Smile And Retain Smile
A diary of the SARS epidemic in Beijing, 2003
A personal record by Dr Anna Xi Zhao MB.BS.

(Anna was swept up in the SARS epidemic in Beijing in April of this year when the state-owned, 1,300 bedded Sino-Japanese Friendship Hospital in which she was working was officially declared a specialist hospital for the treatment of patients suffering from Severe Acute Respiratory Syndrome. This is her diary, a moving account of her experiences that we will publish in several instalments over the coming months.

Anna would like to acknowledge the help of Dr. David Baker, Dr. Robert Sneyd and Mr. Byron Yin in the preparation of this diary. Anna was advised that 'Smile and Retain Smile' is better expressed in English as 'Keep Smiling'. I prefer her turn of phrase however. She has chosen, perhaps inadvertently, a touching mnemonic for the very epidemic she will describe. Ed.)

Monday 28th April 2003
On call today for 24 hrs as usual. The last planned operations have been cancelled according to the decision of the top executives of the hospital. But there is a case, a 73 old man with pancreatic cancer and obstructive jaundice, who had turned yellow already. His close family member is one of the staff of our hospital, and we heard that this person went to the president of our hospital and even knelt down before him to beg for the operation to be done. The patients’ situation can not wait any more. In the event this case proved to be an exception. The last operation was done this morning. My colleagues and I do not know when normal anaesthesia can begin again?

Tuesday 29th April 2003
I am off - duty after 24 hours on call. The patients who are still left in our hospital, about 400, are being discharged or transferred to other hospitals today. The
sharp screaming of many ambulances makes everyone nervous.

Wednesday 30th April 2003

Our first training day. All the staff are called together to watch the training video tape about SARS disease - prevention of cross infection, protection and ventilation. Almost everybody complains that at this time, gathering more than a 1,000 people together in a hospital is not a wise idea. This could cause further spread or cross-contamination. Everybody is wearing sick facemask.

2pm: Still all together to listen to the report from Di Tan hospital to learn about prevention of contamination. Di Tan hospital, located in the north part of the city, not far away from us and even closer to the city centre than us, is an infectious disease specialist hospital and one of the few first hospitals who admitted SARS patients in Beijing. They have their own experience on dealing with SARS.

In the late afternoon, the head of our original anaesthetic department decided to visit Xiao Tang Shan hospital, located in the north suburb of Beijing, in the hope that we could learn something from them regarding the principles of prevention of contamination and apply them to our new ICU. Eight of us went with three nurses. All the medical and managerial staff in this temporary SARS hospital are military staff called from different part of the country. They friendly shared their experience and SARS prevention information with us without any hesitation. Some of them are from military No. 304 hospital in Beijing. We saw eight normal wards with 40 beds in each ward and one ICU with 8 beds as part of the whole hospital. The media said that there will be 1,000 beds in this hospital eventually. Each single or double room is equipped with colour TV set, telephone and separate air conditioner. There are also four to six furnaces under construction for burning the medical and living rubbish.

Thursday 1st May 2003

Training - the second day. Each department was issued with a training videotape to watch. In the afternoon, we were called together to study the “infectious disease principles” made recently as law by the Central Government.

We, all the medical staff, are allocated to different teams within the hospital. All the anaesthetists in our department and the doctors from the Emergency and ICU departments will work in a new big ICU. We are divided into two teams and each will be on duty at the front line for one month, then quarantined for about 10 days and finally rested for 10 days when the other medical team takes over. Many ladies in the medical staff have cut their beautiful long hair, just in case there is an infection risk when wearing the protective suit. It is hard to wear such a three-layer suit in the current weather with summer approaching. Sweating may cause infection. The suit is made from normal cloth and we worry about the quality. Is it sufficient to protect us?

We also discussed ventilation modes. The head of the new ICU prefers invasive ventilation after intubating using muscle relaxants. Some insist on using non-invasive ventilation in order to protect the medical staff from exposure of the open airway of SARS patients. The majority support the latter choice.

Some operating theatre nurses are saying Good Bye to each other since they are sent to different medical teams within the hospital. Sadness is surrounding us.

Friday 2nd May 2003

I cried when waking up this morning, - just could not hold my tears which came quiety. A sunny day again and this is the May holiday. I think about the others enjoying the best season in North China but we are facing a most difficult time. Do not know what the near future will bring. And I do worry about my

Hospital Management MBA course (http://www.nations-healthcareer.com). Is it so important for me and I do enjoy it with my professors and classmates.

8am: We are the first team. In the morning we are going to take the test to see whether we could take on and off the three-layer protection suit properly and strictly follow the infection-prevention principles.

Noon: In the anaesthetic department office where we have our daily morning meeting, we gathered together to look into the details. We heard that in each ICU room, there will be 2 or 3 beds although each room was originally designed for only one. This reconstruction design has been approved by specialists from infection hospitals e.g. You An and Di Tan hospital and even approved by WHO observers! We were told so! There will be a remote camera and an audio system in each room so that the medical staff can observe patients from the semi-contaminated area but do not need to come into close contact with them, only when necessary. Most of the ICU patients are potentially highly contagious, the so-called super-infectors, which means the virus inside their body is very strong, otherwise they would not be critically ill and admitted into the ICU as far as we could understand.

4pm: We were off and everybody went to shop or prepare personal things for the forthcoming one-month’s isolation and two week’s quarantine. Receive many phone calls from friends and relatives who console me. I believe other colleagues have received the same.

Next month: Anna prepares to meet her first patient with SARS.
One subject much on our minds right now is the new consultant contract. I’m sure most of you will have already consulted the online ‘Ready Reckoner’ at www.modern.nhs.uk/consultants and, like me, probably not been too impressed! My trust has actually issued each of us with a personal illustration, presumably in the hope of getting us to sign up asap. However, for the consultants I have spoken to so far, all at very different stages of progression, they have predicted a fall in income, which of course they will magnanimously protect. They’ve got it wrong of course. Interesting.

Whatever happens in the next few weeks, we will at some point have a new contract. Regardless of the contents, it seems to me that the crucial issue will be getting the job plan right. Most of us already have a job plan and I am willing to bet that, in many cases, it bears little relationship to what we actually do. We are being asked to be more accountable. No problem! To account (and be paid) for all the hours we work is unlikely to result in a reduction in salary. Jaideep Pandit has contributed an excellent and timely article containing valuable advice on just how to go about renegotiating your job plan.

Trusts beware! The words ‘Pandora’ and ‘box’ come to mind.

Editing Anna’s fascinating diary of the SARS epidemic in Beijing, evoked contemplation of the possibility of a similar scenario here and how we would deal with it. Would we stiffen our upper lips and roll up our sleeves, or whinge and insist on going home to the family? What would happen to compliant rotas? Is there a clause in the European Time Directive for natural disasters? It is also interesting to speculate on the reaction of hospital management.

I don’t know the answers to these questions. The closest I can get personally to such an experience is one night, many years ago, in a city hospital near here, when a sudden and unexpected late-afternoon blizzard blocked all the roads. This prevented staff who lived outside the city from going home at the end of the working day or coming to work for the night shift. An SOS was put out on local radio and many off-duty doctors and nurses answered the call, arriving on foot or on skis in some cases!

A festive atmosphere prevailed; there was much camaraderie, wry humour and drinking of tea. Those who could not get home and could not be relieved (including myself) carried on working through the night. The next day, the roads were cleared and we all went home feeling tired but good. The SOS call and the magnificent response from the staff was reported in the local paper and we were all made to feel like heroes…until a week later, when all those who had either been stranded or answered the call, and had been lucky enough to find a room to put their heads down for a few hours, were sent a bill for meals and accommodation. At that time - late 70’s - we were scandalised by the insensitivity of the management, and they in their turn were deeply embarrassed. The thoughtless half-wit who had issued the bills was reprimanded and no one had to pay.

I don’t think there would be much embarrassment nowadays. Do you?

Stephanie Greenwell

PS One of my colleagues tells me Pandora had a jar and not a box. Pedant!
Message from the Chairman of the Grants and Awards Committee

Iain Levack

“The Association is now the largest single grant provider for anaesthetic research in the UK”

There is a trio of subcommittees, which evolved from the main Education and Research Committee when the latter became too wide-ranging for one person to chair. These subcommittees are Grants & Awards, Events & Meetings and Educational Development.

Perhaps not widely known by members, though its financial statement is published annually for the AGM, the Education and Research Trust is the bedrock of the Association’s ethos - a helping hand for anaesthetists across Britain and Ireland in the furtherance of the specialty and related research. Evidence of this activity to encourage research is not new; Council Minutes of 6 July 1951 recorded: “Permission was given to use grants made for research fellowships to finance research carried out at teaching hospital departments, and it was agreed to establish a research fund.” This was soon put into effect, with Dr T Cecil Gray becoming the recipient of £60 for use in an investigation of the action of new sympathetic amine compounds and certain other analgesic drugs on the Starling heart-lung preparation. This was one of the earliest research grants awarded and the category continues today, though with changing times and economic inflation its maximum value has increased to £15,000.

Various other types of award were established. In 1968, the prestigious Association Research Fellowship was awarded to Dr Alastair Spence in the Leeds Department of Professor Nunn. The title was “Problems associated with postoperative pain” and the benefactor of this fellowship was Mr J Steinberg, a contact of a past president Dr Ronald Jarman. In the same year, Dr John Bushman in Birmingham was also awarded an Association Research Fellowship for a study on “Automatic ventilators and anaesthetic breathing systems”. The list of subsequent research grant holders, along with successive research fellows is an impressive testimony to the spirit of the Association’s helping
In numerous instances the work was published in peer reviewed journals (most frequently Anaesthesia) and some translated into University higher degrees. Until 1996, recipients of all these awards were listed in the Annual Reports of Council published in Anaesthesia, after which the Association’s Annual Report became a single document. The lists of grants awarded are of course also available in house at Portland Place.

Undergraduates are encouraged to pursue anaesthesia-related topics in their ‘electives’, and the Association annually makes funding available in response to appropriate applications. In addition to this, the Wylie Medal is an undergraduate prize 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. This provides a significant opportunity for members to encourage and guide the seed-corn of our specialty.

In 1995 the Departmental Project Grant was added to the portfolio of awards available. This grant provides financial assistance up to £25,000 to enable a department to undertake a specific project. The funding can be for capital equipment, running costs or as a contribution towards the salary of a technician, nurse or medical researcher. The stipulation is that the applicant must be a member of the Association. One or more of these are usually awarded each year.

The most recent fellowship award to become available has been made possible by the generosity of Datex Ohmeda who have endowed a £100,000 grant to be administered by the Association. Eleven high quality applications are currently under review by selected experts in the appropriate fields of study and the successful applicant will have been identified by the time this article comes to print.

There is parallel intent with the Royal College of Anaesthetists to promote research and some collaboration is realised through the Intavent Research Fellowship (value £25,000) where administration of the grant alternates year on year between the two organisations with cross representation of panel members. The current Intavent Fellow is Dr Martin Beed, supervised by Dr Ravi Mahajan of the University of Nottingham, with a project entitled “Vascular reactivity and systemic inflammatory response syndrome.”

In the past year the Association has funded research in excess of £350,000 and the purpose of this article has been to highlight to members the availability of financial help with research and furtherance of knowledge at all stages in an anaesthetist’s career. The Association is now the largest single grant provider for anaesthetic research in the UK.

It is stressed that not only academic departments are successful in their applications for these grants; a good application either from a district general hospital or from an NHS department in a teaching hospital can be rewarded, as has been the case during the last year. All available grants and guidelines for application can be viewed on the Association’s website (www.AAGBI.org).

The old school motto Omni nunc arte magistra might inspire those who are looking for a helping hand: Now is the time to do our best.
Beauty Aids in Anaesthetic Practice (August 03 edition)

On many intubation trolleys can be found a pile of wooden tongue depressors, which puzzle our younger colleagues. Those of us who are a bit longer in the tooth will remember that they were an essential component of at least one of the Heath Robinson modifications to the old fashioned head harness. While I cannot think of any use for tongue depressors in modern airway management, they are absolutely marvellous for applying one’s leg wax.

Now that Anaesthesia News has a female editor, I hope it will be the sort of journal that knows Oil of Ulay became Oil of Olay several years ago!

Yours sincerely,

Hilary Aitken (Dr).
Royal Alexandra Hospital, Paisley

(Methinks Hilary that you underestimate the wily Ballance! What a jolly good wheeze to promise a prize that does not exist. If I might be permitted to add my own contribution to the ‘Beauty File’ : A carefully applied steri-strip, well disguised with nail polish will provide a near invisible mend in the event of a split nail just before an important engagement. Ed.)

Sir Ivan Magill

I wonder what Sir Ivan would have made of Dr Wheatly’s suggestion of another use for his intubating forceps—i.e. the application of Factor 40 via cotton wool to the inaccessible area of the back?!

Many years ago (when I was an SHO) I had the privilege of meeting Sir Ivan Magill when he came to The Westminster Hospital to visit his old department. He watched me giving an anaesthetic. However I can remember nothing of our conversation apart from his parting remark — “Years ago I invented some forceps. Does anyone ever use them these days?” He did not wait for a reply and I still do not know whether he was serious or joking.

Yours Sincerely
Dr Iris Symons, Consultant Anaesthetist, Barnet Hospital

Philipp Keep

It was a pleasure to see again a selection of Philipp Keep’s colour cartoons in the August edition of “Anaesthesia News”, although I was saddened to learn of his untimely death. I have always been a great fan of his brilliant and humorous artistic and literary talents. May I suggest that when the drawings are returned to the family, they might consider the publication of a collection of both in his memory. Perhaps “Anaesthesia News” would be able to offer assistance with the practicalities of such a venture were the family to agree. I feel that it would be a fitting tribute to the extra-curricular talents of our late colleague, and have no doubt that such a book would give lasting pleasure to those of us who have so much enjoyed his contributions over the years. I would be happy to undertake to purchase the first copy!

John Francis
Retired Consultant Anaesthetist, Exeter

Pensions

Well done with the article from Alistair Lack on Pensions - (p 16 Sept 2003). His Excel spreadsheet for calculating pension entitlement mirrors my own, but apparently much more elegantly. I would, though disagree that the actuarial reduction is “unnecessarily complicated”. It is well explained in the booklet available from the Agency at http://www.nhspa.gov.uk/booklets_new/sd_er.pdf

However, the article did miss out the important web address of the Pensions Agency - www.nhspa.gov.uk - which has all the advice booklets in ‘pdf’ format - and it allows you to contact your “pensions team” by e mail. Most of us now have e mail access at work (if not at home).

D R Derbyshire
Consultant, Warwick Hospital
Dr. DeQuincy and Research (Anaesthesia News, August 2003)

DeQuincy must be getting to that certain age when you feel that you have seen it all, done it and got the T-shirt. One hopes he is not burning out, or just old!

I remember, about twenty years ago, a visit to my department by Dr. Tom Bolton. He gave a lecture on "Anaesthesia in my time", a time when, as Dr. DeQuincy says, many of the crucial discoveries and developments in anaesthesia were made. He concluded by saying that he was sorry for us, who could look forward to a desert of routine anaesthesia for the rest of our careers. Since then, the only developments to enliven our boring routine, have been intravenous anaesthesia, the laryngeal mask airway, several new inhalational agents, a host of new drugs, and the near abolition of anaesthesia related maternal deaths.

Dr. DeQuincy is right that research for its own sake cannot be justified, and that most questions have been answered. However, I suggest that many others remain, in particular, those that require large numbers of patients. The GALA trial, described in the same issue of Anaesthesia News, is such a trial. The multicentre approach has been used much less in anaesthesia than other specialties. I’m sure that colleagues can suggest other subjects. As my starter, anaesthesia for major joint replacement, comparing the relative safety and efficacy of regional and general anaesthesia; with intrathecal opiates, nerve blocks (one shot and infusion) and systemic analgesics. In my own department, there is much variation between techniques and even more data to argue over. All patients get a PCA and have their pain scores recorded but there is not enough time for collection, and probably not enough patients to settle the argument. I am sure that other departments vary in the same ways and record the same data. A multicentre trial could provide a meaningful result.

I would commend this approach to academic departments. It would allow them to train SpRs sequentially in the structure, management and interpretation of trials, rather than risk clinical studies for which they can never recruit enough subjects in their short research attachments, or in expensive animal studies. Each SpR would write up their own contribution as ‘work in progress’ for local publication and CV purposes, and be credited as co-authors of the final paper.

Viva research! For the masses, by the masses!

John Davies

Colour Coding

I should like to comment on Dr. Chris Frerk and Dr. Rae Webster’s letter in the July edition regarding the recent change to colour-coded syringe labels.

I work in two hospitals in the city. One has changed overnight to the new coloured labels. This initially required a bit more concentration, but it took surprisingly little time to adjust. At least the syringes still looked different from each other.

The other hospital has adopted the Northampton proposed system of white labels. On my first list with these I drew up my usual anaesthetic. 2mls of clear fluid in a 2ml syringe with a white label – opiate. 2mls of clear fluid in a 2ml syringe with a white label – anti-emetic. 2mls of clear fluid in a 2ml syringe – suxamethonium. 10mls of clear fluid in a 10ml syringe with a white label – morphine. 10mls of clear fluid in a 10ml syringe with a white label – ephedrine. Need I go on? It was frankly dangerous.

I am sorry to be so down on something they obviously put so much thought into. This just highlights the problem of people who are not actually doing a job coming up with management plans that are flawed. Their psychologist’s theory is no doubt well founded but it just does not work in the real world.

Yours sincerely,
Dr. Claire A. Fouque
Consultant in Anaesthesia and Critical Care, Southmead Hospital, Bristol.
A leading figure in the world of anaesthesia, Alfred Lee was one of nature’s gentlemen, always calm, courteous, polite and unruffled. Like most of his generation of anaesthetists, he purchased a partnership in general practice and later obtained an appointment as a general practitioner in anaesthesia at the local hospital. When Southend General Hospital opened in 1932, Alfred was one of its first general practitioner anaesthetists. In 1940 he became a whole-time anaesthetist in the Emergency Medical Service, working for five years at Runwell Hospital in Essex. By 1947 when he was appointed Consultant Anaesthetist to Southend General Hospital and Southend Municipal Hospital, Rochford he had sessions at a number of hospitals, from East Ham to Southend.

A Synopsis of Anaesthesia was published in January 1947. This slender volume of 254 pages, gave practical advice on the administration of general anaesthesia and regional, spinal and extradural analgesia. It also covered the history, physiology, anatomy, pharmacology, physics, preoperative assessment and postoperative care relating to anaesthesia. It was dedicated to his wife, Norah, and opened with a quotation from Ralph Waters.

The Synopsis rapidly became a pocket bible. Subsequent editions were translated into seven languages and Alfred remained one of its authors until the tenth edition in 1987. It is now published as Lee’s Synopsis of Anaesthesia.

In 1948 Alfred Lee opened the first British anaesthetic outpatients Department, followed in 1955 by the first British postoperative observation ward. These two innovations gave Alfred greater satisfaction than his other accomplishments.

Alfred Lee took a great interest in regional analgesia. I remember juniors being encouraged to use brachial plexus block for manipulation of Colle’s fractures. Following the Woolley and Roe legal proceedings in 1954, Dr. Lee was one of a small number of eminent anaesthetists who kept the practice of spinal and extradural analgesia alive. He welcomed many that were later to become eminent as visitors to his Saturday morning “Block” lists at Southend.

Dr J Alfred Lee was born in Liverpool in 1906, the eldest son of a well known Nonconformist Minister. Educated at Taunton School, he read medicine at University of Durham College of Medicine, Newcastle followed by Resident Medical Officer posts at Princess Mary Maternity Hospital and Royal Victoria Infirmary Newcastle. His distinguished corporate activities include Founding President of The History of Anaesthesia Society, President of the Section of Anaesthetics, the Royal Society of Medicine, President of the Association of Anaesthetists of Great Britain and Ireland, Chairman of the Editorial Board, and Assistant Editor of Anaesthesia, board member, examiner, Faculty Medallist and Honorary Fellow of the Faculty of Anaesthetists; Henry Hill Hickman Medal, Karl Koller Gold Medal, Joseph Clover Lecturer, Gaston Labatt Lecturer, Stanley Rowbotham Lecturer and T.H.Seldon Distinguished Lecturer.

Besides the Synopsis, Alfred was involved in the following publications; Recent Advances in Anaesthesia and Analgesia, Lumbar Puncture and Spinal Analgesia, Practical Regional Analgesia and The Hospitals of Southend.

Outside anaesthesia, Alfred supported Everton FC and Newcastle United, enjoyed sitting in the sunshine, and the music of Wagner and Richard Strauss. J. Alfred Lee was devoted to the specialty of Anaesthesia. A global figure, renowned and welcomed at centres of excellence throughout the world, a kind caring unpretentious anaesthetist willing and eager to go out of his way to help the most junior doctor or nurse.
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In our last article (September 2003) we described the way an inheritance liability could very easily arise for many Anaesthetists. Over the last 6 years alone, average UK house prices have risen by 77%. Over the same period the inheritance tax nil rate band has climbed only 16% to £255,000. (Source, Nationwide Building Society)

In this article, I look at a straightforward way of minimising that liability, in particular concentrating on how a will should be structured.

Many people have their will made on a ‘mirror basis’. This means on first death, the estate passes to the surviving spouse. This is free of any immediate Inheritance Tax (IHT) and is known as an Interspousal Transfer.

The Issue

The estate on death (broadly all assets the deceased owns or is deemed to own) is reduced by the value of assets left to an exempt person, normally the spouse. The remaining estate is then subject to two tax rates. The first ‘slice’ of the estate (£255,000 in the tax year 2003/04) is taxed at a rate of 0% or nil – and is known as the ‘nil rate band’. The balance of the estate is taxed at a flat rate of 40%.

Many married couples avoid paying IHT altogether on first death because everything is left to the survivor. Although this ensures that the widow/er is provided for financially, it wastes the nil rate band of the first to die and compounds the inheritance problem on second death.

The Solution

A simple solution is to ensure that each will has in it a Discretionary Will Trust.

This means that on death, the executors of the first to die will transfer assets or cash, up to the value of the available nil rate band, to the Trustees of the discretionary Will Trust to hold on the terms of the trust. Any assets in excess of the nil rate band will pass to the surviving spouse free of IHT. To ensure that this is done simply and efficiently, it will normally be essential to ensure that each party owns assets to the value of nil rate band.

The Challenge

The challenge however, for all married couples is to make best use of the nil-rate band for inheritance tax (£255,000 for 2003/4) for both partners. This is particularly difficult when a large proportion of the assets are tied up in the family home. There may not be sufficient free assets for both partners to leave the full £255,000 to the children or grandchildren. The surviving spouse may need to use the free assets to supplement income. The ‘loan scheme arrangement’ has therefore been designed to ensure that as a married couple, you utilize your Inheritance Tax (IHT) nil rate bands (the proportion of your estate that is subject to tax at 0% currently £255,000 ( 2003 / 2004 ), whilst still providing financial security for the survivor).

This works as follows: Both wills contain discretionary trust wording which allows the creation of an IOU (or debt) for £255,000 on first death (or whatever the nil-rate band for inheritance tax is at the time of death).

On the first death, the IOU is then created and is held in a trust for the benefit of the survivor and children or other beneficiaries. The surviving spouse receives all the assets from his or her spouse and is able to use them, spend the cash or live off the income.

But on the death of the second partner, the IOU is deducted from the value of the estate before calculating inheritance tax. This allows both partners to make full use of the £255,000 nil-rate band while allowing the surviving partner to live comfortably.

In order for this to work, both spouses must have sufficient assets to utilise their respective nil rate bands. It is therefore desirable to sever the beneficial joint tenancy of the home. This involves changing the basis of home ownership from jointly owned to ‘tenants in common’ – meaning that husband and wife own 50% each of the house.

What about assets above our nil rate bands?

Of course many estates are in excess of the nil rate band for both husband and wife. There are further measures that can be taken to help reduce inheritance tax. These will be explored in future articles.

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

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A SURVEY OF CURRENT ANAESTHETIC TRAINING FROM THE GROUP OF ANAESTHETISTS IN TRAINING (GAT) COMMITTEE- Interim report

The implementation of the “New Deal” work and rest limits has had a significant effect on training opportunities and is the subject of ongoing problems for many anaesthetic departments and trainees in the UK. We currently have no accurate information on the progress that has been made in anaesthesia and, in particular, the implications of work pattern changes on training.

Monitoring exercises, carried out by the Regional Task Forces/Implementation Steering Groups (RATs/ISGs) have only scrutinised the number of hours worked and the rest periods achieved. They have taken no account of training time and have not considered steps that have been taken to ensure compliance of working rotas/shifts in each hospital.

The Group of Anaesthetists in Training (GAT) committee carried out a survey of the trainee membership of the Association of Anaesthetists in July 2003. Our aim was to gain some insight into the current state of training and teaching within the framework of current rotas that are compliant or almost compliant with the New Deal. We also asked trainees to consider what future steps should be taken to protect training, given the introduction of the working time regulations within the European Working Time Directive for junior doctors from August 2004.

In particular, we were interested to find out how many trainees were attending educational activities in their “own time”, because this has been one area causing great difficulties in anaesthetic departments around the country. In this article we present the interim findings from the survey.

Questionnaires were posted to 2850 trainee members of the AAGBI with a pre-paid return envelope. The questionnaire looked at training opportunities within the current working patterns of anaesthetic trainees in the UK for different types of anaesthetic duties and the opinion of trainees on possible changes in the length of training in anaesthesia.

614 (21.5%) questionnaires were returned by the deadline - 21 days after dispatch. Of those who responded, 22.3% were SHOs, 34.2% SpR1-2 and 41.7% SpR3-5. 1.8% did not give their grade. 66% of respondents were working compliant rotas.

Many trainees have attended educational activities in their “own time”. 69% have attended during the pre- or post-call day, 35% have attended when they have been off duty, and 56% during scheduled breaks. For 55% of respondents, this activity would make their rota non-compliant if it were to be monitored in a diary exercise.

The Royal College of Anaesthetists recommends an average of three in-theatre teaching sessions per week. During the most recent four-week (uninterrupted) period, 69% of respondents did not achieve this, including 66% of SHO1 and 60% of SHO2 who responded.

Crucially, 10% of the total group had had no teaching sessions at all over the four-week period. 22% of SHOs in the first year of anaesthesia training and 11% of SHOs in the second year of training reported no teaching sessions over the four-week period.

In the major subspecialties of Pain, Obstetrics and Intensive Care (taken as a group) the figures were worse, with 84% not achieving the RCA recommendations, and 24% experiencing no training at all over the four-week period. 28% of SHO1 and 11% of the SHO2 cohort had had no teaching in the four-week period.

Despite these results, more than 90% of respondents felt confident in administering anaesthetics expected at their stage of training. Eight people had failed a RITA because of inadequate training. 92% planned to take up a consultant post in the UK.

49% felt they would be sufficiently trained within the present system to do so. This implies that training delivery needs to be addressed, but views on the best approach to this were split. 49% favoured a reduction in service commitment and 37% favoured increasing the duration of training. Unsurprisingly, the majority (79%) felt it was unrealistic to expect to train to be a consultant anaesthetist in a total of five years within the current system.

This survey highlights the current problems facing trainees and trainers working within the constraints of the “New Deal”. We plan to carry out a detailed subgroup analysis of the data and will publish a full report in a subsequent edition of Anaesthesia News.

The New Deal, and soon the EWTD, are with us whether we like it or not and from our preliminary data it appears that the fears of the effect on training were well founded.

The full questionnaire is available on the trainee section of the AAGBI website www.aagbi.org/trainee.
The grant is to enable a department of anaesthesia to pursue a research project either by the purchase of equipment or the part funding of a salary for medical or technical help or other support.

Further information and application forms are available from the Association 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, 21 Portland Place, London W1B 1PY.

Specific Departmental Courses can be arranged upon request (fee negotiable)
Applications are invited for the Intavent Research Fellowship. This Fellowship is available for 1 or 2 years to fund research in anaesthesia, intensive care, pain relief and training in research methods. The work should be undertaken in Great Britain and Ireland. Preference will be given to projects that involve predominantly clinical research. Projects that involve the application of basic science to anaesthesia must have clear clinical relevance.

Applications should be made on behalf of a Department of Anaesthesia in Great Britain or Ireland by an individual who is both a Fellow of the Royal College of Anaesthetists and a member of the Association of Anaesthetists of Great Britain and Ireland. Please note that it is not necessary to identify a proposed Fellow at the time of the application; the successful applicant will be required to appoint an appropriate individual to the post of Fellow and will be responsible for supervision and training of the Fellow. The Fellow must be an anaesthetist in training in Great Britain and Ireland.

Further information and application forms are available from:
Carol Gaffney, The Association of Anaesthetists of Great Britain and Ireland,
Direct Line: 020 7631 8812, or email: carolgaffney@aagbi.org
Closing date for applications: Friday 14th November 2003

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**Cleveland School of Anaesthesia**

The James Cook University Hospital
(Formerly South Cleveland Hospital)

Marton Rd, Middlesbrough, TS4 3BW

17th to 21st November, 2003

**Full Exam Practice, Current Topics and Detailed Appraisal of Performance**

**Course Fee:** £350.00
Including Lunch and Beverages
(Course Limited to 12 Candidates, only suitable for candidates Just Prior to sitting Primary Exam)

**Course Organiser:**
Dr S. Graham, Consultant Anaesthetist, James Cook University Hospital
Email: steve.graham@stees.nhs.uk

Application Forms from
Course Administrator
School of Anaesthesia
Cheriton House
James Cook University Hospital
Marton Road
Middlesbrough, TS4 3BW
Tel: 01642 854601

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Workshops and lectures.

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PSOAS compartment blocks.

For application form and programme, please contact:

Shirley Robson, Anaesthetic Department Manager.
Dr Fred Sage, Consultant Anaesthetist, Course Organiser
John Hammond Department of Anaesthesia
East Surrey Hospital, Canada Avenue, Redhill,
Surrey RH1 5RH

Tel: 01737 768511 Ext 6046
Fax: 01737 231886
E-mail: shirley.robson@sash.nhs.uk
**The new consultant contract and anaesthesia: practical implications of the new terminology. A Personal View.**

Jaideep J Pandit, Consultant Anaesthetist, Nuffield Department of Anaesthetics

**Introduction**

The CCSC (BMA) and Health Department have reached Heads of Agreement modifying the 2002 Consultant Contract Framework (see www.bma.org.uk for updates). After ballot, the majority of consultants may work under new terms from as soon as January 2004. Two fundamental and novel principles of the original Framework remain:

1. Currently, the consultant job plan simply consists of a list of fixed commitments (for anaesthetists usually operating sessions) and an open-ended range of other duties (e.g. on-call), which are not explicitly recognized in time commitment. Now, the job plan must be explicit and transparent, with all aspects of NHS-remunerated work detailed in writing: put simply, consultants will not be paid for work that is not in the job plan.

2. The new concept of “direct clinical care” work is defined as distinct from “supporting professional activity”. Table 1 lists some forms of direct clinical care, which should total 7.5 Programmed Activities (PAs; 30 hours/week on average). Table 2 lists supporting professional activities, which should total 2.5 PAs (10 hours/week).

There will be an entirely new terminology describing our work, and while other changes are important (e.g., new private practice arrangements, pay spines, integration of appraisal and revalidation), I argue that it is this new terminology which will have the greatest impact upon our working lives.

**Adapting to the change**

If the New Contract is accepted, all anaesthetists will have to define their “direct patient care” activity. (Table 1)

**On-call.** Anaesthetists must define actual work undertaken (per week on average) when on-call, as distinct from on-call availability. Availability is awarded a pay supplement in the New Contract, simply based upon on-call frequency. Activity (i.e., work in hospital or telephone advice) counts as PAs of direct care. We may estimate on-call activity by: -

(a) keeping work diaries

(b) estimation from time available: Table 3 shows availability for certain frequencies of on-call and reasonably 0.25 to 0.33 of this is actually worked

(c) using data from current intensity payment supplements

The **transitional arrangements** state that until April 2005, a maximum of only 1 PA may be allocated to on-call work: most anaesthetists will achieve this with ease, with the possibility of additional allocation after 2005.

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**Table 1. Direct clinical care activities.** The sum of these should average 30 hours/week (7.5 PAs). The second column illustrates estimates reasonable estimates applying to most anaesthetists. *Further detailed in Table 4.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Actual work</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual work performed on-call (see Table 3)</td>
<td>~4–6 hours</td>
<td>1.5 PA</td>
</tr>
<tr>
<td>Operating sessions</td>
<td>~20 hours</td>
<td>~5 PA</td>
</tr>
<tr>
<td>Pre- and post-operative care</td>
<td>~4–6 hours</td>
<td>~1–1.5 PA</td>
</tr>
<tr>
<td>Ward rounds</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Outpatient clinics</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clinical diagnostic work</td>
<td>~30 min</td>
<td>~0.1 PA</td>
</tr>
<tr>
<td>Other patient treatment*</td>
<td>~30 min</td>
<td>~0.1 PA</td>
</tr>
<tr>
<td>Public health duties</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Multi-disciplinary meetings about direct patient care*</td>
<td>~30 min</td>
<td>~0.1 PA</td>
</tr>
<tr>
<td>Administration related to patient care (eg, referrals, letters, notes)*</td>
<td>~30–45 min</td>
<td>~0.1–0.2 PA</td>
</tr>
<tr>
<td>Travel: (a) to and from home for on-call work; (b) between sites for elective work*</td>
<td>~30–45 min</td>
<td>~0.1–0.2 PA</td>
</tr>
</tbody>
</table>

*Rules relating to professional leave are unchanged, allowing activity related to royal colleges, professional associations and universities to continue, without the need for Trusts (unless they desire it) to program these into weekly remunerated schedules.

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**Peri-operative care.** Currently, this work is rarely a “fixed session” and is an implicit, not an explicit duty [1,2]. The New Contract will require this to be explicit. The Association of Anaesthetists (AAGBI) has previously recommended that 1 session of peri-operative care should underpin 3 sessions in theatre [1]. This advice was later modified to suggest that the relevant time should be monitored (i.e. work diaries kept) [2]. Surgeons are advised to allow 15 min per patient in clinic [3] and a similar time for total peri-operative care per patient would seem equitable. Experience suggests that indeed each 4-hour operating session, on average, requires about 45 min to 1 hour of peri-operative care.

Average allocations of <30 min/session and >1.5 hour/session may be exceptional. Thus, peri-operative care might very reasonably count as 1–2 PAs (1.5 PAs on average) of direct care: this time underpins the ancillary activity required to support 5 elective surgical lists/week (Table 1).

**Other activities.** Anaesthetists generally do not have the outpatient/paperwork burden of physicians and surgeons. However, anaesthetists do not simply turn up to lists and depart: they are an integral part of the surgical team [4]. Table 4 lists some...
relevant direct care activity associated with this role. Finally, all excess travel time (e.g., between hospital sites and for on-call) is counted towards direct care. At least 0.25 - 0.5 PA/week (1-2 hours) allocation for this seems reasonable.

Operating lists. If, as outlined above, 2.5 to 3 PAs are allocated to emergency work, peri-operative care and other clinical activities, then this leaves a maximum of just 5 PAs per week (20 hours) for regular surgical sessions. This is less than at present: most anaesthetic job plans incorporate 6 or 7 fixed operating sessions. We can therefore expect a reduction in elective service delivery. How might Trusts manage this?

Options for Trusts
At one extreme in some Trusts, anaesthetists undertake just 6 fixed sessions, each of 3.5 hours (i.e., 9am - 12.30pm and 1.30pm - 5pm). Each new PA is 4 hours. Trusts might reasonably opt to keep their current schedules, but assign the “extra” 0.5 hour of anaesthetic time per “new” (4-hour) PA to peri-operative care. In this way, the Trust absorbs the bulk of peri-operative care within ~6 PAs of the anaesthetist’s contract. An additional 1.5 PAs are then assigned for on-call and other work, making the required total of about 7.5 PAs. These estimates indicate that in these Trusts the final impact of the changes will be relatively small.

<p>| Table 3. Frequency of on call (first column) related to weekdays (second column) and weekend days (third column) for which a consultant is available. The fourth column shows the resulting total hours available/week. The estimate of hours worked in the fifth column assumes 0.25 to 0.33 of the time available is worked. Since all work out of hours attracts a premium, the table indicates that all rotas listed will reasonably attract at least 1 PA. |  |</p>
<table>
<thead>
<tr>
<th>Frequency weekdays/year</th>
<th>weekend days/year</th>
<th>average hours estimated worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1</td>
<td>18.0</td>
<td>12.6 hours/week 2.6 – 3.4</td>
</tr>
<tr>
<td>1:12</td>
<td>21.0</td>
<td>14.2 hours/week 3.0 – 3.8</td>
</tr>
<tr>
<td>1:13</td>
<td>22.0</td>
<td>15.9 hours/week 3.5 – 4.0</td>
</tr>
<tr>
<td>1:14</td>
<td>23.0</td>
<td>16.5 hours/week 3.8 – 4.3</td>
</tr>
<tr>
<td>1:15</td>
<td>24.0</td>
<td>17.1 hours/week 4.2 – 4.6</td>
</tr>
<tr>
<td>1:16</td>
<td>25.0</td>
<td>17.7 hours/week 4.5 – 5.0</td>
</tr>
</tbody>
</table>

Table 4. Other details of other direct care activity for anaesthetists. For most anaesthetists, the sum of these may reasonably be ~0.25 PAs, with travel being another ~0.25 PAs.

- a. regular involvement in planning of surgical lists, scheduling order of patients on list, timing of list, prior planning of high-risk patients, managing overbooked lists
- b. role of senior anaesthetist on-site as “floor manager” (e.g., allocating patients to under-booked lists, maximizing efficiency of available staff)
- c. managing equipment and drugs in the local theatre environment (e.g., maintenance, supply, reporting, compliance with standards)
- d. pre-operative assessments of patients by special request, before surgery is booked, to prevent cancellation on day of surgery
- e. paperwork, letters, clinical administration related to a-d above
- f. specific multi-disciplinary meetings about clinical care (e.g., with surgeons, liaison with intensive care, with physicians)
- g. morbidity/mortality meetings
- h. regular “business” (e.g., specialty group) meetings related to clinical care, patient management or clinical organisation of the service
- i. formal pre-assessment work, including clinics and any related paperwork and administration
- j. handling complaints

However, consultants in some Trusts have to undertake 7 operating sessions, each of 4 hours (e.g., 8.30am - 12.30pm and 1.30pm - 5.30pm). Here, problems may be severe. If 2.5 PAs are assigned to on-call, peri-operative and other work, there are only ~5 PAs available for operating lists. Such Trusts face a huge reduction in activity of 2 or more operating lists per anaesthetist per week. The offer of additional paid PAs may limit a reduction in service delivery, but at considerable financial cost. This seems severe, but perhaps these Trusts have for too long placed unreasonable demands on their consultants, and the chickens are now simply coming home to roost.

Conclusions
The AAGBI stated that “Recognition of the duties of anaesthetists outside the operating theatre is long overdue” [5]. Subsequent job planning guidance advised that the weekly work program be divided into two parts [2]. Part A lists fixed commitments. Part B, in contrast, lists actual work done. For most consultants, the total hours of Part B far exceeds the nominal allocation in Part A. Wisely, the Association advised that Part B should carry the codicil that “Part B does not represent a contractual duty actually to work the hours so listed” [2].

The New Contract offers an opportunity for all clinical activities to be recognized and remunerated. The process of transferring Part B of the job plan into Part A may be emotionally difficult for established consultants who are used to working long hours, unrecognized, beyond contractual responsibilities. They may feel uncomfortable keeping work diaries, feeling they are “watching the clock” and haggling with managers over time counted towards a PA.

This article makes no conclusion on the merits of the New Contract. It is, however, always important to plan for change. For anaesthetists currently undertaking excessive unrecognized work, and who find it difficult to enforce their current contract to redress this, the New Contract might offer a fresh start and transparency.

Obstetric anaesthesia [6], chronic pain [7] or intensive care [8,9] may require a different approach from the outline above. Respective sub-specialty groups within each Trust should begin to describe their work patterns using the new terminology. Those who fail to do so will ultimately find themselves working unremunerated hours and so will inevitably lose out financially as compared with colleagues who undertake proper job planning.

References
Dr. Ruxton's eye was drawn, as yours may have been, to a recent news headline. "Heart man jokes as surgeons cut!". For the first time in the UK, a patient was awake under epidural anaesthesia while undergoing a coronary artery graft by endoscopic technique. Eager to learn more - Dr. Ruxton regrets that much of his CPD on new drugs and techniques comes from the pages of the more sensational daily newspapers - he read on.

Clearly, the quality of anaesthesia was excellent and the patient required no sedation. The quality of the 'joke' that the unfortunate Mr. Phillipson had been challenged to tell during his surgery may be attributed to the stress of his situation, rather than any dulling of his faculties. It was thoroughly clean, just not very funny. Nevertheless, it got more publicity than Ken Dodd's finest, as he was required to re-tell it on Radio 4's Today programme and it was reprinted in at least two newspapers.

But what really attracted Dr. Ruxton's attention was the anaesthesia content of those reports. They all contain the same information: that this was the first time a patient had remained awake, that the endoscopic operation was otherwise routine, and the names of the patient, the hospital and the surgeon. All good solid reporting, no doubt reflecting the information the journalists were given at the news conference or in a release. The Daily Mail included an excellent graphic showing a gloved, gowned and masked (male) person inserting a thoracic epidural. Other papers expanded on where in the world similar work had been done, several on the potential benefits of the anaesthetic technique. All emphasised the use of regional instead of general anaesthesia, with quotes from the surgeon on the significance of the technique.

Nowhere in any news report was the anaesthetist mentioned, by name or even as a member of the theatre team. Except when Mr. Amhari remarked that the technique could not be used more widely in the UK, "until more anaesthetists have been trained." [Sic!]

Dr. Ruxton has no private line to Harefield Hospital, but while he has no doubt that his colleagues there are as assertive and self-confident as any in the UK, they are curiously self-effacing. The news reports are so congruent in their lack of any anaesthesia recognition that either no information was provided about the anaesthetists, or there was a journalist's conspiracy to ignore us! Dr. Ruxton firmly holds to the cock-up rather than conspiracy theory, so why were our colleagues excluded from the 'news-giving' process? He has no idea if this exclusion was self-imposed or imposed upon them. Either way, he says to them, "Stand up, and make yourselves heard! You have achieved a first for the UK, but you and anaesthesia have missed a unique opportunity for media recognition of anaesthesia's partnership with surgery in the operating theatre."

Anaesthesia is, like life insurance or coffins, a distress purchase that the public doesn't want to think or hear about until needed. Often the only stories about anaesthesia that make it into newsprint are negative, so when a good-news story breaks we must seize the opportunity to make our pitch. If we do not, we have only ourselves to blame when half the population know nothing about anaesthesia or anaesthetists, and as a result are terrified when they do need us.

(Readers can be reassured that, like Dr. Ruxton, the Association was also very concerned at the lack of anaesthetic mention and promptly issued a press release making, amongst others, the general point that most advances in surgery are paralleled by similar, if not even greater, advances in anaesthetic care. There is of course considerable thoracic epidural expertise in these islands. An AAGBI spokesman spoke to several journalists and they may run a more objective feature on this topic at a later date in which we and ACTA hope to be involved – perhaps August 2004. Ed.)

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**Magill Symposium**

**Chelsea and Westminster Hospital**

369 Fulham Road, London

19th November 2003 2-6pm

**‘Postoperative Cognitive Dysfunction’**

Course Fee: £50.00

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@ic.ac.uk

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Dr. Ruxton remonstrates!
Local Anaesthesia for Ophthalmic Surgery
Friday, 6th February 2004, Middlesbrough

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in Education Centre, The James Cook University Hospital, Middlesbrough on Friday, 6th February 2004. The meeting will include lectures and live demonstration of orbital blocks. Attendance is limited to 50 participants. Application form and information from Elaine Tucker (Course Administrator 01642-854601 email: elaine.tucker@stees.nhs.uk). Registration fee is £225 (BOAS Members £200) (inclusive of catering). Cheque payable to Ophthalmic Anaesthesia Education Trust Fund.

PROGRAMME

09.00-9.25 Registration & Coffee
9.25 Welcome: Prof Chris Dodds, Middlesbrough
Chairman: Dr Robert Johnson, Bristol
9:30-10.15 Anatomical considerations for ophthalmic block: Prof Chris Dodds, Middlesbrough
10.15-11.00 Pharmacological considerations for ophthalmic block: Dr. Hamish McLure, Leeds
11.00 - 11.30 Coffee Break
Chairman Dr A P Rubin, London
11.30 - 12.00 Review of eye blocks: Dr Chandra Kumar, Middlesbrough
12.00 - 12.30 Eye blocks in perforating eye injuries: Dr Steven Gayer, USA
12.30-13.45 Lunch
13.45 -17.00 Live Demonstration of Orbital Blocks
Demonstration Co-ordinators: Drs Anthony Rubin, Robert Johnson, Chandra Kumar, Mr Tim Dewed, Mr Mammad El-Naggar, Mr David Smerdon & Prof Chris Dodds
Retraction or paraboloid
Dr Chandra Kumar, Middlesbrough
Dr Anthony Rubin, London
Dr Sean Tighe, Chester
Dr Narinder Dhariwal, Sunderland
Medial peribulbar
Dr K L Kong, Birmingham
Recorded video
Dr Steven Gayer, USA
Sub-Tenon's
Stereotaxis Cannula
Dr Kari Frland, Liverpool
Prof Chris Dodds, Middlesbrough
Runar-Dodds Cannula
Dr Rup Chopra, Middlesbrough
Greenbaum's Cannula
Dr Chandra Kumar, Middlesbrough
Ulrichson Metal Cannula
Mr Barley McNally, Jersey
17.00 Closing remarks
Dr Chris Dodds, Middlesbrough

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

ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND

THE WYLIE MEDAL
UNDERGRADUATE PRIZE 2004

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

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

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

RULES

The deadline for submission of entries is 9 January 2004 and the number of entrants from any one medical school will be limited to a maximum of two. 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.

Nuffield Department of Anaesthetics
University of Oxford

5th Regional Anaesthesia for Carotid Surgery Course

Featuring video feed from the operating theatre of a live case

Monday 27 October 2003
9.30 a.m. to 4.30 p.m.

Details: Dr Mark Stoneham, Nuffield Department of Anaesthetics, John Radcliffe Hospital, Oxford OX3 9DU
Tel: 01865 221590, Fax: 01865 220027
Email: mark.stoneham@nda.ox.ac.uk
Web site: www.nda.ox.ac.uk
Africa has been in the news recently. Commentators have debated what the West can do to help but what does the British Government, through its development agency DFID, actually do?

I have just returned from an informal visit to Malawi. Your readers might be surprised to know how British aid from the tax payer is spent in getting this poverty stricken country on its feet.

In the British High Commission, the health advisor that I knew had left, disillusioned, for a career in osteopathy. Her successor had also left after only a year because of disagreements with her boss. The same boss has quit a year early because he cannot get on with the new High Commissioner.

The impression is that the process of development is more determined by the ego clashes of the expatriates involved, vindictiveness, and the settling of old scores, than by any guiding policy or science. Philanthropy hardly exists..

But criticism cannot be tolerated, no sir. I suggested to one of the DFID staff I met that the organisation would do well to heed adverse commentary on aid, such as often appears in newspapers in the UK. He retorted that people with these opinions, including Simon Jenkins of The Times, only knew about David Beckham on TV!

While the aid people squabble, out on the streets, I was struck by the increase in the numbers of ragged, thin and hungry people - significantly more than when I left two years ago. The economy is in trouble and the President had just returned empty handed from a visit to the UK.

DFID management and process is like a Western disease that has been inflicted upon Africa. In the 1990’s I witnessed health management taking precedence over patient care. The clinical services languished for a decade and undoubtedly more patients died as a consequence of this than all the deaths in the West caused by the AIDS virus going the other way. Missionaries and eccentrics keep the health service going today.

Audit and accounting of DFID projects has reached such a degree of dominance over the actual health objectives that they devour the funds and eclipse the objectives. With the rules surrounding the phenomenon of “forensic audit”, DFID has reached new heights of absurdity.

Thousands of pounds were recently spent on a forensic audit of one project. After 6 months, there was a short, unapologetic letter saying no irregularity had been found. The basis for the audit was perceived to be a personal grudge. DFID, which more resembles an accounting firm than a development agency, has a nastiness from the era of Baroness Lynda Chalker and it has not diminished. “New policy” in health development aid is brought in with each new top person, rather in the manner of a new male lion taking over a pride. He must destroy all the cubs sired by the previous male, now vanquished.

At the very top, the new Secretary of Development (another Baroness) has landed a really cushy number; the perfect portfolio. This is a post that you cannot be sacked from unless you put your foot in it because no results are expected. It is taken as read that no development will take place during the term of office. All that is required is to be politically correct and spend the money allocated.

Everyone in a poor country benefits from the presence of a rich donor agency. An aid worker just has to drive his Land Rover down a dirt road in Africa and he has done some good to someone, by being there and spending his money. President Ghadaffi did it in style in Malawi a year ago with a motorcade of over 100 vehicles scattering dollar bills as he went. The aim of development aid is to do more with the money but can DFID truly claim to have done better than Ghadaffi? There is scant evidence in the health sector.

Indicators are supposed to satisfy the need for evidence but they do not. DFID, far from being the beacon claimed by Prime Minister Tony Blair, has a ‘tick-box’ mentality (the words of the former
Chairman of the Parliamentary Select Committee on International Development). Indicators are selected on the basis that they can be fudged and a project is constructed backwards from that point. In fairness, in the health sector, there is not much else that one can do with indicators. It would be better not to have them at all and put trust in the integrity of people as instruments of health development instead.

The aid industry is more secretive than ever before in these days of false cosiness and transparency. For example, how much of DFID’s health aid to Malawi is spent in consultants, forensic audit, officers’ salaries and countless other expenditure that never reaches the recipient? It is impossible to find out; the forensic audit for that little gold nugget does not exist!

In one of its publications, DFID gives an interesting figure of 0.39 as the ratio of capital flight to private wealth in Africa generally. Clearly, in comparison with Asia and elsewhere, the reader is meant to understand the figure is too high – Africa’s money does not live at home. But what is the equivalent ratio in respect of the DFID budget for Malawi, I wonder?

Clare Short once claimed credit for ‘doing away with the aid-for-trade system’ under which British aid had to buy British products. Expenditure on external consultants has more than absorbed any benefit to the recipients that this reform may have brought.

There are still a few people around who are not employed by DFID, are not the recipients of donor aid, do not work in Ministries that are supported by aid agencies and do not solely watch David Beckham on TV. They do however take an interest in how the health of Africans is progressing - just for its own sake.

Unlike Prime Minister Tony Blair, these people generally consider DFID to be an increasingly ineffective organisation.

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The Association of Paediatric Anaesthetists of Great Britain and Ireland

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Refresher Course 11 March

Immediate Care of the Critically Ill Child

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ASM 12-13 March

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For further information contact:
Dr Louise Aldridge, Department of Anaesthesia, Royal Hospital for Sick Children, Scienness Road, Edinburgh, EH9 1LF. Tel: 0131 536 0226 Fax: 0131 536 0227
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- Epidemiology of cancer pain
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- Lymphoedema & its management
- Opioids and NSAID’s
- Neuropathic pain states
- Complementary therapies
- Pumps and other devices

Registration £150 (trainees £100)

Regional analgesia
Tuesday 11 March

- Pharmacology of local anaesthetics
- Trends in obstetric anaesthesia
- Blocks for the upper limb
- Spinal anaesthesia
- Local anaesthesia for vascular surgery
- Blocks around the hip joint
- Ophthalmic blocks
- Caudal additives in children

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Chronic
Mon/Tue 17 & 18 May

- Day 1
  - Neurophysiology of chronic pain
  - Persistent pain in the community
  - Pain management programmes - current status
  - Neuropathic pain syndromes
  - Medico-legal reporting
  - New directions in pharmacology
  - Chronic pain in sportsmen
  - Spinal endoscopy
  - Chronic pain in neurological disease
- Day 2
  - Headache
  - Widespread body pain
  - Cannabis - the present position
  - Complementary therapies - their role
  - Rehabilitation strategies
  - Exercise and physical therapies
  - Invasive treatments for spinal pain
  - Percutaneous cordotomy

Registration £290 (trainees £195)

Full details:
Mrs S Welham
PANG Administrator
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www.pangmeetings.com

Acute
Tuesday 15 June

- Neurophysiology of acute pain
- Opioid pharmacology
- The role of COX-II analogues
- Acute pain management in the day surgery unit
- Paediatric pain management
- Organising pain services
- Post operative nausea & vomiting
- Adverse effects of acute pain management

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You are a doctor in Africa so you are respected and rich. But as Bob Dylan penned years ago, “the times they are a changing” and these changes will affect us all. The new millennium heralds a different financial fate for many professionals in Africa, doctors included. It is a sad fact that most medical schools spend little time on training students in the matters of ethics and finance. Students are schooled in the ways of the health care professional. The emphasis is on knowledge, clinical excellence, diagnosis and therapy. The care of patients as individuals and treatment in a consented and empathetic way are gaining ground. The ethics of care of the dying and euthanasia are also actively discussed. However, the management of time, personal survival and financial planning for the future are all assumed; the principles of financial stability and self worth are not taught. Many financial advisors have observed that medics are poor at managing finances properly. With people living longer and fewer people paying money into retirement funds the fact is many of us will outlive the provision of our retirement plan. Many will be forced into second careers in some other field. In South Africa less than 7% of the population are able to retire knowing that they have sufficient money to see them out of this world. As professionals, we are only able to sell our time and knowledge or skill. We have no product or commodity to sell. The sale of goods keeps up with inflation, the cost of “time” does not. It is always undervalued. To cap it all, a third party, the insurer or medical aid, dictates medical fees. They tell us how much we are worth and how much we can charge! Our economy in Zimbabwe is in “free fall”, with changes occurring so rapidly that many people have been caught out. Inflation is officially pegged at 360% but independent assessors estimate it to be over 700%. A professor in the school of medicine at the local university will take home less than half of what a counter sales person at a clothes shop clears, and a government medical consultant is only marginally better off. This sum of money is enough to buy 50 liters of petrol, if you can get it! It is a well known fact that academic medicine is poorly paid; they do it for love, or research grants or because they can’t make it in the mainstream of medicine. In Zimbabwe, if academics do not do some private practice, they will not survive. But doing private practice is not what it used to be and ultimately doctors will live in poverty if they do not have another source of income.

For those who stay, there are two choices. One can simply set fees to what one feels one’s worth, after consultation with colleagues and price index advisors. Any connection to the medical aid fee structure is disregarded. These medical fees can then be set to match inflation. Patients will have to accept these high fees, viewed by some as exorbitant, or go to South Africa or overseas for treatment. The doctor is often accused of exploiting the sick. Alternatively, one may have some other source of funding, a trading company, inherited wealth, land or property, a hospital, stock market assets or a position in the ruling party. This allows the doctor to practice medicine as a ‘hobby’, not being fully remunerated but not minding it. The real finance comes from the other sources that will follow inflation. These doctors are the lucky ones because they don’t have to earn a living from medicine. These doctors are frequently praised for being public minded and having a caring attitude.

If the practice of medicine is the primary source of income for a doctor working in Africa, then that medic will probably not be able to educate his children to the standards that he would desire, and he or she may well retire into poverty. The right choice for an individual’s medical career is often the wrong choice for quality of life and for family. The simple fact is that most doctors are poorly trained to look after themselves in the areas of personal health and finances. Time for change is nigh!

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