Scottish Standing Committee Stirling Meeting

The National Institute for Academic Anaesthesia

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ANNUAL CONGRESS 2008
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Abstracts are invited for oral or poster presentation at the Annual Congress of the Association of Anaesthetists of Great Britain & Ireland. There will be three separate sessions for oral presentation – for original research, audit and for case reports or case series. Please clearly mark which session you are submitting your abstract for. Papers accepted for presentation will be published in abstract form in the journal Anaesthesia*. Prizes will be awarded to the authors of the best free papers in each section, as judged by a panel of experts.

For abstract forms and further information, please contact secretariat@aagbi.org or 020 7631 8807/8812

Closing date for submission: 6th June 2008.

*The abstracts must conform to the journal’s usual ethical, methodological and statistical standards. Authors may be asked to make changes to their abstracts before publication.

The Editor-in-Chief reserves the right to refuse publication.
And so to Stirling. Neither gale force winds nor driving rain could deter dedicated anaesthetists from congregating in the conference centre for the Scottish Standing Committee’s 7th open day. Stirling has become the home of this meeting, no doubt because it is central and not in either Glasgow or Edinburgh. The Forth Valley tourist board tells us that the location has historical significance too. A river crossing, a natural gateway to the highlands and an ancient castle perched on a rocky crag in the heart of the city all mean that much history has flowed under the Forth Bridge. The castle may be strategically placed but it did not prevent it changing hands eight times during the wars of independence.

Change was in the air within the SSC. No bloody revolution here: more an orderly passing of the baton or insignia of office as we said goodbye to two of the founding committee in the shapes of Drs Jim Dougall and Neil Mackenzie who demitted office the day before the meeting to be replaced by Drs Matthew Checketts (Dundee) and Mike Fried (Livingstone). The outgoing members had between them held the Convenor’s chair for seven years and were warmly thanked for their contributions by Dr Kathleen Ferguson, the new convenor, as she welcomed the windswept audience at the start of the meeting. Kathleen cuts a slightly shorter figure than Neil and pointed out that the insignia went further south on her torso than it had on Neil’s. Nonetheless she promised to grow into it and the applause following indicated as much a vote of confidence as a message of goodwill.
Our first speaker was Dr Malcolm Booth, a consultant anaesthetist and intensivist from Glasgow Royal, who took us through the burgeoning field of difficult ethical dilemmas in ICU, and what help is available to resolve them. Difficult treatment decisions are not new of course, but they carry an extra layer of complexity if applied to a seriously ill, sedated, intubated patient in intensive care. The Incapacity Act has added the possibility of patients’ proxies in the shape of Welfare Attorneys, but for acutely ill patients such an option may not be feasible. There is still a role for the next of kin, although research suggests that surrogate decision takers are not much more accurate than doctors in determining what patients want, even with the full facts placed before them. Malcolm did wonder whether such theoretical considerations were common points of discussion between partners. Now here is something you could try at home. Snuggle under a warm duvet and as the lights dim, intone as follows “Darling, I was just wondering…” There will be prizes for the tersest replies.

Finally, Malcolm emphasised that the patients’ views are still paramount, even if they appear to us to result in questionable decisions. “There is no law against being stupid” he reassured one inquiry from the audience.

Our next speaker was Dr Jean Turner who has had more careers than most: anaesthetist, G.P., independent Member of the Scottish Parliament (MSP) at Holyrood, and now chairman of the Scottish Patient Association. During her stint as an MSP Jean had been drawn to a number of health issues and gave us valuable insight into how the parliamentary and government processes work. She indicated different ways a group can gain a handle on the levers of power within Holyrood. Public petitions do get noticed and sometimes a sympathetic (group of) MSPs will respond by setting up a cross party group which can apply pressure within the system. It’s easy to be cynical about politicians but in this forum they are seen at their best – doing their best for the disadvantaged.

Dr Nigel Harper’s talk on anaphylaxis was a masterly resume of the subject, incorporating both allergic and non-allergic forms. In the first category anaesthetic related drugs have “previous” as my favourite 1980s detective would say. Muscle relaxants and antibiotics are particularly prone to get your case off to a gut-wrenching start. The clinical picture is reasonably well known - unexplained hypotension, bronchospasm and vasodilation are the cardinal signs. Recognition should trigger a call for help, then note the time if you have enough sang-froid and initiate treatment with 50 microgramme aliquots of adrenaline. Locate the Association’s laminated guide for further management – every good anaesthetic machine should have one attached. After the initial management check the guidance for referrals for specialist testing. Nigel also drew our attention to the forthcoming anaphylaxis electronic database accessible through the Association’s website. We are urged to report reactions for national collation.

Ian Anderson, whose career as a stand up comedian is presumably on hold until he leaves medicine, talked us through the evolution of Emergency Medicine from Casualty via Accident and Emergency. Surgically trained, he voiced misgivings about the switch in the specialty’s name, the direction of junior training with special mention of acute common stem training and the well-kept secret that is the location of the College of Emergency Medicine (it shares a building with another august institution in Red Lion Square). Illustrating his point about the lack of specialty status, he regaled us with a golfing story in which he was drawn in competition against a consultant surgeon who responded by sending his registrar to stand in. Lest you think him a trifle curmudgeonly, he responded to a question by revealing that he claimed to know the good lord. Such is Mr Anderson’s status that I confess I was disappointed when it became clear he was talking about Lord Darzi. The other good Lord I suspect writes Ian’s scripts.

The post-prandial slot was given to the Association’s president, Dr David Whitaker. He pointed out that 2008 is
the 60th anniversary of the NHS (I hope its lifespan is not measured on the human scale). He also updated us on a variety of future events and drew our attention to the fate of two departed ministers from the Department of Health, Patricia Hewitt and Lord Warner. Both have rejected the chance to spend more time with their families and have become paid advisors - you've guessed it - to the healthcare industry!

Following that we had our open forum, a chance for the audience to seek wisdom, voice concerns or ride their hobbyhorses on subjects of their choosing. Our new Convenor acted as ringmaster and kept good order as our panel comprising Drs Whitaker, Chambers and Robb gazed into their crystal balls to see how anaesthetic departments might look in the next five years and how to plan the workforce. As a wise head said only the previous day, the NHS has never been planned properly, so it is unrealistic of us to look too far forward. One question which caused grey, thinning heads to perk up was identifying the appropriate age to cease on call work. Sadly there is no agreed answer; it has to be negotiated within each department. There was just the suggestion of shoulders sagging.

Change was very much the theme for our last two speakers. Professor Philip Cachia brought us up to date with MMC and all its works. His approach was to cover three aspects, namely the regulatory framework, the Government response and the strategic delivery. Like a rock climber scaling a difficult traverse he moved carefully and purposefully through a morass of reports allowing us a clearer view of our progress so far.

There is still work to be done before this peak is scaled, not least a government-led dialogue on the “Role of the Doctor.” However, if the initial response is any gauge, the Tooke report will figure largely in any reorganisation. If you have a sense of deja vu it is because it recommends three early years for “core specialty training” – did anyone mention SHO’s?

Our keynote speech was entitled “Delivering Revalidation” delivered by Sir Graeme Catto, President of the GMC. He looked remarkably well for someone who is supposed to have sipped from a poisoned chalice. Fluent and lucid, he made a complicated subject clear. Revalidation will have two strands. Relicensing will be for all doctors, based on the principles enshrined in Good Medical Practice with components of CPD and 360-degree appraisal included. Recertification, whether for specialists or GPs, will be judged against standards agreed by the Royal Colleges, a major task indeed. It is hoped there will be UK-wide agreement and implementation, with the Scottish government making positive noises on that score. A couple of questions brought reassurance from Sir Graeme. Complaints will be dealt with more speedily keeping distress to a minimum and the local process will be overseen by the Medical Director's office and not a “GMC Affiliate”. The meeting ended in traditional fashion with Kathleen Ferguson making a presentation to Sir Graeme, amidst a sea of flashlights.

The meeting was a great success and our thanks should be directed to its organiser - Dr Alistair Michie.

Some things of course don’t change: outside the weather had got worse.

Gavin Gordon
Secretary, Scottish Standing Committee
The establishment of the National Institute for Academic Anaesthesia was announced in March this year. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) and The Royal College of Anaesthetists (RCoA) believe that this represents a major development and opportunity for anaesthesia and its related specialties. This article, which is being published simultaneously in AAGBI’s Anaesthesia News and the RCoA Bulletin, explains the reasoning behind the creation of the National Institute for Academic Anaesthesia and what this new organisation hopes to achieve.

Many of us remember when most major anaesthetic centres had a large and vibrant academic setup; University academics, NHS consultants and trainees were actively involved in research and published their work widely. This activity had significant impact on the safety and patient experience of anaesthesia and its related specialties, and ensured that academia in its widest sense was embedded within our profession. Unfortunately, the last decade has witnessed a catastrophic decline in University and NHS-based academic anaesthesia in the UK. We are not alone, other specialties have suffered a similar fate; however, several factors have conspired against anaesthesia to make the situation particularly grave.

The backbone of anaesthesia research at that time was clinical investigations. However, university academics engaged in this work began to find it increasingly difficult to thrive in an environment dominated by a new Research Assessment Exercise that rewarded universities who were engaged predominantly in laboratory-based research funded by organisations such as MRC and Wellcome. Clinical research became regarded as soft and received scant recognition. Subsequently, many academics ditched clinical research and dived into the laboratory seeking an anaesthetic slant to locally available basic science themes. Some were, and continue to be, very successful; however, many were not. At the same time, the administrative hurdles to performing clinical research began to mount and eventually became almost insurmountable. Furthermore, anaesthetic trainees, who were essential members of the research team, found commitment to research difficult because of the new rigid training schemes and decline in numbers of potential supervisors.

In response to this situation, the RCoA published its National Stategy for Academic Anaesthesia (www.rcoa.ac.uk/docs/Academic_full.pdf). The working party responsible for the report was very thorough in the work that underpinned its conclusions and recommendations. It sought advice from national academic bodies including the Council of Heads of Medical Schools, the Medical Research Council, Wellcome Trust and the Department of Health (Research and Development). The report confirmed the decline of academic anaesthesia and made numerous recommendations, including the establishment of a National Academic Institute. In my opinion, the most striking fact that emerged from the
Various meetings and discussions that accompanied the report’s publication was that it was absolutely clear that it was the view of many influential national academic leaders and organisations that UK anaesthesia had no academic profile, was fragmented, had no strategy and was almost irrelevant to the health of the nation. This is serious stuff; if anaesthesia is perceived to have no academic base, anaesthetists could readily be regarded as a group of technicians not on a par with other specialties. This despite the unrivalled contributions we have made, and continue to make, to the development of modern healthcare.

A National Institute for Academic Anaesthesia could play a major role in correcting this damaging perception.

Another important consideration is that the recommendation to establish a National Institute came at a time when there were signs that the tide of decline of academic medicine was beginning turn. For example, the new NHS Research and Development Strategy emphasises the importance of good quality clinical research (see the National Institute for Health Research: www.nihr.ac.uk) and established numerous funding mechanisms and infrastructure for its support. In addition, the decline in the numbers of clinical academics in training was finally recognised and the Walport scheme for specific clinical academic training was introduced. The potential benefits of these and other developments have been debated vigorously but there is no doubt that they represent a potential life-line. A National Academic Institute could assist our profession in taking full advantage of them.

The National Institute for Academic Anaesthesia is a joint venture between the RCoA and the AAGBI and has now been established within the RCoA. Its vision is, with respect to anaesthesia and related specialties, to: (i) develop and maximise its academic profile within the healthcare profession, NHS, Universities and major research bodies; (ii) facilitate high profile, influential research; (iii) facilitate and support training and continuing professional education in academia; and (iv) improve patient care by promoting the translation of research findings into clinical practice. Clearly, research is a key issue but the Institute will be involved in facilitating all aspects of academic activity.

Research affairs will be governed by the Institute’s Research Council which is already active. The initial funding partners in this endeavour are the AAGBI, RCoA, the British Journal of Anaesthesia and Anaesthesia. Its agreed aim is to provide co-ordinated research support and rapidly work towards the development of a national strategy for anaesthesia research. It is important that this body becomes recognised by the NHS National Institute for Health Research in order to attract support funding from new NHS R&D funding streams and work is ongoing to achieve this. Changes in the mechanism of applying for research grants from the AAGBI, Anaesthesia, British Journal of Anaesthesia and RCoA have already taken place. These grants will be advertised, assessed and awarded by the National Institute’s Research Council utilising a rigorous, competitive, peer review process.

Another priority for the National Institute for Academic Anaesthesia is academic training. It is vital for all anaesthetic trainees in Walport posts to be successful and the Institute is committed to supporting their training in any way possible. Additionally, we believe that it is also important to support non-Walport trainees who are keen to get involved with research and we are exploring how this can be achieved.

Several other work-streams are presently ongoing. It was important to establish the Institute rapidly and this has been achieved with the involvement of a relatively small number of stakeholders. For its vision to be fully realised, it is essential for the Institute to invite the full participation of other partners, especially the specialist societies within our profession; we are now actively involved in this process. In an attempt to identify important nationally fundable areas of research, the Institute has launched a research priority setting exercise that will seek and explore the views of the profession as to the most important unanswered questions in anaesthetic practice. In addition, the Institute is now engaged with the MOD in planning the development of academic activities within UK military anaesthesia. Numerous other projects are under consideration.

The National Institute for Academic Anaesthesia is not the only remedy to reverse the decline of academia in our profession; however, it is a major and imaginative step forward. It exists to assist the work of any anaesthetist undertaking academic activity in the UK, facilitate academic training and represent our profession at a national level. The agenda is huge and to succeed it will need the support of anaesthetists nationwide. If you have any thoughts on potential work-streams for the Institute or wish to be involved in its work, please do not hesitate to contact us.

Prof David J Rowbotham
Council Member, AAGBI
Board Chairman, National Institute for Academic Anaesthesia
We invite you to join us for the Improving Surgical Outcomes Group's (ISOG) Annual Update

Wednesday 2nd July 2008, 17.30 -19.00
(in association with BAPEN, The Association of Surgeons The Intensive Care Society & The Association of Anaesthetists)

- The new guidelines on peri-operative fluid management will be presented for discussion.
  Jeremy Powell-Tuck (Chair, BAPEN Medical) with core writing team
- The group will also discuss new guidelines on admission to ITU post-operatively
  Jim Down (on behalf of the Intensive Care Society) with core writing team
- And - progress with "Fast Track" surgery programs
  AJ Windsor with colleagues from other units

Places are **FREE** but limited and can be secured via

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Both documents are available on-line

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THE GREAT FLUID DEBATE
A state of the art review of plasma volume expanders and fluid management

Chairman:
Prof Moritz Mythen (University College London, UK)
Prof Mike James (University of Cape Town, RSA)
Dr Tony Roche (Duquesne University Medical Center, USA)
Speakers include:
Prof Joachim Boldt (Germany) Dr Peter Gosling (Birmingham)
Mr Dileep Lobo (Nottingham) Prof Jeremy Powell-Tuck (London)
Prof Andrew Levington (Leeds) Prof Gordon Carlson (Manchester)

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Call for Abstracts ~ £1000 in Prizes
We invite you to submit work for poster presentation. Accepted abstracts for poster presentation are entitled to a £100 discount on registration and selected finalists will be invited to give an oral presentation at the 10th Dingle Conference on Friday 10th October 2008. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 30th June 2008. Abstracts should be emailed in the form of one
The full impact of the European Working Time Directive (EWTD) is almost upon us. From August 1st 2009, this Europe-wide, European Union Health and Safety legislation will introduce a maximum 48-hour working week for all doctors. Currently doctors in training are regulated by EWTD legislation to having a maximum 56-hour working week.

The original legislation, including timescales for implementation, dates back to 1993 but was only adopted by the UK in 1998. In relation to the working arrangements of doctors, provision was specifically made that deferment could be sought by governments of individual member states to extend the timescale of the directive implementation to 2012 for doctors in training. If granted, any derogation would allow an interim 52-hour maximum working week between 2009 and 2012. It is thought that the current Labour government has no plans to apply for such derogation, but no official statement exists. The Conservative Party, however, has indicated that they may apply for derogation if elected in the interim.

**Contentious issues**

**The opt-out:** This is a measure which allows workers to agree to opt out of the 48-hour week. Employers in a number of states make use of the opt-out, but it is most widely used in the UK and Malta.

**Time spent on call:** The European Court of Justice (ECJ) has ruled on two occasions that on-call time for doctors should count as working time, which has left many countries struggling to keep doctors' average weekly working hours below the agreed limit. These two rulings were known as the “SiMAP” and “Jaegar” rulings. As a result of these judgements, staff who are required to be resident in hospitals or other places of work out-of-hours, and who are provided with on-call facilities, are considered to be 'working' during their period of duty. The whole of the resident on-call period counts as working time whether or not the member of staff is actually working. In order to meet the rest requirements of the directive, many doctors have migrated to working full-shift patterns where they are expected to “work” for all of their duty period (usually 12 – 14 hours) and indeed not rest on duty within the hospital – since rest is legally working time.
What else does the Working Time Directive do?

Among other things, it guarantees at least four weeks paid annual leave; a minimum period of 11 hours rest every 24 hours; one day off per week; a rest break if the working day is longer than six hours; a maximum of eight hours night work, on average, in each 24 hour period, and health assessments for night workers.

What will happen to the opt-out?
The European Commission is reviewing whether to allow the opt-out to continue, although it has suggested measures that would make it harder for employers to press staff into working more than 48 hours against their will. However, some countries want this option to be phased out, as does the European Parliament. Other states, in particular the UK, want it to continue. They argue that labour market flexibility helps reduce unemployment. The UK does not have a veto in this area, so could be outvoted, but so far support from Germany and Poland has helped the opt-out remain viable.

What about time spent on call?
The European Commission proposed making a distinction between "active" and "inactive" time on duty. Inactive time on duty would not count as working time. Most countries agree with this, but the European Parliament does not. The Parliament does suggest that inactive time could be calculated differently, but no firm decision has as yet been made. An eagerly awaited report from the European Ombudsman may influence the continuing debate on the opt-out and time spent on call.

At this time, 25 out of 27 EU member states are failing to meet the requirements of the legislation; therefore a huge challenge is ahead to have the directive implemented in full by the 2009 deadline.

In England the latest figures available (September 2006) indicate that 59% of junior doctors were being paid Band 2 salaries, therefore were working in posts with duty hours over 48 hours duration which are not 2009 EWTD compliant.

European Ombudsman

In 2007 a report was issued by the European Ombudsman which heavily criticised the European Commission for failing to take action on the issue of working time. The report specifically concerned a complaint that was submitted by a German doctor who was unhappy with the fact that EU member states were not implementing the (ECJ) rulings on working time.1 The issue has now been taken up by the European Parliament’s petitions committee who will provide a non-legislative opinion on the matter. This report will be debated in the European Parliament over the next six months with a final version due to be published in July. The report will not carry any legal weight but is an interesting indication of the political atmosphere surrounding working time and the intense pressure from MEPs and other stakeholders to find a solution to the problem.

The Portuguese Presidency in 2007 presented a compromise text, similar in content to previous texts, which aimed to maintain the opt-out (under strict conditions) and to overturn the ECJ rulings on on-call time (SIMAP and Jaeger rulings). At a Council of Employment Ministers meeting on 5-6 December 2007, EU Ministers debated the package but were unable to reach agreement. In EU terms, the decision has been ‘postponed’ and the official minutes of the meeting suggest that both member states and the European Commission are keen to continue negotiations under the 2008 Slovenian and French EU Presidencies.2 This means that, for the time being, the status quo will prevail and that the ECJ rulings on on-call time stand and must be implemented. In the interim period the European Commission planned to launch infringement proceedings against all 25 member states who do not implement the ECJ rulings in full. The UK is one of these countries and argues that implementing the rulings in the medical sector would cost the NHS £250 million annually.

If further negotiations are carried out in 2008 and an agreement finally reached, it is important to remember that this will not be the end of the political process. In the event of an agreement, the dossier will need to return to the European Parliament for a ‘second reading’. MEPs are unlikely to endorse an agreement which maintains the opt-out and which over turns the ECJ rulings. By thus delaying the procedure, the dossier may well fall foul of the European Parliament elections scheduled for June 2009. The newly elected MEPs will have the right to return to a ‘first reading’ on the EWTD and to effectively re-start the whole process.

It now remains to be seen whether the European Commission will start the infringement proceedings in early 2008. It is under intense political pressure both from the European Ombudsman who wishes the ECJ rulings to be implemented and from member states who do not wish to respect the rulings.

Peter Maguire
Consultant Anaesthetist
Newry

References
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The Association of Anaesthetists of Great Britain and Ireland is looking for a Deputy Editor-in-Chief to assist the Editor-in-Chief in the period leading up to the end of his term of office, and with a view to taking over the role of Editor-in-Chief in Autumn 2009 (subject to approval by the Board and election by Council of the Association of Anaesthetists of Great Britain and Ireland).

The successful applicant must be highly self-motivated, be able to work to strict deadlines, have a strong publication history and be able to write coherent and elegant English. Significant previous editorial experience for a major scientific journal is essential, as is a strong history of acting as an assessor / referee for manuscripts submitted to peer-review journals.

The Editor-in-Chief typically works for 15-20 hours per week managing the journal, assisted by a part-time Editorial Assistant and (currently) eight Editors. In addition, the role involves close co-operation with the publishers, Wiley-Blackwell, and attendance at regular Board and strategy meetings.

The Association of Anaesthetists of Great Britain and Ireland supports the post with office set-up and maintenance costs, editorial assistant salary, one ‘PA’ paid to the incumbent’s main employer, and an annual honorarium. The Editor-in-Chief is a member of Council and an Executive Officer of the AAGBI and, as such, is expected to attend the regular meetings of the Executive, Council and of some of its committees and subcommittees.

Applicants should submit a curriculum vitae by e-mail to the Editor-in-Chief at anaesthesia@nottingham.ac.uk, with the following headings:

- Publications
- Previous editorial and assessor experience
- Professional areas of interest
- Summary of current activities

Following short-listing, successful candidates may be invited to interview in London by an Advisory Appointment Committee.

Please direct any queries for further information to the Editor-in-Chief at the above e-mail address. The closing date for applications is Monday, 2 June 2008.
Recent incidents involving electrical power supply failure to anaesthetic machines have come to the attention of the public. In some of these the failure was deliberate but, in the vast majority, power cuts, failure of back-up equipment, or accidental damage was the causative factor. Information provided by anaesthetists practising in the UK would lead us to believe that mains supply power cuts in UK hospitals are common, occurring at least once per year in more than 50% of hospitals. Many of the anaesthetic machines currently in service use an integral battery as a backup power supply for such emergencies, but it is apparent from the case reports that not all machines have this facility - a survey of anaesthetists in 2005 indicated that 20% of anaesthetic machines in the UK do not have a battery back. It is also apparent from the reports that the duration of the backup supply is frequently not as long as might be anticipated.

Different battery types are available for use in anaesthetic equipment. These include lead acid, lithium ion, nickel cadmium (NiCad) and nickel metal hydride (NiMH). The nickel-containing batteries offer a good power-to-weight ratio but have the disadvantage that they self-discharge and suffer from an internal “memory”, i.e. their functional capacity is related to the extent of their last charge. Therefore, they are not ideally suited to machines that are on continuous charge and are generally restricted to smaller items of equipment such as infusion devices. Lithium ion batteries have a relatively high capacity but are very expensive and have a limited shelf-life, even when not in use. The vast majority of manufacturers fit lead acid batteries, which are bulkier and heavier than the alternatives, in their anaesthetic machines. Lead acid batteries, although suitable for continuous charge/discharge cycles, have a finite life and suffer from an ageing process. Typical examples are claimed by the manufacturers to have a five-year life with an effective power capacity of one hour, but this figure is variable and unreliable. A recent case report found a three-year-old battery to have a charge capacity <10% of that claimed when new. The degree of battery charge will also depend on the duration of the charging process. A typical lead acid battery requires a minimum of 14 hours to recharge fully – any interruption to this charge time, such as unplugging the anaesthetic machine from the mains supply at night, will subsequently decrease the available backup charge. Most batteries do not have a “fuel gauge”, so unless it is known that a battery is new and fully charged, it is not possible to predict how long it will last. Frequent battery capacity tests cannot be recommended as a means of improving reliability as they would result in increased “downtime” for anaesthetic machines.
Backup batteries are generally described by the manufacturers as a “fail-safe mechanism” and intended to power the ventilator through a brief interruption to the mains supply or to allow an ordered shutdown in the event of a complete supply failure. They are not intended to power the anaesthetic machine for prolonged periods. Electrical power supply failure should not result in an interruption to the anaesthetic gas supply from the machine.

Recommendations:

1. All anaesthetic equipment should be checked before induction of anaesthesia in accordance with the AAGBI Guideline “Checking anaesthesia equipment” (http://www.aagbi.org/publications/guidelines/docs/checking04.pdf).

2. Anaesthetic gas supply from an anaesthetic machine should not be affected by an electrical power failure. If it is, it should be reported to the local Medical Physics Department (or equivalent) and the machine should not be used until the fault is corrected.

3. Medical equipment that has been dropped or damaged must NOT be used until it has been inspected and repaired by the Medical Physics Department.

4. In the event of a mains power supply failure, the backup battery should be used solely to allow time to transfer the patient to an independent anaesthetic breathing circuit and monitors. It should NOT be used for the maintenance of anaesthesia.

5. Where an anaesthetic machine has provision for an integral backup battery, the age of the battery should be checked at regular intervals. Some departments now recommend the replacement of lead acid batteries every two years.

6. Equipment manufacturers should be alerted to problems with backup batteries.

Les Gemmell
Ian Johnstone

TRAVEL GRANT

The Travel Grant is aimed at those undertaking visits in Great Britain and Ireland or overseas which include teaching, research, or study.

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RULES: There is no deadline for the submission of entries and theoretically there is no limit to the number of travel grants that may be awarded. However, grants will not be considered for the purpose of taking up a post abroad, nor for attendance at congresses or meetings of learned societies. Exceptionally they may be granted for extension of travel in association with such a post or meeting. Candidates should indicate the expected benefits to be gained from their visits, over and above the educational value to the applicants themselves.

For further information and an application form please visit our website: www.aagbi.org or email secretariat@aagbi.org or telephone 020 7631 8807.

Application forms should be forwarded to HonSecretary@aagbi.org and a signed hard copy posted to: The Honorary Secretary, 21 Portland Place, London, W1B 1PY

INTERNATIONAL RELATIONS COMMITTEE (IRC) FUNDING

The IRC considers applications from members who are seeking funding for projects usually, but not exclusively, in the developing world.

The project must have a strong relationship with anaesthesia or one of its associated disciplines. Higher priority will be given to small projects which can demonstrate efficient use of funds. Applications to fund equipment purchase must be supported by evidence that the environment and training of local staff is adequate to support appropriate use. Those awarded grants will be expected to provide a report to IRC. If a project lasts more than six months, reports will be submitted to IRC at intervals of not more than six months in addition to the final report.

For further information and an application form please visit our website: www.aagbi.org or email chloesmith@aagbi.org or telephone 020 7631 8807.

Application forms should be forwarded to HonSecretary@aagbi.org and a signed hard copy posted to: The Honorary Secretary, 21 Portland Place, London, W1B 1PY
Last year I attended Stanford University Hospital as ‘Visiting Clinical Instructor’ in Adult General Anaesthesia. With the changes in the UK health service over the last few years I thought it would be beneficial to work in a completely different health system for a year and see things from a different perspective.

The first thing that strikes you as you approach Stanford University Hospital Medical Centre (SUMC) is the beautifully laid out gardens and fountains. You continue walking, passing the valet parking for patients and visitors. You then enter through the electronic sliding doors into an airy hallway, then along the corridor, past the souvenir shop. Yes – the souvenir shop! It then strikes you that you are really in another world - the world of US medicine where first impressions count.

SUMC is situated in Palo Alto in California, approximately 25 miles south of San Francisco and it is part of the 8180 acre campus of Stanford University. It is a university hospital treating a wide variety of patients including private patients and those on Medicare (essential health care for the over 65s, paid by taxes) and MedicAid (essential health care for low income families).

Stanford University Medical Centre is a 612 bed tertiary referral hospital. It carries out all adult surgical specialties including neurosurgery, cardiothoracics and transplants. The anaesthetic department is a large one – and it needs to be! There are over 60 faculty members, 40 fellows and 60 residents. Over 16,000 operations are performed each year not including anaesthesia coverage in MRI, radiology, obstetrics, the emergency department etc. Pretty much every specialist procedure you could think of is done here, providing a potential wealth of experience.

Anaesthesia training is very different here. Medicine is a postgraduate degree which takes four years. After that there is one-year internship, similar to our old ‘houseman’s’ year. Then there is a three-year residency programme, after which you have completed your training. There are no fellowship exams as such: board exams can be taken at the end of residency but are not essential to start work as an attending anesthesiologist (equivalent to a UK consultant). Once you have completed your training you can go into private practice, university medicine, or undergo additional fellowship training in a subspeciality such as cardiac or paediatric anaesthesia. The residents are very aware of how short their training is and so work very long hours and are desperately keen to be involved in any interesting case. They do on average 600 anaesthetics in their first year, and 400 in each of the second and third years. This also means the simulator (Anaesthesia Crisis Resource Management) plays a very important role in their training.
There are opportunities to do specific fellowships in obstetrics, regional anaesthesia, paediatrics, cardiac etc. However it was possible to work in the general OR with emphasis on a specific topic. I took the opportunity to develop an interest in orthopaedics, so I could improve my knowledge in a specialist area while still expanding my skills in other areas.

The normal working day is 6.30am to 5pm – making long days, plus on-calls which are still 24 hours. No European working time directive here. However you do get paid ‘incentive time’ when your list over-runs or when you work late on call. The payment increases after 11pm and also when you are running 2 rooms. This extra pocket money made long on-calls much less painful!

The working pattern was very flexible, requiring you to work an average of 16 days per month, but you can work more days one month and less the next. This works well being a tourist, as there are ample opportunities for long weekends away. California has lots to offer and there are amazing places to visit less than half a day's drive away such as Yosemite, LA or Napa. It is possible to be watching 30-foot breakers with sea otters and grey whales in the morning and then catch the last lift up Heavenly Mountain to overlook the Nevada desert & Lake Tahoe before snowboarding back down, all in one day.

**Daily Life:**

Patients would usually be seen in the anaesthesia pre-operative assessment clinic a week before their scheduled surgery date. This would mean that on the day of surgery all the results of their blood tests, X-rays, echos etc. would be available. Patients were prepared for theatre more quickly on the day, improving efficiency. It also meant that you very rarely cancelled a case. However, as there are many different ways of giving an anaesthetic, patients frequently came in with expectations slightly different from your plan.

The night before your operating list, your resident(s) would find the patients’ notes, test results etc. They would then telephone you to discuss the cases and plan for the next day.

The day would start early at Stanford - the first patients of the day would be in the hospital by 5.30am to be checked in to the surgical admissions ward, minimising delays at the start of the list. I would be in the OR by 6.15 am. The first job of the day was to check (and gather) equipment & drugs. There were no ODAs or anaesthetic assistants.

At 6.45 I would meet my first patient of the day to revisit their histories and amend plans if necessary. It was quite disconcerting at first to be meeting patients for the very first time literally minutes before I was about to anaesthetise them for major surgery. It was very rare for someone to be admitted the night before their surgery. I would either be running one room – which could mean working alone or with a resident; or two rooms with one resident in each (a very busy day!) As yet Stanford has avoided employing Nurse Anesthetists, but I believe they may be in the near future.

At 7 am we would wheel our patients to the Operating Room. This was a job done purely by the anaesthetists, as there were no theatre porters. Some of the larger beds with traction devices attached were really quite challenging – I still have the bruises to show for it!

There was no anaesthetic room so the patient was taken straight into the operating room and positioned on the table (a definite advantage for the many bariatric cases). While this was going on the trays and equipment would be counted in the background, a change from the tranquility of the induction room.

Once we had connected all the monitors, the patient was induced. The circulating nurse could apply cricoid pressure and pass you things if necessary, but
very little else. If you were working alone you needed to be very organized, having everything you could possibly need to hand – from the eye tape to the fibreoptic scope! If you were working with a resident generally you became their assistant, and if you were running two operating rooms simultaneously you needed to be more organized than I had ever thought possible. Although it was tough at first it was amazing how quickly you got used to it.

Once both rooms were started it was a good time for a coffee. With such an early start it was good that the department supplied breakfast. Over a toasted bagel I would informally catch up with colleagues or one of my mentors and discuss interesting cases. Then it was time to do some teaching! As a Clinical Instructor part of my job was to spend a minimum of 20 minutes with each resident to discuss a topic. The residents were very keen and had usually prepared well, so this meant I had to know my subject. I found myself dusting off my FRCA revision books and having a good read the night before as well!

There was usually a meeting of some sort most days which I was expected to attend.

Grand rounds were on a Monday morning where interesting cases and projects were discussed. There was a faculty meeting where any issues about the running of the department, including its finances, were discussed. I learnt a lot about the management side of running a department here, a side of anesthesia usually missed as a UK trainee.

There was also a weekly research meeting. With the department being so heavily involved in research it was fascinating to hear about progress with people’s projects. There were lots of opportunities to get involved – people were always looking for extra hands. Although the approval process for research projects is as protracted as ours and the ability to get a project completed within a year is limited, the research training is good and learning how to submit a project for approval is a good experience.

During my stay I was lucky enough to have the opportunity to go out as an observer with the Life Flight team. This is the emergency helicopter transfer team consisting of two nurses and a pilot. They take calls in a 250 mile radius and the work is split between inter-hospital transfers and emergency calls. This was an amazing opportunity for me to have a little ‘on-scene’ experience and I would thoroughly recommend it. It also gave a good opportunity to see the surrounding countryside!

Final thoughts:

My overall impression was of an enjoyable educational experience that greatly added to my anaesthetic training. I enjoyed the increased responsibility of running two operating rooms simultaneously. I also enjoyed being responsible for ‘bigger’ cases and I feel that I learned a lot. I enjoyed learning about alternative technologies including different drugs, different monitors and a variety of interesting(!) airway devices rarely used in the UK, such as trach-lights and Bullard laryngoscopes.

It also made me appreciative of UK working conditions, in particular the later start in the mornings, shorter on-calls and a trained assistant who can constantly second-guess your next move. We don’t know how lucky we are here!

In conclusion, after some initial difficulty in making the transition between working practices I felt an integral part of the team and enjoyed my time at Stanford. I would thoroughly recommend it to anyone planning a year of Out of Programme Experience.

Dr Joanne Rugen
Specialist Registrar in Anaesthetics
Royal Cornwall Hospital
THE FINAL FRCA SAQ EXAMINATION
OCTOBER 2008

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British Society of Orthopaedic Anaesthetists

13th Annual Scientific Congress
Lancashire, Friday 7th November 2008

CALL FOR ABSTRACTS

We invite you to submit work for poster presentation. In addition, selected finalists will be invited to give an oral presentation at the Congress on November 7th 2008. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 5th September 2008. Abstracts should be emailed in the form of one A4 side of printed text in 'electronic form', Word or PowerPoint, on or before 10th September marked clearly with your name, address, telephone number and email address. Presenters will be required to register for the Congress.

2008 Congress Chair: Dr Matthew Frayne
Email: bsoaCongress@btinternet.com
MMC Selection Revisited

At the time of writing, the MMC selection process 2008 is under way. By the time you read this, many trainees will know their fate for next year, and if one of the lucky ones, for the rest of their training. The system has been revised and greatly improved, so lessons have been learned from last year’s debacle, but it’s still a brutal process. I think I speak for every doctor of SpR grade and above when I say that we would not want to be at that stage of our career now. We have watched with horror and sympathy as promising careers are derailed and families broken up. There is the feeling of a deal which has been reneged on – one embarks upon a medical degree assuming that an interesting post with prospects in the field of your choice will be available. Under the old system, most junior doctors would have the opportunity at least to have a go at their first choice specialty – some would decide it wasn’t for them, or if they were not making headway, the realisation would be allowed to dawn gently, with plenty of time to develop plan B. Now it’s short sharp shock. You wanted a career in specialty X? Well tough, you can’t – ever. We’re not even going to allow you to have a go. You want to live in a particular area, for trivial reasons like that’s where your spouse works? Too bad.

There’s something every generation of junior doctors is brutalised by. I graduated in 1981, and my generation were afflicted by long hours and relatively poor pay. We were the transitional generation, I guess – the cohort before me had even longer hours: they weren’t called “residents” for nothing. Basically there was no rota – they were it. (I have experienced a “1 in 2”, and believe me, that’s no fun either.) Training and supervision was derisory and they were not expected to bother their consultants out of hours. And their pay was laughable. On the plus side, they were looked after in a way that today’s trainees could only dream about. I’m old enough to remember a free cooked meal from a fully functioning canteen in the middle of the night when on call – we just signed a book. I missed out on the shoe-shining, but did once work in an ITU where the auxiliary would bring your breakfast on a tray.

Forty years ago, virtually all consultants were white, middle class males. In Glasgow, it was rumoured, you had to have gone to the right school too (a marker for religion) – but different hospitals were believed to favour different sides of the sectarian divide, so I suppose that’s all right. While things were gradually changing, even as late as the 1980s I consciously discarded surgery as a career choice because (among many other reasons) I realised that to make it as a female surgeon, I would have to put in a superhuman degree of commitment. There’s a reason why all female surgeons above a certain age are outstanding women and scary as anything. Anaesthetics has always been a little more enlightened – if I have been discriminated against on gender grounds, I’ve certainly never noticed, although older patients still sometimes
Help for Doctors with difficulties

The AAGBI supports the Doctors for Doctors scheme run by the BMA which provides 24 hour access to help (www.bma.org.uk/doctorsfordoctors). To access this scheme call 0845 920 0169 and ask for contact details for a doctor-advisor*. A number of these advisors are anaesthetists, and if you wish, you can speak to a colleague in the specialty.

If for any reason this does not address your problem, call the AAGBI during office hours on 0207 631 1650 or email secretariat@aagbi.org and you will be put in contact with an appropriate advisor.

*The doctor advisor scheme is not a 24 hour service
Candidates on recent Mersey Courses advised us that the Mersey Website tended to be a little confusing and not markedly user-friendly. Thus it has been Revised & Refined and, while we have always been concerned to avoid the flamboyant & unnecessary, we hope that what is there now is Enough, Easy To Find & Adequately Informative.

### For Primary & Final FRCA Examination Candidates

- Radiology for Anaesthetists
- Anatomy for the FRCA Examinations
- The Mersey Selective (Basic Sciences Revision) Course

### For Primary FRCA Candidates

- Primary Prep Course (MCQ)
- Primary Prep Course (OSCE/Orals)
- Primary OSCE Weekend Course
- Primary Viva Weekend Course

### For Final FRCA Candidates

- The SAQ Writers Club
- Final FRCA Exam Crammer (Booker) Course
- Final FRCA MCQ Course
- Final FRCA SAQ Weekend Course
- Final FRCA Viva Weekend Course
This year sees the centenary of the Section of Anaesthetics (now renamed the Section of Anaesthesia) of the Royal Society of Medicine (RSM). Our Section is descended from the Society of Anaesthetists founded in 1893, the first anaesthetic society in the world. Within a few weeks of Thomas Morton's demonstration of the use of ether anaesthesia on 16 October 1846 in Boston, it was in wide use in Britain. Steady progress was made and an increasing number of doctors started to practise anaesthesia, so that by the 1890s there came a demand to form a group where they could share their experiences. Dr Frederick Silk of King's College Hospital wrote in 1892 ‘for some years . . . the subject of anaesthetics had occupied a very prominent position in the professional controversies of the period and its importance as a branch of medical education and special practice is becoming more generally recognised. It seemed to me therefore that . . . an attempt should be made to form a special Society of Anaesthetists.’

At a meeting in May 1893 a resolution was passed to create such a society and rules were drafted to govern its membership and activities. The proposed rule that ‘duly qualified medical men . . . be eligible for nomination’ was revised at the second meeting to read ‘duly qualified medical practitioners . . .’, a significant change that later became one of the reasons why the Society was not one of the founding societies of the RSM. At the Society's first general meeting in October 1893, 40 members, including 3 women, had joined and this number steadily increased to over 100 by the turn of the century. Although London based, it had members throughout the country and even a few from overseas.

The Society held its meetings in a house belonging to the Royal Medical Chirurgical Society (RMCS). This Society had been formed some 90 years before and had received its Royal Charter in 1834. The RMCS already had several anaesthetists amongst its members, including Drs Dudley Buxton, Joseph Clover, Frederic Hewitt and John Snow, and had held several meetings on anaesthetic topics. Since 1890 these meetings had been held in the Georgian house belonging to the RMCS at 20 Hanover Square, south of Oxford Street, a house that still exists. The Society of
Anaesthetists paid ten guineas (£10.50) a year and was entitled to hold ten meetings, to have its name recorded on a board in the entrance hall, and to use it as a postal address.

Many specialist medical societies used the same facilities. Eventually many of these realised the advantages of merging their resources to form a single body and a Supplemental Royal Charter dated the 28th May 1907 was granted under the title ‘The Royal Society of Medicine’.¹

The anaesthetists did not immediately join with the original member societies. The Minutes record that Dr Blumfeld, the Honorary Secretary, put forward suggestions for the conditions under which the Society would be prepared to join. These included maintaining full autonomy in their affairs and full rights for all their members. The Society may well have been the earliest medical society to grant full membership privileges to women and by this time about 10% of its members were female. The new RSM proposed to grant only limited associate membership to women doctors. Blumfeld’s proposals were put to the vote and of 56 voters, 45 were in favour of amalgamation, but only if all their conditions were fully met. Thus it was not until the following year, when the RSM was prepared to modify its stance, that the anaesthetists joined. The balance of the Society’s funds was then handed over to the RSM, a total of £112.19.9, a considerable sum at the time. Strangely, in spite of the anaesthetists’ insistence on full rights for all members, it was 48 years before a woman, Dr Katherine Lloyd-Williams of the Royal Free Hospital, was elected Section President for 1956-7.

The first meeting of the new Section of Anaesthetics was on 4th November 1908, at 8.30 pm at 20 Hanover Square, when 18 fellows and members heard Dr Richard Gill talk on ‘Chloroform action’.

Meetings continued here until the RSM outgrew this house and built larger premises at 1 Wimpole Street, moving there in 1912.

In 1931 the Section, stimulated by its Honorary Secretary Dr (later Sir) Ivan Magill, explored the possibility of setting up a Diploma in Anaesthetics, but the Charter of the RSM precluded it from holding examinations, hence a separate body, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) was formed in 1932. The latter delegated the organisation of the diploma examination to the Conjoint Board of the Royal Colleges of Physicians and Surgeons and the first diplomas were conferred in 1935.

Until after the Second World War the RSM Section was the only effective forum for anaesthetists to meet regularly. The AAGBI held no scientific meetings until 1948, the year that the Faculty of Anaesthetists was established within the Royal College of Surgeons of England. For 40 years the Section held sway as the sole venue for regular scientific meetings and attracted audiences and speakers from all over the country and from overseas. In the introduction to the history of the Section² Dr Lucien Morris of Seattle, USA pays tribute to the Section as ‘the oldest continuously functioning organization of physicians actively interested in the practice of anaesthesia’. Many important advances in the field were first propounded at Section meetings. Today many other bodies, including Royal Colleges, Universities and their Deaneries and specialist societies, are involved in both education and spreading of knowledge, but the Section still thrives, having successfully adapted its role to the changes that have occurred over 100 years.

The Section is celebrating its centenary on 13 June 2008 with an all-day meeting at the RSM that both Fellows and non-Fellows of the Section may apply to attend.*

Aileen K Adams.


The records of the RMCS and of the Society of Anaesthetists are held in the archives of the RSM.

* Details and registration on www.rsm.ac.uk/anaesthesia
Dear Editor...

Editor’s Choice letter

All is explained...

With reference to Jeremy Groves’ piece on General & Special Relativity¹ as an explanation for surgeons’ inability to judge the length of surgery, I have for many years been unable to decide between two alternative hypotheses.

The first is that when a laparoscope/arthroscope/anything-else-scope is involved, then the optical properties of the instrument somehow allow light to travel faster than its normal speed locally, thus invoking relativistic time dilation within a certain distance of the scope, to compensate, and apparently slow the photons down to their conventional maximum. Oddly enough, the manufacturers of the equipment have never divulged how they make their instruments do this.

The other explanation seems far simpler, and depends on the fact that surgeons are rational, numerate beings who are in the vanguard of development of rational scientific measurement. Thus, they have moved on to DECIMAL time. None of this “60 seconds in a minute and 60 minutes in an hour” for our modern numerate rational surgeon.

No, each surgical minute contains 100 seconds, and each hour contains 100 surgical minutes (or 10,000 seconds).

Thus “I’ll take an hour” means 10,000 seconds or just over 2 (conventional, old-fashioned) hours and 46 (conventional, old-fashioned) minutes. Sometimes they over-estimate a bit, so you’re impressed with their speed...

I’ve found, somewhat joylessly, that this formula works especially well at night.

Jeremy Weinbren
London


Blue Plaques for Anaesthetists

I was interested on the article about anaesthesia-related blue plaques in London written by David Zuck (Anaesthesia News January 2008), and the subsequent correspondence by Adrian Padfield (Anaesthesia News March 2008) about those outside London. In addition there is a blue plaque dedicated to John Snow in North Street in the City of York. The plaque is on the wall of the Park Inn (formerly the Viking Hotel) facing the graveyard of All Saints Church North Street, where the Register shows that John Snow was baptised on 15th March 1813.

The plaque was erected in 1982. The inscription reads, “To the memory of JOHN SNOW 1813-1858. Pioneer Anaesthetist and Epidemiologist born near here”. The actual house of Snow’s parents, opposite the hotel, has been demolished ¹. I have ascertained from a medical friend in York, that the plaque is still present and in good repair (Peter Dench, personal communication). The History of Anaesthesia Society is holding its summer meeting in York on June 27th and 28th this year. It may be that some registrants would wish to view this plaque and visit the adjoining All Saints church.

There is some circumstantial evidence that John Snow was educated at my old school, St. Peter’s School, York, which was founded in AD 627 ¹, ². Some other alumni of St. Peter’s School were less prestigious than Snow. They include Guy Fawkes 1570-1606 (certainly), and (possibly) the highwayman John Nevison 1839-1684, alias Dick Turpin ³, ⁴.

Thomas Boulton

Further Hazards of Orthopaedic Surgery

There are frequent letters and articles describing critical incidents in the anaesthetic literature, but I cannot recall any reports of incidents similar to the one I encountered recently.

I have the culprit’s permission to describe a rare but potentially lethal incident involving disconnection of the oxygen supply to an anaesthetic machine.

I made the usual safety checks on the Dragar Cato prior to starting the orthopaedic trauma list. The first patient had uneventful surgery and anaesthesia, and I allowed the post-fellowship trainee, assisted by an anaesthetic nurse and trainee ODP to anaesthetise the second case. Although not directly involved, I was present in the anaesthetic room and theatres.

As the SpR opened the oxygen rotameter on the Cato machine after transferring the patient, the classic noise of the oxygen failure alarm sounded. Not a single person reacted to the noise and everyone carried on chatting. Eventually after pointing out the noise to the anaesthetic team (twice) I turned the oxygen cylinder on in desperation.

Having ascertained the patient was safe I examined the oxygen pipeline and found it was not mechanically connected to the high pressure outlet. I had two concerns:

1. No-one reacted to the oxygen failure alarm
2. Someone had tampered with the pipeline.

I launched an immediate enquiry with the theatre staff and when I mentioned sabotage the culprit eventually owned up.

The picture demonstrates an orthopaedic surgeon forcing his way through an impossibly small gap. The obvious solution was to disconnect the oxygen pipeline, though I will never know the whole story.

I can only despair the lack of attention of the anaesthetic team but unfortunately that will take more than a letter!

Fiona M Dodd, Consultant Anaesthetist
Wythenshawe Hospital, Manchester

Another reason to be cheerful

I enjoyed the January editorial “Reasons to be cheerful”. I agree that our lot is pretty good, all things considered. However, one reason to be cheerful was omitted: secretarial typing errors.

This letter was typed by a gastroenterologist’s secretary to the referring GP:

“Dear Dr X,
Thank you for asking me to see Mrs Y concerning her unexplained anaemia. Despite positive faecal occult bloods the colonoscopy I performed yesterday was normal. I shall send a ferret in, and review her in three weeks time.

Yours etc.”

We will all have to wonder if the ferret was disposable or had been through CSSD. What form of anaesthesia was needed? Were the ferrets stored in pharmacy or obtained from a farm?

Dr AJ Coe
Consultant Anaesthetist
Cottingham

PS Of course, what was meant was an iron stores test, serum ferritin!

A new indication for general anaesthesia

It was a normal day at sunny Medway and I was seeing my pre-op patients for a urology list. I explained regional and general techniques to the first patient, a fit and healthy 50 year old. He was quite open to having a spinal and we decided that would be the plan of action.

I then proceeded to see the other patients on the list. As I was leaving the ward, he called me back and said he’d changed his mind and wanted a general anaesthetic. I enquired as to the sudden change of mind, as he had seemed very keen on the idea of a regional. He replied that he could not take any more of the surgeon’s jokes.

I wish we had that option!

Dr Navjot Panesar
Dr Manesha Shah
Medway Maritime Hospital, Gillingham
Dear Editor...

Look smart!

I did enjoy the article from Dr Kay Spooner on the GAT page (Anaesthesia News, March 2008) about the study day at British Airways Flight Training.

However in the group photograph (see picture) I couldn’t help noticing the sharp contrast of the smart uniform of the BA pilot and the sloppy dress of the majority of the anaesthetists. I know that now that I am retired I come from a different generation, but do believe that there are standards in everything.

Judith Blaiklock

Epidural Kit Problem

I would like to draw to readers’ attention a problem with the catheter from a Portex Epidural Minipack.

During insertion of the catheter into a labouring patient I noticed that all markings distal to the 10cm mark were absent just as it was disappearing down the Tuohy needle. This caused some momentary confusion as to whether I had actually threaded in more than 20cm, which could have led me to inappropriately withdraw or remove the catheter with the subsequent need to resite the epidural. Inspection of the markings at the skin after removal of the Tuohy needle showed that it was at the 10cm mark and therefore appropriate catheter remained in the epidural space.

Prior to insertion I had flushed the catheter with saline (to confirm patency and the presence of lateral eyes) but I did not inspect the length markings.

I have reported the problem to the manufacturers and the MRHA. In the meantime I suggest adding a quick visual inspection of catheter markings to usual pre-insertion checks.

Louise Robinson
Associate Specialist in Anaesthetics
Torbay

A novel use of the AIRTRAQ!

The AIRTRAQ is a disposable optical laryngoscope with uses extending beyond intubation, to include foreign body removal and gastroscope guidance. As very imaginative and eco-friendly anaesthetists we have come up with a novel use for the AIRTRAQ. Not only can it be used to intubate the patient, it can then be used for keeping an eye on the surgical procedure! Let the drapes rise further!

Ritoo Kapoor
Sahir S Rassam
Cardiff
Ultrasound Guidance for the Diagnosis and Interventional Management of Pain

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Practical Sessions to Include
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- Optimising Direct Laryngoscopy

5 CPD points applied for from the Royal College of Anaesthetists

Registration fee: £120 inc Lunch and Refreshments
Course Directors: Dr M Mushambi and Dr P Ali, Consultant Anaesthetists
Contact Sam Thurlow, Conference Manager
Tele 0116 2502305 Email sam.thurlow@uhl-tr.nhs.uk

Anaesthetic Research Society
Research Methodology Course
23 to 24 June, 2008

Postgraduate Centre, Belfast City Hospital
Lisburn Road, Belfast BT9 7BL

This two-day course aims to fulfil the RCoA requirements for research competencies for trainees, but is suitable for clinicians of all grades interested in research.

Day 1 Tutorial teaching
- How to develop a research idea
- Study design and statistical analysis
- Practical aspects of clinical trials
- Ethics, NRES & research governance
- Presentation skills
- How to get published

Day 2 Attendance at the Anaesthetic Research Society meeting with feedback from tutors

Cost: £135 (includes refreshments and registration for the ARS meeting on 24 June)

Registration forms available from:
Dr JG Hardman
University Department of Anaesthesia
Queen’s Medical Centre
Nottingham NG7 2UH
email: J.Hardman@nottingham.ac.uk

Preoperative Association
Annual Conference – “A Risky Business” 6th November 2008 at Royal Court Hotel, Coventry

A inter-professional meeting designed for anaesthetists and all healthcare workers involved in the preoperative process.

CALL for ABSTRACTS – 31st July Deadline

Registration: £190 (members of the POA)
£225 (non-members)

For further details including registration forms, please visit www.pre-op.org or contact
meetings@pre-op.org
5 CEPD POINTS
The Obstetric Anaesthetists’ Association (OAA) has just launched the new edition of its booklet “Pain Relief in Labour” which gives patients reliable information about options available. This leaflet is free to download in a number of languages at www.oaaformothers.info.

Printed versions of the leaflet may be purchased from the OAA (www.oaa-anaes.ac.uk)

**Anaesthesia Aphorisms**

Collected by John Asbury

Notice when surgeons suddenly go very quiet during operations - it usually indicates a problem. Check your emergency drugs.

Resuscitation under anaesthesia is very much an unknown quantity, because most of the protocols relate to patients without the added effect of anaesthetic drugs.

Patients tend to disappear down to ECG, X-ray etc when you want to see them on the ward.

Always know the location of and how to get to your oximeter probe, venous access, arterial line etc, even when the patient is fully draped and the surgical staff are round the table.

Running an operation list requires team cooperation; the team includes porters, nurses, and many 'invisible' people - don’t forget them.

If the numbers on the machine worry you, check the patient first, then probes/transducers, then the monitor last.

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Most of my birthdays, which now seem to come round with increasing frequency, are lost in the mists of time. Three, however, will always be remembered.

21st birthday (1943)
Tyndal House Hospital, Aylesbury
My “twenty first party” consisted of a walk to the nearest pub on a cold wet February evening with a fellow medical student, where we each had two half pints of indifferent beer. No matter, we were celebrating, as three days previously we had become clinical medical students dealing with real patients for the first time, a foretaste of what was to become a fascinating career.

74th birthday (1996)
Sulaymaniyah, Kurdistan, North Iraq
Although turned down by the Red Cross as too old for overseas work at 63, ten years later I was fortunate to join “Emergency”, an Italian humanitarian organisation, to help set up a surgical hospital in Sulaymaniyah.

My birthday party (spaghetti for nearly 60) was organised in the United Nations Danish Guards’ Club, an unusual feature of which was a notice requesting everyone to unload their weapons and hand them to the barman, who would return them to the owner when he left, provided he was sober!

I was very moved to receive four presents from the Kurdish staff. They had only known me for a few weeks and did not know if I was any good as an anaesthetist, or was just someone who wanted the use of their few tools to fix things that they had no time to do themselves. Later, after the hospital had opened, I had to borrow the only pipe wrench whenever I needed to change an oxygen cylinder.

Among my many presents were three sets of worry beads. These must have been telling me something, as when I returned for three months in the summer fighting broke out between the two main Kurdish political parties. The city changed hands twice, and for a short time I found myself the only anaesthetist in a city of nearly three quarters of a million people as all the other hospitals had closed.

85th birthday (2007)
Tal y Llyn Railway, Tywyn
To celebrate my eighty-fifth birthday the Railway arranged a special train for my grandfather’s descendents. The engine was built in 1921. Most of the carriages, including the Guard’s Van (from which tickets were issued at intermediate stations) dated from before 1867.

Jacob’s three grandsons, two great-grandsons, three great-great-grandsons, and two of his three great-great granddaughters were in the party of fifteen. His great-granddaughter, Kate, gave me the signal to start the train by mobile phone from Kabul, Afghanistan, where she was in charge of the French Medical Institute for Children. (See picture).

It was a beautiful sunny day, and the one-hour journey each way in the Dysynni valley was delightful. After the journey we all had lunch in the restaurant at the terminus. Although Jacob was a teetotaller, I think he would have forgiven us for drinking his health on the journey.

One birthday perhaps best forgotten was my late wife’s sixtieth. I took her to the cinema and asked for tickets for “one and an Old Age Pensioner”...

David Rowlands
Retired Consultant Anaesthetist