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GE imagination at work
Since the changes to the Clinical Excellence Award (CEA) scheme in connection with the 2003 contract the Association has taken an even greater interest in the implementation of the scheme. President Mike Harmer wrote excellent articles on the subject in Anaesthesia News in 2004 (July and September issues) and anyone who has not read them should do so. This article is largely about the English CEA scheme but some of the points will apply elsewhere in the NHS.

Local Awards at levels 1 to 8 (and some level 9) are awarded through the local trust process. As the Doctors’ and Dentists’ Review Body on pay (DDRB) and BMA contract negotiators increasingly see CEAs as part of consultants’ overall remuneration package, AAGBI believes that all consultant anaesthetists should be fully informed about the CEA scheme and that anaesthesia should not be discriminated against in its implementation.

Recommendations

1. All consultant anaesthetists should fill in and submit a CEA form every year. No one has ever got an award without submitting a form. Only consider missing a year if you were successful recently - but take the opportunity to update the form anyway, which will jog the memory for future years.

2. New consultants become eligible after 12 months in post, so they should complete a CEA form. This is part of the new scheme and they should rapidly begin to become familiar with the whole CEA process which will apply for the next 25 – 30 years of their career.

3. Before completing a form every anaesthetist should read and strictly follow the current instructions on the CEA website. Studying these instructions will also identify areas of extra activity that individuals can develop in future to include in their forms in subsequent years and increase their chances of success. Also read Mike Harmer’s articles again.

4. Reviewing and completing a CEA form should become a familiar annual event (like appraisal) for every consultant anaesthetist.

5. Every Department of Anaesthesia should read the National ACCEA guidelines for the implementation of the Local Awards scheme (levels 1 to 9) in their trust and see that they are carried out in 2006. After three years some trusts are still not operating their Local Award process fully in accordance with these and Departments of Anaesthesia, ideally through their Local Negotiating Committee (LNC) should insist that they do. For example some departments have managed to get an Anaesthetist on the Local Awards committee where there was not one previously. As anaesthesia represents about 6% of the consultant body this should be almost automatic anyway. But your trust may need reminding.

6. A senior consultant anaesthetist familiar with the process should be identified in each department to help others with queries about completing and submitting the CEA forms.

In every year since 1948 the speciality of Anaesthesia has not received anywhere near its representative proportion of the awards available and the possible
reasons for this are covered in Mike Harmer’s articles. The original version of the Merit Award scheme did not emphasise that any equity of distribution should be required and but later versions, in line with changes in society, have.

B holders as % of total
from ‘Health Trends’ journal 1978-84

In June 2004 the DOH Workforce Directorate report ‘Equality and Diversity in the Workforce’ called for better monitoring of the awards process and fairer distribution between specialties. The problems of maldistribution were recognised by contract negotiators as long ago as 1979 and the contract document PM (79)11 stated that to balance out the regional variations which had been identified a ‘formal system of regional quotas broadly pro rata to the number of consultants be employed’. This successfully removed that variation and the current 0.35 awards per eligible consultant in each trust for Local Awards now provides an additional safeguard mechanism.

Referring to maldistribution by speciality, the next paragraph in PM (79) 11 stated ‘the Chairman and his Committee will keep a careful watch on the distribution of awards between specialties. The Chairman during his visits to regional committee will give guidance on the distribution of awards between specialties and set guidelines on targets to be achieved in the medium term’. 27 years later here is no evidence that this ever took place and if it did, it clearly did not work because speciality maldistribution continues. Perhaps a quota system should now be tried for specialties as it continues to be successful for the regional distributions (the ‘indicative number’ in the ACCEA 2005 Annual Report)?

The 2003 revision of the system was to answer some of the previous criticisms. Although these largely centred around National Awards, this part of the scheme appears to have a more objective, transparent and closely monitored process than the Local Awards scheme which seems largely unrestrained. There are still no national data available on Local Awards in the ACCEA 2005 Annual Report and the monitoring and accountability checks do not yet appear to be in place. Last year the DDRB called for a report from the BMA and NHS Confederation on the new CEA scheme’s operation. The Association has fed into this report including provision of data on anaesthesia’s position relative to the other major specialties, and has also communicated directly with Professor Sir Netar Mallick, ACCEA Medical Director.

Although anaesthesia fares badly in the National Awards it is most likely to be doing even worse in the Local Awards (as it was for Discretionary Points). One of the arguments given for fewer National Awards in Anaesthesia is that there are not enough consultant anaesthetists with sufficient numbers of Local Awards (say level 4 or over) to upgrade them to National Awards. It is therefore imperative that Anaesthesia as a specialty and every department focuses on getting anaesthesia fully engaged in the Local Award process at trust level with lots of anaesthesia applicants, submitting optimally completed CEA forms and the National ACCEA guidelines for the Local Award committees being openly followed in every trust. The ACCEA 2005 report says “many trusts are still feeling their way towards understanding and implementing the process” Anaesthetists should volunteer to help their trust - it could even assist towards an award!

‘Under the new scheme, as a Specialist Society the AAGBI has made nominations for National Clinical Excellence Awards following the appropriate guidelines on the ACCEA and Association websites. Anyone wishing AAGBI support in this way should read these guidelines and email their completed form to the Association at president@aagbi.org.uk by 29th November 2006.'
‘Anaesthetist – Why have the lights gone out? ’ I replied. ‘Does nothing work around here?’ the surgeon asked, now slightly irate, at least by Kenyan standards. ‘I guess not’ I suggested as calmly as possible, given the circumstances. We had anaesthetised, positioned and prepared a fairly sick twenty-year-old for a right thoracotomy in an attempt to drain what was rapidly becoming manifest as at least three litres of pus. My assistant continued pumping the Oxford bellows, as the pulse oximeter feebly bleated its last. We had induced anaesthesia with ketamine, were maintaining it with halothane through the OMV, whilst gently dribbling adrenaline through a 500ml glass bottle of saline. I laid one hand on the pulse and another on the chest. The surgeon waited. After about fifteen minutes the generator made its presence felt.

Chogoria is a fine place to live. It’s up in the eastern foothills of Mount Kenya, about two hundred kilometres north of Nairobi, perhaps a three-hour drive over potholed roads, depending on which matatu (minibus) you take. Dense vegetation and tea and coffee plantations define the landscape. It’s stunning. The local economy relies on the hospital and the school. Everyone has a family member who works there, supplementing their meagre income from the land, an income mauled by trade policies and their effects on coffee and tea prices.

The hospital was established in 1922. It’s a particularly aesthetic one - the wards are situated around a hexagonal grassy area. All the buildings are designed to entrap maximal daylight to save power, which has a pleasing effect on ambience. Funding comes by charitable donations through the Presbyterian Church of East Africa, and most of the doctors arrive on a voluntary basis. Nevertheless, standards are relatively high, and as a result patients sometimes travel thirty hours on dusty roads from Lake Turkana or the Somali border to receive treatment. I was the first physician anaesthetist the hospital had seen. Four nurse anaesthetists, trained in Tanzania, were maintaining an impressive service, despite having to double as clinical officers. Their techniques were evidently practised and effective. As an SHO fresh from a teaching hospital, I was a little intimidated, unsure where I would fit in.

Floran showed me around theatres on the first day. I was met with a set of bellows, an EMO, an OMV, ether and halothane. There was no ECG monitoring; the pulse oximeter in the first theatre looked vaguely functional; the one in the second theatre remains a potential health hazard. At least the sphygmomanometers worked. We also had Quinke and Whitacre needles, and 0.5% bupivacaine. ET tubes, plastic or rubber, were disinfected in the sluice and reused many times. Ketamine and diazepam, with nasal prongs became ‘Anaesthetic A’. Pancuronium was the staple relaxant. Oxygen was via cylinders connected to a t-piece before the OMV. A relic of a concentrator hung on the wall. Floran waved a hand, dismissive of it. I asked about the supply of cylinders. It was fine whilst the road from Meru was
open and the hospital had money. A landslide during the rainy season halted the supply for a fortnight.

The week I arrived, a sixteen-day-old neonate was brought in vomiting, never having fed. Ngera, our very talented general surgeon, decided on a laparotomy the following morning, after I'd resuscitated the child. Our laboratory tended to produce results that were at times fanciful, educated guesswork and a little luck. I suspect my general response to the idea of managing this case was appropriate to my previous experience, best described as anxiety and moderate terror.

I called on Betty for help. We rummaged through some cupboards and found a burette, amongst other donated articles, most of which, I suspect, have only historical interest. We ventilated with a small ambu bag connected to the OMV, stethoscope on the precordium, and a finger on the pulse. Ngera separated the biliary tree from jejunum. Thankfully, the child did well.

I lost count of exciting cases. A 22 week molar pregnancy which bled three or more litres in as many minutes. A horrifically septic boy with the worst osteomyelitis I could imagine - another victory for ketamine. A 50 year old man who arrived in the middle of the night with an impressive subglottic tumour, which made for a challenging emergency surgical tracheostomy. A craniotomy on a three-year-old boy hit on the back of the head with a forked jemba (three-prong rake).

On return from a few days' holiday on Zanzibar, Barbara, the obstetric surgeon caught up with me. She is one of those awe-inspiring doctors who has turned her hand to many things, including setting up clinics in lonely outposts of Sudan single-handedly. On this occasion she had a thirty-five week pregnant lady with a history of severe rheumatic fever. So much so that after her last pregnancy she was warned another would definitely kill her. I found her sitting up in bed, distinctly short of breath. ‘She came in a few days ago. Saved her for you’ Barbara said jovially.

This woman should have gone to Nairobi Hospital weeks ago where she would have had access to drugs and a critical care bed, but she didn’t have money. I was left guessing her haemodynamics on clinical grounds, before trying a ‘gentle spinal’. In a place where infant and child mortality is so high, women are under tremendous pressure to produce offspring. This woman almost killed herself out of fear that her husband would get another wife. Her situation alone with one young child would be diabolical.

In theatre we never became bored of examining our cultural differences. Gitonga, a surgical assistant looked up from an open prostatectomy one day and said ‘Dr Derek, how much did you pay for Dr Elsa?’ ‘Gitonga, in England we do not buy our wives’, I replied. He was surprised. ‘If you did not pay for her, how then do you know she will not run away?’

Chogoria is determined to be progressive, and provide the highest quality of care that it can. There are Tuesday morning lectures, Wednesday Grand Round, intern teaching on Thursdays, and morbidity and mortality alternating with journal club on Fridays. I was asked to teach the Postgraduate Nursing School a module on Intensive Care. Although Chogoria doesn’t have a unit, some of the nurses will go to Nairobi to work. Unquestioning in their learning, they sat quietly listening, almost without moving. It’s obvious they grasp every opportunity to learn and gain skills and it was incredibly rewarding to be a part of it although I had to tell them to contribute; to challenge my ideas and ask if they didn’t understand.

Whilst we were in Kenya, the rains failed. First the major rains in March, but then also those in July. The change in vibe was palpable. People were unsure whether they were going to have food to eat later that year. This was in the foothills of Mount Kenya, with precipitation and runoff from those lush slopes. Just thirty kilometres east of Chogoria, in Tharaka, the situation
was worse. Some children were brought into outpatients with frank Kwashiorkor. You can’t admit them, and leave the already poverty-stricken family with a greater burden of debt. If you waive hospital bills too often, you no longer have a hospital. But you know that these young children are weak; that an infection would likely kill them.

It shouldn’t happen. In a country with fertile lands there should be more money and food stores. You can speculate endlessly why this is not the case. Is it the common agricultural policy, import tariffs and export subsidies? Many Kenyans have stopped growing coffee and tea as the 3p per kilogram they received was soul destroying. It could be the lack of inlaid irrigation systems - most have been laid with foreign hands some time ago and do not work well. The education which stimulates good projects is often lacking. You can also point the finger at misgovernment, corruption, and a disparity in wealth. It’s not a unique problem.

We deeply wanted to try and change some of this misfortune. We certainly felt fortunate to have lived and worked in such a wonderful place. At work we’d shared knowledge, skills and humour. (I’d certainly learnt a great deal). Outside work, on a run, Johnstone, (one of the ODAs) was good enough to let me win occasionally, and I think I inadvertently provided entertainment on the football field. As an anaesthetist, I couldn’t irrigate the land, but what was critical in the hospital was oxygen. During our remaining time away from the UK, we cycled across Vietnam, Cambodia, Laos, and Northern Thailand and we asked our ever-supportive friends and family at home for sponsorship. Through their generosity Chogoria has purchased oxygen concentrators for ten acute beds, including theatres, supplied and serviced locally by a Nairobi based company. The dysfunctional ‘relic’ on the wall can now come down, and hopefully we managed to say thanks for such an enjoyable education.

Dr Derek Randles
Specialist Registrar,
Sunderland Royal Hospital
MERSEY
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- It is an Intensive Course of MCQ Analysis. It is NOT a course of MCQ practice.
- It is important that trainees understand that the course has no didactic input and thus they should come to the course expecting to learn but not to be taught.

Assessments PPC MCQ Course August 2006
If it was well worth coming - Mark 5
If it was a complete waste of time - Mark 0.
73% Marked 5
23% Marked 4
4% Marked 3

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“We all love the nice man with the snacks: can we take him home with us”

Application Forms
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“If you feed the children with a spoon, they will never learn to use the chopsticks”
If I may, I’d like to share a small personal anniversary which falls this month with readers of Anaesthesia News. I have now been employed longer in my current consultant post than I was in my first. It’s an odd realisation – I still feel as if I’m the new girl here! But the calendar does not lie – seven and a half years in each post. (I also don’t know how I can possibly have been a consultant for fifteen years, especially when I’m still only 29). So I’ve been thinking about having more than one consultant job. It used to be unheard of, and anyone who had switched consultant posts was viewed with a degree of suspicion - clearly an awkward character who didn’t get on with his/her colleagues. But it’s now relatively common – there are four of us (I think) in my current department, and it’s interesting to hear why people moved.

For myself, I trained in the West of Scotland, where I now work. When I got my ticket, I decided that getting the next consultant job in the local area was all very well, but with no family tying me to any particular area, I decided to go off and see what else was out there. A job in the West Midlands appeared in the BMJ, I went for a visit, they liked me, I liked them, and I got the job. I loved that job, and put my heart and soul into it. I liked the area it was in, and still visit regularly even now. What went wrong? It’s a familiar NHS story, and interestingly is a common factor for most of my current “two jobs” colleagues. It’s change. Basically the job was not what it started out as. Some of my colleagues (the ones who moved after a year or two) found the job they were actually doing was radically different from the one they were promised. For me, some years into the job, the Health Authority went through a prolonged major reorganisation. It’s not just me who had no staying power - many consultants in various specialties left around this time. I don’t know what the financial cost of these departures and replacements was, but I don’t expect it appears on any balance sheet. There is also a human cost, which is never high up the priority list when it comes to these matters.

So I moved, back to where I came from, more or less. It was a huge decision to uproot myself – there was a lot still right about my current job and life. Were the negatives enough to shift self, cats, and chattels back up the M6 (not to mention buying and selling houses, an experience on a par with root canal work, as far as I’m concerned)? I applied, and got the job. Seven years later, I know I made the right choice. There are things about my present job that are not perfect (and whisper this quietly in case my current colleagues get wind of it) and were better in the previous one. Also, I really, really, miss the weather! But lots of things are better, and overall it was the right choice. Never say never, but I should be here till I retire. (Having three consultant jobs – that surely does reflect a flighty character).

There was also an issue about arriving as a new person, but being an experienced consultant. As Jane Austen had the eminently sensible Admiral Croft say in Persuasion, “One man’s ways may be as good as another’s, but we all like our own best”, so a period of tactful readjustment to the new place’s ethos is required. One must try not to say, “When I was in …..” too often (I’m afraid I may have failed that objective). I also remember trying very hard to be sweetness and light for at least six months (funnily enough my colleagues, medical and nursing, seem to have forgotten this!) and the huge pressure of trying not to have a bad day, as people were judging you. I have acquired a new surgeon recently, who has also been a consultant elsewhere. His approach is very different - his way is the way it is done (actually, it’s nothing to do with his previous job – it’s just that he’s a surgeon…..), and we are all training him intensively without him realising. Passive resistance seems to be the way forward, and nobody is better at this than anaesthetists, followed closely by theatre nurses! He’ll learn…

In this month’s Anaesthesia News we have the results of this year’s GAT survey. This is a fantastic initiative which has been going on for some years now. If you’ve attended a GAT meeting recently, you’ll know you get a questionnaire to fill in and return (and shame on you if you forgot or didn’t bother). As its authors acknowledge, it’s not very scientific, but it’s as good a snapshot of what’s happening to trainees nationwide as there is. By repeating questions over several years, evolving situations can be monitored – for instance, the continuing downward trend in on call room availability.

There’s a thought provoking piece from Dr Ruxton – would we all maintain the highest ethical standards practising medicine in a virtual civil war? Let us hope we never have to find out. A more hopeful view of medicine practised in a difficult environment is portrayed by David Rowlands’ article on Kabul – make sure you read right to the end as it has a lovely punchline! And finally, an old favourite has made a comeback. Gas Flo got a new computer a couple of years ago and has been trying to make the email work ever since. She has now done so, and we are delighted to welcome her back, with views as astringent as ever.

Hilary Aitken
For the purposes of this discussion I shall refer to the proponents of MMC as “herdsmen.”

It is August 2006 and I find myself contemplating what I shall be doing this time next year. Usually I enjoy musing over the future. But not now. The future has lost its allure and instead I face subjection to a paternalistic “modernisation,” or should I say “manipulation,” of my medical career. Fellow subjects, never presume that the autonomy we heed in our patients is attributable unto ourselves. And if you dare to dream, dream only of tick-boxes...

We all acknowledge a need to mould healthcare provision to the demands of the nation. “Run-through” training is the conveyor belt which will deliver a new range of IKEA-style doctors to meet those demands. Experience will become a thing of the past. Instead, an intensely time-consuming, tree-consuming surveillance system and a dedicated allegiance to the logbook will override any conceivable advantages of experience. Pattern recognition will become irrelevant to patient management and anybody demonstrating such obsolete behaviour will be considered deviant. There will be zero tolerance of experience. The meat that we feed into the processor must equal the sausages that we get out. Sausages will find it impossible to take electives or do research. There is absolutely every intention to eliminate interesting or novelty sausages from the market.

My own situation is that I have spent two years as a medical SHO, attained MRCP, and am now undertaking a year of anaesthesia/intensive care to improve my competence with critically ill patients. Sadly this “superfluous” year is regarded by the herdsmen as my baptism into a “lost tribe” of SHO’s.

There are a number of people in my position, grooming their confidence and their skills prior to further specialist training. To describe them as a “lost tribe” reduces their experience, their self-appraisal and their service provision to the wanderings of a roaming hippy. The new system will offer around 10,000 run-through “Specialist Training” posts to approximately 20,000 doctors and therefore niftily replaces the lost tribe with the totally excluded tribe, who will be obliged to accept “career posts.” The herdsmen are clearly dictating a two-tier training scheme. A “Specialist Training” ladder for the elite master race. And a slippery rope for the failures and the nomads. What kind of professional solidarity do we anticipate?

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points. MMC appears to have taken its inspiration from the Eurovision Song Contest. How very reassuring.

Of course, these changes are not all that far away, with August 2007 accelerating towards us. For months and months all we ever saw at MMC meetings was an almighty flow chart, a sensational compartmentalisation of our future into “ST,” "FTST" and "Career Post" boxes. But when we probe beyond the web of statistics and timescales the herdsmen remain strikingly inarticulate, dare I say, clueless, about the finer details of MMC. I keep hearing the phrase, "Nobody quite knows how that's going to happen?" Why the hell not? The medical profession is palpitating with insecurity and irritation and time is marching ever onwards.

Interestingly, when we look at the prophetic flow chart, we notice an intriguing resemblance to the current system. It seems that, for many specialties, the Royal Colleges have actually flexed some muscle and impressed upon the herdsmen that training in, for example, anaesthetics, has always taken seven years and will continue to take seven years. Sadly you simply can’t squeeze the Oxford Handbook of Anaesthesia into the dimensions required for a suppository. So we have a “new system,” which is more precisely the old system in a strait-jacket.

It startles me that as a group of thoughtful, self-respecting professionals we are guilty of marked inertia in the face of change. The consultants, despite widespread disapproval of the plans, are adopting a laissez-faire attitude and that is their privilege, as their lives will not be manipulated by MMC. The juniors sense that no one will hear their humble groans and fortunately are too scrupulous to jeopardize patients by striking for a month. But do we trust the MMC perpetrators and their predictions of the unpredictable? Most of us have shed, if not blood, then sweat and tears for our patients. Meanwhile the powers-above shuffle papers and conjure up new numerical targets to add to the crucible. We are left to watch the nurses devoting their attention to breach-times instead of patients. We watch continuity of care being frittered by working time directives. For junior doctors the opportunities to be team players are withering and increasingly they are wedges between shifts, filling a slot with diminishing return. They have emerged amid a culture of hours-monitoring and gain nothing by working beyond their hours. This is a dangerous drift. When you take away the pride of working for a team, of continuing a patient’s care, of being recognised for diligence, then you generate resentful doctors, obsessively defensive of their lifestyles because their job satisfaction is shrinking. Professional morale is languishing.

In conclusion, there is nothing to suggest that the new training system will not work. I suspect that it will work, primarily because it is not so different from the existing system, except the paths to our destinations will be desperately controlled. Doctors are not numbers and we can expect some dispirited professionals, at least until the ‘ologists can be genetically engineered. Fetuses entering the scheme shall equal consultants exiting.

A final plea to the herdsmen. If you insist on presuming that every “F2” has the maturity and experience to divine their ultimate niche, then at least acknowledge that alongside such maturity comes an independence and a passion to be the architect of one’s own destiny. It is highly depressing to find that the hands of fate are gloved in the wool of MMC. You gave us the term “foundation years.” Let us build our own temples of medicine upon those foundations, with freedom, ambition and individuality.

GMC number 6030059
(Once known as Lucy Cottle)
Exeter
New Pain Score Transforms Assessment of Postoperative Pain

Anaesthesia News has recently had communication from Dr R. Ewen Payne of the Postoperative Pain Society (PPS) describing a new technique of measuring postoperative pain which is to be recommended by NICE later this year.

In the past, patients and nurses have been expected to use a variety of semi-qualitative, subjective assessments which require an understanding of the quasi-interpretative model being used. Most experts now agree that analogue pain scores, rule of ten ratings and three point assessments should be consigned to history. “They are inaccurate, difficult to use and, frankly dangerous!” asserts Dr Payne.

The new recommendation is to employ the single point “Ah” test, named after its inventor, regional specialist Dr Ahman Itzor.

The score is started on entry into recovery when the patient is observed carefully for signs of discomfort or pain. The nurse then asks the patient to say “Ah”. Research has clearly demonstrated that those in the most pain tend to pronounce “Ah” as “Aaaaaaarghh” using significant volume and forced expiratory effort, often accompanied by a writhing motion. Those in little pain tend to lie quietly, with a contented “Aah”.

“By using the Ah score, nurses are better able to chart the success of their analgesia administration in a completely objective fashion” explains Dr Payne. “The future is very exciting – one group of researchers has demonstrated that an Ah Controlled Analgesic administration system is undergoing final tests. Patients in the future with scores such as Aaaaaaarghh will automatically receive the analgesia required.” There seems to be little doubt that this new development will contribute significantly to patient analgesia and overall safety.

A visual “Ah” score is currently being developed for patients unable to vocalise at all. A sample of this can be seen below.

Caption contest result

Thank you for your entries to the caption contest featured in the August issue of Anaesthesia News. I regret to inform readers that the unkindest entries came from AAGBI Council members. The winning entry is from David Bogod (Nottingham):

“The individuals in the photograph wish to make it clear that any resemblance between this picture and a serious mid-life crisis is entirely coincidental. The editors of Anaesthesia News wonder who on earth they think they’re kidding”. 
**MERSEY**

**VIVA WEEKENDS**

**Final FRCA Viva Weekend**
2.00pm Friday 1st - 4pm Sunday 3rd December

**Primary FRCA Viva Weekend**
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Intense Presentation Practice
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These Courses are only available to those who can produce evidence of having passed the
The Final SAQ and MCQ papers (October)
or
The Primary MCQ Course (December).

“If you feed the children with a spoon, they will never learn to use the chopsticks”
TRAVEL GRANT

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

GRANTS UP TO £1,000

RULES

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

For further information and an application form, please visit our website: www.aagbi.org or email 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 and HonSecretary@aagbi.org

Local Anaesthesia for Ophthalmic Surgery
Friday, 9th February 2007, Middlesbrough

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in the David Kenward Lecture Theatre, Education Centre, The James Cook University Hospital, Middlesbrough on Friday, 9th February 2007. The meeting will include lectures and live demonstration of different orbital blocks. Attendance is limited. Registration fee is £150 inclusive of catering. Cheque payable to "Ophthalmic Anaesthesia Education Trust Fund".

PROGRAMME

09.00-09.25 Registration
09.25 Welcome: Professor Chris Dodds, Middlesbrough
Chairman: Mr David Smerdon, Middlesbrough
09.30-10.00 Anatomical considerations for ophthalmic block
Dr Robert Johnson, Bristol, Bristol
10.00-10.30 Needle blocks
Dr Robert Johnson, Bristol, Bristol
10.30-11.00 Sub-Tenon’s blocks
Dr Anthony Rubin, London
11.00-11.15 Discussion
Chairman Professor Chandra Kumar, Middlesbrough
11.15-11.45 Coffee break
Chairman Professor Chandra Kumar, Middlesbrough
11.45-12.15 Pharmacology relevant to ophthalmic regional anaesthesia
Dr Hamish McLure, Leeds
12.15-13.00 Choices and preferences of ophthalmic regional blocks
Dr Marc Feldman, Ohio, USA
13.00-13.15 Lunch
13.45-16.30 Live demonstration of orbital blocks
Chairman Professor Chandra Kumar, Middlesbrough
Dr Anthony Rubin, London
Dr Robert Johnson, Bristol, Bristol
Dr K L Kong, Birmingham
Dr Raju Chabria, Middlesbrough
Prof Chandra Kumar, Middlesbrough
Prof Chris Dodds, Middlesbrough
16.30 Closing remarks
Prof Chandra Kumar, Middlesbrough

Meeting Organiser: Professor Chandra Kumar and Course Director: Professor Chris Dodds
Further information and application forms: Mrs Jenny Snaith, Academic Department of Anaesthesia, The James Cook University Hospital, Middlesbrough TS4 3BW. Tel: 01642-854934, email: Jenny.Snaith@stees.nhs.uk

Regional Anaesthesia

Live Interactive Demos in Theatre (via Video Link), Lectures and Workshops covering a full range of peripheral nerve blocks techniques

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Course organised by John Hammond Department of Anaesthesia, East Surrey Hospital, at the Postgraduate Medical Centre, East Surrey Hospital, Redhill, Surrey

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COURSE DIRECTOR: Dr Fred Sage, Consultant Anaesthetist, East Surrey Hospital, Redhill

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Ultrasound Techniques Dr Susanne Krone, Queen Victoria Hospital, East Grinstead
Nerve Blocks for Trauma Surgery Dr Jörg Köhne, North Devon District Hospital, Barnstaple
Anticoagulation and Regional Anaesthesia Dr Barrie Fischer, Alexandra Hospital, Redditch

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Delegates at this year’s Annual Scientific Meeting in Newcastle were asked to complete the annual GAT Training Survey. The results from the completed questionnaires help to provide GAT and the AAGBI with an insight into the current training of UK anaesthetists. The questionnaire evolves from year to year and this year included questions about study leave, study budgets, and potential changes to hospital career structures.

**Questions asked in 2006 Survey**
1. What is your current grade?
2. At which pay band is your current job banded?
3. Do you receive pay protection for your current hospital rotation?
4. In your most recent five weeks of training how many half-day teaching lists or sessions have you had?
5. At night do you currently have a room with a bed for your use?
6. We need to compensate for the reduction in working hours by increasing the duration of training. Agree/Disagree
7. Are you able to take your full allocation of study leave?
8. Have you had a cut in your study leave budget?
9. Do you think the introduction of a Junior Consultant grade would make Anaesthesia less attractive as a career?

69 delegates completed the questionnaire, 55 SHOs (33%), 29 Pre-FRCA SpRs (17%) and 85 post-FRCA SpRs (59%). Two trainees were working non-compliant rotas, 42% working a Band 2A rota, 33% a Band 2B and 20% Band 1A.

Compared to previous years, the banding of jobs appears to be changing. It may be that the provision of more Specialist Registrars or Trust Grade posts within rotas has allowed the introduction of more Band 2B compliant rotas, with the numbers increasing from 14% to 33% of all rotas worked. The proportion of doctors working a Band 2A compliant rota has dropped over the past year from 64% to 42%. Doctors working a Band 1A rota remained steady at 20%. Over half of the delegates completing the survey received pay protection in their jobs.

This year has seen a further small decrease in the number of trainees with access to “rest rooms” during their night shifts, down to 86% from above 90% last year. There appears to be a continuing downward trend, although not at the rate initially feared with the introduction of the shift system.

Last year’s survey highlighted the lack of accompanied teaching list opportunities for Senior House Officers with over 40% of SHOs receiving less than 5 accompanied lists in a five week session. Unfortunately such figures are borne out again this year with 54% of all delegates receiving less than five teaching lists in the previous 5-week period. Splitting the figures down to grades, 47% of the SHOs received less than 5 teaching lists.

The introduction of Band 2B rotas should mean fewer hours are spent providing service out of hours, and more time is spent in the hospital within ‘normal’ hours. This should in turn provide more time for teaching opportunities but we have seen a decrease in the number of teaching lists allocated to trainees.

Delegates were again asked whether the training period should be increased to compensate for the reduction in the number of weekly hours worked. A simple yes/no answer was required rather than the sliding scale range of last year. Delegates were split as to whether training needed to be increased - 55% of responders agreed that it did.

The majority (72%) of delegates were able to take their full allocation of study leave but over the past year 33% of the trainees had seen a cut in their study leave budget from the deaneries, in some instances of up to £600.00.

While confusion and debate still surrounds the future of the career structure of hospital grade doctors, 131 of the responding trainees (78%) felt that the introduction of a “Junior Consultant” grade would make the speciality of anaesthesia less attractive for potential entrants.

As mentioned last year, this type of survey has a number of limitations including the self-selecting nature of the responders, and the overall small number of completed questionnaires compared to the total number of UK trainees. It does however provide a snapshot of training within the UK and highlights several potential problems facing us – the lack of accompanied lists for junior trainees, the erosion of on-call rooms and the significant loss in study leave budgets.

Many thanks to all those who completed the survey.

Michael Parris, GAT committee member
AAGBI SAS Committee – representing the interests of SAS anaesthetists

(This article is adapted from a presentation given by Ramana Alladi at the SAS Review Day)

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recognises SAS doctors working in anaesthetics and their valuable contribution to anaesthetic services in the NHS. Dr Kate Bullen, as an elected member of AAGBI Council, played a major role in raising the profile of SAS doctors, both in the Association and nationally. The SAS committee was established in 2002 under her chairmanship, and was handed over to Dr Ramana Alladi in 2004.

This article deals with what the Association and the SAS committee are trying to do to represent SAS doctors and the issues facing them. To make representation effective and influential a strong SAS committee was constituted and currently it includes three executive members of Council, including the President of the Association. It also includes a representative member of BMA SASC, past and present chairman of SAS committee of RCoA, and three SAS representatives.

The terms of reference of the SAS committee are to represent the interests of SAS members in AAGBI, to advise Council on matters relating to SAS doctors, act as AAGBI’s principal support for SAS doctors, to encourage their professional development and to liaise with RCoA and the BMA and other professional bodies on matters of mutual interest.

According to the RCoA Census of 2004 there are more than 1200 SAS doctors working in anaesthetics. This number is increasing all the time as new Staff Grade jobs are created in hospitals all over England, partly because of the abolition of SHO posts and inability to fill consultant posts, leaving gaps in the provision of services. In 2004 there were only 200 SAS members in the Association. The main aim of the SAS committee recently has been to increase the number of SAS members. There is a particular lack of representation from SAS doctors working in Northern Ireland and Scotland and also among younger SAS doctors.

The Association has taken active steps to improve the situation. Personal letters were written to all identifiable SAS doctors who are not members outlining the benefits of membership, and also to existing members to encourage their SAS colleagues to join. The chairman of the SAS committee made presentations at the linkman conference and to Council earlier this year highlighting the issues facing SAS doctors. The SAS committee has established a database of SAS doctors by writing to the secretaries of anaesthetic departments asking them to provide details of their SAS doctors.

The Association sent out a four-page questionnaire in May 2005 to all UK members, including all SAS doctors. This survey was conducted to ascertain views of members on various issues, and it was possible to review data pertaining to SAS doctors separately. The survey asked questions relating to details of qualifications, employment, job plans, study leave issues, appraisals, CPD activities and other matters of concern so that the Association can identify them and deal with them effectively. It has been an extremely useful survey and gave the Association evidence regarding what concerns all members, including SAS doctors. The results of the survey have been reported in Anaesthesia News and will be available on the Association’s website. Based on the findings and the suggestions from the respondents the Association has already acted upon a number of issues.

The Association has established strong links with the SAS committee of RCoA, and the SAS Review Day is one of the results of this joint venture. A proposal to have a joint meeting of AAGBI and RCoA SAS committees annually is being considered.

The Association published an SAS glossy in 1998 and it has proved a useful guide for many anaesthetic departments and SAS doctors over the years. It is now being updated by the Association to reflect the many changes in the NHS. A working party for the glossy was formed under the chairmanship of Dr
Les Gemmell. Because of the comprehensive nature of the information compiled, the Association has agreed to publish the information in the form of a handbook (similar to that produced by GAT) with an abbreviated form published as a traditional glossy. The handbook was due to be launched at the Annual Congress in Aberdeen in September and will be made available to all anaesthetic departments and managers. The handbook has information on job issues, NHS, PMETB, Clinical Governance, appraisals and several other relevant topics of interest to SAS doctors. It is hoped that it will serve as a useful source of reference.

Articles of interest to SAS doctors, which are generally contributed by SAS members, are regularly published in ‘Anaesthesia News’. There are separate pages for SAS members on the Association of Anaesthetists’ website. They contain useful information for SAS doctors including articles, reports and other relevant documents.

The research committee of the Association has allocated a research grant of £5000 exclusively to promote research among SAS doctors. I would like to encourage SAS members with a worthwhile project to utilise this opportunity and apply for the grant - details appear on this page.

A separate session for SAS doctors will continue to be held at the Annual Congress. This year the session will be followed by a panel discussion and special lunch hosted by the President of the Association. In addition, the education committee is planning to organise a seminar on management issues for SAS doctors in conjunction with Anaesthetists in Management (AIM).

The Association Council and Officers have given and continue to give full support to the cause of SAS doctors. It is important that SAS members also do everything they can to support their cause and take part in all its activities. This is the only way to raise the profile of SAS doctors in anaesthetics.

Ramana Alladi
Chairman, SAS Committee
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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 provided free of charge for everyone at 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 before booking.

BLEEDING, CLOTTING AND HAEMORRHAGE – AN UPDATE
Tuesday 12th December 2006
Organiser: Dr R RaoBaikady, London

- Physiology of bleeding & clotting
- Blood products & transfusion guidelines
- The complex nature of coagulopathy in massive bleeding in trauma/surgery
- Hemostatic resuscitation
- Management of post cardiac surgery bleeding and blood conservation strategies
- Pathophysiology and management of obstetric haemorrhage

COMMUNICATION SKILLS
Thursday 25th January 2007
Organiser: Dr S Gower, Hull

- Communication and the art of teaching
- The art of teaching communication
- Communicating with patients on intensive care
- Debate: 'Good communicators are born not taught'
- Errors in communication and deliberate misinformation: management and politics

STANDARDS AND EQUIPMENT SEMINAR
Monday 29th January 2007
Organisers: Dr Les Gemmell, Wrexham & Dr Mike Wee, Poole

- Training and anaesthetic equipment
- Standards and anaesthetic equipment
- Safety and the anaesthetic machine
- Testing anaesthetic equipment
- The anaesthetic machine driving licence
- The future of the anaesthetic machine

SKIING – BEGINNER OR SEASONAIRE?
POST A-DAY PENSIONS, INVESTMENTS AND SKIING (SPENDING THE KIDS’ INHERITANCE)
Wednesday 24th January 2007
Organiser: Dr Mark Martin, London

- Existing NHS pension and recent changes
- The life and times of a retired anaesthetist
- Private pensions in the post A-day era
- Managing investments - what they don’t want you to know
- 'Wrapping' your investment portfolio
- Escaping Gordon’s clutches - effective inheritance tax planning
- Open workshop - your chance to quiz the speakers on a one to one basis about the day’s topics

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 Directions

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

Seminars Calendar

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CLINICAL EPIDURAL ANAESTHESIA
Wednesday 4th October 2006

GAT: THE CONSULTANT INTERVIEW
Thursday 5th October 2006

AWARENESS AND DEPTH OF ANAESTHESIA
Thursday 12th October 2006

HISTORY OF ANAESTHESIA - FROM TOOTHACHE TO PAIN MEDICINE
Monday 16th October 2006
• “He that sleeps, feels not the toothache………”
• Advances in routes of analgesia
• Discovery in the physiology & pathophysiology of pain
• Evolution of neuraxial techniques in pain management
• Pioneers in chronic pain – the Intractable Pain Society & IASP
  • Establishment of acute pain teams
  • Role of anaesthetists in palliative care
  • Training in pain medicine

ANAESTHESIA FOR LIVER RESECTION SURGERY
Wednesday 18th October 2006

YOUNG CONSULTANTS: BALANCING THE BOOKS
Thursday 19th October 2006

OPHTHALMIC ANAESTHESIA
Tuesday 24th October 2006

ANAESTHESIA & THE ELDERLY
Tuesday 7th November 2006

DIFFICULT AIRWAY PROBLEMS
Wednesday 8th November 2006

ULTRASOUND IN REGIONAL ANAESTHESIA – 3rd National Symposium
Monday 13th 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 14th November 2006

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

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

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

ULTRASOUND FOR ANAESTHETISTS
Tuesday 5th December 2006

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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

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• 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
A Great Teacher

I would like, through your columns, to mourn the passing and celebrate the life of a hero of mine.

Sometime in 1975, Tom Boulton kindly visited me in an Army posting, I think in Northern Ireland, and together we bemoaned the lack of success of JB at the old final. The diagnosis was simple – too much G and T and a good time – and the remedy obvious. I was to leave the service of Her Majesty and get a ‘proper job’.

So I interviewed in Oxford and got the job, I am sure with TBB pulling some strings! Thus I encountered the splendid Nuffield Department of Anaesthetics, with so many heroes on the scene, but especially Dr Roger Bryce Smith. Here was a genius at teaching, as well as a thoroughly nice man, with a wicked sense of humour which, on occasion, would upset a less than robust trainee.

An example of his wit occurred on one occasion when I was placing an epidural into an enormous woman for a hip replacement. The needle pierced the ligamentum flavum as Roger entered the anaesthetic room. “There you are, Sir”, I said, noting the brief sucking in of air from the epidural space. He bent down to listen to the end of the needle plunged all the way into the fat and commented, quietly “bowel sounds, I think!”

Roger could block any nerve you chose and was brilliant at teaching the techniques. On one of my several attempts at the old final, I blanched when asked to go to the table of Dr X but I had been warned that, as long as the skull was not proffered, all would be well. Oh no! Not only was the skull sent in my direction, it was turned upside down and I was asked to identify the sphenopalatine ganglion! Needless to say, I was asked to return in six months.

Back in Oxford and anaesthetising an ENT list for a delightful but famously slow surgeon performing an operation on, I think, the vidian nerve. Hands up those of you who know about this nerve. I thought so! Roger was with me for the start of the list and I mentioned my recent failure at the green baize. With nary a backward glance, he blocked one sphenopalatine ganglion and instructed me in doing the other side.

Roger had gone by the time, seven hours and much grunting later, the surgeon said “It’s really difficult identifying the structures. It’s almost as if somebody has been injecting in the area.” Like a fool I confessed.

Roger Bryce Smith regularly anaesthetised for an irascible vascular surgeon and there is said to be one occasion when the surgeon was momentarily distracted from his work by finding RBS sitting in the corner on a stool. When asked why, he replied “the patient died 10 minutes ago and I have been trying to tell you!”

Roger’s daughter Gillie had been this surgeon’s scrub sister for many years and you might have thought that a bond had been struck. However, during a flu epidemic that winter, she collapsed at the table. “Sister’s fainted” came the cry. “Drag her out and bring me another!”

One other piece of instruction that RBS gave me was the use of open ether. As trainees, we were familiar with and used the EMO but he felt that we would benefit by learning the straightforward technique. To my amazement, a Schimmelbusch mask was produced and anaesthesia proceeded on children on an eye list. The surgeons hated this as both were smokers and were banned outside in the rain.

“The secret, my boy, is a few drops of halothane first, to soften ’em up.” And so it went on, with all the patients happily desquinted, and his final patient anaesthetised by dropping ether onto the sheet over the face! “In case you haven’t got a mask.” Then we came to the last. “Your turn, I think,” was the great man’s cry. Trying to subdue a strapping eighteen year old lad with open ether, with or without halothane, was my final challenge for the day.

I and countless other trainees have benefited from the life and works of Roger Bryce Smith. To know and work with the famous inventor of the double lumen tube might have been enough but the excellent teaching from him was tremendous. It might be argued that his help in unleashing me on an unknowing NHS was not one of his finer achievements but all the others would have been worth it.

John Ballance
Hereford
Policy of Guidance

My Trust has just produced a new policy document. It’s a policy on how to write policies. It’s quite short as far as Trust Policies go – just fourteen pages, with two three-page appendices – and contains some quite reasonable and welcome advice such as “Must have a title”, “Must be evidence-based” (not sure about this one – NICE is cited as a good authority), “Must have an author, a date and a review date” etc. etc. From now on, only policies written to this formula will be accepted. But will anyone pay attention? Or will they continue to use the old Trust method of writing policies which, if written down, would have looked a bit like this?

Trust Policy for Writing Policies

1. Think of a policy for something that anyone with an ounce of commonsense will instinctively know how to handle e.g. Stopping unconscious patients from falling off the operating table.

2. Second at least two fully functional nurses from a poorly staffed critical care area to do an audit across the Trust over the next six months, resulting in at least ninety pages of results with pretty, full colour graphs and pie charts.*

3. Consult widely with patient groups. Do not worry about professional advice or opinion at this stage.

4. If you are writing about an area of specialist expertise such as anaesthetics, avoid doing a search to see if relevant professional bodies have already written national guidelines on the same subject. ‘Re-invent’ and ‘wheel’ should be your watchwords here.

5. Under no circumstances whatsoever allow anyone who has any special knowledge or expertise, particularly consultants, to interfere.

6. Having gathered your data, write the policy in the following style.

- Use a nice touchy-feely font such as Comic Sans MS
- Make sure your spell-checker is set on English (U.S.) so that words like ‘finalise’ can be spelt with a ‘z’
- Make full use of as much jargon, and management-speak as you can. Be prolific with obscure, unexpanded acronyms
- Ensure the following words and phrases are in there at least once: ‘patient-centred’, ‘leadership role’, ‘child protection’, ‘evidence-based’ and ‘empowered’
- Don’t worry unduly about grammar or spelling
- Try and make it as long as possible. More is more in this case
- Do not be afraid of stating the obvious. The words ‘teach’, ‘Granny’, ‘suck’ and ‘eggs’ are a good guide to prose style
- Try and include as much ‘science’ as you can: e.g. ‘Stopping Unconscious Patients Falling off the Trolley’ should be phrased as ‘Protecting the Unconscious Patient from the Effects of Gravity’
- Under no circumstances put your name on the document as you may have to face undeserved criticism after all your hard work
- Don’t date it. Then it will last forever
- When you think it is finished, try to refrain from spell-checking it
- Add a zany, meaningless illustration to the title page such as this **

- Finally, do not circulate to any interested groups that might know more than you do and/or disagree, until it is too late for them to change anything. (A good time to publish Trust policies is during the summer or Christmas holidays when people are away).

Appendix 1

Here are some examples of excellent subjects (in précis form) that could be worked up into a really good thirty page Trust Policy: ***

1. Sharp things are dangerous and must be used and disposed of carefully.

2. Unconscious patients can fall off a trolley, particularly if they only have one leg.

3. The person with least consequence in deciding if a child is fasted pre-operatively is the anaesthetist, the child being the most important.

4. Umbrellas can put someone’s eye out if not collapsed before entering hospital premises on a rainy day when you are late

5. Making tea and toast for patients carries a serious risk of scalds and burns. Designated staff should undergo specific CNST training.

6. Anaesthetists have a nasty habit of cutting identification wrist-bands off in theatre. This puts the unconscious patient at enormous risk of getting lost in recovery. This practice must be stopped or severely punished.

* These nurses will never work again. They will need three months’ IT training and a Masters degree in data collection before they do the audit. They will clog up all the communal PCs available in ITU and Theatres for the next six months so you can’t get at your email, or worse, they may be given your secretary’s office. When they have finished the audit, depending on how bad it is, they will be promoted to a management role in CNST and given another project. Whatever happens, they will have got so used to the 9 to 5 existence they will never go back to critical care and smelly patients. Meanwhile, the critical care area from which they have been seconded will sink into an even deeper staffing deficit.

** Perhaps not so meaningless as it completely sums up my reaction to the majority of Trust policies.

*** One of these is a spoof. The rest are real policies. Not that easy to spot is it?

Gas Flo
When Dr Eric Cheysson, President of Enfants Afghans, asked me to go to Kabul to look at the hospitals in order to interest UK medical workers in Afghanistan, there was some family resistance in view of my age (84). Perhaps they were right, as I broke my small dental plate even before I arrived in Kabul; no matter, it was repaired the next day. Fortunately my son John was able to take some holiday and come with me.

The French Medical Institute for Children was built by Enfants Afghans, a branch of La Chaine de L’Espoir, a French NGO, and was opened on April 8th by Madame Chirac, President Karzai and His Highness the Aga Khan. The hospital is managed by the Aga Khan Development Network. There are 4 well-equipped operating theatres and a 15 bed paediatric Intensive Care Unit.

Specialised surgery is carried out by visiting French teams and the first open heart surgery in Afghanistan was carried out in April. A general surgical team and a further visit from the cardiac surgical team are expected later in the summer. Some of the local staff have been to France for additional experience.

There is a CT scanner, with a large workload. This is no problem with the high tech equipment. The local and international staff are very competent, and there is ‘back up’ from France if there are any problems; for example a retired engineer came to make sure that the new laundry equipment was properly installed. There is a full time biomedical technician from Pakistan, and two 2 Afghan personnel will be trained for this work.

It is an excellent hospital for volunteers who are interested in paediatric anaesthesia, surgery or medicine. In addition, there is the chance to see very high-powered surgery when visiting French teams come. There is the also the opportunity of a short-term (2 to 3 weeks) mission for those who are unable to take time off from their normal post for a few months, or are unsure of whether they would like overseas work; there is attractive accommodation for them on the hospital site. The international staff, mainly from France and Pakistan, live in houses nearby. The language used in the hospital is English.

The Director of the hospital is a Welsh nurse, Khanim (‘Miss’; a term of respect) Kate. We worked together in 1977 when her first post after qualification was as operating department Staff Nurse in my hospital, so I could be regarded as her boss. As she signed my Hospital ID card in Kabul, the positions are now reversed! We have worked together many times since, including in Sulaymaniya in 1996, when the two main Kurdish political parties were fighting each other and the town changed hands twice [1]. She alternated work with Oxfam, the Red Cross and posts in North Wales, finally working overseas continuously since 1996. She first worked in Kabul in 1991 in the International Committee of the Red Cross (ICRC) Hospital, and has been in Afghanistan since 1999, initially in the Panjshir Valley, later in Kabul, frequently moving between there and the Panjshir and other provinces. She was part of the surgical team that entered Kabul on 8th. November, a day or two before John Simpson liberated the city for the BBC! (NB: I said this live on a BBC Radio Wales news program a few years ago without any repercussions!)
She took us on a day tour of this beautiful valley, with magnificent mountain views. She has known Najibullah, one of the senior Afghan administrators in the Hospital, and our driver, Aga Shereen since 1999, when they were Muhajadin in the Panjshir.

Most expatriate health workers live in shared houses or expatriate enclaves, and have security restrictions on their movements. Kharim Kate lives in an Afghan suburban street near some corner shops. The road is unmade, dusty, and like most roads in Kabul has deep gutters one to two feet wide between the road and the pavement. Behind an uninteresting wall is a pleasant garden with trees, roses and two comfortable single story buildings where John and I stayed.

Kabul is a bustling, vibrant city. After 25 years of war, large areas of the city are still flattened wasteland. Many shops and workshops are made out of shipping containers, but there is considerable rebuilding. Unfortunately not all of this is of good quality; I was shown a new hospital that had collapsed; luckily before any patients had been admitted.

I had no worries about security, but I was in much more danger from the traffic. Most of the roads are unmade, and traffic drives (usually) on the right, frequently swerving to the wrong side to avoid large potholes, and there are vicious speed humps. In the rush hour there is often gridlock, if a space just large enough appears, you drive at it and hope to get there first; in all this motor traffic are kids selling mobile phone cards (some of which work). There are pedestrians, beggars in the middle of the road, and loaded handcarts (more chaos when the load falls off). Kharim Kate pointed out two traffic policemen at a particular roundabout who have been there since 199, in spite of political changes.

I visited two local hospitals. At the Indira Gandi Child Health Institute, Dr A Qada, Chief of Anaesthesia, has huge problems. With the help of 7 or 8 largely untrained anaesthetic technicians, he has a large workload of children, many with serious congenital conditions. Drugs have to be bought by the patients in the bazaar; these are of variable quality and occasionally do not work at all. Small endotracheal tubes etc are in short supply.

At the Mariwand Hospital Plastic Surgery Dept. Dr. M. Asif Rastakhiz has two well-trained anaesthesia technicians. He is a keen educator, and is translating an anaesthetic textbook into Pushtu. While I was there, two Italian plastic surgery teams were operating. They were using the hospital’s own anaesthetic machines, but had brought additional monitoring equipment of their own. It’s a small world; Dr. Rastakhiz anaesthetised for the late Prof. Kabir in Pakistan; I often anaesthetised for Mr. Kabir when he was the Surgical Registrar at Llandudno Hospital.

There is a school for anaesthesia technicians, which did not appear to be doing much at the moment. Alberto Cairo, the Director, showed me and my son around the ICRC Orthopaedic Centre. He is one of the most charismatic characters I have been fortunate to meet. It was an inspiring morning, and the centre deserves an article of its own.

Kharim Kate was awarded an MBE in 2002, but has not been in the UK for long enough to attend an Investiture. The highlight of my visit was on Friday, May 5th, when an Investiture was held for her at the Ambassador’s Residence. It was fitting that all the eight guests, (except for John) who came from Afghanistan, England, Pakistan, Italy, and Wales, had worked with her overseas.

Acknowledgements. To my wife, Gilly and my family for making this journey possible, Dr Eric Cheysson for the invitation to visit FMIC, and to all the staff there, who made me so welcome.

Competing interests: Khanim Kate is my daughter.

David Rowlands

Perhaps only older anaesthetists use the term Boyle’s machine when referring to equipment for anaesthesia now, but to several generations it was the usual axiom. ‘Cocky’ Boyle was born in Barbados on 2 April 1875, the only child of Elizabeth (née Gaskin) and Henry Eudolphus Boyle, manager of extensive estates. He attended Codrington then Harrison Colleges and left Barbados for England in 1894 to enrol at St Bartholomew’s Hospital. An intensely loyal Bart’s man, Boyle was a keen sportsman: he played rugby for the hospital and captained the cricket team for several years. He qualified MRCS LRCP in 1901.

Boyle’s first post, in August 1901, was casualty officer for six months at Bristol Royal Infirmary. In April 1902 he returned to Bart’s as Junior Resident Anaesthetist and within a year gave a Presidential Address to the Abernethian Society on anaesthesia with Somnoform, which was published in the Bart’s Journal. Somnoform was a mixture of ethyl chloride, methyl chloride and methyl bromide, first used by Rolland of Bordeaux in May 1902. Boyle found that three ccs/mls produced anaesthesia for two minutes, sufficient for many procedures. He reported on 200 tonsillectomies, uneventful except for two who collapsed but went home later. In May 1905 he was appointed senior resident administrator of Anaesthetics on a four-year contract at £350 per annum and later that year he became non-resident assistant administrator, a post he held for the next 13 years. He stayed at Bart’s until 1906 when he moved to 50 Welbeck Street.

In 1907 he published a popular textbook entitled Practical Anaesthetics. In the preface Boyle says it is a simple book and a practical text for those who were starting their anaesthetic careers and had not had the chance to read larger books. It went through two further editions. In the 2nd edition a new chapter on spinal analgesia makes grim reading - many fearful sequelae are listed; Boyle obviously didn’t care for the technique!

In 1912 the seminal event of his life occurred when he met James T. Gwathmey in New York. Boyle had developed apparatus for administering Somnoform; however, the drug never became popular. He then worked with intratracheal insufflation techniques before developing what became his most famous contribution to anaesthesia. Gwathmey had designed a continuous-flow anaesthetic machine that included water-sight flowmeters for oxygen and nitrous oxide and in 1912 he convinced Boyle that he should acquire one. Boyle persuaded the Governors of Bart’s to import two of Gwathmey’s devices and over the next few years he used them in various settings, reporting on 1000 cases in the Lancet and BMJ in 1917. However, he became dissatisfied with the machine and asked Coxeters to make a similar apparatus with gas-tight fittings for British cylinders. This was known as Boyle’s nitrous oxide-oxygen-ether ‘outfit’; it was first used at Bart’s in September 1917. A description of it as a new invention appeared in both the Lancet and the BMJ in February 1919 and a short report describing its use in more than 3600 cases also appeared. Boyle had been appointed Captain in the Royal Army Medical Corps in September 1914, and in 1920 he was awarded the OBE for his work in caring for wounded soldiers in London during the war.

It has been debated as to who was the true begetter of Boyle’s machine. On the Western Front in France, Geoffrey Marshall had found nitrous oxide and oxygen were the best combination for shocked soldiers and he had used something similar. In a 1966 interview, Marshall said Coxeters had made him a machine but warned him that Boyle had borrowed the drawings. In the Lancet description cited, Boyle thanks Marshall for his suggestions for improving the machines the War Office had sent to France for assessment. Marshall, Shipway and McCardie published details of similar machines in the Proceedings of the RSM in 1920. It cannot be said that it was Boyle’s original idea but he
developed and modified Gwathmey’s device continuously and innovatively over many years to suit British practice. After his death further refinements took place, and although the name ‘Boyle’s machine’ has gone, it remained essentially as he had designed it for the rest of the twentieth century.

Other important contributions to anaesthesia were the development of a special laryngotomy tube and the Boyle-Davis gag (Davis-Boyle in Thackray catalogues), used for decades in tonsil surgery. He also introduced one of the first Sorensen electric suction machines used in Britain after seeing it in use in New York. In 1925 Boyle was appointed anaesthetist to St Bartholomew’s Hospital, a post he held until he resigned due to ill health in 1939.

Boyle married a widow, Mildred Ethel Green on 3rd September 1910, daughter of J.W. Wildy of Coutts Bank. He had one stepdaughter. Affectionately known as Cocky, he was a man of great personal charm; a social person renowned for his rotund frame, hearty laugh, and fund of good stories. His small and elderly Saxon car was a familiar sight around hospitals in the West End until the gearbox dropped to pieces. He was Master of the Rahere Masonic Lodge and entertained lavishly, which might have accounted for his later severe financial difficulties. He received no financial gain from any of his inventions. Boyle was a founder member of the editorial board of the British Journal of Anaesthesia, an original member of the Association of Anaesthetists of Great Britain and Ireland and one of the first two examiners for the Diploma in Anaesthetics. He was a member of the Society of Anaesthetists, which became the Anaesthetic Section of the Royal Society of Medicine. He was a staunch supporter of the Section and served as its President in 1923. He was made FRCS in 1935. In July 1939 soon after his resignation due to ill health, he was elected to the honorary position of Consulting Anaesthetist to Bart’s, a position he filled until he died in London on 15 October 1941 at the Royal Cancer Hospital, Chelsea. He was cremated two days later at Golders Green, survived by his wife. In January 2000, the Department of Anaesthesia at St Bartholomew’s Hospital was renamed the Boyle Department of Anaesthesia in his honour.

Adrian Padfield

Adapted from the Oxford Dictionary of National Biography entry written by David J. Wilkinson.

P.S. AP conjectures: It is said that Boyle’s machines were orientated for lefthanders because Boyle was left-handed. I’ve always doubted this, because the dominant hand was needed for the ‘iron grip’ to hold the mask on the face and maintain the airway.
Dear Editor...

Should skills in surgical handwashing be tested in the FRCA Primary examination?

The importance of handwashing in preventing cross-infections between patients was demonstrated by Dr Ignaz Semmelweis in Vienna in 1847. He discovered that doctors were spreading fatal infections among patients by failing to wash their hands between physical examinations. He instituted a disinfection procedure whereby the physicians were required to wash their hands with soap and water between patients. This reduced the mortality rates noticeably. Now 160 years later we are again fighting against high levels of hospital-acquired infections and MRSA and our attention to handwashing and disinfection has been highlighted by nationwide campaigns, such as the ‘cleanyourhands’-campaign by the National Patient Safety Agency.

I have recently passed my Primary FRCA examination. I noticed that one part of the syllabus was hardly tested at all: Infection Control (The CCST in Anaesthesia II: Competency Based Senior House Officer Training and Assessment: Edition 2: April 2003, Chapter 18). It states that an SHO should have the knowledge of universal precautions and good working practices (hand washing, gloves etc), and skills in aseptic techniques. Should skills in surgical handwashing technique therefore be tested in a 5-minute OSCE station of the Primary examination? I think it is an important skill which is easy to learn but also very easy to neglect unless systematically practised and probably tested. Perhaps some difficult theoretical questions in infection control could also be included in this station to make it another challenging one.

Matti Kuukasjarvi  
SHO, Wrightington, Wigan and Leigh NHS Trust

Risk Management or stating the bleeding obvious?

Because of our reflective nature, innate commonsense and much published guidance from the Association and College, we anaesthetists consider ourselves pretty hot at risk assessment and management. We are obsessional about checking our drugs and equipment before use, carefully dispose of pointy things in theatre, and fastidiously wash nasty germs off our hands between patients.

However, there may be great danger lurking in the kitchens of theatres, ITUs or Departments of Anaesthesia which we have hitherto failed to appreciate. Fortunately for all of us, this terrible gap in our perception has been cunningly spotted and rectified by the electronics department of a local hospital when checking out a new piece of equipment purchased by the theatre staff.

Could this be followed by CNST guidance; with only staff who have attended the relevant training session being allowed to make a nice cup of tea?

Stephanie Greenwell  
Consultant Anaesthetist  
Tyneside

Editor’s note: My own favourite elf’n’safety nonsense is the email we have had at least twice warning us of the ghastly risk of walking along hospital corridors carrying mugs of tea. The person who issued this advice clearly has no concept that anaesthesia as we know it will cease in my hospital should we adhere to this stricture.

If any other readers can come up with good examples (genuine ones only please – we have Scoop to make these things up), please send them in.
I have endeavoured not to pontificate on medico-political issues in my retirement, but I feel bound to declare that I share Professor Wildsmith’s fundamental opposition to the Anaesthesia Practitioner project in the United Kingdom. (Anaesthesia News 2006; No. 229 (August): p.27).

Anaesthesia administered to a patient by a physician on a one to one basis in the United Kingdom and Ireland, as well as in Australasia and Canada, is the successful gold standard which many countries envy and to which they aspire. Other systems have had to develop in other countries and circumstances, chiefly for economic reasons.

I worked successfully with nurse and non-physician anaesthetists in a number of countries. I have attempted to develop suitable, effective and safe techniques for them to use, as well as for military and mass casualty situations. However I do not consider that there is any reason for altering our routine practice of physician anaesthesia in the United Kingdom.

While occupying positions of some influence in various organisations I have never accepted Professor Wildsmith’s premise that, "if we do not do this or that, someone else will do it for us". Not in Professor Wildsmith’s letter, but in other circumstances, this argument is often presented by those who seek to force a particular decision on a committee. I have rarely observed its rejection in favour of reasoned discussion to have dire consequences.

I have never worked in Sweden, but the historical development of its successful anaesthesia system has been very different from that of the United Kingdom. It is not least due to the efforts of Professor Torsten Gordh, the pioneer who was virtually the only physician anaesthetist in Sweden when he returned in 1940 after training with Waters of Wisconsin, USA. However the success of the Swedish experience in its special circumstances is no reason for the abandonment of the long tradition of physician anaesthesia in the United Kingdom.

I cannot accept that there is any reason to criticise those United Kingdom physician anaesthetists who have sought to broaden their experience in Sweden at first hand. One thing is certain, many of them have not been advocates of the adoption of the Swedish system in the United Kingdom on their return.

Thomas B. Boulton.
Honorary Consultant Anaesthetist,
Reading and Oxford

(2)

I am one of the anaesthetists referred to by Professor Wildsmith in his letter in the August, 2006 issue of Anaesthesia News; that is to say that for three years I spent part of my annual leave working with nurse anaesthetists in a Swedish hospital.

I plead not guilty to his accusation that we have to take some of the responsibility for the Anaesthetic Practitioner project. I have repeatedly maintained to anyone who would listen that the use of non-physician anaesthetists under medical supervision is superbly efficient, but has the almost inevitable result of producing a protocol-driven system entirely lacking in the personal touch which must be one of the strongest aspects of our physician-anaesthetist system. How can a patient identify "my anaesthetist" when four or more people may be involved in a simple procedure, as I have seen in Sweden? If more of us had worked in the Scandinavian countries, then more of us may well have been against this project.

Dr P.N.Young
Retired Consultant,
Cheltenham and Gloucester.

This correspondence is now closed

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**Chavtastic ALS Training**

It would appear that the inexorable march of “chavism” throughout our society has finally infiltrated hospital medicine. During recent resuscitation training we were horrified to find our manikin adorned in the shell suit trouser and trainers combination pathognomonic of an urban “chav” - albeit without the baseball cap and hoodie. Perhaps these are available on a higher fidelity model!

Dr SJ Washington, Spr Anaesthesia, North West Deanery
Mr P Moradi, Spr Ophthalmology, Moorfields Foundation Hospital

*Perhaps Burberry manufacture one! Ed*

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**Poetic Airway Management**

The Difficult Airway Society[1] produced in 2004 guidelines for the unanticipated difficult tracheal intubation in non-obstetric adult patient[2]. These were based on evidence and consensus. Anaesthetists are expected to familiarise with these and provide training and teaching related to these guidelines to other trainees and theatre staff. In an attempt to help practitioners memorise these guidelines, we produced these two (amateur) poems:

*The story of DAS on a routine induction is about:*
Lary who had a look into a dark hole, but couldn’t see.
Burped, changed his blade and used a bougie, still couldn’t see.
He tried four times and then called for help.
His cousins Lary Mask and ILMA tried twice to help.
If they succeeded they would have used fibres, but they failed
Face mask wanted to take over, but failed.
Lary Mask came back with a needle and made a hole into the neck.

*The story of DAS on rapid sequence induction is about:*
Lary who had a look into a dark hole, but couldn’t see
Burped, changed his blade and used a bougie, still couldn’t see
He tried three times and then called for help.
Face mask wanted to take over, but failed
Lary Mask came with a needle and made a hole into the neck

Dr A Chekairi
Nuffield Department of Anaesthetics
Oxford

1. www.das.uk.com

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**Paramedic Intubation**

Following the letters by Drs Clarke, Deakin and Zideman and the reply by Dr David Bogod I’d like to point that the method (paramedics and supervising Anaesthetists to seek consent ) used in Dr Bogod’s trust is not practicable and may take valuable time from the busy Anaesthetist in most other hospitals.

It is bad enough that we have to walk the whole hospital looking for patients, then rush back to theatre, check equipment, organize drugs and get on with the list, never mind having to find the said paramedic or medical student and take them with you to see the patient to discuss not only problems and risks in relation to Anaesthesia, but the fact that they may be doing the intubation.

In some places patients are warned from the beginning that training takes place in the institution and that if they have any strong objections they can make it known from the start and their wishes will be respected.

Training of all relevant NHS staff should be taken as part of the package for patients going into hospital otherwise we will never be able to teach anyone and finish any normal list

Julio Nunez
Anaesthetic Consultant
Huddersfield
Take Five...

October Crossword
Compiled by Ranjit Verma

Across
1 Satisfactory (10)
6 Tailor (3)
8 Architects arc is of a distinguishing quality! (5)
2 Challenge (4)
3 Thine (4)
4 Encourage (4)
6 This carving is certainly astute! (6)
9 Negative (2)
20 Muck (3)
21 Breadth (5)
22 Objective form of "I" (2)
23 Not out (2)
24 Shavers (8)
26 Capture (3)
28 In the direction of (2)
30 Rot decade beautified? (9)
32 Narrate (6)

Down
1 Impel scotchman to greater achievement? (14)
2 Along the shore (7)
3 Methodology (9)
4 It shows, a well brought up red being? (8)
5 Supported oneself on a sex diet? (7)
6 Slide around on snow (3)
7 Constituted (3)
9 Present times (6)
10 Succinct mare's condition? (13)
15 Conclude (3)
17 Symbolically speaking, a very poisonous material, in short! (2)
18 Employing (5)
21 Large in expanse or scope (5)
24 Cipher (4)
25 Unit of length (4)
27 Bow (3)
29 An alternative? (2)
31 An abridged morning! (2)

Sudoku
Compiled by Ranjit Verma

Difficulty Level = Intermediate

Across:
1 6 7
4 5 6 8 3
5 9 7 1
3 9 7 4 5
7 4 1 2
1 9 3 4 7
3 8 9

Down:
8 4 2 6 7 9 3 5 1
3 9 5 8 4 1 6 7 2
1 6 7 5 3 2 8 4 9
6 5 3 2 9 4 7 1 8
7 1 8 5 6 3 9 2 4
9 2 4 1 8 7 5 3 6
5 3 9 4 2 6 1 8 7
2 7 1 9 3 8 4 6 5
4 8 6 7 1 5 2 9 3

September Solution

Difficulty Level = Intermediate

1. Satisfactory (10)
2. Tailor (3)
3. Architects arc is of a distinguishing quality! (5)
4. Challenge (4)
5. Thine (4)
6. Encourage (4)
7. This carving is certainly astute! (6)
8. Negative (2)
9. Muck (3)
10. Breadth (5)
11. Objective form of "I" (2)
12. Not out (2)
13. Shavers (8)
14. Capture (3)
15. In the direction of (2)
16. Rot decade beautified? (9)
17. Narrate (6)

1. Impel scotchman to greater achievement? (14)
2. Along the shore (7)
3. Methodology (9)
4. It shows, a well brought up red being? (8)
5. Supported oneself on a sex diet? (7)
6. Slide around on snow (3)
7. Constituted (3)
8. Present times (6)
9. Succinct mare's condition? (13)

1. Conclude (3)
2. Symbolically speaking, a very poisonous material, in short! (2)
3. Employing (5)
4. Large in expanse or scope (5)
5. Cipher (4)
6. Unit of length (4)
7. Bow (3)
8. An alternative? (2)
9. An abridged morning! (2)
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New Council Officers

At the AGM in Aberdeen in September, the following officers took up their posts.
President: David Whitaker
Hon. Secretary: William Harrop – Griffiths
Hon. Treasurer: Iain Wilson
Hon. Membership Secretary: Ian Johnston

Wylie Medal Winner

Marc George, a student at Leeds University Medical School, is this year's winner of the Wylie Medal, which is awarded annually to the best essay by an undergraduate on a subject related to clinical anaesthesia. His essay entitled “The site of action of epidurally administered opioids and its relevance to postoperative pain management” was published in *Anaesthesia* in July.

The Wylie medal is presented in memory of Dr Derek Wylie, President of the Association of Anaesthetists 1980-82.

Marc George is presented with his award by AAGBI President Mike Harmer.

International Relations Committee Travel Grants

The International Relations Committee has recently awarded travel grants to the following members:

Dr G. Homsey (Kent) Monrovia, Liberia
Dr E. O’Sullivan (Dublin) Uganda
Dr S. Rees (Exeter) Uganda
Dr S. Millar (Paisley) Georgia and Armenia

Information about AAGBI travel grants is available on the Association website.

APPEAL FOR ASSISTANCE

3RD NATIONAL ANAESTHETIST AUDIT – NATIONAL AUDIT OF MAJOR COMPLICATIONS OF SPINAL AND EPIDURAL ANAESTHESIA

Spinal and epidural anaesthetic techniques are undoubtedly effective forms of pain relief after surgery with considerable associated benefits. Occasionally they lead to major complications, as recent newspaper articles have highlighted. What is not clear is just how frequent these complications are. Most hospitals see less than one of these complications per year. The Royal College of Anaesthetists’ national audit aims to determine the true prevalence and incidence of major complications of spinals, epidurals, CSEs and caudals. This is an ambitious project and to succeed it needs every UK anaesthetist to support it.

The audit has two parts. First, to determine how many of these procedures are done each year. Second, to log every major complication that occurs for one year. To this end we have established a ‘local reporter’ (a consultant anaesthetist) for the project in every NHS hospital. If you do not have one in your department please contact the project lead (details below) to arrange one. In September, a national census of the number of neuraxial blocks performed took place for two weeks, co-ordinated by the local reporters. This was the ‘snapshot phase’.

Now the audit is in the ‘prospective phase’ when data will be collected on all major complications that occur following neuraxial blockade. The complications are serious infections (epidural abscess, meningitis), bleeding (epidural haematoma), major nerve damage (paraplegia, cord damage, cord infarction, major neuropathy), wrong route errors, and death where the procedure is implicated. The audit intends to identify complications arising from all procedures performed between 1st September 2006 and 31st August 2007. Cases may be reported up until March 2008.

The project has enormously wide support from NHS organisations. AAGBI is encouraging all members to take part, along with other anaesthetic societies. The organisers anticipate that anaesthetists will be the group that become aware of the majority of problems, but the project is additionally supported by neurosurgeons, spinal surgeons, neurologists, and radiologists, all of whom may report cases in order to maximise the scope of the audit.

If you are aware of a relevant complication, please email the project lead, Dr Tim Cook (tcook@rcoa.ac.uk). Please include your name, contact details, the hospital you are reporting from and the hospital in which the procedure was performed. There is no need to send any details of the complication that has occurred. Please do not send any patient specific data. Your report will be followed up through the network of local reporters. All data generated will be anonymous, untraceable and confidential. In particular the College will have no knowledge of (or interest in) the hospital or anaesthetist reporting to the project.

Only with close to 100% compliance can we get useful data that will inform anaesthetists and patients alike of the safety or risks of these everyday procedures.

Tim Cook
Consultant anaesthetist, Bath
Lead for the 3rd National Anaesthesia Audit.
After months of treading water promising to write to you about the NHS Pension Scheme Review I now have the document in my hand, hot off the printer and ready for dissection. This is a brief summary of the proposals only, though, and you shouldn’t use it to base any important decisions on.

So what would change under the proposals? Perhaps it would first be useful to consider two of the main concerns that I heard expressed during the consultation period.

Far and away the biggest worry was that the final salary method of working out your pension would be abandoned in preference to a pension based on average earnings over one’s career (a ‘CARE’ scheme, as offered to GPs). Since it’s often the case that the highest earnings occur in the last few years of a working life (especially so if you receive CEAs/merit awards) this change would inevitably have led to a significant reduction in retirement income for many doctors.

The other gripe was the idea of staff being moved to a normal retirement age of 65, rather than the current 60, in line with the current national zeitgeist of ‘work till you drop’.

The first thing to tell you is that the proposals outline two separate schemes – one for existing members and a new one for new entrants. I’m only going to cover the changes to the scheme for existing members in this article, with information about the new scheme in next month’s edition.

I’m pleased to report that if you’re an existing member of the scheme you will, under the new proposals, retain your normal retirement age of 60 and a pension based on the best of your last three years’ pensionable pay. The pension will continue to be calculated on an accrual rate of 1/80th per year of service, with a 3/80th lump sum per year of service. So, if your final salary is £100K and you’ve worked for 40 full years, you’ll get a pension of £50K per annum with a tax-free lump sum of £150K, just as you would under the current arrangement.

However, the proposals also make it possible take a larger lump sum – up to 25% of the value of your pension when you retire – albeit with a reduction in the amount of pension income you would receive. This is in line with the sweeping pension changes brought in earlier this year (‘A Day’), which allows you, subject to the rules of your scheme, to take up to 25% of your fund as cash from any kind of pension.

And what happens if a pension scheme member dies leaving a partner behind? Until fairly recently only widows and widowers could receive pension benefits on the death of a member. The introduction of civil partnerships extended this provision, but unmarried partners remained ineligible. The proposals make it possible for unmarried partners to receive ‘survivor pensions’ based, like those for civil partners and widowers, on service dating back to 1988. What’s more, if the surviving partner cohabits, remarries or enters another civil partnership, the pension will not be removed as is currently the case. There are also some changes to the length of time surviving children’s pensions would be paid – up to age 23 in all cases rather than until 17 or the end of full time education as is currently the case.

All very well, but what will it cost you? You might not know this but at present the scheme costs some members less than others. Those classified as manual
Under the new proposals you’ll be able to buy up to £5,000 additional pension at any time you’re in pensionable employment, by monthly payments or a lump sum. For higher earners this limit of £5,000 might be rather restrictive and you need to take advice on whether starting to pay old-style added years before the new arrangement begins (and/or making contributions to other forms of pension or investments) might not give you a better result. Any existing added years arrangements will be honoured under the new regime.

In next month’s edition I’ll cover the proposed pension scheme for new entrants, which takes the reforms rather further. Interestingly, existing members will have an opportunity to transfer to this new scheme on a one-off basis. So you’ll also need to consider whether moving across might be in your best interest.

Please email me (markmartin@doctors.org.uk) if you would like further information.

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**Anaesthetic Research Society**

**‘Supporting Research in the 21st Century’ Methodology Workshop for anaesthetists**

**Wednesday 22nd November and Thursday 23rd November 2006**  
**Closing Date for registration: 10th November, 2006**

The Anaesthetic Research Society are hosting their third two-day seminar in generating and supporting successful research for clinicians, led by leading clinical and scientific researchers in their respective fields. Previously held in Leicester and Dundee this friendly, informal two-day workshop has been well received by delegates.

This meeting is suitable for clinicians interested in research and want updated in the many changes that have come in since 2004, as well as all grades of Anaesthesia, Intensive Care and pain management trainees. It meets RCA requirements for research competencies SpR Years 1 & 2. Delegates are warmly invited to attend the Friday ARS sessions free of charge.

Current ‘hot topics’ and up-to-date issues will be tackled to orientate would-be researchers towards success in the research environment of the 21st Century.

**Day 1: Wednesday 22nd November 2006 - Held at the Royal College of Anaesthetists, Churchill House, 35 Red Lion Square, London, WC1R 4SG. Topics addressed in lectures, tutorials and workshop format include:** research governance - research design - ethics procedures - statistics - funding sources - protocol and study design - why projects fail - getting published. The presentations are orientated towards work being presented in the Anaesthetic Research Society meeting over the following two days.

**Day 2: Thursday 23rd November 2006 - Join the ARS meeting at the Royal College of Anaesthetists in London as a conference delegate and observe ‘state of the art’ research presentations in wide-ranging fields of anaesthesia and critical care; discuss and critique them with your tutor during the afternoon session.**

Fee £130 (covers course registration, lunches, ARS conference registration for Thursday and refreshments).

**Application forms available from:**

Mrs Jane Heppenstall, Academic Anaesthesia Unit, Floor ‘K’, Royal Hallamshire Hospital, Glossop Road, Sheffield S10 2JF  
Telephone: 0114 2712510 E-mail: j.heppenstall@sheffield.ac.uk.
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The Research Grant is aimed at those undertaking research in Great Britain and Ireland
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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 £15,000 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, 21 Portland Place, London W1B 1PY and HonSecretary@aagbi.org
2nd National Outreach & Peri-operative Care Symposium
Thurs 2nd & Fri 3rd November, 2006
Manchester International Convention Centre

Just some of the Topics:
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- Major Trauma & Operations
- Peri-operative Endocrine Emergencies
- Optimal Peri-operative Fluid Restriction
- Outreach Services - Their Impact
- Breathing Circuits & Contamination
- Sleep Apnoea & Operations
- And others!!

For details & bookings contact:
Georgina Hall
Tel: (0151) 641 0433
E-mail: sasdocs@btinternet.com

Registration:
- Consultants & NCCG £ 395
- SpR’s & SHO’s £ 195
- Nurses £ 195

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British Association Of Indian Anaesthetists
5th Annual Meeting, Saturday,
14th October 2006
The Village Hotel and Leisure Club,
Brailsford Way, Chilwell,
Nottingham NG9 6DL

The scientific programme will include lectures and discussions with Sir Graeme Catto, Professors Chandrakumar and Ravi Mahajan, Drs. Inder Bali, Ramana Alladi, Chandy Verghese, Jaideep Pandit, BVS Murthy, Roop Kishen, Akbar Vohra, Jonathan Wilson, Mansukh Popat, Anthony Absalom, Ian Russel and other eminent speakers. There are two workshops on “Local Blocks of the Upper Limb” and “Difficult Airway”. The meeting is open to all anaesthetists. Anaesthetists in training presenting papers are eligible for prizes. The deadline for abstract submission is 15th September 2006.

CME 5 Points

There is a Social Programme for the spouses and children, and a sumptuous Indian Banquet for the evening. After-dinner speaker is Mr. Farokh Engineer.

For further details, contact:
Dr Ranjit Verma, Meeting Organizer,
Tel: 01332 785549 • Mob: 07967 501038
e-mail: rv3000@btinternet.com
Website: www.baoia.org.uk

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Derby Anaesthetic Academy

THIRD DERBY UPPER LIMB REGIONAL ANAESTHESIA MEETING

Monday 27th November 2006
Derbyshire Royal Infirmary

The program is dedicated to upper limb regional anaesthesia with an emphasis on practical, hands-on Ultrasound training and experience for those looking to increase confidence in performing regional blockade

Course Organiser: Dr Adrian Searle
CME applied for

Application forms and more information from:
Course secretary Mrs. Shirley Goddard
Shirley.Goddard@derbyhospitals.nhs.uk
Tel. 01332 347141 Ext 2174
Derbyshire Royal Infirmary, London Road, Derby, DE1 2QY
When Dr. Ruxton became the persona for this column, it was because he was an example of a good doctor, turned bad by overwhelming stress. Bad, because he murdered his wife from jealousy, a crime made all the worse by his murder of the couple's maid as well. Good, because his patients thought him such a kind and caring doctor that they petitioned the Home Secretary of the day for mercy. Their altruism was in vain, he was hanged for his crime and although this was before 1949, he was a symbol for the extreme stress that many working in the NHS feel, and a demonstration that even the best may crack under pressure.

Since then, we have had the example of Dr. Shipman. His crime was all the worse, for taking advantage of his profession and reputation and betraying the trust of his patients, but he was not an example of yielding to pressure - in retrospect he could be seen as a pathological personality. Ironically, he was also beloved of his patients for his devotion to duty and frequent home visits.

Now we have another doctor gone bad. Dr. Louay Omar Mohammed al-Taei, who was arrested in Iraq in February, charged with the murder of 43 patients in his care at Kirkuk Hospital. He is alleged to have killed, and has confessed to killing, patients brought into the hospital in that troubled city after being injured, by tampering with their treatment and administering lethal injections. These were not hopeless cases, triaged in expectation of death from their injuries, but policemen, soldiers and officials injured in the continuing unrest in that country. Nothing is known about Dr. Louay, except what is read in the newspapers or on the internet, but, if true, what can have led a doctor to do such a thing?

According to reports, Dr. Louay is cooperating with the police, asserts that he has been well treated and wishes to make a full confession. He also wishes to explain why.

He attributes the moment of his turning away from normal medical practice to being unable to treat a child because the simple medicine needed was not available. The child's father, noting his distress and that Dr. Louay attributed the lack of medicine to their being in an 'occupied country', recruited him into an insurgent group. At first, he was asked to help treat the wounded of this group, who could not go to a hospital for fear of arrest. Then he was told that a senior policeman was being brought into hospital in that troubled city after being injured, by tampering with their treatment and administering lethal injections. These were not hopeless cases, triaged in expectation of death from their injuries, but policemen, soldiers and officials injured in the continuing unrest in that country. Nothing is known about Dr. Louay, except what is read in the newspapers or on the internet, but, if true, what can have led a doctor to do such a thing?

Doctors are human, with all their faults and failures. But doctors have worked and still work in conditions of privation and shortage and do not resort to murdering their patients. Does Dr. Louay's other reason, that his country was under occupation and that his victims were his enemies in a war of liberation, have any justification?

If a foreign military force occupies your country, some will take up arms to resist them. In the UK we have the history, if rarely now the memory, of preparations for a Nazi invasion and occupation. People of all sorts were organised to fight a guerrilla war against them. Would doctors have been asked to betray their impartiality, in the interests of national defence? Our ally, France, was occupied and did organise a resistance that fought without mercy and with little scruple of honour or trust in defence their country, against an enemy that had no such scruples. Again, that resistance involved many doctors whose selfless heroism and sacrifice distinguishes our profession, but the victors write the history books so any doctor who did betray their professional standards to aid the liberation has been forgotten.

Does that view cast a different light over Dr. Louay's crime? His country has been invaded and occupied, and a resistance against the occupiers continues. What would you do in those circumstances? You have the opportunity and means to strike a blow against your enemies. If you see the nation as a body and the occupier as a disease, then aggressive treatment of the disease may be justified, even if that is to murder one of the 'organs of the state', a soldier or policeman.

The answer is not easy and moral argument only confuses, but in practice it is clear. The Red Cross/Crescent, Medicins sans Frontieres, and the Geneva Convention, all concerned in part or all with the effects of war, take the view that impartiality is essential, or else doctors cannot function in a war. Dr. Louay has, by betraying the trust in him for impartiality, by going bad, removed himself from any possibility of doing good for his country and people. Thousands of Iraqi doctors are daily impeded in their work; they are distressed by the plight of their patients and harassed by the occupying forces, yet do not resort to betrayal. If they did, then soon they would not work at all, their patients' plight would be worse and the occupation would continue.

So Dr. Ruxton hopes most sincerely that we in the UK are never asked this question. He cannot justify his colleague, but he can feel a great sadness for a young doctor who did crack under extreme pressure.