New President
David Whitaker says “Get Involved”

An Anaesthetist in Bollywood

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In 2005, as a result of the new consultant contract, many doctors in Wales were awarded a modest pay rise. Implementation of the pay award was delayed and most consultants eventually received a windfall of 6 months' backdated pay. Some colleagues bought a second-hand car, some paid off part of their overdraft while others made a donation to their favourite charity. Nikhil Kaushik, a consultant ophthalmologist at the Wrexham Maelor Hospital, whose patients I have been anaesthetising for the past 17 years, produced a “Bollywood” film!

Nikhil was brought up and went to medical school in Delhi. He has worked as an announcer for All-India Radio and his father was a journalist with the BBC World Service. He has many contacts in the media.

I was aware of his interest in the arts, particularly cinema, but it came as some surprise when, during a coffee break in our weekly eye list, he told me that he had written a script for a film called “Bhavishya – The Future”. It is a romantic drama, telling the story of two junior hospital doctors, one from Delhi and the other a British Indian. He planned to direct the film in and around our hospital in Wrexham with some scenes being filmed in India.

North Wales has strong links with the film industry. We have recently hosted productions starring Richard Gere, Angelina Jolie and Demi Moore. In 1968, the greatest of the “Carry on” series, “Carry on up the Khyber”, was filmed on location in the foothills of Snowdon.

Many of the actors for the film were recruited from hospital staff and from Nikhil Kaushik’s family and friends. Two third-year medical students studying at Manchester University (Akansha Tyagi and Vikrant Gautam) ably filled the leading roles. Consultant colleagues with suitable gravitas were drafted in to play Royal College examiners and hospital seniors. Stefan Coghlan, a consultant anaesthetist colleague, played a guest at a party who enjoys introducing and complementing other guests.
My only previous theatrical experience was as a writer/performer in a medical student review but my wife and I were cast against type as affluent hotel proprietors. Local scenes were filmed at a number of locations in and around Wrexham. Hospital scenes were shot in the evenings and at weekends.

Filming was colourful and outwardly chaotic with large numbers of interested bystanders and much laughter. Noted actor Saeed Jaffrey agreed to play a cameo role. He has starred in numerous classical Indian films as well as in European films and TV. He arrived on set amid great excitement, showed great patience with stage-struck amateurs, and gave out autographs, encouragement and technical advice.

Irrespective of the critics’ verdict, involvement in this venture has been a fascinating and morale-boosting experience for us all. So if you can bear to see us on screen, judge the artistic side of us in North Wales for yourselves.

Simon Underhill
Consultant Anaesthetist
Wrexham Maelor Hospital
www.bhavishya-thefuture.com
My first President’s report must start by paying a fulsome tribute to my predecessor Mike Harmer and the way he has skilfully conducted the affairs of the Association for the last two years. I first sat on Council as a member of the Junior Anaesthetists’ Group (JAG, now GAT), when the AAGBI headquarters was two rooms and a cupboard in BMA House. Through the magnificent efforts of our predecessors the organisation has grown exponentially and the issues, events and business that Mike and his Council have had to cover in the last two years make it the busiest yet. Mike is a great and accomplished servant of anaesthesia who has been an outstanding President and dealt with all that has presented itself very successfully. He will of course be staying on Executive as Immediate Past President a further year, for which I am grateful, but I am sure he will continue to serve our specialty in other roles. Mike has also been ably supported by Dick Birks as Honorary Treasurer, who has consolidated our financial position; and Alastair Chambers as Honorary Secretary, who has streamlined a number of administrative processes. The membership owes them all a great deal of gratitude.

2007 is our 75th Anniversary Year and the Inaugural Meeting in 1932 presided over by Henry Featherstone stated the primary object of the Association was to promote the development of anaesthesia. Other objectives were coordinating anaesthetists’ activities, representing anaesthetists, establishing the first examination in Anaesthetics, the Diploma (DA), and also encouraging friendship amongst anaesthetists. Our colleagues at the Royal College now run the examination system but the rest still apply to the Association just as much as they did 75 years ago.

The seemingly old fashioned concept of friendship amongst anaesthetists is probably even more relevant today with all the current turbulence. This leads me back to the headline ‘Get involved; feel involved’. The Association is an inclusive organisation; over 90% of anaesthetists voluntarily sign up but I would like to feel that anyone who wishes take a further step and get more closely involved with AAGBI would feel welcome to do so. Considering the following review of our operations many indicate to individual members how they can get involved even in a small way. You will find being involved professionally rewarding and more enjoyable than you think.

The primary duty of the President is to chair Council, the ultimate decision-making body of the Association, whose elected members are voted in by the membership each June. Council oversees the activity of all the other AAGBI committees and working parties which work on behalf the specialty, our patients and the nation’s health care system in general.

The Safety Committee was set up by our far-sighted predecessors in 1976 when no other specialty (or anyone else for that matter) thought safety was a major healthcare issue. The rest is history: the monitoring guidance and equipment checklist documents alone fundamentally changed every anaesthetist’s practice, and will have improved patient outcomes and saved the NHS litigation budget – all for the investment of a couple of thousand pounds of the members’ money. The Government’s £35 million budget for the NPSA has yet to emulate this. We are not complacent and the next phase of safety work now needs to be done. Many of the lessons are already known - they just need to be uniformly implemented which, of course, is often the hardest part. Getting involved with this locally is a way every member can help. The world is getting smaller and many of these are global matters - the Association is forging international links to accomplish this. Our Standards Committee, the forum where all UK anaesthetic standards representatives meet, is all part of this important work. Following our notice last year in Anaesthesia News, a number of new members who wanted to get involved and help in this crucial work have been recruited.

Developing anaesthesia through education has always been a major role of the Association and our Events Committee continues to put together a programme of successful educational meetings which always include a friendly social side. The Winter Scientific Meeting (WSM), first held at the Royal College of Surgeons in 1988, has grown out of all recognition. The Annual Congress programme has in recent years responded to members’ requests and is now offering something for everyone with three parallel streams plus workshops. Any member that has not been recently should get involved and come and see. I predict the hot ticket for 2007 will be our Dublin Congress in September. Book early: we have already had some overseas enquires. The outstandingly successful Seminar Programme continues to expand and apart from attending, all ordinary members can get involved suggesting new topics or even becoming the organiser of a new seminar – don’t worry, all the administrative work is done in-house.

The Museums, Archives and Library Committee oversees our
stewardship of the heritage of anaesthesia, securing appropriate acquisitions as they become available - let us know if you hear of any, and do visit our museum if you are in London. The International Relations committee was another visionary initiative and has been increasingly successful in recent years promoting education in developing countries through overseas lectures courses and CD-ROMs. The Association’s own new Overseas Anaesthesia Fund (OAF) hit the ground running and has already distributed, with some transport help from colleagues in industry (thanks to Intersurgical in particular), 1500 copies of the latest edition of the Oxford Handbook of Anaesthesia to anaesthetists working in Africa. The opportunities for membership involvement here again are considerable: at this year’s WSM many members got involved and gave up their lunch hour for focus group meetings with a pharmaceutical company who then made a substantial donation to the OAF.

Many (although not all) of our consultant members are involved in Independent Practice and this committee is as busy as ever with current issues. Even those members who never treat a private patient can have their working lives in the NHS influenced by aberrations in the private sector which we continue to address for the benefit of all.

The Association is grateful to the Editors of Anaesthesia, past and present, their editorial teams and our publishers for providing our members with a continually successful journal in all respects. Again, membership involvement is the lifeblood of this activity, and contributions to both Anaesthesia and Anaesthesia News are always welcome – indeed without them, neither publication could exist.

Medical research, including anaesthetic research, is also undergoing reform but our Research Committee continues to provide grants of varying sizes to suit all projects. Consider applying yourself or encourage trainees to get involved. The committee also looks at the bigger picture and lobbies for increased research into anaesthesia generally.

The Group of Anaesthetists in Training (GAT) is part of the future of the organisation and like myself, is where a number of officers first got involved. The GAT Committee is a microcosm of Council and very active and productive. Trainees can easily get involved - come to the GAT Meeting in Brighton in June 2007 and see what’s going on.

The SAS Committee is a recent addition to the portfolio, reflecting the value of this growing group of Association members and again the opportunity for their involvement in its activities and meetings is wholeheartedly encouraged.

As well as these committees from time to time Council constitute working parties to look a particular subjects often producing a “glossy” guideline or reviewing and updating a previous edition. Members get involved by identifying future topics and some with particular interests or expertise may be co-opted. Although there is currently wide consultation before publication Council have decided that final drafts should be made available on the new website for members to comment beforehand if they wish. We pride ourselves that it is very rare for completely new ideas that have not been considered by the working party to emerge after publication but sometimes the occasional phrase may have a different possible interpretation from that which the working party intended. Members will be able to help their Association produce even better documents in this way.

Council also have to consider how best to represent anaesthetists on issues of the day and respond to consultations from the DoH or other bodies. Such questions are discussed at the Annual Linkman Meeting and members can get involved and support their local Linkman. A recent example is the Donaldson report which Mike Harmer covered in some depth in September’s Anaesthesia News. Our links with the Royal College of Anaesthetists often bear fruit on such occasions, and indeed we cooperate where appropriate at different levels through all our subcommittees and working parties. Judith Hulf has just taken over from Sir Peter Simpson as President of the Royal College. I have known Judith for many years as a fellow cardiothoracic anaesthetist. We all wish her well for her own term of office and look forward to working together with our respective Councils for the benefit of the specialty and our patients.

Those of you know me well will wonder how I could have written so much without mentioning the word parity, and will be worried for my sanity. All is well and parity for NHS work is covered in another article in this issue. Suffice it to say this is another area where members’ involvement can, has, and is continuing to make a difference. Even if you never wish to do any of this new NHS work, the fundamental principle of parity must be maintained everywhere as the fall-out from not doing so will affect every man and woman in anaesthesia.

It is tremendous honour and privilege to be elected President of the Association of Anaesthetists of Great Britain and Ireland. Together with the current talented Council and the wonderful staff at 21 Portland Place we will all do our best to serve the Association and its members. The more members who get involved in the whole range of our activities, the more successful it will be in the future.

I am the President, but you are the Association - get involved with it and enjoy it!

David Whitaker
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“In the Discipline Lies the Reward”
Last month, David Whitaker wrote about applying for CEAs, and I hope many of you have heeded his advice and are thinking about completing a submission. At the moment I’m taking part in an exercise which represents the other end of the process – this year I was fortunate enough to be deemed sufficiently meritorious to be awarded a discretionary point (and before you all write in, here in Scotland we still have good old-fashioned disco points – none of your new-fangled CEAs for us). Recently our medical director, in negotiation with the LNC, put a system of monitoring in place. This year is the first time it has operated, so we are guinea pigs – it may be refined for future years.

The initial proposal was that all submissions had to be signed by the applicant’s Clinical Director, which was rejected as unrealistic – for instance my CD only has my word for it that I do all I say I do when I go to London on Association business, and frankly has better things to do with his time than check up to 20 discretionary points submissions. The agreed procedure was that a random sample of successful applicants would be asked to provide documentary evidence of chosen sections of their submission. I was chosen to be monitored (as was the only other female anaesthetist to get a point – we’ll be watching the randomisation closely in the coming years) and was asked to provide evidence in support of 3 items on my submission – my participation in the Association’s research committee, a presentation I gave at an AAGBI seminar (in 2004! Fortunately I keep everything), and an audit within the hospital. So I’ve supplied copies of minutes and of my presentations, which hopefully will provide adequate evidence of my claims. In addition my CD was asked to review the submission and confirm that as far as he was aware, all was well.

Is this ghastly, suspicious, micro-management? Personally, I have no problem with an exercise of this sort being undertaken. One does hear stories, which may or may not be apocryphal, of hospitals where every single consultant physician claims to be a member of the Drug and Therapeutics committee! Most of us have nothing to fear, and if this process does weed out (or discouragement from applying) anyone whose talents lie in creative writing rather than achieving things, it gives everyone else a better chance of succeeding. The problem is of course, that discretionary points submissions are a bit like CVs – one has to tread a line between making achievements sound as impressive as possible without resorting to outright fibs! Knowing this process was in place, I certainly had a final look at my submission to check I could prove every single statement on it before sending it in.

What will happen if anyone is unable to provide evidence? Would an outright lie result not just in removal of the point, but disciplinary action? What about previous points awarded to an applicant who is caught by this process? It all seems fairly painless and fair at the moment, but there are all sorts of ramifications. This is the first such scheme I’ve come across – does anyone else have a process in place to monitor discretionary points/CEAs? Let us know what’s happening in your area.

This month in Anaesthesia News we have a useful GAT page written by Sara Hunt, the GAT chairman, who was recently appointed to a consultant post - she has written about all the things they don’t tell you about becoming a consultant! As a trainee, you have so much focus on crossing the “finishing line”, and it can come as a shock to find that there are further obstacles past the post. I remember having many of the same concerns in my first post (and also my second, as I wrote about last month!), and it’s good to see them addressed. Fortunately most anaesthetic departments work as a team and such support is readily available for the neophyte consultant – not true of all specialties, I fear.

John Moyers writes about the work of the World Federation of Societies of Anaesthetists – we are all familiar with WFSA, but not sure what it does (or is that just me?) so it’s good to hear about the work going on in so many places. Anaesthesia News is all for blowing the trumpet for the good work (often unsung) done by anaesthetists worldwide.

Anaesthesia News is less keen on giving credit to, or even being nice to, surgeons (see this month’s Scoop!). However we offset the balance on this month’s history page, which acknowledges the contribution others made to our specialty in the time before specialist anaesthetists existed. As always, it’s fascinating stuff. Keep reading – and keep writing in!

Hilary Aitken
Ranjit Verma

Ranjit Verma is a Consultant Anaesthetist in Derby with an interest in obstetric anaesthesia. He trained in Liverpool and Nottingham, with a one year sabbatical at University of Michigan, Ann Arbor, USA. He previously served on AAGBI Council from 2001-05.

He says, “I was born in India: I emigrated to UK at an early age but I have been very fortunate to be able to enjoy the positive aspects of both cultures, switching from one to the other at the drop of a hat. I am a social animal and enjoy interacting with people from all walks of life and particularly enjoy company of those who have a sense of humour. I enjoy organizing things and am forever organizing events, social and otherwise.

I am delighted to be re-elected to the AAGBI Council and feel I have much to contribute. I am looking forward to my term of office with relish and enthusiasm and am well prepared to take on whatever challenges that lie ahead.”

Most irritating habit: Blatant honesty. Sooner or later it upsets most people!

Claim to fame: 1) Dabbling in computers, especially relating to data capture using optical mark readers for clinical audit which was adopted, adapted, copied or “borrowed” and used in anaesthetic departments in over 20 health authorities!

2) On purchase of a new laptop, sold the old one to the editor of this journal. The new laptop has died; the old one is in perfect health.

Favourite bad TV programme he shouldn’t really watch: Anything to do with science fiction - the tackier the better. If you haven’t seen “Revenge of the Killer Tomatoes” you haven’t lived.

Val Bythell

Val Bythell is a Consultant Anaesthetist in the Royal Victoria Infirmary, Newcastle upon Tyne and the programme director for anaesthesia in the Northern Deanery. She started anaesthetic training in Brighton, and subsequently trained in Seattle and St Mary’s, London, where she was also (briefly) a consultant.

Her anaesthetic areas of interest include training, obstetrics (OAA committee member 2002-05), anaesthesia for lower GI surgery “and lots of other things really”.

She says, “What I’m good at: hard work, going the extra mile, being ‘helpful’, practical procedures except arterial lines, seeing other people’s point of view/empathy, sense of humour (described as odd by teenage daughter).

What I’m not so good at/should work at: Tendency to pessimism. Not listening properly/talking too much (editor’s note – will fit right in at Council meetings).

Current big idea: We have allowed ourselves to be diminished as professionals by our government and management. Paid more than ever, but more disgruntled, more ‘jobsworthy’. We are better than this. We need to move forward, take control, stop blaming others and circumstances.”

Most irritating habit: According to her children, “getting stressed”. She has not asked her husband as she hasn’t got all day.

Claim to fame: doesn’t really want to be famous, but had to ask for a sick bowl during Final FRCA examination.

Favourite bad TV programme she shouldn’t really watch: Lost. The people are very stupid. They ask no questions; they forget the most incredible events. So why do I keep watching it?
Andrew Hartle

Andrew Hartle is a Consultant Anaesthetist at St Mary's Hospital, London, where he has been Director of Anaesthesia since 2005. He was previously an Attending Anaesthesiologist at Duke UMC, Durham, North Carolina, and prior to that trained in the RAF and at St Mary's. His areas of anaesthetic interest include obstetrics, ICU, regional anaesthesia, obesity and ethics.

He says, “I've had a varied career; The RAF, the NHS, Duke in the US. I never foresaw I'd end up being a London Teaching Hospital Consultant, let alone running the department before I was 40, and I'm still not sure how it all happened. There are times when I need to learn to say “no” to new things, but I’m not very good at it. It's still sinking in that I've been elected to Council, and I only hope that I'm up to it – I'm all too well aware of the responsibility I've been given, and I'm flattered that members of the Association have put their trust in someone so relatively young.

The scale and rate of change being forced on the NHS is scary. I’m astounded at how much we’re supposed to achieve so quickly, yet maintain quality of care and quality of service. Getting it right is going to be a real tight-robe act! If members of the Association don’t think we are getting right, button-hole me at meetings.”

Most irritating habit: smoking

Claim to Fame: once gave a general anaesthetic on Platform 2 at Paddington Railway Station.

Favourite bad TV programme he shouldn't really watch: Eurovision Song Contest

Anaesthesia Practitioners – Supplement to Previous Position Statement

Early in 2006, the Royal College and the Association issued a joint Interim Statement on the Anaesthesia Practitioner project (Anaesthesia News, May 2006). The statement confirmed both bodies’ support for the programme as it had been developed under the guidance of the Stakeholders’ Board. That support continues but recent changes in NHS funding have led to a reassessment of priorities by some Strategic Health Authorities (SHAs) with a consequent diminution of interest in the training for the Anaesthesia Practitioner role. In the face of this change, there is a risk that alternative approaches may be considered by some to develop a similar role to the Anaesthesia Practitioner or to employ overseas - trained staff such as Nurse Anaesthetists. Patient safety has been of paramount importance in all stages of development of the Anaesthesia Practitioner programme and any deviation from the agreed training may endanger that principle. The Royal College and the Association, therefore, do not support any alternative strategies, and would counsel their fellows and members against being involved in any such initiatives.

Mike Harmer, Immediate Past President, AAGBI
Judith Hulf, President, RCoA
David Whitaker, President, AAGBI
Congratulations! You have been appointed to the job of your dreams (clearly this is pre MMC run-through training when there were still consultant jobs to be had). You feel rightly proud of your achievement and you cannot wait to start…..

Day One … You spend the day being induced, filling in forms, and most importantly getting your new badge with “Consultant Anaesthetist” clearly imprinted on it, off you saunter down the corridor with the badge proudly displayed feeling very pleased with yourself

Day Two….Reality kicks in when you encounter the sickest patients you have ever seen brought in especially for your list….

Obviously what happens from here on will vary greatly depending on your job plan and where you work...

Having survived the first six months as a fledgling consultant, I thought it might be useful to share some of my thoughts and experiences in the hope it may help those of you about to take that “giant step for mankind”.

The job I was lucky enough to be appointed to is over 150 miles from where I completed my training. No, I didn’t move because I didn’t like the place I trained, I moved because this was the job I wanted to do and unfortunately no such job was available within my region.

As you all already know there are both pros and cons to moving regions. Pros include the fact that you will never have been known as anything other than a consultant in that place and you can bring as much or as little history with you as you like. If you stay where you trained it may take a little longer to stop being treated as a senior SpR. The biggest negative point about moving is that you know NO ONE! - which can be quite daunting. It is not the same as moving when you are a trainee, you don’t have the same cushion of camaraderie, and you WILL be expected to know what you are doing when you turn up for your list! I was very lucky: on arrival I was invited out to dinner in a restaurant where I was introduced to many members of the department which was a great way of meeting people. If you stay where you trained the fact that you know your colleagues and many of the theatre staff can be a great help and comfort when you are first starting out.

I took the time before I started the job to make an appointment to meet the surgeons with whom I would be working closely so I knew what was expected of me and they knew what I expected of them. At this time I politely asked to be informed in advance of any particularly challenging patients so I could
arrange to see them prior to surgery and formulate a plan. In many hospitals this will happen with pre-assessment but it is still helpful if your surgeon pre-warns you! Six months on I am glad I took the time to do this as I am sure it has helped the working relationship with my surgical colleagues.

Staying local ensures all issues surrounding how things work, where things are and who you need to know are already “in the bag”. It is definitely much harder to get urgent investigations done if you are unknown, (and no, pulling the trump card of being a consultant doesn’t make it any easier!) There are still many people who I have never met of whom I am asking favours.

In general most people have been very helpful and will bend over backwards to accommodate your requests. That said you must be prepared to reciprocate. If people ask you to do something extra once in a while, oblige.

Just because you have become a consultant doesn’t mean you are now the fount of all knowledge; you know no more than you did last week when you were a SpR. KNOW YOUR LIMITATIONS, ask for advice/help if you need it. It is much better than getting into a complete pickle and having to get someone to bail you out, or worse still endangering a patient. You will be expected to take on the more challenging cases, and you will gradually find that you are pushing yourself a little more….You cannot have your hand held forever. The amount you feel you need support will vary depending on what your job plan is.

Many people said to me the first 6months/12months/18 months (great, it goes on and on!) are the most difficult. You know the saying “if it can go wrong it will”, believe it! Try explaining to the ODP when you do a dural tap in your second week there that it is four years since that last happened to you ( the look of “we don’t believe you “ is written all over their face!)

I think one feels an added pressure to prove oneself in a new region and suspect this pressure would be less if one stays within region.

I have days when I feel like a SpR; days I wish I WAS still an SpR.

I definitely feel a much greater responsibility to my patients than before.

If you think it’s tough being an SpR think again. Long gone are the days of consultants on the golf course. I seem to be in the hospital much more than when I was a trainee!

I am still adjusting to being non-resident on call and at present spend the evening checking that my land line/mobile/pager are all still functioning. On a 1 in 6 rota I need to learn to chill out a bit!

Once again I was very lucky - for the first month I was on call I had a senior consultant rostered on at the same time. This gave me some cushioning as often the problems are political or managerial and if you are somewhere new a little help to smooth the waters goes along way...

Use your SPAs properly and BE SEEN to be doing so. It can be difficult when you first start and you will have to come up with some innovative ideas for audits etc. Trainees (as you well know) rotate frequently and will, with a little persuasion help you out!

In summary:

- Becoming a consultant comes with its own challenges and there are many things that no one tells you about, and you really wish they had!
- Be polite and pleasant to everyone –you don’t know when you might need their help.
- If you wish to address a problem don’t do it in public and be calm and succinct.
- Smile A LOT!
- Use your colleagues for advice
- Say yes to social events - it’s a way of getting to know people better.
- Try and enjoy yourself- you are going to be doing this for the next 30years!!!!
In last month’s article I wrote about the proposed changes to the NHS Pension Scheme for existing members. These included changes to the employee contribution levels, the partial lifting of the ‘earnings cap’, a revised scheme for buying added pension and new death benefit arrangements, amongst others.

I also mentioned that there is a proposal to set up a different pension scheme for new entrants. Although most readers of Anaesthesia News will be existing members, the relevance of explaining this scheme to you is that you will have an option under the proposals to move across to the new scheme on a strictly one-off basis.

Whilst the existing scheme retains the current normal retirement age of 60 the new pension sets a standard retirement age of 65. Clearly, if you have no plans to stop work before 65 then this isn’t necessarily an issue. If you are forced to stop because you’re seriously unwell, the arrangements for early retirement due to ill-health will still be in place.

The other big change is the way in which the pension accrues, and the income it is based upon. As you know, the current scheme builds up benefits at the rate of 1/80th per year of service, with the pension based on the best of the last three years’ incomes. On taking benefits you automatically receive a tax-free lump calculated on a 3/80ths accrual. So if you retire on a ‘final salary’ of £00,000 having worked for 40 years your pension will start at £50,000 per annum (i.e. 40/80ths), with a lump sum of £50,000. The theory is that if you invest the lump sum wisely for income – hopefully in a tax-efficient manner – you should receive a maximum total of about 2/3rds of your final salary when you retire.

Final salary schemes based on 1/80th accrual are typical of the public sector, whilst those private companies still offering such schemes (fewer and fewer!) generally offer accrual at 1/60th per year. Using this method, working for 40 years would give you 40/60ths and thus two-thirds of your final salary. There’s no obligatory lump sum, but instead you have the right to ‘commute’ some of your pension for cash.

The potential disadvantages of having an obligatory lump sum in lieu of pension income are:

a) Those unused to suddenly coming into large amounts of cash could easily be tempted into having a bit of a splurge with money designed to help them through their dotage. Of course I don’t include the sage readers of Anaesthesia News in this, but I’m sure you see my point.

b) Those who do manage to invest the lump sum without spending a jot of it on wine, people and song, new cars, guttering or holiday homes are still at the mercy of investment returns. The value of investments and the income you receive is not guaranteed and may fall as well as rise, as they say. Not only do you need to generate a good income but it’s necessary to maintain the real value of the original capital against inflation. Often easier said than done.

So with a 1/60th scheme you can receive up to 2/3rds of your remuneration as a guaranteed and index-linked income, rather than a maximum of half-pay under the current 1/80th accrual rate. And yet, if you wish, you can also benefit from a lump sum through commutation. This works on the basis that you would receive a £12 tax-free lump sum for every £1 of pension income you sacrifice; up to a maximum of 25% of the pension value, which itself is defined as 20 times the annual pension amount.

However, what’s the pension based on? Well, it’s not the current definition of final salary (best of the last three years). Instead the new definition is proposed to be the average of the best three consecutive years in the ten years before retirement. Each year’s pay will be revalued in line with the Retail Prices Index to avoid erosion of value.

Whilst this isn’t a move to career-average pensions, the averaging effect will have some effect on pension values in some cases. As an example, take a consultant with earnings...
in the last three years before retirement of £80,000, £80,000 and £100,000. For a moment we’ll assume that the accrual rate for both schemes is the same. Under the best-of-the-last-three-years ‘final salary’ definition and based on 40 years service, the pension payable in year one would be £50,000 per annum plus lump sum. Under the averaging system this would reduce to £43,333 (i.e. £260,000/3 = £86,666 * 40/80 = £43,333). You could argue that the higher accrual rate of the new scheme might compensate for this.

However, if your idea of the run-up to retirement is a gradual wind-down and a corresponding increase in the time spent on the golf course, then this ability to base your pension on income received over a longer period could well prove beneficial.

The employee contribution rates outlined above would apply to the new scheme, together with the new method of buying extra pension. Pensions for non-married partners would be based on entire service and the earnings cap would not apply at all.

If the proposals go through in their current form, and if you are allowed to purchase a one-way ticket to the new scheme, you need to think very carefully about which would be better for you.

If you need further information please feel free to email me at markmartin@doctors.org.uk.

The Association of Paediatric Anaesthetists of Great Britain and Ireland

Annual Scientific Meeting in conjunction with The European Society for Regional Anaesthesia (ESRA) G-MEX Convention Centre, Manchester 8th - 10th March 2007

Thursday 8th March

Regional Analgesia in Children

• ESRA –APA Specialist meeting
• Lectures from A Bosenberg, B Dalens, PA Lonnqvist & M Johr on novel techniques in regional anaesthesia

Rotating Workshops (10 stations)

• Videos, demonstrations
• Interactive discussion

ASM 9-10th March

• The extremely pre-term infant
• Debate: TIVA vs. Inhalational
• Technology in Paediatric Anaesthesia
• Evidence based review of vomiting
• Free Papers and Posters
• Trainee prizes

Jackson Rees Lecture

• Professor Baroness Greenfield ~ “What is Consciousness?”

For further information contact:
APA 2007 (Delegate Registration) 21 Portland Place London W1B 1PY. Tel 02076314352
E-mail: apamanchester2007@hotmail.co.uk or consult the APA website: www.apagbi.org.uk
Final FRCA Examination

**VIVA WEEKEND**
2.00 pm Friday 1st - 4.00pm Sunday 3rd December

**Intense Viva Practice**
This course has proved to be most popular & potential candidates are encouraged to view the many plaudits at msoa.org.uk (Classes & Courses).

Primary FRCA Examination

**VIVA WEEKEND**
2.00 pm Thursday 28 - 4.00pm Saturday 30 December

**Intense Viva Practice**
The aim of the Weekend is to suffuse the candidates with so much exposure to Viva Practice that, on the day, they will be immune to the Stress & Stupidity that so often spells Disaster.

Primary FRCA Examination

**OSCE WEEKEND**
2.00 pm Friday 5th - 4.00pm Sunday 7th January

Master Class in Communication Skills
Master Class in Oral Presentation Skills
Practice at OSCE Stations
Analysis of OSCE Stations
Introduction to the Simulation OSCE

Venue – University Hospital Aintree, Liverpool.
All Weekend Course Fees - £250
(Including Breakfasts & Lunches)

Details, Comments & Application Forms

www.msoa.org.uk
Seminars at 21 Portland Place

Education for Anaesthetists is a prime objective of the Association of Anaesthetists. To this end it organises a programme of highly popular seminars.

Seminars are held at the Association of Anaesthetists' headquarters, 21 Portland Place, London, W1B 1PY.

We aim to time seminars so that it is possible for those attending to travel to and from the venue on the day of the meeting, without the need to stay overnight.

A hot lunch and refreshments are included in the cost of the seminar.

How to book a seminar
For availability, to look at programmes and download individual application forms please see the website at www.aagbi.org. Alternatively you can complete and send the generic application form enclosed in this section (please photocopy to apply for more than one seminar).

Unfortunately we are unable to reserve places or accept telephone bookings.

Cancellation Policy
All cancellations must be received in writing. Written cancellations received more than two weeks before the seminar will be subject to an administration charge of £20. Delegates cancelling after this date will be liable to pay the full seminar price unless the Association considers there to be exceptional circumstances that would warrant a refund.

Waiting List
If we receive applications and the seminar is fully subscribed, your payment will not be processed and you will automatically be placed on the waiting list. Should a place become available through cancellation, we will contact those on the waiting list on a first come – first served basis. When a repeat seminar date is fixed, we will write to all members on the waiting list before we advertise the seminar generally.

To be placed on the waiting list, please e-mail David Williams at seminars@aagbi.org.

Please note that you cannot attend an Association seminar if you have not applied in advance. Health and Safety codes dictate we are unable to admit anyone who arrives on the day without prior arrangement.
## New Seminars

For comprehensive information, listings, programmes and availability please see the Association Website [www.aagbi.org](http://www.aagbi.org) before booking.

### CARE OF HEAD-INJURED PATIENTS IN NON-NEUROSURGICAL CENTRES

**Joint meeting with NASGBI**

**Thursday 22 February 2007**

**Organiser: Dr M Nathanson, Nottingham**

- The cervical spine
- Anaesthesia for non-neurosurgical injuries in patients with head injuries
- Update on AAGBI transfer guidelines (recommendations for the safe transfer of patients with brain injury)
- Continuing care of head-injured patients in a district general hospital
- Systematic effects of head injury

### MANAGEMENT OF MAJOR TRAUMA

**Monday 26 February 2007**

**Organiser: Dr J Nolan, Bath**

- Pre-hospital trauma management
- Airway management in the emergency department
- Massive haemorrhage
- Chest trauma
- Damage control surgery
- Management of trauma in the ITU

### PERIOPERATIVE MYOCARDIAL INJURY: IMPLICATIONS, DIAGNOSIS AND MANAGEMENT

**Wednesday 28 February 2007**

**Organiser: Dr S J Howell, Leeds**

- The changing view of myocardial injury
- Diagnosis of perioperative myocardial injury: the electrocardiogram
- Diagnosis of perioperative myocardial injury: echocardiography and haemodynamics
- Diagnosis of perioperative myocardial injury: serum markers
- Prevention: protecting the heart
- Management of perioperative myocardial ischaemia and injury

### GAT: PAIN SEMINAR

**Tuesday 6 March 2007**

**Organiser: Dr P Johnston, Belfast**

- The mechanisms of chronic pain
- Psychology of chronic pain
- Complex regional pain syndromes and their medical management
- Aspects of interventional pain relief
- Training to change pain

### SCOTTISH SEMINAR

**To be held at Scone Palace, Perth**

### CLINICAL EPIDURAL ANAESTHESIA

**Thursday 8 March 2007**

**Organiser: Dr M Stoneham, Oxford**

- Anatomy of the epidural space
- Awake and asleep issues and consent
- Epidurals and anticoagulation
- Epidurals and outcome studies
- Why epidurals fail

### SCOTTISH SEMINAR

**To be held at Scone Palace, Perth**

### ANAESTHESIA AND THE ELDERLY

**Friday 9 March 2007**

**Organisers: Prof C Kumar, Middlesbrough & Prof C Dodds, Middlesbrough**

- Do physiological changes make a difference during anaesthesia in the elderly?
- Assessment of elderly patients for anaesthesia
- Day case anaesthesia in the elderly
- Anaesthesia for colorectal surgery in the elderly
- Anaesthesia for gynaecological cancer in the elderly

**Local co-ordinator: Dr C Connolly, Dundee**
ANAESTHESIA & THE ELDERLY  
Tuesday 7 November 2006

DIFFICULT AIRWAY PROBLEMS  
Wednesday 8 November 2006

ULTRASOUND IN REGIONAL ANAESTHESIA – 3rd National Symposium  
Monday 13 November 2006

Supported by:

- Relevant physics of ultrasound for regional anaesthesia – brief overview – new developments and machines
- Sonoanatomy – the more you know the more you see
- Brachial plexus – how many approaches do we need?
- Abdominal wall blocks – a safe alternative to epidural?
- Deep plexus scanning – lumbar plexus and sacral plexus
- Pain procedures
- New kids on the block – new blocks on the kids
- Evidence and training methods

REDUCING THE RISKS IN VASCULAR SURGERY  
Tuesday 14 November 2006

MAGNESIUM; A 21ST CENTURY PANACEA?  
Thursday 23 November 2006

CURRENT TRENDS IN PAEDIATRIC ANAESTHETIC PRACTICE FOR THE NON-SPECIALIST  
Tuesday 28 November 2006

EVALUATION OF CARDIAC RISK IN NON-CARDIAC SURGERY  
Thursday 30 November 2006

ULTRASOUND FOR ANAESTHETISTS  
Tuesday 5 December 2006

BLEEDING, CLOTTING AND HAEMORRHAGE – AN UPDATE  
Tuesday 12 December 2006

Supported by an unrestricted educational grant from Novo Nordisk

SKIING – BEGINNER OR SEASONAIRE? POST A-DAY PENSIONS, INVESTMENTS AND SKIING (SPENDING THE KIDS’ INHERITANCE)  
Wednesday 24 January 2007

COMMUNICATION SKILLS  
Thursday 25 January 2007

STANDARDS AND EQUIPMENT SEMINAR  
Monday 29 January 2007

The AAGBI is located in central London, just north of Oxford Street and within easy access of underground stations.

Great Portland Street is a 4 minute walk. (Circle, Hammersmith and City and Metropolitan Lines)

Oxford Circus is a 7 minute walk. (Bakerloo, Victoria and Central Lines)

Please note Regent’s Park underground station is closed until June 2007 for renovation.

The National Rail stations of Paddington, Euston and King’s Cross are all nearby - a few minutes’ journey by taxi. All of the other London Termini can be reached by underground or taxi.

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

Travel advice can be obtained from www.transportforlondon.gov.uk where you can download underground and bus maps and also view the latest travel updates. To check latest national rail information go to www.railtrack.co.uk
To book a place on a seminar, please complete this form and return to: David Williams, Association of Anaesthetists, 21 Portland Place, London, W1B 1PY or fax to: David Williams 020 7631 4352. For availability, see website www.aagbi.org or telephone 020 7631 8862. We regret that we cannot accept telephone bookings.

**Title of seminar**

**Date of seminar**

Membership no ............................................. Male/Female .................................. Title .........................

Surname .............................................................................................................. First name ................................

Address ................................................................................................................

......................................................................................................................... Postcode  

Daytime phone ........................................... Post held ..................................................

Email .......................................................... Name of hospital (not trust)  

Special dietary requirements .................................................................

Please pay by Sterling cheque drawn on a UK bank and made payable to the Association of Anaesthetists; Credit Card (only Visa/Mastercard/Delta); or Switch. **One cheque per seminar application please.**

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**Cancellation Policy**

All cancellations must be received in writing. Written cancellations received at least fourteen days before the seminar will be subject to an administration charge of £20. Delegates cancelling after this date will be liable to pay the full seminar price unless the Association considers there to be exceptional circumstances that would warrant a refund.
Informed consent for labour epidurals

We must make a real effort to educate mothers in the ante-natal period. Labour is the wrong time to burden women with excessive information [1]. Preventing difficult consent scenarios from happening in the first place is surely better than having to deal with it at the last minute. It is important that every obstetric unit provides antenatal advice for women concerning pain relief and anaesthesia during labour and delivery. Up-to-date, informative handouts about ways to tackle labour pain and potential complications associated with it should be provided. The leaflets published by the Obstetric Anaesthetists Association form a vital source of information for mothers. Making sure they read and understand these leaflets in subsequent visits is just as important. After reading the handouts and discussion with a midwife, should the patient wish to discuss any techniques with an anaesthetist, then she should get an opportunity to do so.

A well-constructed birth plan is can be useful as it often includes reference to anaesthesia and analgesia. If the mother loses capacity during labour, the birth plan should be treated as an Advance Directive, and any documented refusal of therapy must be respected. However, competent women who request epidural analgesia during labour, despite recording a refusal in their birth plan, should have their request respected, although they should be asked to countersign any documentation concerning consent for the procedure.

Of course, the patient must still be provided with appropriate information at the time of the procedure. Accurate and contemporaneous notes are a cornerstone of the consent process. The significance of a post delivery visit cannot be overemphasised. Above all be nice, as nice doctors are less likely to be sued!

Ranjeet Shinde
SpR, St Richard’s Hospital, Chichester

References

Surgeon’s Brain found in Coffee Room

From our correspondent Scoop O’Lamine

Managers at a major NHS Trust were recently faced with a serious incident involving a surgeon. Senior theatre sister Vickie Stern explained,

“I was just finishing for the day when I noticed a discarded brain sitting on the table in the surgeons’ coffee room. I had been at work all day and had not noticed anyone acting oddly. Fortunately I was able to make contact with one of our pathologists to ask for advice. He suggested putting the brain in some warmed saline and bringing it to the lab as quickly as possible.”

The brain (pictured) was urgently inspected by Dr Rubic Suduko, Consultant in Brain Pathology. “I immediately recognised it as a monosynaptic Primapeus orthopedicus model. Although it had obviously been out of the skull for some time, it did not look to have been activated recently, so I was able to suspend it in a preservative solution until the owner could be contacted. These are interesting brains as they have an unusual neurotransmitter "BUPAmine", a chemical known only found in large quantities in this, and one other brain - Slimopium plasticus. I should add the brain in question was pristine and showed very little evidence of wear, which is said to be a typical feature of this genre”.

Mr Roger Whackit, 59 year old senior orthopaedic surgeon, was delighted to be reunited with his vital organ. “I knew I wasn’t quite right, but managed to get through my usual list of operations. When I got home my wife did think I was a bit more forgetful than usual, although considerably more charming”.
One of the best things about passing the final fellowship exam is that it enables you to start going to meetings which sound interesting rather than those intended to help you to pass an expensive exam.

Thus I found myself one cold winter afternoon on a plane heading for Belle Plagne in the French Alps. The meeting was started over 17 years ago by a group of South Thames consultant anaesthetists and has now expanded to having over 300 delegates consisting mostly of consultants and senior trainees: however there were also a few SHOs (shouldn’t they be studying for the Primary?) from all over England.

Belle Plagne is located at a height of 2000m, and thus has excellent snow conditions in January. The basic cost of attending the meeting was £300. This entitles you to attend all the lectures and any of the workshops you may be interested in. Doctors’ Updates also provide an accommodation and travel package, but I found it was cheaper to book these using a tour operator.

The conference itself was five days long and began on a Monday morning at 8am. It is held in the Sale de Congress in the centre of town. Each day there are lectures from 8.00am to 9.30am and from 4.45pm to 7.00pm. These were held on a variety of fascinating topics by highly regarded speakers. I particularly enjoyed “Flu virus pandemic and its potential impact on ITU” by D Goldhill, “Renal rescue” by M Palazzo, “Lessons from the July bombings” by K Fong and “Anaesthetic Practitioners” by A Tomlinson.

Alternatively delegates could choose to visit up to 17 workshops on topics such as ultrasound guided regional anaesthesia, airway anaesthesia and awake intubation, appraisal, and X rays for the anaesthetist. I went to the workshop on X rays given by
a consultant radiologist and it was one of the clearest pieces of teaching I have ever been given on this topic.

Between the morning and evening lectures there is rest and recuperation time which you can spend any way you wish. Most delegates decided it might be fun to discuss interesting points brought up during lectures on the ski slopes.

Overall I really enjoyed the meeting and it was very interesting to combine being updated in your field and also having the opportunity to improve your physical health. After all, many of us spend far too much time sitting down whilst working. It is a great way to spend your study leave, learn a lot, make some good contacts and have a nice holiday!

Dr Sanjay Wijayatilake
Specialist Registrar Anaesthetics
St Barts and the Royal London Hospital
Because the development of research and clinical practice in the UK was taken up so much by one man, John Snow, there is the danger of our concept of the history of anaesthesia being distorted by a tendency to regard this as the norm. In fact it was very unusual. Snow’s domestic situation - unmarried - allowed him the time, the space and the means to pursue his interests in a country where, unlike France and Germany, science was not in the forefront. So we are, perhaps, conditioned to the idea that advances in anaesthesia were always made by ‘anaesthetists,’ overlooking the fact that in the early days there weren’t any. We tend to regard contributions from others whose main practice was something else as anomalies.

The first ether inhalers were designed by dentists and pharmacists. Startin was a pioneer dermatologist, and his vaporizer, which worked on the injector principle, was probably more efficient that Snow’s. Simpson, of course, was an obstetrician, and James Syme, Scotland’s most experienced chloroformist - 5000 administrations without a death according to his son-in-law, Joseph Lister - was principally a surgeon. It is to Lister that we owe the concept of respiratory obstruction. The early ‘anaesthetists,’ even Snow, apparently did not recognise the condition. It does not appear in his publications, nor is the word ‘cyanosis’ to be found. But Lister researched the condition on himself, using the indirect laryngoscope invented by the singing teacher Manuel Garcia in 1855, and devised his method of relieving laryngeal stertor by tongue traction. To Lister do we owe the inspiration for the various designs of tongue forceps that used to adorn the Boyle’s machine.

The other potentially life-saving instrument before anaesthetists became adept at laryngoscopy and intubation was the mouth gag. The commonest models were designed by surgeons for their own purpose, repair of congenital cleft palate. Sir William Fergusson was a pioneer who much improved the conventional operation, and Francis Mason,
on the staff of three teaching hospitals in his own right, was his first assistant for twelve years. Ferguson's modification of Mason's rather unwieldy tongue plate was a great benefit to anaesthetists, though that was not his purpose. Ackland, who designed the parallel blades, making them thinner and easier to insert through clenched teeth, was not an anaesthetist, but a dentist practising in Bristol. The contribution of dentists has hardly been recognised; the nasal mask, and demand for commercial firms to produce nitrous oxide in cylinders, came from dentists.

The pioneers, and to a large extent the practitioners, of spinal anaesthesia in the UK were surgeons or obstetricians. Anaesthetists were rarely involved until the founding of the NHS. Writing from the only academic teaching department in the country, Professor Macintosh and Dr Mushin, in a letter to the Lancet in 1944, confessed that ‘our practical experience is very limited …’

It is fairly well-known that the keeping of anaesthetic records, the charting of the pulse rate, and later the blood pressure, was initiated not by an anaesthetist but by a surgeon, Harvey Cushing, though this is not to say that anaesthetists did not keep any records. John Snow, of course, had his Case Books, and much of the clinical material in the first edition of Hewitt's textbook was based on records that he had kept for the previous ten years, supplemented by notes of 2350 cases by Dr C E Sheppard of the Middlesex Hospital.

In the United States the devisors of the first automatic ventilators during the first decade of the twentieth century were all surgeons; and the chapter on anaesthetics in the French surgeon Eugene Doyen’s textbook of surgery of the same period is an eye-opener to today's historian of anaesthesia.

How have things become so different? A specialty needs organization, communication, recognition, a communal sense of purpose. These came about very gradually, starting in 1893, with the founding of the Society of Anaesthetists, and gathering pace in the early 1930s, when the Association of Anaesthetists was set up and the first academic unit was inaugurated in Oxford. Much is owed also to the research department at the RCS, which, during the 1950s and ’60s, under the leadership of the late Ronnie Woolmer, brought physiology into anaesthetic practice.

David Zuck
Dear Editor...

Patient – centred management

I have been a consultant anaesthetist in a hospital on the South coast since 1972. I have had some amazing experiences in theatre, but this one comes pretty near the top. I was in the middle of an operating list recently, and asked my ODA to send for the next patient. I overheard this conversation on our theatre’s portable phone (brackets and italics are the replies my ODA told me later):

"Hello. Is that Boneset Ward?"
It is.
"Can I speak to Sister or Staff Nurse, please?"
There are no nurses on the ward.
"Who are you then?"
I’m a patient: they asked me to answer any calls.
"Oh. Do you happen to know if there’s a patient called Mr Crackwrist there in bed with a gown on?"
No. He’s not.
"Oh. How do you know he’s not?"
I’m Bob Crackwrist, and I’m still in my outdoor clothes.
"Well, in that case, could please you go to the loo, then put on the gown which should be on your bed, and I’ll send a porter up for you?"
OK.

When the porter arrived, a flustered nurse had magically appeared, and the patient came to theatre, where he had an uneventful operation.

Joe MacDonald
Consultant Anaesthetist
(Joe MacDonald is the pseudonym of a consultant who wishes to keep his job!)

Don’t Tell the Resuscitation Council….

I was impressed with Scoop’s unveiling of the new cardiac arrest protocol [1]. As a senior member of HECT (Hospital Emergency Cuppa Tea) I still feel one should follow the trusted ‘ABC’ approach.

A: Arrive- never run. Always give the ward staff a good head start.

B: Blame- preferably someone who isn’t present to defend themselves. When in doubt pick a surgeon.

C: Criticise- Quite easy to do with the retrospectoscope

D: Declare unfit for ICU

E: Exit- to the kettle!

Some junior members are always a bit suspicious at the start but soon realise this means adequate fluid resuscitation for the staff.

I do hope this is of assistance for future critical care scenarios.

Yours sincerely,
Dr. M. Ewsed.
Specialist Registrar in a Hospital near you.

References

Editor’s note: I have always been a great fan of the ABC approach in theatre – Anaesthesia, Biscuit, Coffee.
Silver Lining – or Brick Wall?

So the time has come; the last SpR numbers have been advertised in my region. There are nine jobs and in my hospital alone, thirteen people in the running. That is before you consider the rest of the region and beyond. We clearly cannot all succeed and progress in our chosen speciality at this point in time. Then along comes MMC with a projected number of ST3 posts across the region well below that needed to accommodate current SHOs.

I suspect that there have always been a small number of trainees that hit a ‘brick wall’ and seemingly can go no further on a particular career path. I wonder if the MMC masterplan includes any support for such individuals as I fear there are brick walls springing up nationwide and trainees hitting them on an unprecedented scale.

It seems the MMC cloud lacks that all important feature, the silver lining….

Helen Jewitt
LAS SpR Swansea

Don’t give me the elbow

I remember when I was revising for my MBChB finals I developed student’s elbow or olecranon bursitis as the ‘bone doctors’ like call it. Well, two months into my revision for the Primary FRCA… no, not olecranon bursitis, but ulnar nerve compression at the elbow. I thought it was funny that my left little finger and half my ring finger felt numb after a hard session at the books. If it doesn’t get better, I might have to turn up to the exam with elbow protectors, or a full body armour suit like an ice-hockey player – I wonder if that would sway the examiners to pass me?

James S Dawson
Senior House Officer
University Hospital Birmingham NHS Foundation Trust

Keep your voice down!

Two of our theatre nurses were sent to an NATN conference where they were expected to report back to the rest of the team. They had been asked to find out about advances in endoscopy in particular, and both decided to make a good set of notes to bring back to the hospital.

The first day went well, copious notes were taken and all lectures attended. The evening went particularly well with a very heavy session ending in the small hours. Both my colleagues awoke to find themselves feeling distinctly unwell and late for the first session, which was to be the European expert in endoscopy.

They rushed to the conference venue, and arrived just as the lecture was starting. Since the speaker was Italian, simultaneous translation was being provided, and both of my colleagues were handed a headset for this purpose. There were not many seats left and our nurses made a bit of a spectacle getting themselves seated down at the front, in the middle of a long row.

The lecturer was not slow in speaking, and the translator did a valiant job keeping up. Badly hung over, our nursing colleagues tried to write down everything that was said, but the task proved impossible.

One of my colleagues, Alice, looked at the other one and mouthed a few words. Her friend took her headphones off and Alice said “I can’t understand a **** word this twit is saying”. Unfortunately since she was still wearing her headset this was spoken much louder than intended, and during a lull in the proceedings. The lecturer stopped and the whole auditorium turned to look at Alice. The pair of them, mortified, left the theatre abruptly, and the lecture did not restart until they left.

We never did find out about the endoscopy update but enjoyed the description of the event enormously!

Iain Wilson
Consultant Anaesthetist
Exeter
28

The World Federation of Societies of Anaesthesiologists

The World Federation of Societies of Anaesthesiologists (WFSA) was established at the first World Congress of Anaesthesiologists in The Netherlands in 1955. At that time, there were 28 member societies. Currently there are 116 from nations across the globe, including AAGBI. Anaesthetists worldwide are encouraged to visit the WFSA Web site at www.anaesthesiologists.org, where they will find information about the Federation, its member societies, WFSA committees and the WFSA newsletter. Anaesthesiologists throughout the world convene every four years at the World Congress of Anaesthesiologists. It is anticipated that over 10,000 anaesthesiologists from more than 135 nations will attend the next Congress in Cape Town, South Africa, in March 2008.

Worldwide Education
The WFSA Education Committee has been very active throughout the year under the direction of its Chair, Angela Enright, (Canada). The committee works cooperatively with other organizations, including AAGBI, in support of education for anaesthesiologists from more than 40 counties in the developing world. Highlights are included below:

Rwanda has been the scene of much anaesthetic activity over the past two years. Through Phillip O. Bridenbaugh, chair of the American Society of Anaesthesiologists (ASA) Overseas Teaching Program, and Dr. Angela Enright, representative of the Canadian Anaesthesiologists’ Society (CAS) International Education Fund, ASA and CAS are cooperating in assisting the Rwandans to develop a training program in anaesthesia for their physicians. This effort is now just under way and will be a long-term project for both societies.

First Paediatric Fellow
In September 2005, the first Fellow in Paediatric Anaesthesia arrived in Cape Town from Nairobi, Kenya. This was the culmination of many years of effort, particularly by program director Adrian Bosenberg. The Fellows have the opportunity to take part in all aspects of anaesthesia for children, including regional anaesthesia and pain management. One Fellow, Zipporah Gathuay, has had her first publication, a case report in the South African Journal of Anaesthesia and Analgesia, and was scheduled to present a poster at the South African Society of Anaesthesiologists (SASA) Conference in March 2006. Charles J. Coté, ASA member on the WFSA Executive Committee, has been instrumental in the development of this and similar paediatric anaesthesia training programs in Santiago, Chile and Vellore, India.

Success in Ghana
The “teaching the teachers,” the program in Accra, Ghana, has been a successful cooperative venture of ASA and WFSA. All regional hospitals in Ghana now have at least one staff member formally trained in anaesthesia. There is now also a Fellowship Program of the Ghana College, and more trainees are applying for those positions. Since its inception in 2000, the training program has 15 graduates from Ghana, one from Sierra Leone and two from Nigeria.

Flagship Bangkok Program
The Bangkok Anaesthesia Regional Training Centre (BARTC) continues to be the flagship training program, very ably led by Professor Thara Tritrakarn. The ninth class included physicians from Bhutan, Myanmar, Mongolia and Cambodia. All the trainees spend seven months in a university hospital and then rotate to a provincial hospital for three months to prepare them better for work in their home countries. They spend their final month back at the university and then sit their exit examination. All of the trainees were successful this year.

Israel Training Center
The Training Center in Beer Sheva, Israel, led by ASA affiliate
member Gabriel M. Gurman since its inception, continues to flourish. Beer Sheva concentrates on trainees from Eastern Europe. This year saw two from Slovakia, four from Bulgaria, one from Moldova, two from Romania and four from Macedonia spend a month each at Beer Sheva. Feedback received from the trainees has been positive.

**Education Materials for All**

During the past year, the WFSA Publications Committee, chaired by Iain Wilson, (United Kingdom), has worked together to improve access to educational material for anaesthetists worldwide. “Update in Anaesthesia” is published in English and translated into French, Spanish, Chinese and Russian. They are available in electronic or paper format, except for the Spanish edition (electronic only) and the Chinese edition (paper only). Over the past year, the Publications Committee has continued its work on journal and book exchanges, which has been led by Berend Mets, (United States). Those willing to donate literature are asked to register on the World Anaesthesia Web site, where their information is collated along with those requesting books or literature. The system is run electronically and is starting to gather momentum. For more information, see www.world-anaesthesia.org.

An Editorial Board has been established to run the “Tutorial of the Week.” This is a web-based tutorial that changes on a regular basis to provide straightforward education for its participants. Because many anaesthetists cannot access the Internet but can receive e-mail, an electronic version of the tutorial in simple text files will be developed. This will provide a powerful educational tool and, in time, will allow the committee to develop a curriculum for many anaesthetists working in isolation, but who have the ability to access e-mail.

WFSA and AAGBI have together produced two CD-ROMs of educational material supplied free to anaesthetists in the developing world. These have proved to be an excellent way of supplying large amounts of material in a compact form, and have been well received.

**A Well-Run Organisation**

WFSA has a record of minimizing administrative costs and placing funds into publications and educational activities, especially in the developing world, although there is always more to be done. Dr. Bridenbaugh, Chair of the WFSA Foundation, is doing an excellent job in structuring the WFSA Foundation to get information about WFSA publications and educational activities into the hands of potential donors. In accomplishing this, the WFSA Foundation also is sensitive to the need to avoid competition with the various foundations within each of the member national societies.

AAGBI can be proud of its past and continuing support of our colleagues throughout the world through WFSA. In a continuously violent and dehumanizing world, the scientific and cultural diplomacy aspects of WFSA are our hope for sanity and our path to safe anaesthesia care for our fellow human beings.

John R. Moyers, Secretary, WFSA
RESEARCH GRANT

The Research Grant is aimed at those undertaking research in Great Britain and Ireland

GRANTS UP TO £15,000

RULES
Theoretically there is no limit to the number of research grants that may be awarded. Funds are available for the purchase of apparatus for specific projects and the application should enclose a precise quote from the manufacturer. The applicant must indicate why a particular make has been chosen. Such apparatus remains the property of the Association and must be labelled as such. At the end of the project, or after such interval as seems appropriate, ultimate disposal of the apparatus will be considered by E & R. It is the express wish of the Association that any equipment will continue to be used for research purposes. Salaries may be payable in the form of part-time Fellowships for doctors and salaries for technicians of other assistants. Only in exceptional circumstances will grants of more than £5,000 per annum be made to any individual department. Candidates should indicate their qualifications and experience to carry out the project. Those holding trainee appointments should have a consultant (or equivalent) as a referee, preferably the individual who will supervise the work.

For further information and an application form
Please visit our website: www.aagbi.org or email info@aagbi.org or telephone 020 7631 1650.

Application forms should be forwarded to the Honorary Secretary, The Association of Anaesthetists, 2 Portland Place, London W1B 1PY or HonSecretary@aagbi.org

Society for Education in Anaesthesia (UK)
Annual Scientific Meeting
‘Modernising Medical Careers: The Anaesthetic Response’
Monday 19 March 2007
‘Novotel’ Arundel Gate SHEFFIELD

- National Entry for the run-through grade.
- Interviewing for run-through training: a competency based approach.
- Assessment in the run-through grade: the RCA view.
- The role of simulator based training.

Plus
- Workshops and Free Papers.
- Abstracts invited for Free Papers.
- Trainee Prizes of £150 and £300.

Submission deadline 14 February 2007
Posters welcome deadline as above Prize £50
Limited to 100 delegates
Cost: £125 for members/£150 for non-members (including one year membership)
For further details, please contact:
Barbara Sladdin, Administrator, Northern Schools of Anaesthesia, Royal Victoria Infirmary, Newcastle upon Tyne. NE1 4LP. Tel No: 0191 282 5081 or email: Barbara.Sladdin@nuth.nhs.uk or visit www.SEAUK.org

Magill Symposium
Chelsea and Westminster Hospital
369 Fulham Road, London
Wednesday 29th of November, 2-6pm

‘Burn injury’

Course Fee: £75.00

Further details available from:
Elizabeth Ogden
Department of Anaesthetics
Chelsea and Westminster Hospital
369 Fulham Road, London, SW10 9NH
Tel: 0208 746 8816
Email: e.ogden@imperial.ac.uk

State of the Art 2006
The Intensive Care Society
State of the Art 2006 Meeting
11 - 12 December, the Hilton London Metropole, London
Mark your diary and book your study leave now!
11 CPD Points
An essential meeting for Consultants and Trainee Intensivists and anyone involved with caring for the critically ill including doctors, nurses and others working in anaesthesia, outreach, emergency or acute medicine.
State of the Art 2006 - equipping you with the information you need to keep pace.

www.ics.ac.uk
Take Five...

November Crossword
Compiled by Ranjit Verma

Across
1. A refined gulf race? (8)
2. Acquired (3)
3. Rubber (6)
4. Not unhealthy (3)
5. Mixture of oxygen, nitrogen and some other bits and bobs (3)
6. One spotty cube (3)
7. Menaced a tenth reed? (10)
8. To a high extent (9)
9. Guest (7)
10. Apparently (9)
11. Indemnity against case run-in? (9)
12. Up and down play things (2-3)
13. Keep an eye on is a bit verbose! (7)
14. Uneasy (13)
15. Metal container with ability! (3)
16. Ducts (8)
17. Do away with (3)
18. Are you fond of Toni? (as the young say) (4)
19. Cock-a-doodle-doo! (4)
20. Singular (3)
21. Justly (7)
22. A young woman (4)
23. Yell (4)
24. Morose (3)
25. Publishes a paper with a tie rod? (6)
26. Perform (2)
27. Ceased functioning (4)
28. Spared as he fled without looking back (3)

Down
1. Acquired (3)
2. Mixture of oxygen, nitrogen and some other bits and bobs (3)
3. Rubber (6)
4. Served food to (3)
5. Sent mettles to the colonies? (11)
6. Explained in detail on cider beds? (9)
7. To a high extent (9)
8. Guest (7)
9. Indemnity against case run-in? (9)
10. Indemnity against case run-in? (9)
11. Indemnity against case run-in? (9)
12. Up and down play things (2-3)
13. Metal container with ability! (3)
14. Are you fond of Toni? (as the young say) (4)
15. Cock-a-doodle-doo! (4)
16. Justly (7)
17. Spared as he fled without looking back (3)
18. Are you fond of Toni? (as the young say) (4)
19. Singular (3)
20. Inform (4)
21. A young woman (4)
22. Scream (4)
23. Morose (3)
24. Perform (2)
25. Publishes a paper with a tie rod? (6)
26. Indemnity against case run-in? (9)
27. Ceased functioning (4)
28. Spared as he fled without looking back (3)

Sudoku
from Ranjit Verma
Difficulty Level = Moderate

October Solution
1 6 9 4 3 2 7 5 8
8 3 2 7 9 5 6 1 4
4 5 7 6 1 8 9 3 2
5 2 5 8 4 9 3 7 1
6 3 9 1 2 7 6 8 4 5
7 4 8 1 5 3 8 2 9 6
5 1 6 9 8 7 4 2 3
9 8 4 3 2 1 5 6 7
2 7 3 5 6 4 1 8 9
As you will have read in previous reports of the results of the 2006 AAGBI Membership Questionnaire published in Anaesthesia News (August and September 2006), more than 3,000 members completed and returned their questionnaires. This large number of respondents makes the results highly representative of the experiences and views of the membership. One of the most important issues for anaesthetists throughout the UK, the issue of parity, is a vital element in the response of anaesthetists to the rapid and fundamental changes being inflicted on the NHS.

The NHS Plan of 2001 consulted widely, asking the public what they wanted to see in the NHS. The number one thing the public said “was more staff, better paid”. Without the same consultation process ‘A Patient-led NHS: delivering the NHS improvement plan’ was published in 2003. Under this up to 15% of NHS elective operations will be directed under ‘patient choice’ initiatives to additional capacity available in Independent Sector Treatment Centres (ISTCs) and Independent Hospitals.

The Department of Health describe this activity done by Consultants as “NHS work in non-contracted hours”, which it is, but the managers involved unthinkingly and illogically decided to adopt historic private practice arrangements and offer anaesthetists 40% of surgical pay rates. At the same time Rt. Hon Patricia Hewitt said in her first speech as Secretary of State for Health that she wished to embed the principle of equal pay for work of equal value in NHS work. So much for an organisation with a memory. In February 2005 AAGBI Council reiterated that it believed that consultants of all specialties should be paid the same hourly rate for caring for NHS patients regardless of the location in which they are treated.

Here, we present the opinions and experiences of AAGBI members on parity issues. We asked members whether they supported this stance on pay parity. Only 3.2% disagreed with 92.1% of our members supporting this stance and 4.6% undecided.

The next question we posed was whether members had achieved pay parity for NHS work conducted in their Trust outside of contracted NHS duties. Of those who replied and to whom this question was applicable, 50% have achieved parity all the time or usually, 17% have achieved parity sometimes, with 33% reporting that they have not achieved parity.

When asked whether they had been offered NHS work at non-parity rates, two thirds of those who responded and to whom the question was applicable answered that they had been offered non-parity rates. One third of all who responded had been offered non-parity rates and had refused to do the work at those rates. When asked if
in future they would be prepared to do NHS work at non-parity rates, less than 10% of anaesthetists agreed.

Analysis by region shows that parity has been achieved in some hospitals in every region. The blue riband goes to Scotland and Wales, whose rates of parity achievement are the highest. Anaesthetists in every region have been offered NHS work at non-parity, none more so than in the East Midlands and Wales. We are uncertain as to why Wales is such a shining example of parity, when more of its anaesthetists are offered non-parity deals than any other region while they ultimately achieve parity to a greater extent than any other region. Could it be something to do with the Immediate Past President of the AAGBI being based in the Principality?

What conclusions should we draw from these data? We think that the information provided by our members allows us to state that:

- The overwhelming majority of anaesthetists in Great Britain & Ireland support the principle of pay parity for treating NHS patients.

- Parity is achievable. In spite of being offered NHS work at non-parity rates throughout the country, the majority of anaesthetists have achieved parity at some point.

- If Trust, NHS, ISTC or private hospital managers try to tell you that parity is not possible or has not been achieved in other areas, you can show them this article and tell them that their information is incorrect.

- Only a tiny minority of anaesthetists in the UK would now be prepared to do NHS work at non-parity rates.

We at the AAGBI are grateful to the thousands of our members who returned the questionnaires, and we are particularly grateful for the overwhelming support for our stance on parity that has been demonstrated through these questionnaires. The BMA, HCSA, MWF and others have made similar supporting statements - even the Health Select Committee Report on ISTCs raised the problem.

As further new NHS work is being contracted for 2007 remind those managers arranging it of their overriding HR responsibilities (equal pay for work of equal value) and like the majority of anaesthetists do not accept non parity rates. We will continue to press the matter centrally and if you have particular problems in your area with regard to parity issues, please contact your linkman or contact us direct on president@aagbi.org.

David Whitaker
President

William Harrop-Griffiths
Honorary Secretary

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CONFERENCES & EVENTS

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


British Society of Orthopaedic Anaesthetists (BSOA)
11th Annual Scientific Congress
10th November 2006, Telford: Chair Dr Chris Emmett, www.ucl.ac.uk/anaesthesia/meetings

**** LIMITED PLACES REMAINING ****

“MedReg 2006” - £75/day
A 3 day, intense, complete crammer on everything you will need to run an acute medical take. Ideal for Anaesthetists & Intensivists of all grades.

2nd National Conference on Myocardial Infarction – 3 days from £299
An intensive course for anyone who treats patients who has suffered (or is suffering from) a Myocardial Infarction.


4th Paediatric Sedation: How to do it Safely
IET/Savoy Place, London, 7th & 8th June 2007, Chair: Dr Mike Sury, GOS, London
CALL FOR ABSTRACTS
We invite you to submit abstracts of audits in relation to Paediatric Sedation, either prospective or retrospective, in particular those featuring new core plans, treatment protocols and the use of ketamine vs. other sedation agents vs. no sedation. Any work is acceptable which has not been accepted for publication in peer reviewed journal by the abstract deadline of 31st December 2006. Submission should be a maximum one A4 page and emailed to SothinMythen@btinternet.com by 31st January 2007. A number will be accepted for poster presentation and finalists will be asked to present at the Paediatric Sedation Conference 2007.

6th EBPM: Evidence Based Peri-Operative Medicine Conference
IET/Savoy Place, London, 5th and 6th July 2007, Chairs: Dr Mark Hamilton & Prof Monty Mythen, UCL, London
Invited speakers include: Prof Henrik Kehlet ~ Dr Mark Garfield ~ Dr Neil Soni
Prof Henrik Kehlet ~ Dr David Lubarsky ~ Prof Mervyn Maze ~ Prof Mervyn Singer ~ Dr Neil Soni
Prof Matt Thompson ~ Prof Jean-Louis Vincent ~ Dr Andy Webb
Provisional agenda, venue and booking details available at www.ucl.ac.uk/anaesthesia/meetings
(Do you know 2007 Tour de France is scheduled to start from London on the morning of Saturday 7th July?)

“Dingle 2007”: 9th Current Controversies in Anaesthesia and Peri-Operative Medicine
10th-14th October 2007, Daingean Uí Ór, Co. Kerry, Ireland
CALL FOR ABSTRACTS: £1000 in prizes
We invite you to submit work for poster presentation. Selected abstracts will be invited to give an oral presentation in Dingle on Friday 12th October 2007. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 30th June 2007. Abstracts should emailed in the form of one A4-side of printed text and in word or PowerPoint on or before 30th June 2007 marked clearly with your name, address, telephone number and email address.

FREE ON-LINE VIDEO CLIPS & PRESENTATION ARCHIVE INCLUDING PROFESSOR HENRIK KEHLET
in interview with Prof Monty Mythen, commenting on the practice of fluid restriction and Dr Paul Old's lecture on The Use Cardiopulmonary Exercise Testing for the Evaluation of the High Risk Surgical Patient available FREE at www.rockfacemedicine.com

Contact: Siobhan Mythen, Event Administrator on behalf of Centre for Anaesthesia, UCL
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A Tanzanian Perspective

I have recently returned from Tanzania, having worked in the anaesthetic department at Kilimanjaro Christian Medical Centre (KCMC) for three weeks. This 450-bed hospital opened in 1971 and is one of only four tertiary referral hospitals in the whole of Tanzania (population 39 million). At any one time there may be 600 inpatients (those without beds are termed ‘floor cases’). It provides good care for patients despite limited resources.

The anaesthetic department consists of two consultants, one resident (registrar level) and ten nurse anaesthetists. The majority of the anaesthesia is administered by the nurse anaesthetists, with the consultants acting in an advisory role, moving between theatres as required. This is standard practice in Tanzania where Nurse Anaesthetists qualify after completing one year of formal training. Once qualified they are expected to manage their own lists without any supervision, including paediatric cases as well as obstetric, major GI and trauma lists.

I was invited to help set up a theatre database to record workload, and complications (surgical and anaesthetic) for one of the departments. Prior to my visit, anaesthetic outcomes and complications were not formally recorded. The database will facilitate formal morbidity and mortality meetings, provide personal portfolios for local clinicians and improve theatre booking and research.

My visit was also a fantastic opportunity to experience anaesthetics in a completely different environment to the UK. The choice of anaesthetic drugs was limited, as one would expect. A large number of cases are carried out using spinal anaesthesia, including emergency appendicectomies. Supplementation with ketamine was often required for partial blocks or sedation. In a regional hospital I also came across an ether vaporizer, which was still in regular use.

KCMC is a comparatively well-funded tertiary referral centre. However, despite this “disposable” anaesthetic equipment such as endotracheal tubes, spinal needles and epidural needles were all washed and reused. Saturation and non-invasive BP monitoring were sometimes available; however inspired/expired gas monitoring was not. ECG monitoring was performed using electrodes created from cotton wool soaked in saline.

Taking annual leave to work voluntarily in a third world country is undoubtedly a tiring way to spend your hard earned holidays, but it’s worth every minute. I gained invaluable experience and returned to work in the UK with a fresh perspective. As the NHS considers employing anaesthetic practitioners, perhaps lessons can be learned from the Tanzanian system.

Dr Andrew McEwen
Derriford Hospital, Plymouth