The sun always shines on GAT meetings, or so it would appear, as we were warmed by an Indian summer sky on the first day. Bristol city was looking better than ever as the vast, neo-gothic Wills Memorial Building provided a suitably peaceful spot for the scientific meeting in Clifton’s cool university precinct. The meeting got off to a great start with Professor Gianni D’Angelini (by far the most interesting cardiac surgeon I’ve ever met) leading the ‘Medicine and the Media’ session. A truly legendary man, who ran middle distance for the Italian Olympic team and invented a battery chicken-catching device before becoming a world famous cardiac surgeon, he told us how to manage media attention and gave us a lesson in Italian history to boot! Dr. Chris Monk then gave a very honest account of ‘The Bristol cardiac story’ from his perspective as clinical director of the anaesthetic department at the time; and placed it in context with subsequent reforms. This was a sobering talk and he gave valuable advice on how important it is to keep good records. The session was rounded off by Joanna Crosse, who has vast experience within the media and now trains professionals to cope with the press.

I immediately liked Professor Andrew Wolf, who kicked off the ‘Paediatric Anaesthesia’ session, because he showed us a picture of his motorbike. The rest of his talk was equally interesting to me, as he informed us about total spinals for paediatric cardiac surgery (triple yikes!) He sensibly suggested we didn’t try this at home… and then Dr. Anthony Moriarty from Birmingham concisely outlined the difficulty non-paediatric specialists now face since centralisation of paediatric services has occurred. We can’t afford to ignore this space. Dr. Ian Jenkins then went on to outline the real crux of the problem - transferring a critically ill child
to a definitive centre - and how best to train non-paediatric specialists for this role.

The last session of the day was great fun. Dr John Leigh gave a witty lecture on appraisals and portfolios. Dr Alex Goodwin followed with advice on how to win at interviews, which was comically delivered and full of good hints. Finally, Dr Pat Oakley gave us a fascinating insight on how the changes within the NHS might affect us once we become consultants and progress to become ‘eminences grises’!

That night, we enjoyed a great party within the grounds of the magnificent Ashton Court. A buffet dinner and musical entertainment were laid on, and there were even dodgem cars and a fairground ride called the Energiser (never again!) As if that wasn’t enough, there was the opportunity to blow-off some steam by donning a sumo wrestling suit. There were reports of a stray sumo on the dance floor and two in the dodgems - but I didn’t see any.

Day two of lectures was attended by a slightly contracted audience for some reason but was, nonetheless, stimulating. The pros and cons of clinical governance were debated by Dr. Alexander Mayor and Dr. Neville Goodman (playing devil’s advocate). Dr. Sheila Willatts followed with a sound talk on how to stay out of trouble. The registrar’s prize was hotly contested with six presentations, and won by Dr. Robert Self with his study on platelet sensitivity to low dose aspirin. Well done Robert. Thanks to all who took part in this prize and in the audit and poster presentations.

During the AGM, Dr. Jim Down was elected as GAT committee chairman, and Drs. Fitzwilliams, Hopkins and Ryan were duly elected as new committee members. There followed the trainee conference, with talks on how to do research, get an MBA, get a postgraduate teaching qualification and on representing trainees. All good stuff for the C.V! Nevil Hutchinson presented data from the most recent GAT training survey, and Peter Maguire gave us an update on the ever approaching European Working Time Directive.

The Pinkerton lecture is always hotly awaited and this year was no exception. Mr David Boxall of Cameron Balloons gave us all a fascinating insight into the world of hot air balloons and applied high altitude physiology. We were treated to the highs and lows (!) of the Breitling round-the-world balloon expedition.

The Annual Dinner started off with a champagne stroll through a simulated rainforest. The 5-course feast that followed was extremely well attended and followed immediately by a band that rocked! When you needed a breather, you just wandered outside to a terrace overlooking Bristol’s famous harbour side - very Hollywood.

The last day was, fortunately, only a morning, but contained a variety of hot topics, including managing bleeding in Jehovah’s witnesses (Dr. Dafydd Thomas), as well as obstetric (Dr. Mark Scrutton), airway (Dr. Tim Cook) and neuroanaesthesia (Dr. Samantha Shinde) sections.

Finally, Dr. Peter Simpson, President of the Royal College of Anaesthetists gave the inaugural Wylie lecture on the changing face of anaesthetic training; a talk right from the top that gave a clear view of how the College plans to manage inevitable manpower issues.

During the meeting the two workshops - Simulator, and Paediatric Blocks (supported by B Braun) - ran extremely well and we thank all concerned for their efforts.

I think this was a superb meeting, and I congratulate the local organising committee, and in particular, Dr. Claire Gleeson. We should also thank Abbott Laboratories for their generous support of this conference. Finally, I think we should recognise the great commitment of our retiring chairman, Dr. Sarah Harries, who has worked tirelessly for GAT- thanks Sarah!
With the Association’s involvement in Euroanaesthesia in Glasgow earlier this year, it had been decided some time ago to cancel our traditional September Annual Scientific Meeting. For legal and financial reasons, it became apparent that we would have to hold a separate Annual General Meeting, which is normally subsumed in the ASM. The AGM usually takes less than an hour and to justify the gathering, it was agreed to pair it with a stand-alone Linkman Conference on 12th September.

This was held at the Royal College of Physicians in London and turned out to be a most successful occasion with almost 200 Linkmen in attendance. A full report will be sent to Linkmen and made available on the web-site in due course. Although independent practice featured as always, three other subjects dominated. Kate Bullen gave a thought provoking presentation concerning the current problems and future developments of non-consultant career grades. It is clear that we have paid too little attention and offered insufficient support to this large and important group of colleagues, and this is something we will rectify in the forthcoming year.

The Consultant contract generated much, heated debate. Opinion is divided, not only among the Linkmen, but also among elected Council members and, indeed, the Association’s Executive. In these circumstances, it would not be prudent for the Association to recommend a “yes” or “no”, but it is important that members are properly informed. To this end, we have issued comparative evidence concerning the various proposed contracts. We advise all members to seek as much information as possible, particularly from the BMA web-site, before reaching a personal decision. The BMA is the sole negotiator on our behalf. There will be an opportunity to vote on what has been proposed and that will probably have been completed by the time you read this. There are certainly undesirable features that have persisted in the new negotiations but there are also attractive conditions for some. When the dust settles, the Association will give specific advice on how anaesthetists should interpret any new arrangements particularly regarding job planning. Whatever emerges, accurate job planning will be fundamental and it is vital that you all keep a work diary accurately recording your activities, both clinical and supportive, on behalf of the NHS.

The other major hot potato discussed at the Linkman Conference was the development of non-medical anaesthetic practitioners. Iain Wilson from Exeter and Jeremy Rushmer from Northumbria, who are involved in two of the six pilot sites exploring non-physician input to the anaesthesia team, described the background and how developments were being piloted in each of their hospitals. Both stressed that these will, at all times, be supervised roles and not an introduction of an independent nurse anaesthetist model. Although committed, both had a realistic awareness of the difficulties and dangers of the proposals, and this was emphasised by comments from the audience and a vote that indicated there was still considerable concern amongst anaesthetists about this role. It is something we shall return to in the next few months.

The underlying manpower problem, which precipitated the exploration of alternative providers for anaesthesia, featured in a number of comments from the floor. The disastrous implications of the introduction of the new European Working Time Directive conditions in August 2004 will clearly impinge on every department in the land. The introduction of a few pilot anaesthetic and critical care practitioners will almost certainly have no effect, and there is, unfortunately, no easy solution. In the longer term a reduction of the number of acute emergency sites is required, but this is politically unattractive, particularly after Kidderminster. It is, nevertheless, less than a year away. I bet few Trusts have realistic plans on how to cope, and there appears to be a lot of heads in the sand at every level. The Linkman Conference emphasised to me that the EWTD deadline next year, which we all seem to have been inconclusively discussing for ages, is the most important and urgent problem that faces us today.
NEW AAGBI SMALL AWARDS FOR CLINICAL RESEARCH PROJECTS

The Association of Anaesthetists of Great Britain & Ireland is establishing a new system whereby small research grants can be awarded to anaesthetists wishing to undertake clinical research projects. The successful applicants for these awards will be assisted in the planning, prosecution and publication of the studies by members of the AAGBI Editorial Board of Anaesthesia. These awards are targeted at anaesthetists who have only limited experience of clinical research and would suit trainees, although consultants and SASs are also eligible to apply. Priority will be given to applications from departments of anaesthesia without an established track record of clinical research.

The AAGBI will initially make five awards, each of up to £2,000. Applicants must be members of the AAGBI. There are no application forms; applications should take the form of a study protocol, and should be accompanied by details of the cost of any equipment to be purchased with the grant. Applications should be sent to the Editor-in-Chief of Anaesthesia. A letter of support from the lead clinician or academic head of the department from where the application comes should accompany the protocol.

The applications will be ranked in order of priority by the Editors of Anaesthesia. The awards will be made by the Grants & Awards Committee of the AAGBI. Each successful application will be allocated an Editor, whose role will be to advise those conducting the study on matters relating to the planning and conduct of the study, and its subsequent preparation for submission to a journal. All papers should be submitted to Anaesthesia, although publication cannot be guaranteed – the papers will be treated in the same way as all submissions to the journal.

The closing date for applications is 31st January 2004. The first awards will be made in the Spring of 2004. Applications and queries should be sent to:

Dr D Bogod
Editor-in-Chief, Anaesthesia
The Association of Anaesthetists of Great Britain & Ireland
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For further details please contact Nicola Woodbridge-Smith, Anaesthetic Department, Torbay Hospital, Lawes Bridge, Devon, TQ2 7AA/
E mail: Nicola.woodbridge-smith@nhs.net or tel: 01703654311
During September, AAGBI members have enjoyed a successful Linkman conference, the AGM and the GAT meeting. Do other Associations make such an effort to network with their members and keep the morale of trainees so high? These opportunities are increasingly valuable as we face major challenges such as the consultant contract and other pressures within the NHS.

The consultant contract was much debated at the Linkmen conference, with almost all the audience (except one Welsh voter) agreeing to take the Welsh contract! Unfortunately, this does not appear an option for England or Scotland. Now that devolution has resulted in several different contracts within the British Isles, is a national contract really deliverable for all NHS consultants? Hospitals facing political targets without the skilled consultant workforce to deliver them, may not agree. The DoH is still considering pilot sites for fee for service, or incentive schemes as a way of changing working practice.

In this issue of Anaesthesia News, we cover a range of topics. Two articles advise on pension planning for members. This is an area that is about to be reviewed by the NHS – new consultants watch carefully! For those already enjoying their well-earned pensions, the AAGBI is considering practical ways of maintaining links with its retired members through the formation of a specialist group. Names for this organisation have proved difficult, the most popular being the Senior Members Group, although certain difficulties with acronyms have arisen! It is hoped that an annual dinner can be planned in our new premises, with an accompanying social program. Following a decision at the AGM, senior members can retain their membership with the AAGBI, and also receive Anaesthesia and / or Anaesthesia News.

The AAGBI makes substantial contributions to anaesthetic research in the UK. In an imaginative scheme, the editors of Anaesthesia have decided to support the trainee research projects. Trainees can apply for a grant of up to £2,000 but more importantly, have access to the expert advice of one of the editors of Anaesthesia. This is a brilliant concept, and should prevent that awful feeling of the paper rejection blues, so familiar to aspiring researchers.

Whilst proof reading Brigadier Houghton’s article on the history of military anaesthesia, I was amazed how the use of ether had spread through the world within the space of a few months, easing the pain of both civilian and military patients. Anyone trying to introduce such a radical change to the health service now would not find it so easy. Nowadays, we would require proof in animal studies, ethics approval, pharmaceutical company sponsored multi-centre controlled studies, involvement of focus and user groups and gradual introduction after funding agreement with the PCTs. Eventually NICE guidelines would be produced and the place of ether secured.

The letter from Ghana reminds us that the AAGBI is not just focussing on members’ efforts in the UK and Ireland. We have clearly made a substantial contribution towards improving the safety of anaesthesia in places as far away as Ghana. In addition, the International Relations Committee, ably chaired by Ellen O’Sullivan, is working towards a major educational venture for the developing world that will revolutionise access to learning materials for thousands of colleagues. Details of this project will be published soon.

Finally, the humour of anaesthetists can be found in the succinct cynicism of the letter’s page and Dr de Quincy. What a great specialty– this is your newsletter – please write for it!

Iain Wilson, Assistant Editor

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Welcome to the real world

I read with interest the report of the survey on current anaesthetic training (GAT page October). It would seem that trainees are finding it difficult to fit all their training into a compliant rota and are even having to attend educational activities in their ‘own time’. Well I’m shocked. How insensitive can departments be, arranging seminars and teaching during scheduled breaks. Every cloud has a silver lining however, and perhaps this is good training for future life as a consultant.

I am prompted to consider how much activity (including conducting seminars and teaching) I have to fit into my ‘own time’ each week. Overrunning lists, visits to the ward, telephone calls from patients and relatives, endless writing of references for all manner of personnel, impromptu conferences with colleagues in the corridor, appraisals, dealing with complaints, CEPOD and incident forms to name but a few. Welcome to the real world kids!

Dr. Shattered N. Drained.
Hectic DGH
Hard-Workington

(Real name and address withheld for reasons of self-preservation!)

More on Chest Examination


It is my practice to listen to patient’s hearts unless a result of a recent auscultation by a doctor or pre-assessment nurse is recorded in the patient’s notes. I wonder if you would like to share the following comments with readers of Anaesthesia News.

When asked about his/hers customary levels of activity and any limitations thereto, a patient is not likely to say, “I do not have a heart murmur”. If asked directly, the answer is likely to be “I do not know” or “I do not think so”. What next?

Bacterial endocarditis is a rare complication but antibiotic cover is currently recommended in the presence of heart valve lesions for surgical and anaesthetic procedures causing bacteraemia. Reasons for listening to the lungs are not necessarily the same as the reasons for listening to the heart in anaesthetic practice. The views of anaesthetists differ, cardiologists may give advice but it will be lawyers who decide.

Dr Z. Zych
Consultant Anaesthetist
Princess Alexandra Hospital, Harlow, Essex

....and more

I slightly disagree with Dr Peter Fletcher about not learning anything from examining the chest of a fit patient. A GP friend claims that he uses it to buy valuable thinking time when he is stuck for a diagnosis. Perhaps this is not a problem that anaesthetists often encounter.

Yours sincerely,
Aileen Adams

.... and even more!

I think it would be undesirable if the final impression of this correspondence was that most/all anaesthetists consider such an examination by a doctor to be unnecessary. Of course, examining patients in no way precludes taking an appropriate history.

The commonest finding I have found is a murmur. Frequently this is a flow murmur but sometimes there is pathology such as a small septal defect or mitral valve prolapse which is not haemodynamically significant but leads to consideration of antibiotic prophylaxis.

Occasionally, asymptomatic patients have conditions such as hypertrophic cardiomyopathy (where a minority have a murmur) or congenital aortic stenosis. If there are physical signs, I would like to spot them. If there are no physical signs and the patient suffers cardiovascular collapse intra-operatively, I would feel better in myself knowing I had looked for signs and to be able to tell the patient or family this.

I would also like to be able to convey the same message if a coroner or lawyer were to be involved.

Yours sincerely,
Dr J Cotter
The Royal London Hospital, Whitechapel
Until a VIP Council member engaged me in conversation at lunch during the very first College NCCG day in the late ‘90s, casually enquiring as to whether I had any regrets about not choosing the consultant pathway, I must admit it hadn’t crossed my mind that I had indeed made such a choice. Subsequently, however, I have given it further consideration.

Being espoused to a consultant member of the same department, I am mistakenly expected to be fully aware of all departmental controversies – not so!! However, I can claim to have done my share of “on calls by proxy” over the past 20 years. Being party to half a telephone conversation in the small hours of the morning can be deeply disconcerting and late returns are extremely disruptive. Catering for an evening meal which may be required at any time from 19:00 to 03:00 hrs. is not straightforward and on more than one occasion the message “supper in the dog” has been only too accurate. Had I pursued my career, up to 50% of our lives would have been spent on call. No life at all!

Who then, would have taken up the domestic reins and marshalled the two and four-footed members of the family? On reflection, it would appear that I chose this as part of my career and there are no regrets. I feel I have a close relationship with at least all the two-footers. Juggling up to four school time-tables is quite as arduous a task as formatting the departmental rota. At no time did we consider engaging a nanny. School trips alone would have worn her /him out.

Financially, no doubt, there may have been some increase in remuneration and perhaps even the invitation to partake in local private practice – currently denied to SAS members even if they hold Specialist registration. Would we have required two consultant salaries to raise our brood of four? It would of course have helped. It seems to be a common misapprehension that the second [female] income is only to add the “icing” to a more that satisfactory lifestyle. In our family these “extras” include food, clothing, second car [as our rural setting does not provide adequate public transport], birthday and Christmas expenses plus the occasional holiday. The primary income is frittered away on housing, schooling and the wine cellar. The private educational sector was more suited to our working hours and on many occasions the local prep. school acted as my early evening babysitter. Over the years this has been a considerable drain on resources.

With the youngest now starting his second year of university, we can almost anticipate “pay-back” time. Will they really live up to their promise to keep us in the way we would like ……etc. etc.? I wonder which sporty car I’ll choose once the days of floor to ceiling estate trips are completed? Happy thoughts to mull over in theatre while the surgery stretches on [and on…]

I suppose I could have chosen to apply for a post at another institution, but geographically we are out on a limb, the nearest alternative being at least fifty miles from home. This would have been far too disruptive a prospect during school years. Perhaps now it bears further consideration, though it would mean creating a second home and what about the dog? Who would stop his recently acquired habit of self-mutilation were I away for longer periods of time? To me this is not an entirely appealing scenario.

And so I reach the twilight years in my specialty as an associate specialist. Have I failed to reach my potential? Should I in fact have chosen the consultant pathway?

Reduction in trainees hours; controversial new consultant contract; potential demands for consultants to be resident on call in the future – on reflection I really don’t think so!!

Viva the SAS.
Although the military are sometimes thought upon as a race apart, it is, perhaps, no surprise that they should react similarly to the trials and tribulations of life as the population from which they are derived. Doubtlessly, soldiers and sailors must have feared surgery without anaesthesia as much as their civilian brethren.

Hippocrates was aware that ice and snow could be used for analgesia and cold water was suggested in a leechbook written by an unknown Anglo-Saxon monk in 1050 A.D. before scarifying around pocks. However there is no record that this knowledge was extended to surgery until 1807. Baron Dominique Larrey at Preyss Eylau observed that amputations could be performed painlessly after using ice, although he does not appear to have used or encouraged its use in surgery again. The usually military regimen was to give soldiers a bullet on which to bite whereas sailors were offered a strong tot of rum prior to surgery.

It is generally accepted that William Morton’s demonstration of the use of ether for a dental extraction on 30th September and for the excision of a jaw tumour on 16th October 1846 at Massachusetts General Hospital marks the start of anaesthesia. The news spread remarkably quickly and widely. Morton soon wrote to the US Navy and the Surgeon-General of the US Army suggesting that ether could be used, ‘for the relief of suffering soldiers and sailors in the Mexican War’. He proposed to send, ‘agents to Mexico at once, whose expenses to the Government would only be but a few hundred dollars’. The offers were declined.

The first known use of anaesthesia in battle was by Dr Edward Barton who had been Professor of Materia Medica in Louisiana. He took anaesthesia apparatus and ether with him, which he used after the landing of US forces at Vera Cruz. Injured Americans received ether for their amputations but, whilst the Mexicans were looked after, ‘the band was ordered to play, so that the lamentations could not be heard.’

The next use in battle was by Professor Nicholai Pirogoff. After being the first to use anaesthesia in Russia on 14 February 1847, he then went on to research its use and also developed rectal anaesthesia. In June 1847, he went to the Caucasus to test, use ether anaesthesia, and instruct for the treatment of the wounded in the front-line dressing stations. By August, he had demonstrated nine anaesthetics and he and his assistants had given 25 anaesthetics.
The British Army’s first recorded use of anæsthesia in battle was at Grahamstown by District Surgeon Atherstone during the Kaffir Wars of 1850 – 1852. Surgeon Irwin (27th Regiment of Foot) was in attendance for the amputation. In 1851, Assistant Surgeon W McEgan of the Indian Medical Service described the use of chloroform in 18 amputations after a battle in the Deccan with all but three surviving. However the Royal Navy were more advanced in their use of anæsthesia. Assistant Surgeon T Spencer-Wells was serving at the Royal Navy Hospital, Bighi in Malta in 1847. He received news of the introduction of anæsthesia on 9th February 1847 and, jointly with Dr Burmeister, experimented with ether using an inhaler of his own design. He also sent for a Hooper’s ether inhaler from London which he received on 6th March 1847. By 16th March, he described his work on anæsthesia to the local medical society and anæsthetised two of its members. Only five months later, his paper, ‘Remarks on the results of the inhalation of ether in one hundred and six cases’ was published in the London Medical Gazette. The first known use of anæsthesia on board a RN ship was the use of chloroform on HMS Columbine, possibly in December 1847.

These limited number of cases show that the army and the navy were as quick to take up anæsthesia as their civilian counterparts. In much later conflicts, the military needs for anæsthesia have played a major part in the development of our specialty.

‘Now Bagrationovsk, Kalingrad, Russia

Acknowledgements

Much of the information for this paper has been sourced from:

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* “If you feed the children with a spoon, they will never learn to use the chopsticks”
Is your pension an Inheritance Tax liability?

For those anaesthetists who have, or are building up, a personal pension from their private practice income, it is important to consider how best to maximise these pension funds for their families.

When a person dies, their estate is subject to Inheritance tax (IHT). There is a tax free allowance (£255,000 for the tax year 2003/04), but the estate over this tax free amount is taxable at 40%. The tax charge does not come into effect when property passes on the death of a spouse. It does, however, come into effect when the inherited property passes after the death of the surviving spouse. The 40% charge seriously depletes the assets passing to the next generation.

How can you minimise that 40% charge while at the same time ensuring that your surviving spouse may benefit from the family assets during his or her lifetime?

The problem – an example
Dr Brown’s husband has just died leaving her the following:-
- His one half of the house £300,000
- Other assets £250,000
- Personal pension death benefit £200,000
- Total £750,000
Her own estate is valued at £250,000
If Mrs Brown subsequently dies, her IHT liability would be:-
- Estate inherited from husband £750,000
- Her estate £250,000
- Less nil rate band £255,000
- Sub total £745,000
- IHT @ 40% £298,000

A Spousal By-pass Trust
Can anything be done to reduce this tax bill? The answer is ‘yes’, and comes in the form of a pension trust (henceforth known as a spousal by-pass trust)

The solution is to put your pension into a trust, sometimes known as a spousal by-pass trust. This is a straight forward family trust. The death benefit from your personal pension is paid into the family trust on your death. Whilst this affords the surviving spouse complete access to the lump sum death benefit, on his or her subsequent death, the lump sum will not form part of the spouse’s estate for IHT purposes. Just as important, is that it will not be assessed for long term care. The trust can lend to beneficiaries creating a debt on their estate so reducing their liability.

When should I set up the trust?
The ideal time to set up the trust is at the time you set up your personal pension. But, the Spousal By-Pass Trust may also be set up at any later time during your lifetime, perhaps following a financial review of your affairs. It is important you are in good health at the time you set up the trust. Putting pension death benefits into trust is a chargeable transfer for inheritance tax purposes – however, providing you are in reasonable health at the time your pension is assigned to the trust, the death benefits have only a nominal value.

The Solution – an example
If Dr Brown’s personal pension death benefit was subject to a spousal by-pass trust, £200,000 would be removed from Mrs Brown’s estate as follows:-
Dr Brown’s husband has just died leaving her the following:-
- His one half of the house £300,000
- Other assets £250,000
- Personal pension death benefit £200,000
- Total £750,000
Her own estate is valued at £250,000
If Mrs Brown subsequently dies, her IHT liability would be:-
- Estate inherited from husband £750,000
- Her estate £250,000
- Less Personal pension death benefit (£200,000)
- Less nil rate band (£255,000)
- Sub total £545,000
- IHT @ 40% £218,000

Continued over:
An inheritance Tax saving of £80,000 with full access to capital and income if required.

Now consider where the trust loans Mrs Brown £100,000
If Mrs Brown subsequently dies, her IHT liability would be:-
- Estate inherited from husband £750,000
- Her estate £250,000
- Less Personal pension death benefit (£200,000)
- Less Loan repayment to trust (£100,000)
- Less Nil rate band (£255,000)
- Sub total £445,000
- IHT @ 40% £178,000

A further Inheritance Tax saving of £40,000
The spousal bypass trust can be used for
- Personal pensions
- Income drawdown
- Stakeholder pensions
- Retirement annuity contracts (RAC’s)
- Phased retirement.

Is it appropriate for me?
For those of you who have any of these pension contracts it is important to review them to see if they are:-
- In trust, and at least have a death nomination
- Are competitively charged. Older pre-stakeholder contracts will be highly charged, this could affect the potential growth of the pension funds.

At all times it is important to take independent financial advice to decide how best to maximise your pension benefits.

For more information, please speak to Dr Mark Martin, Director 20Twenty Independent or David Rose, Inheritance Tax specialist, on 020 7400 8613 or 020 7400 8625.

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Further details and application form:
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THE ASSOCIATION WILL BE HOSTING AN AFTERNOON OF GUIDED TOURS OF THE NEW HOUSE FOR MEMBERS AND THEIR GUESTS.

All visitors will be invited to toast the house with a complimentary glass of champagne.

The tours will be held at selected time slots throughout the afternoon of Monday 3rd November 2003. For more information and to book your place please contact: Janine Grainger, on 020 7631 1650.

Places will be allocated on a first-come-first-served basis.

MERSEY SCHOOL
ANAESTHESIA & PERIOPERATIVE MEDICINE

The Pilot Staging of A NEW COURSE

FINAL FRCA
VIVA WEEKEND

4 pm Friday 14th November – 4 pm Sunday 16th November

Available Only to Candidates who have been invited to the RCA for the Oral Examinations the week beginning Monday December 1st

Further Information
WWW.MSOA.ORG.UK
Local Anaesthesia for Ophthalmic Surgery

Friday, 6th February 2004, Middlesbrough

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in Education Centre, The James Cook University Hospital, Middlesbrough on Friday, 6th February 2004. The meeting will include lectures and live demonstration of orbital blocks.

Attendance is limited to 50 participants. Application form and information from Elaine Tucker (Course Administrator 01642-854601; email: elaine.tucker@stees.nhs.uk). Registration fee is £225 (BOAS Members £200) (inclusive of catering).

Registration and Coffee: 09.00-09.25

Welcome: Prof Chris Dodds, Middlesbrough

09.25-10.15 Anatomical considerations for ophthalmic blocks:
- Prof Chris Dodds, Middlesbrough

10.15-10.30 Coffee Break

Chairman: Dr A P Rubin, London

10.30-11.00 Pharmacological considerations for ophthalmic blocks:
- Dr Sean Tighe, Chester

11.00-11.30 Orbital blocks in perforating eye injuries:
- Dr Steven Gayer, USA

11.30-12.45 Lunch

12.45-13.45 Live Demonstration of Orbital Blocks

Demonstration Co-ordinators:
- Dr Chandra Kumar, Middlesbrough
- Dr Anthony Rubin, London
- Dr Sean Tighe, Chester
- Dr Hamish McLure, Leeds

13.45-14.30 Phaco & or peribulbar:
- Dr Chandra Kumar, Middlesbrough
- Dr Steven Gayer, USA

14.30-15.00 Medial peribulbar:
- Dr K L Bang, Birmingham

15.00-15.30 Recorded videos:
- Dr Steven Gayer, USA

15.30-16.00 Sub-Tenon's:
- Dr Gori Reed, Liverpool
- Prof Chris Dodds, Middlesbrough

16.00-16.30 Retrobulbar:
- Dr Raya Oder, Middlesbrough

16.30-17.00 Ultrasound Technicians:
- Mr Bartley McNeela, Jersey

17.00 Closing remarks: Prof Chris Dodds, Middlesbrough

Programme director and meeting organiser: Dr Chandra Kumar, Consultant Anaesthetist, University Department of Anaesthesia, The James Cook University Hospital, Middlesbrough TS4 3BW. Tel: 01642-854601, email: cmkumar@boas.org

BRISTOL MEDICAL SIMULATION CENTRE
FORTHCOMING COURSES

22nd January 2004, Mature Consultants Course, for mature consultants in Anaesthesia (£150)

2nd & 3rd Feb 2004, 2 Day Paediatric Anaesthesia Critical Incident Day (GRL), for paediatric anaesthetists (£275)

11th February 2004, Management of Obstetric Emergencies Course, for O & G trainees & anaesthetists (£250) (To book Tel 0117 9595176)

26th & 27th February 2004, Management of Obstetric Emergencies Course, for O & G trainees & anaesthetists (£250) (To book Tel 0117 9595176)

17th March 2004, NCCG (SAS) Critical Incidents Day, for staff and associate specialist anaesthetists (£150)

19 March 2004, Paediatric Anaesthesia Critical Incident Day (GRL), for occasional paediatric anaesthetists (£160)

1st April 2004, Mature Consultants Course, for mature consultants in Anaesthesia (£150)

28th April, Management of Obstetric Emergencies 1 Day Course, for O & G trainees & anaesthetists (£150) (To book Tel 0117 9595176)

29th & 30th April, Management of Obstetric Emergencies Course, for O & G trainees & anaesthetists (£250) (To book Tel 0117 9595176)

1st July 2004, Mature Consultants Course, for mature consultants in Anaesthesia (£150)

8th November 2004, Mature Consultants Course, for mature consultants in Anaesthesia (£150)

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

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

Children Nationwide Pain Research Centre
UCL and Great Ormond Street Hospital for Children NHS Trust

Paediatric Pain
- research update -

Thursday 11 December 2003

at The Royal College of Physicians

11 St Andrews Place, St Pancras, London

- a symposium for clinicians and scientists -

Faculty
- Professor A Dickenson
  Professor of Neurophysiology, UCL
- Professor R Fitzgerald
  Professor of Developmental Neurobiology, UCL
- Professor M Kutsukake
  Professor, Neuropathy Unit, ICH
- Professor R Frackowiak
  Chair, Children's Nursing Research, GOSH
- Dr A Goldstein
  Consultant in Paediatric Care, GOSH
- Dr N Thomas
  Consultant in Health Psychology, Guy's & St Thomas' Hospital
- Dr P Howard
  Consultant in Anaesthesia & Pain Management, GOSH
- Dr O Williams
  Consultant in Anaesthesia & Pain Management, GOSH
- Mr M Baico
  Research Fellow, Anatomy & Developmental Biology, UCL
- Dr S Schmelze-Toldini
  Research Fellow, UCL
- Dr S Walker
  Research Fellow, UCL
- Dr O Gatterman
  Research Fellow, ICH

Programme
- Neurobiology of paediatric pain
- Sensory reorganisations in children
- Mechanisms of analgesia
- Neoplastic pain in childhood
- Pain measurement
- Long-term pain and disability

Registration

£150.00

includes lunch and refreshments

Information and applications

Dr Richard Howard, The Royal College of Physicians
25-29 St Andrews Place, London NW1 5NW
Tel: 0161 428 4365
Email: rhoward@rcp.ac.uk

Primary FRCA REVISION COURSE

DATE: Wednesday 14th - Friday 16th January 2004
VENUE: Clinical Education Centre, Leicester Royal Infirmary
FEE: £295.00 (non-residential)

Exciting new course format for 2003

If you are taking the Primary FRCA exam in December 2003/January 2004, this course is for you. Phase 1 consists of practice MCQ papers by post in October & November 2003. Phase 2, in January 2004, is a 3-day course devoted to intensive VIVA & OSCE preparation, individual appraisal, and small group tutorials, directed by experienced teachers and examiners.

For more information and registration please contact Christine Gethins
Tel: 0116 258 5291/email: chg2@le.ac.uk
Dr Jonathan Thompson & Dr John Parker
Course Directors

Places are strictly limited

Division of Anaesthesia, Leicester Royal Infirmary
Statistics made easy
by Prof. C. Square

Some colleagues have problems with statistics. I hope that the definitions below will help clarify some of the more complex areas.

Standard Deviation  A pneumothorax occurring during a subclavian puncture
Two standard deviations  Bilateral pneumothoraces
Tea test  Test of trainee competence – consultant leaves theatre
Paired Tea test  Test of ODP competence – both anaesthetists leave theatre
Bias  Pharmaceutical term. Originally “buyus” our lunch and we’ll use it
Mann Whitney U test  Surgical assessment of anaesthetist’s performance. Originated in Scotland – “Oh man, whit nae you!”
Chi Test  ODA competence. Origin Nepal “Chai” = tea. Yates correction is for coffee.
Best fit  Assessment of convulsion during ECT session.
Confidence intervals  Marks on a Tuohy needle.
Non-parametric  Anaesthetist who doesn’t join in at conferences. A sociable colleague is said be parametric
Newman - Keuls  Female nurse assessment of new male colleague
Analysis of variance  Determination of sexual preferences
Regression analysis  Consultant knowledge during career

Paediatric Intensive Care Services in Wales Present:
Stabilisation of the Critically Ill Child Course
What to do Between Resuscitation and Retrieval!
Thursday 6th – Friday 7th May 2004
At the Millennium Stadium, Cardiff
A two day course of practical sessions, clinical scenarios and lectures aimed at Consultants and Specialist Registrars involved in the initial management of critically ill children prior to retrieval for paediatric intensive care.

Topics covered include:
• Advanced Paediatric Airway Management
• Ventilation Strategy and Portable Ventilators
• Management of Severe Sepsis
• Burns and Trauma
• Head Injury and other Neurological Emergencies
• Preparation for Transport

Fee £380
CEPD Applied for

For further details and application form please contact:
Dr. M A Price, Paediatric Intensive Care Unit,
University Hospital of Wales, Cardiff CF14 4XW
Tel: 02920 746423 • mark.price@cardiffandvale.wales.nhs.uk
Your financial position

So what changes on retirement? We can look at capital and revenue.

Capital

You are given a tax free lump sum of about 3 times your pension (though this is reduced if you retire early).

This may be used in whatever way you choose, but some common uses are:-

1. To clear any outstanding debts such as a mortgage.
2. To fund further outgoings such as children at university
3. To buy toys for retirement – garden tools, a new car, a world cruise
4. To purchase a further annuity from an insurance company if your pension looks too small.

Alternatively, you could put the lump sum into an interest bearing account, and draw down the interest and capital over, say, 10 years. As a rough guide, £100,000 invested at 3.5% (though that is a bit optimistic at the moment) will produce £1,000 per month for ten years – then the capital and interest will be used up. But that’s a tidy extra for the first, most active years.

Revenue

As you approach retirement, if you have purchased all the added years possible, you may be effectively working for less than one third pay – your pension may be half your salary, and if you invested your lump sum as described in option 4 above, that would be topped up to nearly 70% of your working salary for the next 10 years. That is leaving considerations of private practice aside.

If you are on 5 DPs, aged 60, with 40 years service, staying an extra year will give an extra pension of less than £1000 – or 2.5%. After tax, that’s £600!

How much pension do you need? That depends entirely upon your intended lifestyle. With no mortgage, no professional subscriptions to speak of (except for the GMC which still extorts the full whack if you still want to be able to write the odd prescription), a life of reading, writing, golf and gardening may be very cheap. However, indulging in expensive hobbies such as sailing, holidaying in style and the theatre might soon hurt the bank balance. This most frequently asked question is therefore impossible to answer.

When should you retire?

Apart from ‘When you can afford to’, several personal issues may arise in later working years.

Many senior doctors find themselves forcibly reminded of the aging process. Perhaps the most common is getting a poorer night’s sleep; this may be either because of aches and pains, urinary frequency, or simply disrupted diurnal rhythms. It becomes too easy to lose concentration in the afternoon,
particularly after a disturbed night. These effects are often very concerning to a conscientious anaesthetist.

Complaints made against doctors rise in proportion to their age, and one is less resilient in terms of accepting the inevitable psychological reverses that are part of doing a critical job. Too many doctors are on the receiving end of a complaint in their last years, often as a result of outdated behaviour. Years of unblemished conduct count for nothing in today's NHS.

**Summary**

Almost nobody that I have come across regrets retiring early – many wish they had not left it so late. Although the old adage 'retire at 60 and have 18 years to live; retire at 65 and have 18 months to live' is probably an exaggeration, it is certainly the case that many people say that the first thing that happens when they retire is that they find a burden lifted from their shoulders, and then that the extra exercise that they are able to take makes them much fitter. Altogether more healthy!

So, the message is to retire whilst you are still well enough to enjoy it. Working on may be important to achieve a particular personal goal, but often the financial benefits for your retirement are not very great.

**The Spreadsheet**

In September 2003’s newsletter I described the way in which the basic NHS pension is calculated, and I have written a spreadsheet to accompany this calculation. It is available for downloading from the downloads page of the SCATA website.

It does contain macros, so your security settings will need to allow these.

Firstly, the disclaimer – I think everything is correct, but don’t rely upon it. I have not built any figure for inflation into the calculations, so all are done on today’s value of the pound.

The spreadsheet is designed for medical staff aged over 50, who will not be changing their sessions between now and retirement; obviously I could not build in any of the ideas proposed for a new contract.

Firstly check that the base figures are correct – they are for 2003. This is the basic consultant salary (B17), the intensity payments (B20:B23), and the award weightings in L7:L18.

Boxes B6:B8 should then be completed, using the drop-down boxes as appropriate.

B10 and B11 are obtained as previously described from the NHS pensions agency, with the date to which they refer in box B9.

Any added years and days you may have purchased are inserted in B12 and B13

The number of sessions you are contracted for go in B14, and the date for which you want to make the calculation goes in B15.

The results are shown in the green box. You can model other dates by inserting them into G19:G23.
There are more administrators than beds in the NHS. Unsurprising, you might think, as bed numbers have been shrinking while the chaos this causes leads to the appointment of more and more administrators to try to sort it out. You might even cite the analogy of the Admiralty, which has more admirals than it has ships, and how both systems have changed in response to changes in mode of service delivery. But hang on, I hope you'll respond, admirals are sailors, but administrators are not doctors or nurses, and besides, a bed is more comparable to one sailor, and a ship to a hospital. Well, all analogies break down eventually, but the question still hangs there in the air, what on earth do they all do? Recent output from the DoH reveals the answer: they reinvent the wheel.

First, the wonderful NICE comes up with guidelines for preoperative investigations. Brilliant. What will they think of next? (I'll come to that...). Why complain, isn't it a good idea? Well, yes, except that every hospital I have worked in for 20 years has had such guidelines, either agreed with the surgeons, or simply issued by anaesthetists. Admittedly, these guidelines are simpler than NICE's, needing only a laminated A6 sheet as compared to the NICE wall-chart. Admittedly, the surgeons, especially from the hard tissue disciplines, can have a little difficulty grasping that there are tests we do not think are necessary. Nothing is perfect. But what do NICE's wall-chart and glossy booklet add? Not a lot, except jobs for the boys (and girls).

Next out, I'm reliably informed, is 35 pages on Preoperative Assessment. Patients should be assessed. Sick ones should be assessed by an anaesthetist. I won't repeat the whole lot (I am writing this in a meeting and it might be obvious if I got the document out to refer to), I am sure you get the drift. The only serious reason I can think of for writing this document is to show that there is one person - probably a whole committee, in fact - in the DoH who understands what we are doing. Well, hooray. But why tell us to do what we are already doing? What possible effect can it have, except to irritate us when someone comes along to tell us we are not doing it the official way? Jobs for the boys/girls, again.

We know why it happens: Civil servants, like all administrators, are governed by one of C. Northcote Parkinson's laws, which says that their status is assessed by the numbers of their subordinates. The bigger your department, the more important you are. You therefore have a direct incentive to take on more staff. Thus do we arrive at the ludicrous position where so much chaos is produced by massive over-management that you need more managers to sort it out!

The man who won the third world war without bothering to fight it, Ronald Reagan, was quoted as saying that you cannot reduce the number of government employees by encouraging "downsizing". What the great Ron realised was that to reduce the payroll, you need to close down whole departments. Nothing else works.

Right. Let's start with the Department of Health.

What does the DoH do for us, after all? I once wondered vaguely at a meeting, when Professions Allied to Medicine was mentioned, whether there were Professions Opposed to Medicine (POM). Thinking about what the DoH does for us, I realise suddenly that there is only one POM, the DoH civil servant. As far as I can see, everything it does is against us. We do not try to work with it because we can't: We vaguely grapple with its initiatives, hoping they'll soon go away. We do this because we are usually trying to find ways to carry on doing our job in spite of the DoH: We hope that they will lose interest and think up a new idea before the old one causes too much trouble.

But surely, you say, close the DoH and the whole system will collapse, without Auntie DoH overseeing it all! Hmm, maybe, but who has ever met a civil servant or hospital manager who has understood how the NHS works, or why? Who has met one, who is not surprised that, 6 months after outpatient waiting lists are "initiatived", you suddenly have a glut of 6-month waiters! Why do we need to waste half our productive lives telling them what we do in the other half? How are these people contributing to stopping the NHS collapsing?

And besides, wouldn't it be better collapsed? Any hospital can run itself, without purchaser nor as provider. Removal of government involvement would free us to develop new hospitals, new services: it had already started to happen before New Socialism got back in and put a stop to it!

Scrap the DoH! Let a hundred flowers bloom.

Dr de Quincy
(Dr de Quincy is a consultant in a DGH near you)
ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND

THE WYLIE MEDAL
UNDERGRADUATE PRIZE 2004

The Wylie Medal will be awarded to the most meritorious essay concerning anaesthesia or associated clinical practice written by an undergraduate medical student at a university in Great Britain or Ireland.

Prizes of £300, £150 and £50 will be awarded to the best three submissions.

The overall winner will receive the Wylie Medal in memory of the late Dr W Derek Wylie, President of the Association 1980-82.

RULES

The deadline for submission of entries is 9 January 2004 and the number of entries from any one medical school will be limited to a maximum of five. The Association recognises that most medical schools already offer prizes to medical students for an essay on a topic related to the specialty, and it has been decided that the winning of a local prize will not bar the essay from being entered for the Association Prize.

Essays should be prepared according to the general format of the Notice to Contributors at the end of each issue of Anaesthesia and be 2500 – 3000 words in length.

Four copies of the essay should be forwarded to:

The Honorary Secretary, The Association of Anaesthetists
21 Portland Place, London W1N 1PY.

ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND

Undergraduate Elective Funding
Up to £750

All medical students in the UK who have successfully completed two years of clinical medical training are eligible to apply to the Association of Anaesthetists of Great Britain and Ireland for funding towards a medical student elective period.

Preference will be given to those applicants who can show that their intended elective has an anaesthetic, intensive care or pain relief interest.

For further information and an application form please visit our website: www.aagbi.org
or email carolinestrickland@aagbi.org
or telephone Caroline Strickland on 020 7631 8807
Closing date 9th January 2004

MERSEY SCHOOL
ANAESTHESIA & PERIOPERATIVE MEDICINE

Basic Obstetrical Anaesthesia Course (BOAC)

TUESDAY NOVEMBER 11TH

• A one day course specifically designed for SHO anaesthetists on the threshold of Obstetrical Anaesthesia responsibilities.

LECTURES
TUTORIALS
CLINICAL SKILL PRACTICE

• SHO anaesthetists from beyond the Mersey Deanery are welcome to apply for this course.
• SHO anaesthetists within the Mersey Deanery should discuss the possible need to attend this course with their College Tutor asap. Study Leave is required to attend this course & Endorsement from the Mersey School will be required.
• The Course is held at the Liverpool Women’s Hospital.
• The Course Fee of £95 includes the cost of Lunch & Refreshments.
• Course Convenor: Dr Philip Barclay

Please See www.msoa.org.uk for Application Procedure, Accommodation etc.
9:30am: We arrived at the local hotel which is 5 minutes drive from our hospital. The living standard is only so so. Double room, no running hot water. Ready for the battle.

We had a look at new ICU this morning before departure. Separate rooms. Still under construction.

12:00noon: We had lunch. The volunteers wear full protection to serve us lunch. The food is OK but they are treating us like SARS patients. I suppose this is understandable. If we have this self-protection and prevention in advance, perhaps even a couple of weeks earlier, things could turn better.

2:30pm: Back to hospital. The Vice President of our hospital came to our department and gave us a speech. He mentioned that he went to Guangdong province with other high executives from other hospitals and learned a few things. Our ICU mission is to decrease the mortality rate! First, we will have 10 ICU patients transferred from our own EICU, the current isolated SARS ward in our hospital. Then we will admit critical patients from Beijing.

At the initial stage in Guangzhou, the capital city of Guangdong province, the medical staff infection rate was as high as 44.2%! Intubation and tracheotomy are the main reasons. And the patients with tracheotomy mostly died afterwards. So far in Beijing, there are over 30 patients with tracheotomy and the medical outcome is similar; only one case is an exception. This patient is the head of the medical department of Beijing Chaoyang hospital who is still surviving with tracheotomy. It is probably because she is medical staff so that the colleagues put most effort on her treatment, but without ventilation support, she will immediately die. So perhaps intubation, both nasal and oral, are better choices than tracheotomy. CPAP is preferable especially in the early stages. The other thing is to prevent medical staff infection, the mouth, nose, eyes and ears (such organ capacities) must be disinfected after treating patients. In Guangzhou city, most of the medical staff go back home after work as usual and are not under enforced isolation as in Beijing.

Medical staff who are going to resign at this moment will be definitely fired and no doubt their medical license will be stopped immediately. Already three medical staff have been punished like this in the Beijing Meitan hospital.

We have so many things to arrange. Ventilators, monitors and infusion pumps, We have to sort out all these things by ourselves.

7:30pm Many colleagues are called back to the hospital from the hotel to clean the ICU ward because Mr. Liu Qi, the secretary of the CPC (Communist Party of China) Beijing municipal committee, will come and visit our hospital. I stayed at the hotel to translate the medical equipment e.g. ventilator and monitor instruction from English into Chinese. Most of this medical equipment is imported. Several other senior doctors are busy setting up clinical admissions procedures and standard treatment protocols for our ICU.

11:30pm Very tired. The others who went to the hospital to do the cleaning job still not back yet.

Wednesday 7th May 2003

Mr. Liu Qi is supposed to pay an official visit to our hospital so we all went to the hospital to set up the ventilators and monitors to show that we are ready for admitting patients. The majority of our team came back very late last night and are so tired but they still have to go. We, the doctors and nurses, taught each other about medical equipment and tried to get to know each other because we are from different departments before joining this new ICU. The visit will be shown on BTV news tonight.

2:30pm We all, (A4 ICU ward), gathered together. Several officials from the Ministry of Health and the editors from national “health” newspaper etc. came to motivate us. The original head of our anaesthetic department said something that we agreed with very much and clapped him loudly.

Receive many phone calls from old friends and persons I know. They all watched the TV and knew the news regarding our hospital and gave me their sincere greetings. One of them said she is proud of me. My secondary school teacher even phoned my home to say “take care”.

Get phone call from Fr. Francis Xavier Zhang, the parish priest. He said “profession is vocation, and vocation is
mission”. Since I am Catholic, so this is my current mission. He asked about my parents and I told him that they look calm and ready to wait for me for a month, when the first round of the battle against SARS will be fought.

On the way back to the hotel, we saw many people are doing physical exercise. This is a good symbol that the Chinese people are paying more attention on spirit things not just material or money issues with the big change of economic reform.

In the evening, I called an anaesthetist professor in Guangzhou city and he shared their experience with me very friendly. He is a Christian and said he will pray for me.

Got another phone call from Germany, the Nations HealthCareer School of Management. Ms Dagmar Moeller asked me what I need currently. This is such a lovely surprise. I asked for about 100 sealing masks and prevention suits. They will try to transfer these things via Lufthansa then German Embassy in Beijing. Thanks be to God. This is a positive response from the school. I have to miss my module in Phoenix. Pity pity pity.

Meetings once again to arrange the transfer of patients for tomorrow until 11pm. Tired very much.

TV news: Mortality is high and 30% in the senior people, over 65 years old. 70.9% with original complications, 25.6% with DM, 30% with HBP, 2.6% with CHD, 20% with more than two complications.

Tired. Tomorrow we will have SARS patients. Face to face.
I read Dr de Quincy’s excellent article on research in the August 2003 edition of Anaesthesia News. As an anaesthetist and research scientist (both clinical and basic science research), I felt it provided me with the perfect opportunity to air my thoughts on the subject of anaesthetists doing research. Although I accept the article is written tongue-in-cheek, it exactly encapsulates the way a lot of anaesthetists out there think about the relevance of research to them and to their patients.

I would like to start by making two statements about Dr de Quincy’s views. First, I agree with everything he says. Second, I disagree with everything he says. Let me start with the areas of agreement. In the past, there has been a staggering degree of pomposity associated with anaesthetic research meetings, which frankly outstrips the quality of much of the research that is being presented. Yes, I am talking about the Anaesthesia Research Society, and since the members of this Society are already aware of my views, I feel no shame in repeating them here. I admit I have only attended one of their meetings, but I was surprised by the aggression of the questioning, and also its triviality. Of course appropriate statistics and correct grammar are important. No paper should be published if either of these is deficient. What was staggering was that these seemed to be the only real areas of discussion. The actual research or its relevance was of secondary importance. Negative comments about petty issues, expressed in a patronising manner, to registrars who are already scared out of their wits by having to present to the ‘great and good’, are hardly a recipe for generating enthusiasm for research. These attitudes convince juniors that research is a waste of time, a view which they carry into their consultant posts.

Nevertheless, it would be wrong to blame the ARS for all the ills of anaesthesia research in this country. Dr de Quincy then asks what is the use of research to an individual registrar?

If research is simply viewed as an ‘add-on’ to spice up the CV, it is no use to anybody. The registrar who requests research for CV purposes often gets handed a project that is a) half-done badly by a predecessor, and b) yet another poorly-powered study on PONV (as Dr de Quincy rightly points out). There is no sense of achievement associated with such research, and it reinforces the idea of the apparent pointlessness of it all.

And now to my areas of disagreement. There is no question that University Departments of Anaesthesia have taken a severe battering over the last ten years, with many closing down. These problems are not confined to Anaesthesia. Clinical Departments struggle to meet the demands of both NHS and University targets. Since clinical departments inevitably generate less grant revenue as a result of having to provide a clinical service as well, Vice Chancellors see them as an expensive luxury. The situation is no better in the States. Believe me, I’ve been there and done that. In this climate, considerable praise is due to the Professors of Anaesthesia we do still have, who are walking a very difficult tightrope.

Finally, my most important area of disagreement is with Dr de Quincy’s view of the relevance of research. It is not acceptable to say that because the anaesthetic itself is relatively safe, there are no worthwhile research issues. We should regard ourselves as peri-operative scientists who have a strong interest in the physiology of disease. They are basic science. Can we not apply our knowledge to these problems?

A research project requires thorough background reading, the ability to read a research paper critically, the development of a hypothesis, and an understanding of the techniques required to test it. I have involved several anaesthetic registrars in research projects and am completely confident of their ability to perform these tasks, whether they are basic science or clinical research. Even if they never do research again, the performance of a decent project gives them more confidence and hopefully a more sympathetic understanding of the role of research in clinical medicine. Originality and creativity can solve all sorts of problems, even in a DGH (N.B. Dr de Quincy). If we must develop a box-ticking approach to anaesthetic training, I strongly believe that there must be a box for research, and the box should only be ticked when a worthwhile project has been completed. If we do not do this, we will have trainees on our hands who can intubate but have no soul.

There is no point in highlighting a problem without also trying to solve it. I am organising a National Anaesthesia Research Meeting on 3rd and 4th June 2004 sponsored by Draeger Medical Systems. The aim is to allow anaesthetists to present their research projects, however small, in a relaxed and informal atmosphere. There will be ‘how to do it’ seminars with real scientists who have a strong interest in the physiology of disease. They are easygoing friends of mine who will look at your research gently and offer advice. All research subjects are welcome, and the box should only be ticked when a worthwhile project has been completed. If we do not do this, we will have trainees on our hands who can intubate but have no soul.

Karen Stuart-Smith
Consultant Anaesthetist
Birmingham Heartlands Hospital
Birmingham
Intersurgical can now offer a full range of humidification chambers supplied separately or complete with the Heated Wire Breathing System.

A range of three chambers complete with protective cassette and integral fill set:

- Auto Fill
- Low Volume
- Manual Fill

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An Appreciation of the work of the AAGBI

The reputation of the AAGBI for looking after the welfare of their own members will be well known to readers of Anaesthesia News. What may be less well known however, is the concern shown by the Association for the welfare of those practising anaesthesia in less developed areas of the world, and of their expertise in bringing about practical aid to those in greatest need.

I am writing to draw attention to an act of generosity which has been greatly appreciated by anaesthetists throughout Ghana and is likely to have a profound effect on the practise of anaesthesia here.

Three years ago, at the instigation of the then President, Professor Leo Strunin, a grant of £20,000 was awarded to enable 3 new Glostavent Anaesthetic Machines to be introduced into our country.

For several years, my colleagues and I in Ghana have felt that the modern, ultra-sophisticated anaesthetic machines that work so well in the United Kingdom, may not be ideal for practice in parts of our country, where conditions are very different.

Apart from the prohibitive purchase price of a modern sophisticated anaesthetic machine, the expertise required to maintain and service a piece of apparatus of this complexity is simply not available in the typical hospital in Ghana. Consequently, they rapidly deteriorate and become unusable. Furthermore, their dependence on an uninterrupted supply of compressed gases and electricity is a serious handicap in this part of the world, where supplies are frequently disrupted without warning.

The Glostavent, however, has been specifically designed to enable anaesthetists to overcome the difficulties that so frequently beset the Ghanaian anaesthetists and our initial experience is that it is exactly suited to our circumstances.

Trainee anaesthetists have found its simple design and logical layout very easy to understand and have quickly been able to master its operation. It is extremely versatile, and seems to be suitable for our needs in the operating room and the intensive care unit.

At a time when expensive aid is frequently given without much consideration for the wishes of the recipients and may be either irrelevant or unsuitable, I would like to assure members of the Association that the donated Glostavents are exactly what is needed here and that the grant could not have been more appreciated.

With many thanks and best wishes,
Frank Boni