This month...

Prof Mike Harmer writes his first report as our new President

An elective in Chinese Medicine: medical student Rachel Thomas reports

New GAT training survey: Ben Fitzwilliams gives details

Dr de Quincy despairs of government plans to modernise medical training
Elective in Traditional Chinese Medicine
Suzhou, China

Rachel Thomas, University of Glasgow

I have recently returned from my Senior Elective in China, where I studied Traditional Chinese Medicine (TCM). My experience was made possible thanks to funding from many sources, including The Association of Anaesthetists of Great Britain and Ireland.

I spent four weeks in a large town called Suzhou, on the East Coast of Jiangsu Province, a one-hour journey from Shanghai. I chose this elective as I had lived and taught in English in Suzhou previously and wanted to return to experience an alternative form of medicine. I stayed with a host family I had met during my previous visit.

My studies mainly concentrated on acupuncture, having been advised that it was the largest and most prominent part of TCM. My day started with a Suzhou hospital visit to observe the doctors at work, and in the afternoon I would either spend more time at the hospital or I would receive private tuition from Dr Qian in a home environment.

Dr Qian is a retired TCM doctor who had over 40 years of clinical experience and is the author of many acupuncture journal articles. She studied at Suzhou University for 3 years but the Cultural Revolution disrupted her studies so she continued her training with her father, a well-known acupuncturist.

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Today, Chinese medical students all study Western Medicine from a curriculum very similar to the UK and they have the option of studying TCM during their final years. I met many medical students and we all shared a common empathy for the volume of facts to be learnt!

I went to China with many preconceived views about TCM, especially acupuncture. I thought that acupuncture could be used instead of general anaesthetic, that the needles wouldn’t hurt and that it was a strict discipline in which a disease could be relieved or cured by application of a needle to a certain place. After a month’s study, however, I realised that there was much more to acupuncture than I first thought.

I found that the hardest part to grasp was that TCM has a different physiology to Western Medicine. TCM is based on achieving a balance of vital energy or “chi”. After a continuous four-week period of study, I appreciated the benefits and uses of acupuncture but still found it impossible to consider that disease was a consequence of imbalance in one of the five interlinking organ systems (consisting of stomach and spleen, liver, kidney, heart and lung).

Dr Qian’s treatment regimes were based on the TCM belief that organs, through a series of links, affect other organs. Consequently, a TCM doctor would strive to strengthen the weak link in the chain to cure an illness. For example, someone suffering from stomach ulcers would first have their liver strengthened. This concept was well known and accepted by both practitioners and patients to whom I spoke.

As in Western Medicine, a TCM diagnosis is usually reached from history taking and examination but I found there was a different emphasis. For example, in TCM Dr Qian placed great importance on signs of illness from someone’s tongue, their subtle skin changes and from extensive pulse examination. The characteristics of the pulse were very subtle and I fear that four weeks was not long enough to hone my diagnostic skills.

In contrast, the examination techniques routinely learnt by all Glasgow medical students were found by Dr Qian to be as incredible and amusing as I found the tongue examination. History taking was very similar to the UK method although some questions surprised me, including “Are you afraid of wind?”

A diagnosis was then proposed in a manner very similar to Western style. Despite the language barrier, we could describe diseases to each other, including diabetes, rheumatoid arthritis, spina bifida, hepatitis and syphilis, using diagrams and mime. I fear that my mime...
for haemorrhoids will not be easily forgotten! However, certain diseases could not be effectively translated. Chinese doctors often encounter patients whose stomachs were too low, causing pain, for which I could not think of a Western equivalent. Similarly, Dr Qian had not heard of morning sickness or ME.

After reaching a diagnosis, Dr Qian prescribed acupuncture to various points on the body. She knew the points and their uses off by heart but luckily I had a chart and translation booklet to help me. She also prescribed herbal medicine, which the patient would drink, take as tablets or use in a footbath.

According to TCM, the body has invisible meridians along which the chi energy moves. In healthy people, the chi moves uninterrupted along arms and legs to the chest. However, during illness, the chi is disrupted and the flow blocked. A main principle of acupuncture is to insert thin needles into this blocked meridian, and rotate them until the blockage is released, thus restoring health and function.

When I received acupuncture (or performed it on myself!), I experienced only a small nip as the needle broke the skin. However, patients with disease often felt tenseness around the needle insertion point and then, either a shooting sensation, or pins and needles along the meridian once the blockage had been removed. This was taken as a sign that the diagnosis was correct and the illness had been relieved but I found this hard to explain using my Western principles.

If the blockage could not be relieved by manual rotation alone, then electricity or burning herbs could be applied to the ends of the needles. At this point, to my Western eyes, the clinic looked very odd indeed. Patients were in different positions with metal needles in them that either moved rhythmically with the electric current or else smouldered and smelt of ginger. I found it hard to believe that patients were comfortable but they assured me that the treatment was effective and painless.

The needles usually remained in situ for 20 minutes and there was rarely any blood loss when they were removed.

The most common patient request was for analgesic acupuncture and Dr Qian was very successful in providing rapid relief. Duration of treatment was usually directly related to duration of symptoms. Dr Qian said that it was not unusual for patients to be successfully treated for an acute muscular strain after one 20-minute session.

I had thought that each disease would have a particular acupuncture point but I discovered that many points overlapped and individual practitioners have their preferences. I was surprised to find that the points that Dr Qian used on my back

Continued...
Elective in Traditional Chinese Medicine

could be used for lower back pain (my complaint) but also for hysteria, depression, infertility and incontinence!

The effectiveness of acupuncture treatment was hard to gauge. Evidence-Based Medicine is rare in TCM and much of Dr Qian’s experience and teaching comes from personal clinical findings. She had many success stories that she shared with me and was able to quote her many papers supporting acupuncture. TCM is performed on an outpatient basis at the main hospital in Suzhou and I saw a wide variety of diseases treated, including CVA, Down’s syndrome, common cold and many illnesses of pregnancy. Unfortunately I was not in Suzhou long enough to see the outcome of many of the patients’ illnesses. Memorably, Dr Qian told me of how she had used acupuncture on a man who collapsed in her clinic with a suspected MI. She inserted the needles into the palmar aspect of his wrists until the needles emerged at the other side and then rotated! The man regained consciousness after one minute and still visits Dr Qian to express his gratitude. I was encouraged to try this but I am not sure how the Greater Glasgow Health Board would feel about such a treatment!

I was very interested in seeing acupuncture used instead of general anaesthesia but it is not widely practised. Dr Qian had little experience but had been present when acupuncture was used locally for a thyroid operation. She definitely thought that acupuncture was useful for local pain relief and neuropathic pain but she expressed doubts about its applicability as general anaesthesia.

The one element of TCM that came as a surprise was the lack of consent and communication skills between doctors and patients. The doctors found my habit of comprehensive explanations to patients very bizarre, and in return, I could not get used to the way the doctors would insert needles into patients without warning them first!

I enjoyed my elective and learnt a lot in the presence of an expert who was kind enough to share her knowledge and enthusiasm. How much I shall use acupuncture in my professional life remains to be seen, although I have not been short of volunteers amongst my family and friends. After my Chinese elective, I took the Trans-Siberian train home via Mongolia and Russia, and during the long journeys I was often asked to perform acupuncture. However, the motion of the train often led me to decline!

I have gained a lot from my medical experience in China and believe it will benefit my career in the UK regardless of the path I choose. My lasting impression of the Chinese will be the huge amount of health promotion activities that were widely undertaken by the majority to prevent illness. I believe that the West can learn much from TCM, and in the future I hope that the UK will wish to incorporate some into our health system.
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One day of thematic lectures and practical sessions on CPX
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Contact: Dr Mark Hamilton c/o uch.acru@btinternet.com / www.ucl.ac.uk/anaesthesia/meetings

Provisional Announcement's for 2005
• KnO2wledge - Lessons from Life at the Limits 20th and 21st January
• 2nd Paediatric Sedation: Developing Safe Practice ~ 3rd and 4th March

The Royal National Orthopaedic Hospital Stanmore
Anaesthetic & Critical Care Jamboree
15th, 16th, 17th September 2004
Day 1: Core Orthopaedic Anaesthesia - (A didactic course primarily for anaesthetic trainees)
Day 2: Advanced Orthopaedic Anaesthesia and Critical Care
Day 3: Spinal Surgery and Injury. Anaesthesia and Critical Care
Meeting Chair: Dr David Goldhill, RNOH, Stanmore
Further Details www.mch-stanmore.org.uk/pgmecourses.asp / Telephone: 020 8909 5326
This is to be the second staging of the course. On the advice of those who attended the inaugural course in June, places are to be limited. The course will only be of value to those candidates who survive the SAQ/MCQ hurdle and who have been invited to London for the orals. Interested candidates should submit an Application Form with Payment ASAP and places will be allocated on a first-come-first-serve basis subject to success in the papers. Candidates with places on the course who fail to merit a viva will lose their place which will be made available to those successful candidates on the Waiting List. If the SAQ/MCQ results are not out in time, it is for the candidate to decide whether to come on the course or not. No cheques will be processed prior to the course weekend & only those of candidates who attend the course will be processed.

The Course Method

The Mersey School has an adequate collection of vivas with which to play. The Director of the Mersey School, who will be conducting the course, has a fair idea as to how candidates should present themselves in a viva situation. For most of the weekend, the candidates will be performing as Examiners and as Examinees in as formal a circumstance as can be mustered. There will also be the opportunity to peruse & analyse a large collection of Basic Sciences Vivas. The aim of the weekend will be to suffuse the candidates with so much exposure to Viva Practice that, come the day in London, they will be immune to the Stress & Stupidity that so often spells disaster.

Feedbacks From Viva Weekend #1

"Good practise (sic)"
"I liked the two to one situation"
"Lots of ground covered"
"Thoroughly enjoyed"
"Very hard work"

"Very good experience being an examiner - gained insight into features of good candidate and also how boring it all is"
"Also I think you need a fixed number of people on the course to make it run more smoothly"

"I do feel this weekend was a worthwhile experience"
"Good course"
"Well organised"

"Thank you for organising this course, it was worthwhile"
"Organisation - very good, Meals - good, Value - good"

"Otherwise excellent, a lot of effort has obviously been put into the question books"
"It was useful"

"Course definitely improved presentation skills"
"All aims achieved"
"Fee fine"

Venue: **University Hospital Aintree**   Course Fee: **£200 (Including Breakfast & Lunch)**

See Website for Details & Application Form etc :  www.msoa.org.uk
Those of you who know Stephanie Greenwell will know that when she asks you to do something, it would be a very brave person who says no. So I find myself as one of her assistant editors of Anaesthesia News! Shortly after telling me how little work this would involve, I got an email – “November editorial – 500 to 600 words by next month – OK?”

It’s a time of great change for us all. At the beginning of August, the European Working Time Directive came in for our trainees, and like many departments up and down the country, we have a new trainee rota of Byzantine complexity which the College Tutor and the Clinical Director claim to understand, but which bewilders the rest of us, trainees and consultants alike! The trainees don’t like it – although the shifts are shorter, fewer weekends are entirely free. On Saturdays and Sundays a new trainee appears at 5pm and my experience is that on busy days it’s much more down to the Consultant to keep things moving along. Most of us are familiar with the lag period when theatre nursing shifts change over, and now the trainees change shift as well.

However, the Consultant body in my neck of the woods has just received the long-awaited back pay, so we’re quite cheerful at the moment. After prolonged wrangling and numbers produced out of nowhere with regard to everyone’s seniority, amazingly our finance department seems to have done its sums correctly, and my new salary and back pay are both correct. I just need to keep an eye on the incremental dates now! The new contract has come in relatively smoothly in our trust compared with many places. I voted “no” in both ballots – in Scotland, Saturday morning elective working is still a possibility – but there’s no doubt most anaesthetists stand to gain financially. I for one feel slightly (only slightly) more cheerful when I’m in at night knowing that at last it’s counting towards my total hours.

Only time will tell whether it’s been a good thing – much depends on how the contract is applied; how our employers interpret it. This scope for interpretation has been a frequently expressed concern, and anecdotal evidence suggests it is proving to be a stumbling block in many areas. This month’s Anaesthesia News contains a preliminary report from September’s Linkman conference in which problems from round the country were highlighted. It’s clear a fair amount of pressure is being applied in some places to do more than is being contracted for, or to accept a reduction in SPA time, or various other shenanigans not dreamed of by the BMA.

Also in Anaesthesia News this month, Rachel Thomas, a Glasgow medical student, writes about her elective in which she studied traditional Chinese medicine. The most alien thing about her article to me was the concept of patients doing what they’re told! Rachel was supported in part by a grant from the Association – a reminder that funds can be granted to well chosen student elective projects. If you know a medical student who might benefit, contact Portland Place for details. Dr de Quincy is in fine form, having a rant about the development–by-stealth tactics the Government seems to be adopting, and Dr John Blizzard has an “Antiques Roadshow” moment, finding a mystery inhaler in an antique shop!

It’s become clear to me that the items I’ve had published in Anaesthesia News get far more comment than being published in the Association’s other journal (you know, the white one that comes free with every copy of Anaesthesia News). Anaesthetists obviously read and enjoy this publication, so I’m delighted to be associated with it. It’s only as good as the stuff you send us, so keep it coming in – it makes our job a lot easier!

Hilary Aitken
Assistant Editor

Sharp-eyed readers will no doubt have noticed a classic spelling mistake in last month’s Editorial, a few paragraphs before my rant about spelling and grammar! Well pride goes before a fall as they say. It was spotted, but the print gremlin contrived to omit the correction from the final proof. Nuff said. Ed

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Theatre rituals and old habits die hard

Asking patients to remove their dentures pre-operatively causes embarrassment and often prevents effective communication. They will frequently hold their hand up to their mouth. Dentures give the face shape and structure and, more often than not, help with maintaining an airway during facemask and laryngeal mask anaesthesia. By keeping them where they belong they are less likely to go astray.

Insisting patients remove their underwear before coming to theatre is still practised in many surgical units. Again it causes embarrassment to the patient and serves no useful purpose unless it is necessary to gain access to the operative field.

Patients are often required to wear a hat to cover their hair. Why? There is no evidence to suggest that the patients’ hair is the cause of an increase in infection. Is it appropriate to remove a patient’s wig or toupee prior to theatre?

Ever tried shouting to a patient at the end of the operation only to find that the nurses have removed their hearing aid?

Is it such a cardinal sin to ask patients to walk to the theatre suite? Ward nurses increasingly question as to whether this is appropriate. Most patients are capable of walking as they managed to arrive in the hospital unaided, and the majority seem only too happy.

Theatre efficiency tends to improve when the number of links in the chain are reduced. Hospital blankets are taboo in theatre, as they are perceived as a source of infectious organisms. There is no evidence that this item of hospital linen needs to be anything but socially clean. No study has ever proven that they harbour bugs to a clinically significant degree. It has been shown that the skin of staff working in the operating theatre is the major source of bacteria dispersed into the air [1]. Blankets, whether used to cover torso or lower limbs, can be as good as a warm air blanket and much cheaper during the shorter surgical procedures.

Parents are often invited to dress with overgown and overshoes whilst accompanying their child into the anaesthetic room. There is no evidence to support this, and overshoes have been shown to actually increase floor colony counts [2].

Rituals are actions that are performed according to custom, without understanding the reason why they are practised. Many have developed with the aim of preventing postoperative wound infections. This sort of routine behaviour becomes comfortable and familiar, and enables systems to be streamlined. But operating theatre rituals are problematic to challenge and even more difficult to change. The health service works in a different way to how it did decades ago. Although the matron has returned to our wards, I think it’s probably time to question some of the practices that we do take for granted and apply some common sense and logic (and even evidence base) to some of these out-dated customs.

J. M. Cupitt, Consultant Anaesthetist
Blackpool Victoria Hospital, Lancashire, UK

References
High altitude headache

I would like to thank Dr White and Dr Wilson for their interest in my article on High Altitude Everest Medical Trek 2003, published in the May 2004 edition of Anaesthesia News, and would like to respond to the points they have raised. My original intention was to write a travel article with broad appeal to anaesthetists seeking solace from the daily grind, and possibly stimulating interest in high altitude trekking. My intention was not to write an evidence-based review article on the use of hyperbaric and chemoprophylactic methods of preventing and possibly treating the physiologic manifestations of altitude in as controversial and exhaustive an area as the Everest region of Nepal!

I would like to address two specific points however.

1. Concerning the use of acetazolamide as chemoprophylaxis against acute mountain sickness (AMS) I would like to draw attention to a recent large, prospective, double-blinded, randomised, placebo-controlled trial performed above 4200 m in the Everest region of Nepal [1]. The conclusion was that acetazolamide 125mg twice daily was effective in decreasing the incidence of AMS in the Himalayan trekking population. Acetazolamide also improves sleep quality by reducing the respiratory periodicity provoked by the alternate stimulation of hypoxia, and the inhibition of hyperventilation induced hypocapnia [2].

2. Regarding the use of the Portable Altitude Chamber (PAC) I did state in my article that the chamber was ‘invaluable as a means of treating the symptoms of AMS, and the life threatening complications of High Altitude Pulmonary and Cerebral Oedema (HAPE and HACE)’. The PAC treats the symptoms and facilitates safe descent. I absolutely agree that the gold standard treatment for altitude-related illness is ‘descend, descend, descend’. However, weather conditions may not permit this, and in this instance the PAC is often life saving. Dr Jim Duff is the co-designer of the PAC and the leader of the expedition; we were studying whether hyperbaric therapy improved mild symptoms of AMS such as headache. We were not using the PAC as a means of routine acclimatisation or to aid ascent.

I absolutely advocate referring to the sources cited by Drs White and Wilson for comprehensive coverage of all aspects of high altitude medicine and that the first line treatment for altitude-related illness should, ideally, be descent. However, as with most things in life, experience is everything. In my personal experience, acetazolamide aids ascent to altitude and allows you to enjoy the view from the top without a headache!

Dr Damon Kamming
Airway Fellow and Specialist Registrar in Anaesthesia
University College London Hospitals
damonkamming@hotmail.com

References


Hunt for old copies

Dr John Zorab is trying to complete his collection of the books, “Synopsis of Anaesthesia” by J. Alfred Lee. If anyone has early editions, particularly 2nd, 4th, 5th, 6th and 7th that they would be willing to exchange for an appropriate cheque, please contact him at JZorab@compuserve.com
Dear Editor...

Something else to worry about

While Professor Strunin reports that he has yet to see a bird fly past his aeroplane window at 35,000ft (Anaesthesia News 206, September 2004), he may or may not be pleased to know that an aircraft has indeed encountered a bird at an even higher altitude [1]. On 29 November 1973, the engine of a commercial aircraft flying over Côte d’Ivoire, West Africa entrained a bird at 37,000ft above sea-level, causing the engine to shut down and forcing a landing at Abijan. Feathers adhering to the inside of the damaged engine allowed the species to be later identified as Gyps rueppellii, Rüppell’s griffon vulture, a hefty creature with a two-metre wingspan.

Grant Hutchison,
Consultant Anaesthetist
Ninewells Hospital, Dundee.


Old Trout

Post op surgical remarks can on occasion, not often, be helpful. A lady complained to her anaesthetist that she had been awake during her operation. She had heard her surgeon talking.

“OK then, what did he say?”

“He said, ‘How is the old trout?’”

He always did this as he took off his gloves, so the matter could be hastily, if embarrassingly, passed over!

Dr HMC Corfield
The Old Parsonage Barn, Barn Street, Crewkerne, Somerset, TA18 8BP

Still more Travelling

I enjoyed the letter from Leo Strunin about his flight to Kyoto for the World Congress in 1972. I was also on that flight. The Japan Airlines (JAL) ‘plane had been chartered by British Oxygen for AAGBI and all the passengers (about 120) were anaesthetists. There was one event which Leo might not have witnessed depending on where he was sitting. Soon after take-off, there was the usual demonstration by an air hostess of the safety measures. The girl had just reached the point of explaining about the oxygen apparatus. A nearby anaesthetist, rather unkindly, whispered in her ear that the passengers were all anaesthetists and knew a little about oxygen administration. The poor girl, tore off her demonstration life jacket, burst into tears, and fled. We all felt very sorry for her. However, in a remarkably short space of time, another air hostess appeared in Kimono and all the trimmings bearing a tray of drinks. We all felt a little shame-faced but the congress was a great experience and the views of the Northern Lights on the return journey were, literally, out of this world but, Leo, no birds!

John Zorab
Emeritus Consultant Anaesthetist
Frenchay Hospital, Bristol.

More hopeful travelling

Further to Professor Strunin’s interesting letter in the September 2004 Anaesthesia News, I thought that he might be interested to know that high altitude migration is fairly common amongst birds! The bird that flies highest most regularly is the bar-headed goose Anser Indicus, which travels directly over the Himalayas en route between its nesting grounds in Tibet and winter quarters in India. They are sometimes seen flying well above Mt. Everest at 29,035 ft. This is facilitated by the unique respiratory system possessed by birds, coupled with a haemoglobin with particularly high oxygen affinity (T H Jessen, R E Weber, G Fermi, J Tame, and G Braunitzer, Adaptation of bird hemoglobins to high altitudes: demonstration of molecular mechanism by protein engineering. Proc Natl Acad Sci U S A. 1991 August 1; 88 (15): 6519-6522). These adaptations, together with a unique musculoskeletal system (containing air sacs), make bird anaesthesia an interesting sub speciality!

Louise Clark BVMS, CVA, Dipl. ECVA, MRCVS.
European Specialist in Veterinary Anaesthesia
Animal Health Trust, Lanwades Park, Kentford, Suffolk
When in doubt – blame the anaesthetic

Brian McEvedy was one of the finest and most courteous surgeons I ever worked with. He believed there were no surgical complications of any sort. His view was that there were high anaesthetic complications and low anaesthetic complications.

Low anaesthetic complications included things like wound dehiscence, failure to excise the pathology adequately and infection. High anaesthetic complications included assault upon the surgeon and failure to pay the bill.

Ed Charlton

I can testify to this. One of BMcE’s patients once suffered a complication at my hands. In the course of an open cholecystectomy, the common bile duct was almost divided as a result of too much relaxation. The first and last time I have ever been accused of such an obvious mistake by any surgeon! Ed (Greenwell not Charlton)

A Bit of Financial Advice

As a member of the medical profession, you will probably have discovered that financial advisers will have already found you, which may lead you to believe that they have saved you the problem of researching the market for yourself.

Would that life were so simple!

When seeking financial advice, it is important to choose an adviser who is totally independent, rather than one who is tied to a single company or even a small group of companies. It is in your best interests to choose someone who has access to the whole market of financial products - no single company has yet been able to deliver the range of products capable of dealing with every person’s needs.

Do bear in mind that an adviser who is tied to a single company (or even a limited group of companies) is an agent of those companies, while an independent adviser is the agent of his client. That means you.

Ask yourself the question, “If I need advice; do I want someone to be acting for me or for the company he represents?”

Happily, all advisers now have to be qualified to some extent before being let loose on the public. This has not always been the case, as some of our colleagues may care to testify. The minimum qualification these days is the Financial Planning Certificate, awarded by the Chartered Insurance Institute.

Financial advisers now have an array of courses available to them and, if you are looking for someone who can help plan for your financial security in retirement, you should seek one who has not only achieved the Chartered Insurance Institute Advanced Financial Planning Certificate (AFPC), but who has also passed their Pension Paper, which is a degree level course in itself. You should also ask if your chosen adviser has previous experience in dealing with members of the NHS pension scheme because, in some cases, particularly those affecting GPs and Dentists, some rather arcane rules may apply.

There may be times when you want advice that may not require the purchase of any sort of financial product which would earn commission for your adviser. In that situation, you would be well advised to ask if their firm is willing to work for fees as an alternative to commission as the basis of their remuneration.

John Ballance
The 29th annual meeting of Association Linkmen took place in September in the stylish surroundings of the Royal College of Obstetricians and Gynaecologists on Regent’s Park. I’m sure I was not alone in looking around enviously and hoping the new premises of our own College might, in time, achieve the same elegant functionality.

180 Linkmen attended; an excellent turnout and indication that the scheme continues to thrive. Following registration, coffee and a warm welcome from President Peter Wallace, the morning session consisted of short presentations from Diana Dickson, Chair of the Anaesthetic Sub-Committee of the CCSC, on the new contract, and David Whitaker on independent practice and new treatment centres. Needless to say, these topics provoked much heated discussion amongst the Linkmen during the open forum session. It was clear that departments, in England at least, were widely divided in progress made towards signing the new consultant contract, although Scotland had made smoother progress. It also emerged that differential pay between UK surgeons and anaesthetists providing care for NHS patients in treatment centres is a very serious threat to the specialty. Of course, the Association will be fighting this hard but it is important for all anaesthetists to insist on compatible rates when providing this kind of service.

After lunch, we enjoyed a lively presentation on training issues, delivered by the President Elect, Mike Harmer; followed by talks on the ‘Hospital at Night’ from Vice President David Wilkinson and ‘New Ways of Working in Anaesthesia’ from Iain Wilson. An equally lively discussion took place in the afternoon open forum, much of it concerning supervision issues and ‘the named consultant for every anaesthetic given’. The Association is to issue a document on this topic outlining consultants’ responsibilities, although, because of the wide variation in service provision and infrastructure of different hospitals, it will not be possible to be completely comprehensive.

An electronic voting system was put to good use throughout the meeting, allowing Linkmen to express their views and the Association to gather important data for use in future policy making.

A full report, including the results of the electronic question and answer sessions, will be published and made available to all Linkmen, who should disseminate the information to all members of their departments later in the year.

Stephanie Greenwell
Honorary Membership Secretary and Linkman Co-ordinator
It feels rather strange sitting down to pen these lines when the Annual General Meeting has not yet taken place and I have not officially been voted in as President – but such are deadlines for publication! Equally, it is difficult to give a report on recent activities or events when I haven’t yet had to undertake any official duties. So I think I shall just indulge myself in a few thoughts as I start my term of office.

The most immediate thought is that I have a difficult task to follow Peter Wallace. Only those close to him will know the trials and tribulations he has had to struggle through during the past two years; few outsiders will appreciate the enormity of some of the problems. To name but a few, we have the Royal opening of 21 Portland Place, the introduction of the Working Time Directive, the exploration of non-medical anaesthetic roles and the dawning realisation of the impact the Hospital at Night project might have on our specialty. At all times, Peter has been careful to ensure AAGBI managers are being very short-sighted. Leads one to consider that some of members being more involved in salary but the battles that are occurring in Trusts over the definitions of supporting and outside activities leads one to consider that some managers are being very short-sighted. The possible constraints within the new contract that might limit the possibility of some members being more involved

that I shall be calling on his wise counsel in the months to come! That makes me wonder what my successor will say about me in two years time. What challenges will I have to face and how will I perform? Whilst musing on this matter, I wondered whether history might help to inspire me. As the Association’s 31st President, how have other ‘31’s’ in history coped and been remembered? The 31st President of the United States of America was Herbert Clark Hoover who held office from 1929-33. He achieved office on the back of sound fiscal policies that everyone thought would ensure prosperity for all over the ensuing years. Within months of his taking up office, the Wall Street Crash and worldwide depression happened. Hoover was made the scapegoat and he suffered a crushing defeat by Roosevelt in 1932. Perhaps Hoover is not a good omen, though in fairness, the events were not under his control.

What of the 31st Prime Minister of the UK? To be honest, if you blinked you might miss him, so short was his period of office. The 14th Earl of Derby first entered politics in 1820 as parliamentary member for Stockbridge (a seat purchased for him by his father!). He was notable for not having made any speeches in the House of Commons during his four years as MP. He subsequently moved constituencies to Preston (another ‘fixed’ seat). In these seats, he was a supporter of the Whigs, though when offered a ministerial post with the Tory government of 1827, he changed his allegiances. His political life remained unpredictable and when the leader of the Whigs resigned in 1852, he put himself up as Prime Minister and tried to form a Government, but to no avail and by December 1852, he had resigned following the defeat of his budget proposals. He tried again in 1858 to form a minority government, with the same result. He had a third spell as Prime Minister in 1866, though ill health lead to his being replaced by Disraeli. Again, hardly an auspicious example on which to base my Presidency.

Would the 31st monarch be a better example? A visit to the website where you vote for the ‘Greatest Monarch of All Time’, shows the 31st monarch to be in the number 6 position, ahead of Henry VIII and only just behind Victoria. At last some hope of an inspiring role model! The 31st monarch was Edward I who during his 35-year reign did much to unite the country – in fact, unity was his absolute passion and lead to years of conflict with the ‘Celtic Fringes’. He battled and defeated the Welsh under Llywellyn ap Gruffydd and then imposed his son as the first Prince of Wales. He equally battled against the Scots; he was obsessional in his campaign against William Wallace that ultimately lead to the capture and execution of the latter. Edward I is generally accepted as the underlying cause of the hatred of the English still evident amongst sports fans from the Celtic countries. So again, whilst a quest for unity has much to commend it, is Edward a good role model given that the outgoing President is a direct descendent of William Wallace and that it has taken nearly 30 years for me to be thought of as Welsh!

So I think the best thing is to stop speculating, be myself and see how things go over the next few months. The challenges ahead are multiple: challenges to the healthcare system itself, challenges to doctors as a whole, to anaesthetists specifically and challenges to the Association. It might be useful to consider some of these in predicting what trials we might face in the next two years.

Morale in the health service is low; there are predicted workforce shortages which will not be helped by the introduction of the Working Time Directive. The new contract for consultants should see improvements in salary but the battles that are occurring in Trusts over the definitions of supporting and outside activities leads one to consider that some managers are being very short-sighted. The possible constraints within the new contract that might limit the possibility of some members being more involved

Continued
in Association activities may require us to consider matters such as becoming a recognised trade union. For trainees, there is the ever-decreasing duration of training and concerns over the practical experience they may obtain, coupled with fears of the development of a sub-consultant grade.

For anaesthetists in particular, there are major concerns over the introduction of local treatment centres that appear determined to break the NHS tradition of equal pay for equal time with payments to anaesthetists being set at a fraction of those for surgeons. Equality of pay for all consultants was one of the founding principles of the NHS and we must not let that principle be lost. The historical relationship between anaesthetic and surgical fees in the private sector remains a major concern and in the UK we need to strive towards the situation in Ireland where a much fairer relationship exists. Equality of pay for all consultants was one of the founding principles of the NHS and we must not let that principle be lost. The historical relationship between anaesthetic and surgical fees in the private sector remains a major concern and in the UK we need to strive towards the situation in Ireland where a much fairer relationship exists. The invidious position of being bottom in the ‘Merit Award Stakes’ is unacceptable and there is clearly a great deal of work needed to redress the situation. The Hospital at Night project holds huge challenges that, if handled correctly, may enhance the role of anaesthetists but could equally lead to increased pressure to provide more out-of-hours and, possibly, subservient work. Finally, one must not forget the Anaesthetic Practitioners. Whether you view this development as a threat, an opportunity or a challenge, there can be no doubt that the next few years will be crucial in the clarification of the role they will take.

As for the Association, it may be hard to see what might threaten a body with a membership in excess of 9000 but as we grow and provide more services, so our financial expenditure grows. It is vital for the next generations that we have a sound financial policies upon which to base the future. It is also vital that the current good working relations between the Association and the Royal College continue, and that, where appropriate, joint initiatives are used to make people listen to what we have to say.

At the end of the recent Linkman conference, I turned to a colleague and pondered as to who would want the President’s job with so many difficult and interacting challenges to deal with! It seems to me that I shall have plenty to keep me out of mischief over the next two years and I look forward to keeping you up to date with a regular column. However, if you as a member think that I or the Association are not dealing with the necessary problems, let us know.

It is a great honour to be your President and I hope that I can serve you well.

Mike Harmer

50 years ago

The 13th World Congress of Anaesthesiologists in Paris in April, 2004 saw the publication of a book on the history of the World Federation of Societies of Anaesthesiologists (WFSA) to celebrate its 50th anniversary, although the organisation was actually founded in 1955. It is interesting to note this item in the section headed “Association News’ in Anaesthesia, 1955, 10, 209.

“The Treasurer of the Association of Anaesthetists (Dr Cecil Gray) has been in touch with the Bank of England about a special allotment of foreign currency for those attending the First World Congress of Anaesthesiologists at Scheveningen in September, 1955”.

Fig. The 1st World Congress and its guests in front of the “Ridderzaal” (The Hall of Knights) at The Hague.

I am sure that many of those who attended the Paris congress would have welcomed a “special allotment” but I think somehow that, in 1955, this was to overcome foreign currency regulations rather than a gift from the Bank of England!

John Zorab

Consultant Anaesthetist (retired)

All the fun of the fair

Peter and Jenny Wallace enjoying all the fun of the fair at the Abbott-sponsored Thursday evening, Annual Congress, Cardiff.
“If you feed the children with a spoon, they will never learn to use the chopsticks”

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The GAT annual training survey is becoming an important part of the committee calendar. Last year the survey took the form of a national postal survey of all trainees. This year the survey took place in June at the GAT scientific meeting in Portsmouth. This enabled us to achieve an excellent response rate (83%), and survey all 202 trainees who attended the meeting; at minimal cost.

The 2003 survey, although having a low response rate, showed that many trainees were attending teaching in their own time. However, over 90% felt that their competence was appropriate to their current level of training.

The questions in this year’s survey were simplified to make the form as easy as possible to fill out. The questions asked were:

• What is your current grade?
• In which pay band is your current job?
• In your most recent five weeks of training, excluding leave, how many half-day teaching lists or sessions have you had?
• At night do you currently have a room with a bed for your use?
• Do you have an educational plan in your current job?
• Have you had an appraisal in your current job?
• Do you think your current anaesthetic training scheme will prepare you adequately for your chosen career?
• Do we need to compensate for the reduction in working hours by increasing the duration of training?
• What would you do to help improve life for trainees?

The results showed that, of those who completed the survey, 29% were SHOs, 18% pre-fellowship SpRs and 53% post-fellowship SpRs. 66% worked on rotas banded 2A, with 12% still on ‘non-compliant’ band 3 rotas (34% in 2003). Only 22% were on lower pay bands. This change is likely to continue with the reduction in hours and the full implementation of shift systems.

The number of teaching lists each trainee was able to attend appeared low. 35% of all trainees and 50% of post-fellowship registrars reported only one or less training list per week (see Figure 1). Other evidence suggests that training opportunities are decreasing (1).

The issue of ‘resting rooms’ is very topical - perhaps a new name for on call rooms now that most trainees are no longer working ‘on call’ rotas? 93% of trainees reported that they still had rooms with a bed for their use, but several warned that these were due to be taken away. One trainee reported already having to share a room with other grades! The responses do suggest that all is not lost but action must be taken now if these rooms are to be saved.

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65% of trainees had an educational plan in their current job, and 68% had received an appraisal.

Those who felt that their current training would prepare them adequately for their chosen career were in the majority (79%), up from 63% in 2003.

Opinion was evenly divided as to whether the length of training should be increased to compensate for the reduction in working hours, with strong opinions both for and against a change.

The question of what should be done to improve training prompted a wide range of ideas, and in Figure 2 the main topics of concern are set out, along with a sample of the replies received.

The survey only looked at a self-selected group of conference attendees, but the excellent 83% response rate makes it a highly credible survey.

The GAT committee will use the survey results to continue to press for improved training standards, and will share the survey results with the Royal College and other groups in order to achieve this aim.

The issue of ‘resting rooms’ is causing concern to many trainees and there will certainly be more developments in this area in the coming weeks. The fact that 93% of these still appear to exist has already been raised with the Association Council.

The GAT committee plans to repeat this survey in a similar format at the Oxford ASM in 2005, so the level and quality of anaesthetic training remains in the spotlight, allowing changes to be identified and addressed. A more detailed report can be found at www.aagbi.org/trainee.asp. Please do contact the committee (gat@aagbi.org) if there are issues you would like to see highlighted.

Reference
Kate Bullen

After the AGM in Cardiff in September, I shall relinquish my place as Council member of the Association, and everyone I have met has been friendly, considerate and engaging, from my own perspective, I have always felt how much I had enjoyed being involved during this period in committee work, seminars, meetings and working parties.

I have been approached for advice by many people during my tenure on issues relating to SAS doctors; not only by SAS colleagues but also by Human Resource managers, Lead Clinicians and Consultants. My impression has been that a genuine desire was emerging to address the issues relating to the role of SAS doctors, and that a momentum was developing to absorb them into the wider professional group and give them access to the supportive environment enjoyed by others. I gave out the best advice I could and congratulated myself on having made a small contribution to improving the lot of at least a few SAS anaesthetists out there.

It is with no small sense of personal failure therefore that I leave, after recounting the tale of one of the last enquiries I received: one that saddened and shocked me and for which I could offer little help. For reasons which will become obvious, I do not wish to identify the person in question here and for the purposes of the article, shall refer to him as Dr X.

I was informed that Dr X wanted to speak to me because he was having a bit of trouble with his Trust and I anticipated that this would be another enquiry, typical of many, about a job plan or a proposed change to it.

How wrong can one be?

Dr X is an SAS anaesthetist of mature years who has been employed for over a decade in his hospital - a large one serving a significant population. The anaesthetic department has ITU, HDU and Obstetric responsibilities as well as a heavy surgical workload. There are no middle-grade, training staff, so out of hours cover is provided at the first level by relatively inexperienced SHO doctors who often require substantial, second level cover from SAS doctors and both are supervised by on-call Consultants.

Conflicting demands from the critical care facility and the obstetric unit occur frequently and the SAS cover is stretched regularly to meet these demands while providing support for more junior staff.

In these circumstances, it is not surprising that consultant support is often requested but, for Dr X in the case of one of his colleagues, it is not forthcoming. Moreover, not only is he expected to "manage" without help (presumably by splitting himself into three parts), but is also regularly admonished for failing to "cope" adequately on his own. This criticism is usually delivered publicly and at full volume, with frequent references to Dr X's past career, training, background, age and general competence. And to ensure that the message has been driven home sufficiently, it is peppered with expletives referring to his mother's marital status, his skin colour and sexual preferences.

It is hardly surprising that Dr X has had several periods off work with stress related illness and, if there is one encouraging aspect of this sorry tale, it is that the Occupational Health department has been extremely supportive throughout. Dr X's department certainly hasn't, because the Lead Clinician, when acquainted with these incidents, took the view that the consultant in question simply held rather idiosyncratic opinions and expounded them in a quaintly amusing, if at times disconcerting, manner.

At the end of this sad saga, I reassured Dr X that he had a very serious case and made, what I hoped were going to be useful suggestions of how he might take it forward; asked what further help I might give or who I might contact on his behalf to provide advice and support. His reply was that he didn't want or expect me to do anything as he had explored every avenue himself and no longer had an appetite for the battle to continue. He had simply wanted to tell someone about what was happening to him and hoped I would understand and offer a sympathetic ear. He had no more fight left in him and just wanted to get the rest of his working life over so that he could retire to peace and quiet.

Why did this story, of all the ones I have heard, make me so angry and ashamed?

I am angry because of the extreme contrast between this SAS doctor's experience and my own, and I simply cannot imagine being treated in this manner by my colleagues or reduced to the same state of impotence, uncertainty and fearfulness.

I'm angry because that department has chosen collectively to interpret as an amusing, almost endearing idiosyncrasy what are, in reality, the totally unacceptable actions of an arrogant and unrepentant bully.

I'm angry that this Trust either doesn't have, or chooses not to administer, a policy to expose - and remove where necessary - those who bully and harass their colleagues, juniors or other employed staff, however lofty or established their own position may be.

But mostly I am ashamed that this should happen to an anaesthetist as a result of the actions of another anaesthetist, because I hoped that we as a specialty were above such behaviour. I believed that our occasional proximity to some of the more arrogant and insensitive elements in the medical profession would have alerted us to the dangers and vanities of behaving in this fashion, and I trusted that our exposure to the pain, grief, fear and vulnerability of ill people in ITU, pain clinics and surgery would have refined our compassion and fundamental humanity in our approach to patients and colleagues alike.

I had hoped to leave Council on a happy note, able to demonstrate how far SAS anaesthetists have come. Instead, I am left reflecting on how far some of us still have to travel.

Kate Bullen
A few years ago, I saw the object shown in the central photograph in an antiques centre in Marlborough and I thought that it bore a remarkable resemblance to the original Morton ether inhaler shown above. It was unlike most medical equipment however, being of poor quality brass, with no makers mark, but with an obviously made-to-measure felt-lined wooden stand. It was fitted with a rubber bung and a small glass connection for rubber tubing.

A search through Barbara Duncum’s book ‘Development of Inhalational Anaesthesia’ and the many British textbooks in my possession produced no likeness. It was not listed in British manufacturers’ catalogues, so I took it for identification to several History of Anaesthesia meetings, all without result. It was only when I recently acquired several American publications that the mystery was solved.

In the United States, many surgeons chose to use ether even after the introduction of chloroform. Nitrous oxide was also widely available, and the use of the combination of this followed by ether was popular. A great advantage of using an inhaler for ether, rather than a cloth and sponge, was economy, with less wastage and leakage into the general theatre atmosphere. A saving of more than 50% was quoted by some makers and many pieces of equipment were designed in the USA, Great Britain and Europe in the third quarter of the 19th Century. A Dr. Otis demonstrated the use of the Clove nitrous oxide/ether apparatus in New York in 1877 (the year of a report of a death using this apparatus in University College, London). Henry Lyman, Professor of Medicine and Physiology at Chicago complained in his book of 1881 that, “…it is heavy, inconvenient and unclean”. However, changing over quickly from conventional nitrous oxide apparatus to an ether sponge (and back again, if there was a problem with coughing for instance) which some anaesthetists did, was also inconvenient and problematic.

Professor Lyman was therefore pleased to find that, “…those ingenious instrument makers of Boston have succeeded in producing an apparatus which surmounts all these difficulties!” This inhaler received the Centennial Judges Award in 1876 for “…the novelty design, perfection of its execution and general suitability to the rapid and safe administration of anaesthetics”.

The apparatus is shown on the next page and is, unusually, named after its makers, Codman & Shurtleff, rather than after a surgeon or anaesthetic designer. The globe in my possession appears to be the ether attachment. Laurence Turnbull, surgeon and physician of Philadelphia, writes in his 1878 book, “I have received a beautiful inhaler through the politeness of S.S.White & Co. of Philadelphia. The points they claim for superiority are durability, convenience (suitable for one-handed operation) and with no disagreeable nose clip needed… cleanliness and accurate working of the valves”. The rubber hood of the mask was described as disposable – a modern concept; a hard rubber mouthpiece could be supplied as an alternative to the metal mask. The globe, which held a sponge, had covers for the filler and outlet to avoid loss of ether when not in use.

Thomas Codman was a mechanic from Roxbury, Massachusetts who, in 1838, made a successful cupping instrument which sold widely. He joined with partners Asahal Shurtleff and Franklin Whitney in 1855 and moved to Tremont Street, Boston, a few doors from Dr. Bigelow’s Medical School, where he mysteriously became Dr. Codman, running a medical practice as well as the instrument making business. The company made atomizers (widely exported, with instructions in five languages!) and amputation sets for the Civil War, and issued their first catalogue in 1860. Their financial state
was particularly precarious in the depression of the 1930s, but the use of skilled immigrant Germans enabled them to maintain their reputation as high quality instrument makers, and to train another generation in the skills required.

They made munitions parts and divers knives during World War 2. In 1938, the company was bought by the sales manager Frank Ruggles who assured its survival with repair work, and Codman & Shurtleff is still in business today, based in Randolph, Massachusetts.

There is no example of this inhaler in the possession of the Association of Anaesthetists or the Thakeray Museum in Leeds, although the latter have a catalogue of 1883. More than once in the past, I have acquired the two halves of a piece of equipment from widely separated sources, but have so far failed to trace the rest of this apparatus.

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Well, here we go again. Just when you thought depths of duplicity had been plumbed, the plumbers go deeper.

It used to be that Government[1] was relatively straightforward in its approach to policy. First, it quietly set up a working party, which decided policy, then produced a “consultative” document. Consultation duly took place, comments were made, outrages cried out. Government went away and cogitated on the input from consultees, and then proceeded to ignore the whole lot, which it always intended, and went ahead with Plan A.

Now it is different (slightly). Government has achieved the difficult task of unifying doctors. It has produced plans so dangerous, so upsetting, so revolutionary, with such unknowable possible outcomes, that no-one can stomach them. Just ignoring the opposition might not work, so the powers that be are adopting a different approach. First, publish the “consultative” document, and then sit back. Absorb the flak. Evince concern. Come over reasonable. Discuss, even. Then (and here’s the first new bit) announce that they have taken to heart much of these concerns, and will amend the plans. Then (and here’s the second new bit) go quiet, wait about a year, then, unannounced, quietly, unnoticeably, go ahead with the plans unchanged.

No change, you say? Just the same though, with longer gaps? Yes, but surprisingly, resistance seems to fade with this delaying tactic. There is apparently nothing to oppose, and opposition dies away. Everything seems OK, relief is sighed, heads once again buried in the sand. Then plans are quietly revived, and go ahead uncontested.

And what is the main policy area that has been getting this approach? Why, Modernising Medical Careers, of course! First up: run-through training. Opposition was immense, well thought through, and apparently accepted. Government had second thoughts, we were told, and would revise. Now we are told – well, sort of hear on the grapevine - run-through starts as soon as the first FY2 is complete, August 06 (or was it 07?). Don’t bother resisting. And though there are changes, you would be forgiven for being unable to detect them. How will they deal with those - perhaps 25% - who will want to change specialties? How about those who deliberately join a training stream they don’t want, then change to one they do want, or perhaps just change to a different geographical area, to one that is oversubscribed? Will there be competitive (re-)entry, and more important, competitive transfer? Answers on a postcard, please, but not to me! Ask the GovDocs, and they say, ‘Oh, well, we have plans’, [don’t worry your (pretty little) head...]

Next application of the new plan: the shortened training and the sub-consultant grade. Hang on, you think, PMETB has just said the standard for training under the new regime will be the same as before, the CCT will be the same as the CCST. And there have been frequent statements that there will not be junior consultants, sub-consultants, senior registrars again, or everyone to be an NCCG for a bit. This plan has been abandoned [not wrong, you understand, just too difficult!]. You might be forgiven for thinking, hey, not so bad! They’ve realised it’s a really barking mad idea! They’ve realised it is unnecessary because of other developments. And you relax...

But don’t relax! Because the GovDocs have been heard, within days of the PMETB announcement, talking about how to replace Consultants with ‘Specialists’ and, with a conspiratorial glee reminiscent of Dennis the Menace saying “tee-hee” in the Beano, saying how independent consultants will soon be a thing of the past, as doctors will be working in groups. This can only mean that sub-consultants are back on the agenda (were they ever off?), and it’s back to the German model again, or worse!

Come, come, you say; the German model can’t be all bad. Well, I have addressed that before, but try talking to a German. Massive frustration at having to be subordinate most or all your working life; resistance to innovation resulting from central control; nursing work done by doctors (yes, nursing work done by doctors!), more doctors, but fewer nurses, 1:2 nurse: patient ratios in level 3 ICU!; oh, and lower pay. I think that means lower standards, poorer outcomes, a return to the past.

Or worse: groups of “specialists”, no-one in charge, clinical decisions by committee! AAARRGH!!

Do current trainees know that the junior consultant is only on hold? Do NCCGs know that even if they get on the specialist register, they won’t be consultants? Do the great and good, some still perhaps on our side, know what the GovDocs are up to? Or are they part of it? Do the patients know their treatments will depend on who happens to drift into the committee that day?

I think they should be told.

Dr de Quincy.

(1. Once called civil servants, nowadays doctors working for government {you can identify them by their titles for “services to medicine”, really services to the New Socialists).}
One of the most consistent topics to hit the papers over recent months has been that of pensions. With the NHS Scheme currently under review, and the state pension stretched further and thinner to meet the aging demographic of the country, the need for private provision continues to increase.

Once benefits of the NHS scheme has been maximised, personal pensions are often used to make-up any shortfall in retirement. Furthermore, for those doing private practice there is usually a need to also replace that income in retirement.

It is vital to consider private schemes seriously, continually reviewing and amending arrangements to ensure that they are in the most suitable environment.

One of the most difficult but important decisions is the selection of provider for your pension. You should be considering issues such as the strength of the company, flexibility of the contract, charges, the investment philosophy and previous track record.

At 20Twenty, we have experience in meeting the demands of medical professionals, and as such have negotiated an arrangement specifically for the members of the Association of Anaesthetists that improves on an existing and popular contract; offering terms not available to the general public. The selected scheme is run by Friends Provident. Please find detailed below a summary of the key benefits of this scheme and why this particular company and pension scheme have been chosen.

- Friends Provident are a FTSE 100 company. They were established in 1832, and have a long track record of managing client's pension funds.
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- Friends Provident and ISIS are specialists in the increasingly popular area of ethical investments. 2004 marks the 20th anniversary of the renowned Stewardship funds, and Friends Provident have the largest amount of ethically invested funds under management.
- Additional expertise can be accessed by four well-known external fund managers: Newton, Baillie Gifford, Merrill Lynch and Barclays Global Investors.
- A single annual management charge of 0.9% per annum, below the government stakeholder standard of 1%. This has been specially negotiated for the Association of Anaesthetists (for example, a fund of £100 would have a charge of only 90p deducted per annum).
- There are no other charges on the plan. It can be transferred away to another provider or an employer's pension scheme, if allowed by the new scheme, without penalty.
- Members have the ability to view their statements and amend their fund selections on-line. All members are provided with a unique individual login ID and password.

For those that are ahead of the game and have already started contributing to a personal pension, a couple of points should be noted. It is common for us to meet new clients that have not reviewed the fund selection within their pensions, even for pensions set up as many as 20 years previous. What’s more, 1987 and 2001 saw significant changes in the structure and charging of pensions. For those that haven’t reviewed their existing pension provision, it is highly advisable to do so.

Most importantly, if you have built pension funds (including the NHS scheme) to a value of more than £1.5m, you will almost certainly be affected by A-Day (April 2006). At this point a cap is to be placed on all pensions, limiting the potential retirement income to the individual. For anyone who is likely to incur this penalty of saving ‘too much’, safeguards can be put in place to maximise protection of existing savings.

Should you have any questions regarding to the newly available personal pension for the members of the Association of Anaesthetists, or any general queries, please feel free to call Joe Clark or Dr Mark Martin on 020 7400 1947.

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**The Abbott History Prize**

**£1,000**

(For Anaesthetists in Training)

Abbott Laboratories Limited have kindly sponsored a £1,000 cash prize for a member of the Association in a training grade. The prize will be awarded for an original essay of 4000-6000 words on topics related to the history of either:

- anaesthesia; intensive care;
- or pain management

Submissions should be double-spaced on single sided A4 with references in the Vancouver format. Illustrations are allowed. The paper should not previously have been published.

The £1,000 prize and an engraved medal will be awarded for the best entry, and the winner will be invited to present their paper at the GAT Annual Scientific Meeting in Portsmouth in June 2004. A runner up prize may also be awarded.

Six copies of the essay should be submitted to:

The Honorary Secretary

Association of Anaesthetists of Great Britain and Ireland

21 Portland Place, London W1B 1PY

Closing date: 25 February 2005
The Intersurgical SOLUS™

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Everyone needs a professional role model, particularly during their formative years; that role model may possess exceptional qualities in knowledge or practical skills, or have an exemplary attitude to others. The latter was the case for my role model, John Horton, who sadly died in June of this year. His untimely death has robbed me and many colleagues of a dear friend.

John started his anaesthetic training in England, spending time in Southend under the influence of Drs Lee and Atkinson, before coming to Cardiff and taking up a consultant post in 1971. From the start, John was not afraid to get involved and soon became the departmental ‘Mr Fix It’. His ability to work hard, plan meticulously and deal with people made him a natural leader within the department. Perhaps his greatest strength was the ability to treat everyone with the same degree of respect and interest. I well remember him greeting me in Cardiff when I started as a registrar in 1977. His concern for my wellbeing was obvious and an immediate rapport developed into a valued friendship.

John was in the forefront of the implementation of so many organisational developments. He was the obvious choice for College Tutor and was able to balance control with empathy for training issues. He subsequently became Regional Advisor and saw the implementation of the Calman Report. With the establishment of Trusts, John was the first Clinical Director of the department. He worked tirelessly to ensure good relationships between management and his colleagues. At times, he had to wrestle with the demands of service versus training needs of the department; to his credit, he would always champion the latter.

John was an examiner for the Royal College but never sought greater involvement nationally, choosing to concentrate his efforts locally to ensure a successful and respected department. His enthusiasm for everything and his eye for detail made him a good choice as the first editor of Anaesthesia News. Even from the early days, he was able to mould a mixture of news with contentious articles that has remained a feature of the publication.

He was special to many of us; in the past 30 years, no trainee would have passed through Cardiff and not have been influenced by him. Outside of his caring attitude in work, John was a family man with strong religious beliefs and a love for music.

When John decided to retire, we all wished him and his wife, Maureen, a long and happy time together. Sadly, that was not to be. All who knew John, and anaesthesia as a whole, have lost a dear and caring friend.

Mike Harmer

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Obituary - Dr John Horton

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**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 info@aagbi.org

Closing date 7th January 2005

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**THE WYLIE MEDAL UNDERGRADUATE PRIZE 2005**

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 2005 and the number of entrants 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