It was a beautiful sunny day. Regent’s Park beckoned, but for the 70 or so of those who attended this year’s Equipment Study Day at the plush premises of the Royal College of Physicians, it proved to be educational, stimulating and entertaining. The delegates were Anaesthetic Equipment Officers in the main, but there were also some non-medically qualified Technical Equipment Officers and anaesthetists with a particular interest in equipment.

The first session opened with Mr Clive Tomsett, Assistant Director of Surgery, Theatres and Anaesthesia at the National Patient Safety Agency (NPSA) who outlined the function of this new Agency, set up in 2001 with the purpose of improving patient safety by reducing the risk of harm through error. The NPSA is setting up a “National Reporting and Learning System”, which is there to share alerts and guidance so that health professionals may learn from mistakes, and change practice or system factors to reduce risk. To achieve a successful reporting system, a blame-free culture is required. Such a system should be confidential, non-punitive and responsive. Clive Tomsett covered some of the current programmes of work in which the Association and other organisations are involved, in particular the Wrong Site Surgery Working Group, and the all embracing topic of Risk Assessment of the Anaesthetic Process. He referred to the appointment of Dr Ian Woods from York as the Clinical Specialty Adviser in Anaesthesia to the NPSA. The Association Safety Committee is looking forward to developing areas of mutual interest.

Clive stirred up some lively discussion, particularly by referring to the potential advantages of copying the Ministry of Defence purchasing system whereby bids are submitted and one sole supplier gets the order. All well and good, unless, as some of the delegates commented, you end up with leaky boots only available in small sizes or rifles that jam in sandy conditions!

The second speaker was Mr Clive Bray, Director of Device Technology and Safety at the newly formed Medical and Healthcare products Regulatory Agency (MHRA-the p is silent!), an amalgamation of the Medical Devices Agency and the Medicines Control Agency. Clive explained the role of the
MHRA in safeguarding public health by working with manufacturers, legal representatives, and users to ensure that medical devices meet appropriate standards of safety, quality and performance; and comply with the latest relevant directive of the EU. His department has long been responsible for issuing Hazard Notices, and it was salutary to note that almost 9,000 reports were investigated in 2002, leading to 56 safety warnings, 385 product recalls, 306 cases requiring advice on safety or training issues, and over 1000 cases where the manufacturer undertook action to improve their product. The number of reported adverse incidents continues to rise, year on year, and about 15% are user error – which suggests better training is required and the manual should be read!

Clive finished his talk with a range of illustrated horror tales of adverse incidents, including a kettle plugged into an anaesthetic machine socket, and a picture of an oxygen cylinder in an MRI scanner.

The morning session was completed by a presentation from Mr Colin Walker, Head of Medical Engineering at the Trust with the biggest overspend - £45M at the last count. This was entitled The Management of Medical Equipment. We were taken through purchasing, commissioning, maintenance, repair, replacement, decontamination and disposal in a logical manner, interspersed with humour. Colin also referred, in some detail, to the National Audit Office Report on the Management of Medical Equipment in NHS Acute Trusts in England, and finished by pointing out that we should expect, and get, the same quality of service and back up with anaesthetic equipment that we have with a new (quality) car.

A hot lunch and a post-prandial stroll through Regent’s Park, or a viewing of the College’s impressive silver collection set us up for the afternoon session. This started with a presentation on decision making in medical purchasing by Dr Gareth Greenslade of the aforementioned overspent Trust. Choosing what to spend on a limited budget is hard. A case may be made for spending to save money in other areas. For example, intraoperative hot air heaters may reduce the need for ITU admissions. Standardisation of equipment across a Trust can save money on training and servicing. Organisations, such as the Hospital’s League of Fiends (sic), may help out with one-off purchases. The long-term planner, however, will have decided on a rolling replacement plan to spread the replacement costs over the lifetime of a product.

We then heard from Dr Dick Birks, the Hon Treasurer Elect of the Association, about the revised AAGBI publication on Checking Anaesthetic Equipment which is due out within the next few months. The widespread introduction of anaesthetic workstations, increased use of single-use equipment and the tragic death of a young boy by failure to recognise that an anaesthetic connector was blocked have driven some of the changes. Not only must equipment be checked, but it must be recorded as having been checked, and by whom. Furthermore, this process should be audited. Delegates were given the opportunity to feedback to the Association any comments on the revisions, and these will all be considered for inclusion in the final draft.

The final session of the meeting was a debate on the NICE Guidance on the use of 2D ultrasound for insertion of central venous catheters. The Association had previously asked Equipment Officers their views on the NICE Guidance, and over 60% had expressed disagreement. Dr David Scott (Edinburgh) speaking in favour, and Dr Alan Cohen (Bristol) against them. David made a cohesive argument, likening the use of 2D ultrasound to a blind man gaining his sight, whilst Alan analysed the references, threw out most of them as irrelevant, and turned the rest on their heads. As Alan said, it was a largely fatuous debate as the NICE Guidance had already been published, however he was able to reassure the audience that there should be no legal comeback for experienced practitioners using the “standard anatomical landmark recognition” technique.

The motion was defeated, with over 90% of delegates disagreeing with the Guidance.

I would like to thank all those who took part in this meeting, not only the speakers but also the delegates who all contributed to the lively question sessions and returned the evaluation questionnaires which will be invaluable in planning next year’s meeting.

Dr John A Carter
Chairman, Safety Committee AAGBI
A new Editor and a new start for Anaesthesia News! While welcoming Stephanie Greenwell, I must pay tribute to John Ballance, her predecessor, who has turned Anaesthesia News around, not only in appearance, but in content and is now off to a well-deserved retirement. I look forward to the initiatives that Stephanie will introduce but I would make a personal plea that readers communicate more often and beef up the correspondence columns.

Transition seems the current name of the game at the Association. Although the move from Bedford Square to Portland Place was accomplished relatively painlessly, alterations in Portland Place are only now being completed and the builders should finally be out by the beginning of August. The latest developments have been in the basement, where the new museum and library are being created and look visually stunning. The Members Forum, where we will be able to cater for up to 70 for seminars and other functions, is taking shape. We have been particularly fortunate in the support that Abbott has provided in these improvements and I am sure you will be impressed when you see them.

These new facilities will allow us to augment our educational programme, particularly with the ever popular in-house seminars. The Intavent Suite on the first floor will permit larger seminars with up-to-date audio-visual facilities. The traditional scientific meetings will be expanded to include parallel sessions and more workshops, which have proved to be extremely popular. We are looking at taking seminars out of house, around the country, and the Education & Development Committee is exploring how the Internet and electronic revolution may be best utilised.

Education will remain one of our highest priorities.

We will also continue to support research initiatives. With the support of Datex Ohmeda, the Association is now the largest single grant provider for anaesthetic research in the UK, having distributed almost £250,000 last year. There are departmental grants, research fellowships and individual grants available and we shall publicise these over the forthcoming months.

Uncertainty has persisted over the Consultant contract negotiations but at the time of writing there does appear to be a chink of light. Hopefully, a satisfactory conclusion will be reached. We believe strongly that the imposition of local contracts and incentive schemes would be to the detriment of anaesthesia, but recognise that devolution itself will bring variations. In conjunction with the BMA, we will need to interpret these for specialty-based problems.

Another sensitive area is the proposed introduction of non-physician practitioners to the Anaesthesia Team. This, as you know, has followed a review by the RAC and the NHS Modernisation Agency, suggesting that the time is right to revisit this matter. There is no doubt that the manpower problems we face over the next few years are insurmountable unless major changes are made to where and how we practice.

I do not believe we should be Luddites, stick our heads in the sand and hope it will all go away, but enter the debate and influence the outcome. Patient safety is paramount. I believe that anaesthesia is a medical act and should always have a medically qualified anaesthetist responsible and in charge. We have seen an evolution of responsibilities within the Anaesthesia Team over the last few years and I see no reason why we should not explore further development, providing the above caveats are maintained. As you have probably heard, half a dozen pilot sites are envisaged to assess the introduction of these “Anaesthesia and Critical Care Practitioners”. I sit on the Stakeholder Board which is supervising this initiative and I have been impressed with the care and caution with which all involved are proceeding. No one is proposing the introduction of independent non-medical anaesthetists to compete with physician anaesthetists, as occurs in the USA, but rather extending roles within the Anaesthesia Team; always under the supervision of a physician anaesthetist. I hope that it may provide more flexibility, more manpower and the opportunity to target particular skills more appropriately. It is not a cheap option, poses many difficulties which will require careful auditing, and most certainly will not solve the manpower problem on its own without other necessary changes. In particular, the restructuring of acute hospital service in the UK to reduce emergency sites. Watch this space and I will report in subsequent editions of Anaesthesia News when the proposals are more clearly defined. Rest assured that I am aware of the reservations that many of you have about this and shall represent your views robustly.

I hope to write a President’s Report every couple of months to keep you in touch with what is happening. It is fair to say that John Ballance had asked me to do this some time ago but I never quite got round to it. I am, however, much more frightened of Stephanie than I was of John so I am more likely to comply!

(I’m a pussy cat – honestly. Ed.)
Well, a new look for Anaesthesia News and a new Editor, yours truly with two hard acts to follow, Ed Charlton and John Ballance. I must thank them both and give full credit for conceiving and developing Anaesthesia News into the popular read that it is today. I hope that I can carry the baton with as much style in my turn. I won’t be alone. Two new Assistant Editors, Council members Ranjit Verma and Iain Wilson are to join the team and Claire Elliott will continue to co-ordinate from Portland Place. We also have a new designer, Amanda McCormick and printer, Arkle Print.

It is, however, your newsletter and inevitably a product of the input, feedback and enthusiasm of the membership. So get writing, there’s no excuse in these days of e-mail, nothing so easy than a letter or article sent down the wires.

It’s not easy to be so enthusiastic about anaesthesia and the NHS these days. Almost every week we read reports of the progressive demoralisation of hospital staff caused by the stress of management bullying, ever increasing targets, initiatives, incentives, working time directives and all the rest. The feel-good factor is hard to locate. As anaesthetists we should feel good about ourselves. We are well organised and communicate effectively with each other through schemes such as the Association Linkman. Unlike our less fortunate colleagues in Malawi, Zimbabwe and other less developed countries, we have reasonable working conditions and no shortage of modern drugs. We have two strong organisations to represent our interests. And have you noticed that almost every scheme thought up in the last few years by the NHS Modernisation Team and other Government agencies has already been intelligently explored by our specialty? Safety, teamwork, risk management, prevention of stress in the workplace, theatre efficiency,
pre-operative assessment, job planning to name but a few. We are well ahead of the game and this does not go unnoticed by Government agencies such as the National Patients Access Team (see Equipment Study Day).

There is nothing quite so satisfying as being asked to sit on a multi-disciplinary committee in your trust and going along to the first meeting with some sensible ideas and an Association glossy containing comprehensive guidance on the subject. It is my experience that hospital managers often appreciate the considered and objective view anaesthetists are able to take in knotty issues such as theatre efficiency. Of course, this presupposes that anaesthetists are invited onto these committees. To that end we must all maintain a high profile and continue to get involved.

Time is always a problem and unless human cloning is perfected soon and made legal, manpower difficulties will certainly not improve overnight. Whether we like it or not, the specialty will be highlighted in the local newspaper every time a small maternity unit or A&E department is forced to close. With the help of the Association and the College, we could use this publicity to promote the specialty rather than allow ourselves to be represented as simply difficult, inflexible and uncaring. For years we’ve complained about being invisible to the public. Now is the time to stand up and be counted. Quite literally. The Government and public must be made to really grasp just how pivotal service specialties such as ours are to critical care and waiting lists, and that there simply aren’t enough of us. There might just be a chance that funds can be found or even diverted, sensible rationalisation carefully managed and (I hardly dare whisper this) training numbers increased. It’s not rocket science.

OK, so I’m a cup-half-full person and maybe things really are as bad as they seem and about to get worse. Maybe there is a hidden agenda. I would, however, ask why highly intelligent professionals such as ourselves would allow themselves to be demoralised and bullied into unsafe practices and ridiculous hours. Who, after all, can do the job instead of us? If we are doing our very best, what can there be to fear?

Stephanie Greenwell
Dear Editor  

I was amused to read the ditty by William Harrop-Griffiths in the August edition of anaesthesia news. Whilst I have never read "Vanessa Wilde's Secret Diary", from the description, it seems to me that the "slim naked model" holding Magill's intubating forceps close to her back, has obviously just been using them to help apply self tan to that inaccessible part of the back between the shoulder blades that one's hands cannot easily reach!

In fact, I think I shall try to acquire a pair of forceps to take on holiday with me. Just the thing to help me apply the Factor 40 to that said inaccessible area, with some cotton wool! Do you think I would be OK packing them in hand luggage - or might they be mistaken for a dangerous weapon?

Yours sincerely
Sarah Wheatly, Consultant anaesthetist
South Manchester
- who so far has never used any airway equipment for anything other than what it is meant for - but might be reconsidering....

P.S. Just as adrenaline has to be renamed, so the makers of face cream... Oil of Ulay no longer exists, it is now Oil of Olay.

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Oops!

Intra-operative erection is always a problem but the Annals of the Royal College of Surgeons have the answer:-

"Dorsal penile block is another effective treatment option. Safe doses of lignocaine or the longer acting pubivacaine can be used."

Dr Charles Allison

(Does anyone disagree? If not this subject is closed. Ed.)

More on Chest Examination

Pamela Laurie's vet acquaintance
(Anaesthesia News Letters, July 2003)

"....wouldn't dream of anaesthetising an animal without listening to its heart and lungs" - neither would I. Fortunately, however, most human beings can talk! Listening to what a patient says when asked about his/her customary levels of activity and any limitations thereto will give one a much better idea of the state of his/her cardiovascular and respiratory health than will "listening to his/her chest", however golden one's ears. For those that can't answer and those whose answers suggest that all may not be well, a directed physical examination may give invaluable additional information, but I do not recall ever learning anything useful from listening to the chest of a fit, active, young patient.

Peter R. Fletcher
Consultant Anaesthetist
Hinchingbrooke Hospital,
Huntingdon, Cambs.

SEND YOUR LETTERS TO:
The Editor, Anaesthesia News, AAGBI, 21 Portland Place, London W1B 1PY or email: anaenews@aagbi.org
The Society was formed in July 1997 at the Royal Society of Medicine, and its first Annual Scientific Meeting was held in Glasgow later that year. The object of the Society is to promote education and facilitate research into the use of drugs administered intravenously in anaesthesia and science related thereto, and to disseminate and help implement the useful results of such research.

Membership is open to anyone in the UK who has an interest in intravenous anaesthesia, and currently stands at just over 300.

Committee and Office Bearers
President – Professor Gavin Kenny, Glasgow; Honorary Secretary – Dr Kiran Jani, Stevenage; Honorary Treasurer – Dr Douglas Russell, Glasgow. Committee – Dr Tony Absalom (Norwich), Dr Sue Hill (Southampton), Dr Nigel Huggins (Birmingham), Dr William McFadzean (Swansea), Dr Alastair Nimmo (Edinburgh), Dr Lawrence Rowe (Norwich), Professor John Sear (Oxford) and Dr Milda Simpson (Manchester).

2003 Annual Scientific Meeting
This was a joint meeting with EuroSIVA, and was held in the Glasgow Marriott Hotel on 30th & 31st May. Dr Jaap Vuyk had put together a stimulating programme for the 250 delegates from across the world, and 23 papers were accepted for poster display. Those by Dr Jung Un Lee (South Korea), Dr Alain Olinga (Belgium) and Dr David Beattie (United States of America) were selected for oral presentation and Graseby Medical Ltd awarded a prize to all three presenters.

The meeting was granted a Civic Reception, which was hosted by the newly appointed Lord Provost of Glasgow, Mrs Elizabeth Cameron, and held in Glasgow City Chambers.

News, images and abstracts, including Dr Beattie’s prize winning presentation entitled “THRX-918661: a novel, pharmacokinetically-responsive sedative/hypnotic agent” are available on the SIVA UK website.

Next UK TIVA Meeting - ‘Totally TIVA’; Wednesday 26th November 2003 in Glasgow
This meeting is aimed at anaesthetists who wish to develop an interest in Intravenous Anaesthesia. TIVA techniques will be demonstrated live from the Operating Theatre by interactive video-link, as will “Depth of Anaesthesia Monitoring” using Auditory Evoked Potentials (AEP), the Bispectral Index (BIS) and Entropy.

For full details and registration visit http://www.TotallyTIVA.co.uk. The £100 registration fee can be paid online via the secure servers of WorldPay. Details and registration forms are also available from Departmental Secretaries, or by telephoning 0141 201 1658. The venue, the Walton Conference Centre at the Southern General Hospital, is 10 minutes from both Glasgow City Centre and Glasgow International Airport, to which a number of airlines have affordable flights.

2004 Annual Scientific Meeting – Thursday 25th & Friday 26th November
This will be held near Birmingham, with scientific sessions on Thursday afternoon and Friday morning. Conference Organiser Dr Nigel Huggins has the Marriott Forest of Arden, home of the English Open Golf Championship, at the top of his list of possible venues.

Honorary Membership
“Persons of distinction who have contributed to the advancement of i.v. anaesthesia are eligible for election as Honorary Members”

Dr Iain Glen has been a member of the UK Society for Intravenous Anaesthesia since its inception since 1997. He has made a unique contribution to Intravenous Anaesthesia, and was awarded Honorary Membership at the Annual Scientific Meeting held in Belfast. A copy of the full citation is available on the website.

Join SIVA UK
Membership application forms are available from the Honorary Secretary; Dr Kiran Jani, Consultant Anaesthetist, Lister Hospital, Stevenage SG1 7AB. Alternatively, join at http://www.sivauk.org.

Please note that the copy deadlines for editorial and advertising for Anaesthesia News have now altered.
Please contact Claire Elliott at the Association of Anaesthetists for a new schedule.
Tel: 020 7631 1650 x 817 or email: claire.elliott@aagbi.org
In December 1967 there was the electrifying news that Christiaan Barnard had performed two successful heart transplants at the Groote Schuur Hospital in Cape Town. Internationally, it was regarded as surprising that the first clinical heart transplant had taken place in South Africa. It is probably significant that Christiaan Barnard visited Shumway’s unit at Stanford where there was a successful animal experimental programme for two months in 1967, was heard to remark that the procedure was straightforward, and that “I am going to do that”. The suggestion of removing the beating heart did not arouse such strong emotions in South Africa as in the U.S.A and UK. Norman Shumway never complained that Christiaan Barnard had all the glory and failed to give due recognition to the pioneering work carried out in Stanford. In fact the initial successful operations in South Africa made it easier for surgeons throughout the world to overcome local ethical objections, and Norman Shumway carried out the world’s fourth cardiac transplant less than a month later, in January 1968.

1968 was a bad year in the story of cardiac transplantation; over 100 transplants were performed with a mean survival of less than a month. In the UK, Donald Ross and his colleagues at the National Heart carried out the world’s tenth cardiac transplant in May 1968. The patient survived for 43 days, by which time two more transplants had been carried out in London with equally unsuccessful results. The surgical team was briefly lionized by the media and then vilified as all the patients died. By 1970 there were less than 20 cardiac transplants worldwide; over half being carried out in Shumway’s unit in Stanford where the one-year survival increased from 22% to 65% in the ten years from 1968 to 1978.

I went to Papworth in 1969 to find that Ben Milstien, a very active surgeon, had obtained some local research funds to allow a limited experimental programme in pigs. They were non-survival experiments, the money ran out, and by then it was generally accepted that cardiac transplantation was not part of mainstream practice. A letter from the Chief Medical Officer, George Godber, reinforced this point in 1973, establishing an official moratorium on cardiac transplantation in the UK.
Mr. Terence English (later Sir Terence) was appointed to Papworth in 1973 and visited Stanford after a few months to evaluate topical hypothermia for myocardial preservation during valve surgery. During this stay, Terence was exposed to Shumway’s successful human heart transplant programme and became enthused with the idea of a cardiac transplant programme in the UK. The presence of Professor Calne’s transplant unit nearby meant that a cardiac transplant programme based on Papworth and Cambridge was a reasonable suggestion. In the event, after some combined experimental work, the surgical collaboration did not occur. The separate Papworth animal experimental programme at Huntingdon Research Centre was producing long-term survivors early in 1977.

The translation of the successful experimental work into a clinical programme depended on several factors. The publication of the criteria for brain stem death in 1976, the agreement of Cambridge Health Authority to allow the hospital’s NHS funds to be used to cover the costs of two transplants, and the successful transplant in Keith Castle who was a great supporter of the cardiac transplant programme. Initially, the success of Keith Castle’s operation generated charitable funding to keep the programme going. An evaluation of the two UK cardiac transplant units at Papworth and Harefield was funded by the BHF and resulted in Supra regional funding for both units in 1985.

The initial patients were barrier nursed for 28 days in a positive pressure cubicle, and it seemed unlikely that the unit could manage more than a dozen transplants a year. Increasing experience and the use of cyclosporin has dramatically reduced the need for barrier nursing. The shortest ITU stay I can remember after a cardiac transplant was eight hours. Into the unit at 6.00am, on the ward at 2.00pm! There was a rapid increase in the number of heart and heart lung transplants, which reached a plateau of about 100 per year at Papworth and 3500 world wide, the limiting factor being the availability of donor organs. Throughout all the development of the transplant programme, one essential criterion was that it must not interfere with routine cardiac surgery. This aim was “helped” by the fact that donor hearts seem to become available towards the end of the day, resulting in most transplants being performed “out of hours”. The politics surrounding the early days of the Papworth Transplant programme both locally, regionally and nationally were fascinating and not always helpful.

For first hand accounts of the early days of cardiac transplantation in the UK consult. Early Heart Transplant Surgery in the UK. Wellcome Witness to Twentieth Century Medicine. Vol 3 Published by The Wellcome Trust 1999.
Winter Meeting Manchester
12th to 14th November 2003

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Depth of anaesthesia monitors
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Join in working groups to develop new international standards for anaesthetic records

Booking Forms and Contact Details
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Peter Ashford
Email peter.ashford@nhs.net
Web www.scata.org.uk

Conference Administrator
Juliette McCormack
Email mail@ mccormackassociates.co.uk
Telephone 01722 504261
Fax 0870 121 3450

Regional Anaesthesia Course
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Workshops and lectures.
Upper and lower limb blocks.
Interpleural blocks.
PSOAS compartment blocks.

For application form and programme, please contact:

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

Tel: 01737 768511 Ext 6046
Fax: 01737 231886
e-mail: shirley.robson@sash.nhs.uk

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Cutting the taxman out of your estate: Inheritance Tax: Part 1

Introduction

When the subject of Inheritance tax (IHT) is broached, “That’s not an issue for me” is likely to be the standard response from most Anaesthetists. However, perhaps if we were to ask the following simple question, it could certainly potentially save them significant sums:

Who would you not like to benefit from all your years of hard work?

a. The people you choose
b. Your favourite football team
c. The Chancellor of the Exchequer (cough)
d. A charity

It may be that we would have to take the lead from a popular game show and suggest that perhaps they then need to go 50/50:

a. The people you choose
b. The Chancellor of the Exchequer (cough)

It is not much of a choice is it?

However, even now, the majority of the population still feel that the IHT question is one that they will never have to face. Time, therefore, to ask a few additional questions:

● Will you pay off the mortgage one day?
● Do you have a portfolio of shares/investments/PEPS/ISAs?

As the answers to both these questions are likely to be ‘yes’ then it is clear that a significant proportion of anaesthetist’s need to be thinking about inheritance tax planning.

The Problem

“But isn’t there a lot I can pass on without paying tax?” might be an initial response, and yes, we can see that the nil rate band (the allowance below which no tax is paid) has increased to £255,000 (2003-2004) from £215,000 in 1997. That is a significant amount and indeed an increase of 18.7%, so how come IHT planning is now such a big issue? Close analysis of house prices highlights that, while indeed the threshold has increased ahead of inflation, it has not kept pace with rising house prices. In England and Wales the average house price increased 22.24% between 2001 and 2002 alone, compared with the most recent IHT increase of 2% (Money Management June 2003).

Due to rising house prices, the levels of additional savings that a client now requires before they fall into the IHT trap are not that significant. In the UK, the average house price has now risen so much that it would be taking the average London homeowner around only £13,000 worth of additional saving to breach the nil rate band of £255,000. How many of them know that and how many of them would be willing to give up significant elements of their estate to the Treasury?

Additionally, it is worthwhile taking time to consider PEP and ISA investments that clients may have in addition to their property. One of the big issues with PEP’s and ISA’s is, of course, the fact that they cannot be written in trust and as a result they automatically form part of a client’s estate.

For example, based on the current nil rate band, the effect on a £500,000 estate of inheritance tax is as follows:

£500,000 less £255,000 = £245,000;
40% of £245,000 = £98,000.

This is shown in chart 1.

That means that the estate will pay £98,000 to the Inland Revenue with only £402,000 going to the family. The client has given up a staggering 24% of their estate as a result of not using any form of IHT mitigation.

The Solution

There is much that can be done to significantly reduce inheritance tax, such as:

● Maximising your IHT ‘life time gift exemptions’.
● Altering your will to use both spouses IHT allowances, rather than only one.
● Investing in assets that obtain Business Property Relief
● Putting life insurance into trust.
● Giving money to charity

These are beyond the scope of this article and will be covered in future articles.

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

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Web site: www.medical-acupuncture.co.uk
The General Medical Council (GMC) is empowered to oversee and safeguard good medical practice and to protect the public, maintaining high confidence in the medical profession. It has strong, effective legal powers (Medical Act 1983) designed to maintain the standards the public expect.

For the vast majority of anaesthetists, their primary dealings with the GMC currently involve payment of the annual retention fee in order to stay listed as a medical practitioner on the Register. The Medical Register shows doctors who are properly qualified to practise medicine in the UK. Containing about 200,000 doctors, it is updated daily. Commencing April 2005, there will be a requirement to prove continuing fitness to practice in order to remain on the Register. This is called revalidation and successful completion of the process will result in the granting of a Licence to Practise (in addition to registration) for a five year period. All doctors will be revalidated during the period 2005 – 2010 for the first time. More specific information on this process can be found on the website www.revalidationuk.info

The other functions of the GMC are:

**Fostering good medical practice.** An example is the issuing of guidance, both generally, such as Good Medical Practice, and in more specific areas, such as Confidentiality and Consent.

**Promoting high standards of medical education.** Doctors need to learn and to maintain their knowledge, skills and attitudes. The GMC also has statutory responsibilities to promote high standards, and to co-ordinate all stages of medical education. There is a statutory GMC Education Committee.

Dealing firmly and fairly with doctors whose fitness to practice is in doubt. If any doctor fails to meet those standards set out in Good Medical Practice, the GMC can put the doctor through their fitness to practice procedures, which act to protect patients from harm. This may result in striking the doctor off the register and removing their right to practise medicine.

The governing body, GMC Council, has recently been reduced in size to 35 members:

- 19 doctors elected by the doctors on the medical register
- 14 members of the public appointed by the Privy Council
- 2 academics appointed by educational bodies - the universities and medical royal colleges

The GMC is best known to the public through handling complaints and when a doctor’s fitness to practise is questioned. It has legal powers to act against problem doctors but can only act where there is EVIDENCE that a doctor may not be fit to practise. Lesser problems should usually be resolved locally, in particular through NHS procedures.

**Fitness to Practice Procedures** are invoked:

- When a doctor has been convicted of a criminal offence
- When there is an allegation of serious professional misconduct
- When a doctor’s professional performance may be seriously deficient
- When a doctor with health problems continues to practise whilst unfit

Currently, a decision is taken at an early stage to stream a complaint into one of three procedures: health, performance or conduct. Each has a different potential outcome, and not all can lead to being struck off from the GMC’s register.

From 2004, there will be a new single complaints process. All complaints will go through the same process. This will mean that a doctor’s fitness to practise will be considered as a whole, rather than being ‘labelled’ early as a health, performance or conduct case. The same outcomes and sanctions will be available to every case as appropriate. No Council members will sit on the panels that decide the case against a doctor. Associate Members will be empanelled to decide the case. Over 200 Associate Members have been selected and trained by the GMC, and include both medical and lay members. Over the past 5 years there has been a very substantial increase in the work done by Fitness to Practise committees. The empanelment of Associate Members has enabled these committees to sit more frequently and to occupy less of Council members’ time. This has resulted in increased efficiency and reduced backlog of cases waiting to be heard.

The GMC is rapidly changing to meet both the needs of the public and the Medical profession. All anaesthetists can expect to have more contact with the organisation in the future than they are currently accustomed to. Revalidation is a process we should welcome. Trainees are accustomed to annual appraisal through the RITA process. For consultants, annual appraisal will be the tool used working towards revalidation.
The 6th Fundamentals of Critical Care Support Course

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E-mail: Jan.Gaffey@uhb.nhs.uk

Obstetric Anaesthetists’ Association

Refresher Course on Obstetric Anaesthesia and Analgesia

Wednesday 8 October: London

A one-day course aimed at Consultants, Staff Grades and Associate Specialists who cover obstetrics on-call but do little, or no, elective daytime obstetric work. This course will concentrate on practical aspects of current obstetric anaesthetic practice, and will also touch on some controversial issues.

Topics include current management of analgesia for labour, anaesthesia for emergency Caesarean section, what you need to know about pre-eclampsia and obstetric haemorrhage, and a joint anaesthetic-obstetric session on obstetric crises. Plenty of time will be allocated for audience questions and panel discussions.

This is your chance to pick the brains of an expert panel, and to ask all those silly little questions that you may be too embarrassed to ask at work.!!

5 CEPD points.

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This annual course, now in its 27th year, is one of its kind in the UK and has proved extremely popular with anaesthetists from both the UK and overseas. Leading specialists will present a wide range of core and relevant topics in obstetric anaesthesia and analgesia, including aspects of maternal medicine and fetal well-being. Many areas of current clinical controversy will also be explored and addressed. All presentations will be made using PowerPoint data projection, and registrants will receive an abstract book.

Whilst designed primarily for experienced anaesthetists with a commitment to obstetrics, this intensive course may also be of interest to trainee anaesthetists, midwives and obstetricians. In addition, senior anaesthetists who cover obstetrics on-call but do little or no elective daytime obstetrics may also find this a useful way of being brought ‘up to speed’ with current practice and opinion. 15 CEPD points.

Obstetric Anaesthesia - Versailles 2004

Friday 16th - Saturday 17th April 2004

Jointly organised by Club des Anesthésistes Réanimateurs en Obstétrique (CARO) and Obstetric Anaesthetists’ Association (OAA)

The satellite meeting of the 13th World Congress of Anaesthesiologists in Paris (18 – 23 April) will be open to both members and non-members. The Palace des Congrès de Versailles is next to the entrance to Louis XVI’s Château de Versailles, one of the most outstanding chateaux in the world. Hotel accommodation will be available within easy walking distance and the official language for the meeting will be English, but slides and abstracts will be produced in both English and French.

Deadline for submission of abstracts: 28 November 2003. 10 CEPD points.

Registration Enquiries
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Dept. of Anaesthesia, Box 93
Addenbrooke’s Hospital
Cambridge CB2 2ZQ  Tel: 01223 217434
E-mail: martin.herrick@addenbrookes.nhs.uk
Registration fee: £240  Approved for C.M.E.
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A One-day Symposium for Anaesthetic Trainees and Consultants

Monday 10 November 2003
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- Ethical Issues in Research
- End of Life Decisions
- Case Scenarios & Panel Discussion – Ethics
- Case Scenarios & Panel Discussion – Law

Delegates are invited to submit questions prior to the conference for panel discussions

5 CME points applied for

Course Organisers: Dr P Spiers, Consultant Intensivist & Dr J Tring Consultant Anaesthetist

Registration Fee Including Lunch and Refreshments: £65

Further details from:
Jackie Howarth, Conference Co-ordinator, Clinical Education Centre, Glenfield Hospital, Groby Rd, Glenfield, Leicester LE3 9QP
Tel: 0116 250 2305 • Fax: 0116 256 3334
E-mail: jackie.howarth@uhl-tr.nhs.uk

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Email: steve.graham@ses.snh.nhs.uk

Application Forms from
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3rd November, Simulated Airway & Ventilation Emergency Course, for SpRs & consultants in Emergency Med, ITU & Anaesthesia (£150)
13th November, Mature Consultants Course, for mature consultants in Anaesthesia (£150)
14th November, Medical Emergencies Course, for SpRs & consultants in Emergency Medicine, ITU & Anaesthesia (£200)
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A pension is a return on our savings. For most of us, our savings are made up of two parts. That which is put aside from our earnings during our careers into pension funds, and the assets we have accumulated during the years – property, antiques or shares.

The NHS Pension

This note refers to doctors retiring over age 50, and takes no account of extra earnings such as domiciliaries etc.

We who have a NHS pension fund are extremely fortunate in that the pension, when paid, is linked to a cost of living index. This index is roughly linked to inflation, but will not keep up with some rapidly rising factors such as council tax or property prices.

It is important, well before retiring, to contact the NHS Pensions Agency, Hesketh House; 200 Broadway; Fleetwood FY7 8LG (01253 774 774) and ask for a statement of service recorded. You will need to give them your National Insurance number.

The statement will show what they have recorded of your service in the NHS, including dates that you may have been abroad (and whether you paid contributions for that time) or between jobs, and if you have been part-time. This needs to be checked. Do bear in mind however, that years are only counted as 365 days – we work each February 29 unpensioned!

The total will be shown as ‘calendar’ service and ‘reckonable service’; ‘reckonable service’ is calculated by multiplying the ‘calendar service’ by the sessions worked. Thus 15 years whole time service (perhaps as a trainee), and 22 years as a 10/11 consultant gives 37 calendar years and 15+ (22 x 10/11) =35 reckonable years.

You can accrue (technical term for accumulate) up to 40 years calendar service at age 60, and 45 years at age 65. If you have less than 40 calendar years service at age 60, provided you have a minimum total service, you may be able to purchase added years to bring the calendar years up to 40. Whilst this may seem expensive, even bought at the end of one’s career, it only takes about 10 years retirement to get the money back.
The rules covering added years are quite complex, but covered in booklet SDAVC, one of many detailed guides obtainable from the NHS Pensions Agency. Since the cost is based upon current salary, the earlier they are bought in your career the better.

It is however your reckonable years at retirement, divided by 80, that give the fraction of your final whole time equivalent salary that will be your pension. So whether you are on 10/11, or 5/11 your pension is still your (reckonable years/80) times your whole time equivalent (WTE) salary.

This WTE salary is ‘pensionable salary’, and is calculated over a whole year; so if you take up the post of clinical director (whose pay is often, but not always pensionable – check the position in your Trust) six months before retiring, half of the extra pay is counted towards your final salary. The same applies to annual increments, points or awards.

In addition to the pension, you will be given a lump sum of cash equal to three times your pension, though service before 1972 only gave a lump sum equal to pension unless you bought the top-up.

If you retire before age 60, both lump sum and pension are reduced by what would appear to be an unnecessarily complicated formula, the ‘actuarial reduction’, so you get the double whammy of less years service and reduced lump sum combined. For example, retiring at age 50 will cut your lump sum to 75%, and your pension to 60%, of what the years of service ought to bring you.

Private Pensions

With the current atmosphere of uncertainty regarding private investments it is important to remember a number of points. Although private pension investment schemes seem at first sight attractive, there are disadvantages

- Although pension contributions are eligible for tax relief, the pension itself is taxed. So all that really happens is that the payment of tax is postponed (though for those with not much income, at a different tax rate).
- Once you die, the pension companies keep all the capital and your heirs get none back.
- As with many financial investments; the fund managers take their slice and commission whether your investment has performed well or badly. Caveat emptor!

What is the alternative? Well, any tax free investment. The best investment over the years has of course been property, and one’s own house is free from tax; so buying big and downsizing when appropriate, or taking out a later-years mortgage is just as efficient as a private pension scheme.

But you can also invest in any disposable asset which in your judgement is likely to appreciate – clocks, silver, antiques, or whatever you choose, with the added advantage of being able to enjoy it. Make your antique collection your pension scheme! But of course take good advice before doing so.
I have a secret sin, that of reading Science Fiction. Not the modern, fantasy, “swords & sorcerers” style, but from the Golden Age of SF, the 1950s & 60s. That kind of novel is no longer published and so I scour second hand bookshops for my favourite reading. I was rather pleased recently to score a double, of buying a copy of a book that I read long ago and had lost, and another by the same author that I had not read. My old favourite was titled ‘Gunner Cade’ and dealt with a hierarchical, authoritarian world state on Earth and how the freedom loving people of Mars threw off their chains - a strange mixture of Cold War anticommunism and Left anti-authority, almost anarchist sympathies.

The second, new to me, book is called ‘Outpost Mars’, and is almost a Western, of prairie homesteaders battling not against fire, flood and ‘injuns’, but against a hostile planet. There is even an honest and forthright community leader, a doctor as it happens, who carries the Day and wins the Girl. To be honest, the novel is not very good, either as SF or as a Western. What fascinated me was the major sub-plot, of conniving capitalists and politicians, who conspire in illicit traffic in an addictive drug, that can only be produced on Mars. That drug is called marcaine.

The author was Cyril Judd, and these are the only books to be written together by two American authors, Judith Merrill and Cyril Kornbluth. They were clearly fond of conflating names and words, from their own names for their ‘nom de plume’, so guessing why they chose ‘marcaine’ for their drug is not difficult. The first syllable, “Mar-” must be for the planet where they set their story. Addiction to cocaine and the beginnings of a criminal drug culture were of much concern to the USA of the ‘50s, so the “-caine” is for cocaine as an archetype addictive drug.

Unfortunately for parallel world or conspiracy theorists, in this “Cyril Judd” Mars, marcaine is clearly an opiate, rather than a local anaesthetic. Equally unfortunately, Kornbluth died in 1958 only a few years after co-writing these stories, while Judith Merrill survived only to die last year. So we can’t ask them. But we can ask the originators of the real Marcaine. The drug was synthesized in the ‘60s, so “Judd” cannot have been inspired by its name, and would not have chosen the name of a real compound anyway. Could it be that the influence was the other way, that this obscure novel from an obscure branch of literature influenced the Swedish chemists in their choice of name?

Ms.J.McKenna of the AstraZeneca Customer Information Department kindly contacted her counterpart in their Swedish offices, who passed my question to Dr.Bertil Widman. Dr.Widman was one of the first experimenters with and clinical users of Marcaine at its introduction in 1963. He replied, “I knew most of the people at Nobel Bofors-Pharma in Mölndal, Sweden who were involved in the development of Marcaine (project name LAC-43). Back then I asked the Bofors people the same question, about naming Marcaine, and they told me that the “Mar-” prefix had no special meaning or relation to any person. Together with the marketing people the researchers tested several suggested names for one that would be easy to use in several languages, and finally found that “Marcaine” seemed to be the best, and of course all local anaesthetics should end in “-caine”.

Of course this could be another manifestation of “The Endochronic Properties of Resublimated Thiotimoline” but that is another story, by Isaac Asimov this time.
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Three Months in Malawi

Fran O’Higgins
Bristol

In a last bid for freedom before starting my consultant post in the UK, I took the opportunity to visit and work in Malawi for three months. Here, with the aid of a travel grant from the Association of Anaesthetists, I acted as a Visiting Lecturer to the College of Medicine of the University of Malawi and to the Malawi School of Anaesthesia at the Queen Elizabeth Central Hospital, Blantyre.

Malawi is a relatively small country, smaller than England, landlocked by Tanzania, Zambia and Mozambique. With 11 million people, it is the most densely populated country in Africa, and is currently facing severe food shortages following crop failure and the inexplicable sale of its maize reserves. Malawi is among the very poorest countries in the World and this is reflected in its demographic and health indices. Sixty-five percent of the population live below the poverty line. The average life expectancy is between 35 and 40 years and is falling rapidly, with AIDS being the leading cause of death in the adult population. Due to the economic situation of the country, healthcare receives little financial support and consequently the hospitals are usually underfunded and overcrowded. The main medical problems are HIV related illnesses (accounting for 70% of all in-patients), malaria, TB, malnutrition and road traffic accidents.

The Queen Elizabeth Central Hospital is the largest hospital in the country with over 1,000 beds and an occupancy rate of well over 100%, which means that the conditions are overcrowded and the system is stretched to the limit. There are nine operating theatres throughout the hospital, covering most of the major specialities. There is a four-bedded intensive care unit, while a recovery/high dependency unit is currently being built. The Anaesthetic Department is run by Professor Meursing and Dr Haisma, both from the Netherlands, as well as two medically trained anaesthetists and nine Malawian anaesthetic clinical officers.

As with many developing world countries, the anaesthetic services rely mainly on clinical officers and medical assistants. Anaesthetic clinical officers complete a basic medical training and then undertake a further 18 months specialist training at the Malawi School of Anaesthesia. This was established in 1989 by Dr Paul Fenton and is based at both Blantyre (directed by Mr Goddia) and Lilongwe. At present there are 21 trainee anaesthetic clinical officers. However, funding is due to run out at the end of the present course and there is great uncertainty over the future of this valuable anaesthetic school. Working with the clinical officers was often inspirational. They accumulate a vast amount of clinical experience, working with scarce resources and a great sense of innovation and improvisation. A large amount can be learnt from them about providing anaesthesia in this difficult environment. I found it humbling and embarrassing that, despite all my ‘high-tech’ training, I often considered that I delivered inferior anaesthesia to theirs.

As a Visiting Lecturer, my main commitment was to teach trainee anaesthetic clinical officers, nurses and medical students. I also undertook a large clinical component, working in the intensive care unit as well as providing anaesthesia in theatre. Equipment and drugs were, not surprisingly, basic. Although most theatres had pulse oximetry, ECG and automated blood pressure monitoring, these often proved unreliable and the ‘finger on the pulse’ approach provided more dependable information. I now have a whole new appreciation of ventilators and modern monitoring.

In Malawi, there is no such thing as single use, disposable equipment. Everything that could be, would be cleaned and reused. Spinal anaesthesia was used whenever possible as it is not only cheaper but, more importantly in these circumstances, a safer option. For general anaesthesia, the main induction agent was thiopentone although even this ran out whilst I was there and we resorted to methohexitone - a challenge to use with a LMA! Muscle relaxation for intubation was supplied mainly by suxamethonium with patients usually breathing spontaneously through the operation whilst, slightly incongruously, the only nondepolarising agent available was rocuronium. Maintenance of anaesthesia tended to be with halothane, with drawover apparatus using oxygen from a concentrator. However, for more unstable patients, ketamine and ether were frequently used.

The ICU can accommodate four monitored, ventilated patients, although the fourth ventilator was an old Manley, requiring two oxygen concentrators to provide enough gas flow to ventilate an adult. The patients often have to travel great distances to receive medical care. As a result, they regularly presented with advanced pathology and were often in extremis, sometimes having tried the local ‘witchdoctor’ therapies first. They were accepting and usually very grateful for the limited treatment they received. Not surprisingly, the personal injury lawyers ‘no win no fee’ culture has yet to hit Malawi. The main source of patients to ICU was from theatre, often with gross intra-abdominal sepsis and admitted for postoperative care. There were also many eclamptic patients requiring intensive care. Trauma is another big problem in Malawi as it has one of the world’s worst road death statistics. Despite these major problems, the ICU has an overall mortality rate of approximately 35% which is a great achievement considering these difficult conditions.

Blantyre is also home to the Malawi College of Medicine. The first doctors to be trained wholly in Malawi qualified in 1999 and now close to 200 medical students have graduated, helping to reduce the doctor/patient ratio of 1:5200. At present, both the College and QECH are supported by the Netherlands Government but this help is due to end. The ‘Dutch Exit Strategy’ has been set in place to prepare for their withdrawal in 2004.

Outside the hospital, Malawi has a huge amount to offer. It is known as the ‘warm heart of Africa’ for good reason. The people are welcoming, friendly and unfailingly polite. For an African country, Malawi has relatively little crime, a hangover effect from Hastings Banda’s day when he ruled with an iron fist. The highlights are, without doubt, the awesome Mulangi Mountain and the beautiful expanse of Lake Malawi. It also boasts some of the best bird watching in Africa, as well as plenty of larger animals in the national game parks. Enough of the tourist plug - get out there and see for yourselves!

I consider myself very fortunate to have had this opportunity to spend time in Africa and encounter a very different style of anaesthesia. It was an extremely memorable and rewarding experience and I would like to thank the Association of Anaesthetists for its financial support. My lasting impression was of the unfailing Malawian sense of humour, as well as their kindness to the endless visitors that come to support their work.

Finally, some things are common to anaesthetists all over the world, as I found out when one of the clinical officers asked in all seriousness “Is it true that surgeons don’t shout in your country?” Oh, if only they knew!