<tr>
<td>North East</td>
<td>11.8%</td>
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<td>Northern Ireland</td>
<td>0%</td>
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<tr>
<td>London Rotations</td>
<td>18.8%</td>
<td>15.6%</td>
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<tr>
<td>Others</td>
<td>11.8%</td>
<td>4.9%</td>
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<tr>
<td><strong>Total</strong></td>
<td>13.7%</td>
<td>9.0%</td>
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A further 14.2% of hospitals nationwide have plans to remove at least one anaesthetic on-call room.

In all regions except the South West, the percentage has increased. The reason for the reduction in the South West is that in several hospitals, the SHOs are no longer resident overnight and so do not require a room. It is therefore now immaterial whether that room is there or not.

Once again there is a preponderance towards removing rooms in the South East and London rotations although, over the last year, the greatest increases have been outside London. Perhaps the capital’s bad habits are catching.

GAT stands by its view that overnight ‘on-call’ shift-working anaesthetic trainees must have individual rooms in which they can ‘power-nap’, ‘anchor-nap’ or just plain sleep if necessary [2]. These rooms must contain a bed. We do not accept the opinion that all trainees on night shift should be awake for the duration of that shift simply because it is now 12 or 13 hours long. To believe this would be to ignore circadian rhythms of activity and concentrating ability, as described in a recent Royal College of Physicians publication [3]. Crucially, this view also dismisses the fact that, with current shift patterns, some weeks will contain over 80 duty hours. Since the advent of shortened shift periods, trainees undertake significantly more travelling and need to be safe doing so. They also need to readjust to daytime work as soon as possible after nights in order to maximise learning opportunities. If those shifts are of light work intensity, it is madness to prevent doctors from sleeping. These views are echoed in the AAGBI publication, “Fatigue and Anaesthetists” [4].

GAT has raised its concerns by contacting national, local and medical press, all apparently so far to no avail. The greatest impact we have had has come from furnishing individual trainees and consultants with the relevant arguments, and it is no secret that you are more likely to still have on-call rooms if your department is supportive. We will continue to press this issue on your behalf, using the results of this latest survey.

There were two additional survey questions this year. The first related to juniors’ perceptions of the impact of the EWTD on their training. The vast majority stated they had noticed a significant drop in exposure to elective lists, including those supervised by a consultant. For those who had logbook data to hand, it would appear the reduction is in the order of 150–200 cases per year.

The second question asked if trainees had ever come into work when not rostered to do so, in order to increase exposure to either specific subspecialty lists, or for teaching sessions. In
an astonishing 13% of all hospitals surveyed, this was indeed the case. It would appear that trainees recognise their own inexperience and are taking measures to rectify this. Perhaps competency-based training and the EWTD are not so well-matched after all.

As before, comments by trainees paint the true picture:

**The Royal Surrey, Guildford (South Thames):** “We do 6 nights in a row, the rooms are now offices, we use the theatre coffee room chairs and the juniors’ office has a mattress.”

**UCH (North Thames):** “There were no on-call rooms on the plans for this new hospital so at least we’ve not been surprised. We use the mess or go to the canteen.”

**Anonymous:** “Management took our rooms away, but now we’ve got unofficial rooms, there are no signs on the doors.”

**Margate (South Thames):** “The rooms have been converted into a nurses’ changing room and offices. There are now 3 of us in sleeping bags on the floor in 1 room, it’s really unsuitable, especially when we have mixed-sex, on-call teams. The Regional Advisor visited and we complained but so far nothing’s been done. The department is not behind the juniors at all.”

**Anonymous:** “The department bought us collapsible beds when the rooms disappeared into offices, but management aren’t aware.”

**Wansbeck Hospital (North East):** “We use the sofa-bed in the Pregnancy Assessment Unit.”

**Northampton General (Midlands):** “We’re currently using an office as a napping area but there are even plans to take that away.”

**St Thomas’ (South Thames):** “When they built the new Evelina Childrens’ Hospital, there were no on-call rooms for us. The department have been fantastic, and there are now plans for a room in another block. In the meantime, we have to fight for a room in the adjoining ‘hospital hotel’, if there’s no key, we sleep on the table in the anaesthetic department.”

**Freeman Hospital (North East):** “There’s a lounge chair in the anaesthetic department but no post-call facility.”

**East Surrey, Redhill (South Thames):** “The Chief Executive said if anyone was caught sleeping overnight, they’d be disciplined. The night managers go round looking for sleeping doctors.”

**Hinchingbrooke Hospital (East Anglia & Trent):** “There’s one sofa in the mess, it’s first come, first serve. The house officers have arranged camping beds for themselves.”

**King’s Lynn (East Anglia & Trent):** “The SHO room has gone, they use a reclining chair in the anaesthetic office.”

**Leicester Royal Infirmary (East Anglia & Trent):** “They’ll give us a room somewhere in the Trust for £20 after a night shift, but not necessarily at your base hospital.”

**The Royal London (North Thames):** “They’ve moved the on-call room 3 streets away during ‘renovation work’. There was a security guard provided for escorting the on-call female doctors through the streets of East London, but that ‘gesture’ disappeared after a month, it’s not a safe journey at night.”

**Cardiff (Wales):** “We’re sleeping in chairs in the theatre coffee room, there are bedrooms available but we’re not allowed to use them.”

**Epsom (South Thames):** “One room was given to the second on-call ODP! It was reinstated after a fight, with the Clinical Director on our side.”

**Anonymous:** “We use the ODAs’ room on the quiet.”

**Glenfield Hospital (East Anglia & Trent):** “There’s a chair in the registrar’s room or else it’s the doctors’ mess with everyone else. We can request a room if we’re willing to pay for it. There’s really low morale here right now.”

**And on a brighter note:**

**Derby City General (East Anglia & Trent):** “I’ve seen the plans for the new hospital and there are on-call rooms on it!”

**Tunbridge Wells (South Thames):** “The department has represented us brilliantly, we’re to keep our on-call rooms in the new hospital.”

We hope you understand that in order to maintain anonymity for those departments and trainees who chose to confide their ‘off-piste’ sleeping arrangements to us, we won’t be publishing the full version of this survey’s results on the website.

**Chris Meadows**

**VC GAT Committee**

**PS: Don’t miss out on the big one – GAT Newcastle June 21st – 23rd.**

**References**

3. Royal College of Physicians, Working the night shift: preparation, survival and recovery. www.rcplondon.ac.uk/pubs/brochures/pub_print_WNS.htm
4. AAGBI, Fatigue and Anaesthetists. www.aagbi.org/guidelines.html
Crossword No 9
Compiled by Ranjit Verma

Across
2 Not very often (6)
5 Disrobe in Las Vegas? (5)
8 The big C at 23 degrees 27 minutes North perhaps! (8)
10 Indeed (2)
12 Kept in check (6)
14 Sinister (4)
15 Trash container (3)
16 A sport for mystic nags! (0)
17 Alternative (2)
18 A recent AAGBI glossy addresses this issue in theatres (10)

21 Each and all (5)
23 Duvet content (4)
25 Sparcity of movement, electrically speaking! (6)
27 Whatever (3)
28 Consume (3)
29 Amusing (3)
30 Sensory organ (3)
31 Second person pronoun (3)
32 Great grandfather of my nephew’s son (3)
33 A national daily (3)
34 Look (3)

Down
11 Acted as a baby-sitter (3)
12 Assonate (5)
13 Assign to a specific task (6)
14 Cerebrally unaware (11)
15 Kylie’s returning home? (10)
16 A reduced department for computer geeks? (2)
17 Postnatal in a tree producing region? (11)
18 Watery expanse (3)
19 Daft Leo surfaced from the deep! (7)
20 Even so (3)
21 Even so (5)
22 A repetitive toy (2-2)
23 Loan (4)
24 Loan (4)
25 Loan (4)
26 Sign of the infinitive case (2)
27 Whatever (3)
28 Amusing (3)
29 Amusing (3)
30 Sensory organ (3)
31 Second person pronoun (3)
32 Great grandfather of my nephew’s son (3)
33 A national daily (3)
34 Look (3)

Sudoku
from Ranjit Verma

Across
2 Rarely, 5 Strip, 8 Latitude, 0 So, 2 Reined, 4 Ugly, 5 Bin, 6 Gymnastics, 7 You, 32 Dad, 33 Sun, 34 See.

Down
11 Acted as a baby-sitter (3)
15 Kylie’s returning home? (10)
16 A reduced department for computer geeks? (2)
19 Daft Leo surfaced from the deep! (7)
21 Even so (5)
22 A repetitive toy (2-2)
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24 Loan (4)
25 Loan (4)
26 Sign of the infinitive case (2)
27 Whatever (3)
28 Amusing (3)
29 Amusing (3)
30 Sensory organ (3)
31 Second person pronoun (3)
32 Great grandfather of my nephew’s son (3)
33 A national daily (3)
34 Look (3)

April solution

Sudoku: 1 6 9 4 3 2 7 5 8
6 2 5 8 4 9 3 7 1
3 9 1 2 7 6 5 8 4
4 5 7 6 1 8 9 3 2
5 1 6 9 8 7 4 2 3
9 8 4 3 2 1 5 6 7
2 7 3 5 6 4 1 8 9

Solution

The solution for the crossword puzzle is as follows:

Across:
2 Not very often (6)
5 Disrobe in Las Vegas? (5)
8 The big C at 23 degrees 27 minutes North perhaps! (8)
10 Indeed (2)
12 Kept in check (6)
14 Sinister (4)
15 Trash container (3)
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Down:
11 Acted as a baby-sitter (3)
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26 Sign of the infinitive case (2)
27 Whatever (3)
28 Amusing (3)
29 Amusing (3)
30 Sensory organ (3)
31 Second person pronoun (3)
32 Great grandfather of my nephew’s son (3)
33 A national daily (3)
34 Look (3)
GAT 2006

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<td>Three days</td>
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For your registration book or further information, please contact Nicola Heard or Emma Hollington on 020 7631 8805/8 or email: meetings@aagbi.org
If you would like to become a member of the AAGBI, please contact our membership department on 020 7631 8801 or members@aagbi.org
“Record-breaking snowfalls – four feet in seven days!” Such was the early season buzz on the local TV stations. And luckily (or not as it turns out) I had managed to relocate an early December skiing trip booked in Lake Tahoe (where the resorts were closed due to lack of snow) to the high, cold and snow-laden Rocky Mountains of Colorado.

All went well until the final morning when a tumble on an easy groomed run projected me head-over-heels in what cognoscenti will recognise as the ‘wipe-out’. But instead of getting up and putting skis back on as usual, my left knee hurt, and I didn’t want to move it. This being safety-conscious North America, there was an emergency telephone 20 yards away across the piste, and the blood-wagon was summoned. In an extraordinarily short time the Breckenridge St Bernard arrived and I was whizzed down to the first-aid centre at the base.

Here I was faced with making the decision of whether to see a doctor or not, and considering I still didn’t feel like moving the knee, the thought of X-rays and a medical decision seemed comforting. Less reassuring, however, once I knew I had sustained a “nasty” depressed tibial plateau fracture, but it did cheer me to hear them say “Wow, you must have a high pain threshold!”. The stiff upper lip and all that.

I was taken by road ambulance to the brand new (“opened two days ago”) nearby private hospital, a startlingly expensive journey. The invoice for the eight mile trip was over $1100. The hospital looked like a new luxury hotel with glorious wood and slate in the public areas, vaulted ceilings, and beautifully appointed guest rooms. However, a six-hour wait in the Emergency Room before being transferred to the ward seemed reminiscent of more familiar hospitals closer to home.

The following day, four hours of surgery on my knee were deemed a great success, and the resultant x-ray made for a novel Christmas card. Alas for the anaesthetist. In an interesting twist on professional etiquette, I had three anaesthetic practitioners in total: a nurse who did my spinal (which didn’t work and needed conversion to a general anaesthetic), the Attending who left during the case to go to a staff party, and the next Attending who dealt with my intra-operative pulmonary aspiration, and who confirmed the constituents of the previous night’s pasta and sauce. Funny things happen to medics, don’t they, but maybe the stories about pain and opioids reducing gastric emptying really are true! And I have to wonder how useful that cerebral function monitor they put on me at the beginning of the case was?!

Post-operatively, it quickly became apparent that polished wood and beautiful slate do not a viable hospital make, and everything just about fell apart for lack of facilities, systems, or communication. It’s been a long time since I knew first-hand what ‘nursing care’ is supposed to mean, but in this hospital it didn’t stretch to (assistance with) washing or wound dressings (the ‘daily’ dressings were done once in five days). All rather Mediterranean in approach, where family and friends do the nursing and providing! Absence of basic equipment such as a commodes, shower stools, lidocaine jelly (a significant omission when it comes to urethral catheterisation for urinary retention), even litter bins of any sort, made it a difficult place to convalesce.

Hypoxia was the one major impediment to post-operative well-being, seemingly under-recognised by everyone, myself included. The hospital lay at an altitude of over 9000 feet, and the combination of high altitude, aspiration pneumonia, intra-operative haemorrhage and post-surgical catabolism undoubtedly affected my oxygen flux. No wonder I felt lousy, nauseous and breathless. Intermittent pulse oximeter readings varied between 84% and 97% saturation, but as soon as they approached anything like normal values, the oxygen prongs were whipped off. One would have thought that, as an anaesthetist, I would have realised what was going on and sneakily turned the flow-meter up rather than taking the oxygen off! But even the Cheyne-Stokes-like periodic breathing that woke me at night didn’t ring the right bell. Only after descending over 4000 feet to Denver for the flight home and feeling immediately better, did I realise the value of good, thick, fresh air. Or maybe it was just the sheer relief and joy of stepping out of adversity onto a British Airways plane, homeward bound!

A few thoughts persist - the insurance company was fantastic in dealing with the financial side of everything, and getting me home safely and efficiently. Frankly, the thought of being uninsured in the USA, with the immense financial and administrative burdens that could impose, is inconceivable. Secondly, one should not under-estimate the effect high altitude hypoxia makes in the recovery period – keep that oxygen going! And finally, beware the hospital that has just opened its doors, no matter how high the vaulted ceilings...

Paul Howell  
Consultant Anaesthetist  
St Bartholomew’s and Homerton Hospital, London
Research Methods Workshop for anaesthetic trainees

Wednesday 21st June and Thursday 22nd June 2006

The Anaesthetic Research Society and the University of Dundee are co-hosting a two-day seminar in generating and supporting successful research for clinicians, led by leading clinical and scientific researchers in their respective fields.

Day 1: Wednesday 21st June 2006 - Held in West Park Conference Centre, University of Dundee, Dundee. Topics addressed in lectures, tutorials and workshop format include: research governance - research design - ethics procedures - statistics - funding sources - protocol and study design - why do projects fail? Tutorials will be given by conference delegates presenting papers at the following day's ARS discussing their paper's genesis and progress.

Day 2: Thursday 22nd June 2006 - Join the Anaesthetic Research Society meeting at the West Park Conference Centre, University of Dundee as a conference delegate and observe 'state of the art' research presentations; discuss and critique them with your tutor during the afternoon session.

This meeting is suitable for clinicians interested in research and want updated in the many changes that have come in since 2004, as well as all grades of Anaesthesia, Intensive Care and pain management trainees - It meets RCA requirements for research competencies SpR 1&2.

Delegates are warmly invited to attend the Friday ARS sessions free of charge.

Fee £100 (covers course registration, lunches, ARS conference registration for Thursday 22nd June and refreshments).

Application forms available from:
Mrs M A Thomson, University Department of Anaesthesia, Ninewells Hospital, Dundee, DD1 9SY.
Telephone: 01382 632427  E-mail: m.a.thomson@dundee.ac.uk.
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Tel: 0114 2712510
Fax: 0114 2713771
E-mail: j.heppenstall@sheffield.ac.uk

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With 11 official languages, South Africa is a modern Babel.

I have recently returned from working as an anaesthetist in KwaZulu Natal where the main languages are English and Zulu. At least, that’s the theory. Unfortunately, at Edendale (a 900 bed township hospital) no-one seems to have told the patients that they speak English. So when I started last year it rapidly became clear that, unless I wanted to spend my days searching for elusive nurses to translate for me, I would have to get to grips with at least basic Zulu.

To begin with it didn’t appear to be too hard: clinic was *ikliniki*; theatre, *itheatre*; drugs, *amadrugs*, and so on. It all seemed fairly self explanatory. Even asking the anaesthetic nurse for *amafentanyl* had (kind of) the desired effect as she shoved a hand deep inside her ample bosom and retrieved a tissue-wrapped vial.

Then, however, came the clicks. C (as in *ncese*) is pronounced as a *tsk* sound with the top of the tongue on the front of the hard palate, Q (as in *qaphela*) is a harder sound made with the tongue on the back of the hard palate (as was beautifully demonstrated by the donkey in *Shrek 2*) and the X (as in Xhosa) is made with the side of the tongue on the inside of the molars to produce the noise people often make to horses. Eventually, after much patient tutoring from the nurses, I managed to get through most of the day without having to be dug out of a linguistic hole and without congratulating too many children on having been very ‘liver’ (*isibindi* does also mean brave but apparently the context is all important!).

A trip out of the hospital though was still a very different proposition. Using my Zulu in the supermarket would have involved asking the checkout girl to lie flat and relax and do all sorts of things simply not done at Tesco!

But things did improve and I still manage to practise with the Zulu nurses who are working over here. And if anyone is interested in learning a spot of Zulu, this is a good phrase to start with (just don’t forget the click on the C!): *Ngi cela ababini utshwala, unngani wami uzokhokha*: "Two beers please, my friend will pay".

Good luck.

**Hugo Wellesley**
Anaesthetic Clinical Fellow
Bristol Royal Infirmary.

Footnote:
There are two excellent films that have at least some Zulu in them: the 1960s film ‘Zulu’ gave Michael Caine his first big success and also starred the notorious Chief Buthelezi as the Zulu King; and ‘Yesterday’ which is entirely in Zulu, was nominated for an Academy Award this year for Best Foreign Language Film.
I was chatting up a urologist today. That may seem a strange thing to do; he had a beard as well, but this is the background. I left the Honkton Royal and am now doing a couple of weeks at Oakpark General (Purveyor of Fine Health Care to drunks, drug addicts and psychopaths, as well as members of the public, no trees visible). They have trouble recruiting top academic staff here. This is why Dr. Ivan Ezegas, FCAM, jets in from Moldania to help, moonlighting from his regular job as Deputy Commissar in the Gas and Vapours Administration Dept at Rovpol Municipal Lying-In.

At the Oakpark I keep the humdrum side of surgery ticking over. Mostly old ladies with broken hips. These cases don't excite the clever doctors but I like them. It seems there are hundreds of old ladies living around here with broken hips so, to keep the numbers down, it is normal to cancel cases because the blood tests aren't in, the potassium is too low, they have a murmur or the ECG isn't right. But I have found these things don't matter much. Either you can fix them right away or they can't be fixed. So I do them all. And the old ladies are so cheerful afterwards. Even the demented ones cheer up when something has been done. I wave at them through the glass in the ward. “D’you think he’s a Russian?”, they ask each other.

We don’t have these old ladies in Moldania. Perhaps they die young from being harnessed to bullock carts or else they have been rounded up and are all in a gulag somewhere.

It seems that top academics don’t want to be posted to Oakpark. Poor quality of life, run down area, bad schools, crime, violence, etc. No private practice. Apparently they prefer places like Hemel Hempstead or Southampton. It’s a bit rough where I stay. I don’t venture far at night. People shouting. So, for food, I keep a look out for undesirables and nip across the road (avoiding last night’s vomit) for a takeaway pizza from a nice Iraqi bloke. Speciality: American Extra Hot; no irony intended. The place I am staying in is just a box with a bed and a WC down the corridor. It stinks of cigarette smoke and other things from the previous occupant.

Looking after the bodily essentials and getting about are the main problems with this nomadic gasman’s lifestyle. Even though we Slavic hordes have invaded England and have our people everywhere, it is still every man for himself around here. Most hospitals have sold off their accommodation to private enterprise, so now if they need staff, they have to rent their own places back again. Comrade, if you ever thought that Government officials back home were lazy slobs, you try these privatised people! It would be nice to blame the one they call Blair for that but I have learned it was another one called Thatcher.

There was just a mattress on the bed, not even a sheet or a pillow so I had to raid the anaesthesia department on-call room and the hospital laundry for linen and blankets. The boss said this was OK because no one used the on-call room anyway. Rosters had changed. Getting out with my bedding was funny. They have a new hospital superintendent called the Chief Executive. He was having a crack down on fraud, theft and falsified time sheets. Cameras everywhere. So here was the anaesthetic department Clinical Director plus the new locum stealing hospital bedding – with the CCTV cameras rolling. Luckily it was part of a system, so no one was looking.

Anyway, back to the urologist: he was telling me about his yacht which he keeps moored at the local marina. Yes, there is one. All through the summer he goes sailing, and for the winter he told me about the assorted hazards and hardships of skiing holidays in the Alps. I began to understand about ‘poor quality of life’. I recommended he try the snow and accommodation around Magadan but I was more interested in the yacht. What about an invitation to join him this Summer? I hinted.

But it will not be. The seasons are moving on. Spring is coming and it is time for Ivan to set off on the annual gasman’s migration to summer pastures on the Steppe.