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Clinical excellence

As you read this, those members of the Association with school-age children will most likely be returning from their summer holidays in time to get the little darlings back to school in early September, while lucky Scottish anaesthetists will already have packed theirs off for the new term. Those whose children are not yet of school age will be looking forward to the time that they too will have the privilege of paying well over the odds to join the smelly, jostling throng of humanity who are forced to holiday at the hottest and busiest time of the year. Those whose children are no longer of school age will be looking back wistfully to August holidays but looking forward to enjoying child-free adult holidays in the far cheaper month of September. Those members with the good sense not to reproduce will be looking back wistfully to August holidays but looking forward to a bit of a rest after having worked particularly hard covering fecund colleagues who spent most of August on holiday. Ah, Autumn – season of mists and mellow fruitfulness - and, for most consultants in England, the start of the annual ACCEA round or, as it is known in my department, Passover.

I am sure that all Association members are aware that anaesthetists have the lowest and fewest Clinical Excellence Awards (CEAs) of all hospital specialties. The situation is the same in all the home nations, whatever form the scheme takes. The Association has held meetings with Professor Jonathan Montgomery (ACCEA Chairman) and Professor Hamid Ghodse (ACCEA Medical Director), and much time has been spent during these meetings trying to determine why anaesthetists are not as successful at gaining CEAs as every other medical specialty. In Scotland similar meetings have taken place between members of the Scottish Standing Committee and SACDA (Scottish Advisory Committee on Distinction Awards). There are probably many factors at play. The current forms seem to favour bed-holding specialties that run services. They also favour...
departments in the hospital that are well-funded and have research fellows whose publications can readily be claimed by consultants. It is evident that although anaesthesia is the single biggest subspecialty in almost every hospital in the country, representation on Local Awards Committees does not reflect this, and the committee as a whole may therefore not understand the true extent of the activities of anaesthetists in the hospital and what constitutes excellence in the practice of anaesthesia.

With local award progression (levels 1 – 9) being slow, fewer anaesthetists are acquiring national awards (levels 9 – 11) than other specialties – we achieve only half of the “indicative number” of higher awards that ACCEA gives out on average. Higher award committees have traditionally considered that someone on low local award levels must not be contributing significantly on a local level. However, things are changing, and we are pleased to be able to report that in England, central ACCEA authorities are taking a very close look at anaesthesia this year. In particular, low local award levels will not be presumed to be the result of low levels of activity, and anaesthetists with relatively low local award levels will be seriously considered for national awards. Interestingly, when anaesthetists do apply for Bronze (national level 9) awards, they are more successful than the average applicant. Although this may simply reflect the fact that by the time anaesthetists have sufficient local awards to have a realistic chance of a national award, they have a curriculum vitae and track record that is better than their younger colleagues in other specialties, it does highlight the fact that advancement to national awards is possible.

The Association and the College have prepared a PowerPoint presentation that gives very useful advice to departments on applying for CEAs. This has been sent to every AAGBI Linkman and has been posted on the Linkman Portal of the AAGBI website. If you have not seen this presentation, contact your hospital Linkman and ask him/her to acquire a copy for you. Ideally, your Linkman should make this presentation to the whole department to allow widespread dissemination of the advice and discussion of the important issues involved. While this presentation refers specifically to the scheme operating in England, there is much useful general advice which can be adapted for other schemes, so Linkmen in the other home nations may wish to consider adapting it to local circumstances.

One of the main problems identified in the low level of awards given to anaesthetists is the fact that few anaesthetists seem to apply for local awards. This was confirmed during the AAGBI Linkman Conference in London in June. There are a number of reasons for this, foremost amongst which seem to be a lack of confidence in the system and a belief that there is little point in applying because there is little chance of being successful. The Association strongly recommends that every eligible consultant, i.e. every consultant, applies for an award every year. If you don’t apply for an award, you will certainly not get one. If you apply for an award, you stand a chance. The AAGBI, as a specialist society, is allowed to nominate members for higher awards. If you would like to be considered for a nomination, or would like further advice or information, please contact me on honsecretary@aagbi.org. The deadline for a ranked list of nominations for England to be submitted to the College is 3rd October 2007, so now is the time to start working on your application form!

**Productivity**

The new consultant contract launched in 2003 increased salaries for most consultants in the UK. It is arguable that this did not represent a substantial pay increase; rather, it allowed consultants to be paid for a longer working week than before, for additional work that they had previously been doing for free and allowed their salaries to “catch up” after a number of years of sub-inflation pay rises such as the one we have been given this year. Whatever the truth of the matter, there now seems to be a distinct government spin that consultants (and GPs for that matter) are being paid a lot more money for doing a lot less work. Cynics would say that the Government is not too displeased by this misconception, as it will allow more sub-inflation pay increases to be offered to the profession.

However, there is a limit to the extent to which our pay can effectively be frozen. Another new buzzword in the ever-expanding and confounding lexicography of the Department of Health has therefore appeared: “productivity”. It is likely that over the next few years, consultants will be expected to justify the pay increase inherent in the “New Contract” and subsequent year-on-year increases by showing that they are becoming increasingly productive. All very sensible and reasonable, you may think, but many different books have been written on how to measure NHS and medical productivity, and the new GP contract is partly based on some of those thoughts. However, just as anaesthetic excellence may not be readily comprehensible to those charged with distributing ACCEAs, will anaesthetic productivity be as easily measured and recorded as the productivity of other hospital specialties? If you are a physician whose work is to a large extent based in the outpatient clinic, demonstrating greater productivity will be relatively simple. If you see and treat 25% more patients, you will be able to claim a 25% increase in productivity. If, as a surgeon, you perform 15% more arthroscopic meniscectomies...
in your all-day operating list, you will rightly be able to claim a 15% increase in productivity. Our pain medicine colleagues may find it relatively easy to demonstrate productivity increases in terms of patients seen and procedures performed, and intensivists may be able to show decreased durations of stay and improved survival as indicators or both quality and productivity. What about the anaesthetist?

To judge anaesthetic productivity simply by the number of anaesthetics given would, I will argue, be a mistake. The number of cases that we do a day is only partly dependent on our speed and skills. There are many other factors that determine the actual number of anaesthetics given, not least of which are the availability of beds, the efficiency of the admission and patient transfer processes within a hospital, the number of porters and the speed of the surgeon. The challenge that may therefore face us as a specialty is defining anaesthetic productivity in a way that does not disadvantage us by making our “productivity” wholly or mostly dependent on the vagaries of clinical management systems within the hospital. Anaesthetists play an important role in pre-assessment and in the management of patient throughput in operating theatres and day surgery centres. They are therefore at the heart of productivity in many processes within a hospital, and indeed it is reasonable to argue that no increase in surgical productivity is possible without an increase in anaesthetic productivity to drive it.

However, there are perhaps other significant indicators of anaesthetic productivity. The length of time a patient spends in recovery is dependent in large part on the quality of the anaesthetic given, in that nauseous patients and those in pain usually spend longer in recovery. This is also true with respect to the duration of hospital stay, in which the quality of postoperative analgesia is known to be a factor. The number of published and acknowledged safety standards that an anaesthetist meets and exceeds could be one of the measures - one of the GPs’ productivity measures is the number of patients whose blood pressure they record. We should therefore make plans for defining anaesthetic productivity in a way that truly reflects the extensive role anaesthetists play in the overall productivity of a hospital. The Council of the Association is currently considering this matter and will be presenting its view of anaesthetic productivity to those charged with the task of assessing it in hospitals. The hope is that we can develop robust and objective indicators of anaesthetic excellence and productivity that can help members define their contribution to the work of the hospital in a meaningful, realistic and comprehensible way, satisfying both the productivity assessors and the ACCEA committees. In the meantime, we welcome comments on this subject from members.

Bikes

The second annual AAGBI European motorcycle trip took place in June. Nine intrepid bikers returned from the ESA meeting in Munich “the wrong way round” – through the Dolomites, Northern Italy and the French Alps. Last year’s stalwarts (Iain Wilson, Phil Bayly, Neil Vass and myself) were joined by five welcome newcomers: Yoav Tzabar, Tom Neal, Gary Bryan, Ian Johnston and Isabeau Walker, this latter courageous traveller sitting on the back of Wilson’s bike the whole way back. I will not trouble you with tales of breathtaking scenery, scintillating roads, excellent victuals and even better company. However, I will share a photo from the trip with you. Few members may be aware that the Honorary Membership Secretary is both a keen caravanner and a motorcycle enthusiast. The picture below shows him combining these two interests by contriving to be towed on a bike, thereby conjoining the outdoor exhilaration of motorcycling and the innate safety and sensibleness of caravanning. Truth to tell, his fuel pump broke while on an autobahn. Fortunately, this happened some 10 miles from where BMWs are made, so the repair was performed quickly, and the Hon Memb Sec was soon back on the road.

Next year’s trip will see us return from a meeting in Copenhagen via some fantastic scenery and tortuous roads. We may also build next year’s AAGBI Annual Congress in Torquay into our vehicular plans. Any other Association members who fancy joining us on a trip should contact me at the usual email address. We already have a firm offer of company from the Editor-in-Chief of Anaesthesia, thereby providing a much-needed injection of intelligence, academia and acerbic wit into our journeys. All he has to do now is persuade his wife to let him buy a bike. Good luck David!

William Harrop-Griffiths
Honorary Secretary
We live in interesting times here in Paisley. As I write (early July), we are surrounded by nice young men in uniform who are our companions for the moment in the anaesthetic department. You will have spotted from the news that we have been having a little excitement here recently. Obviously I can’t say too much at this particular time about what's been going on here – suffice to say, our main source of information is also the TV news, but I can reveal that a controlled explosion is not as exciting as it sounds.

Following the London bombs in 2005, a number of people asked me if I felt any concern about going there regularly for Association business. Ironic, as it now transpires the risks may be a lot closer to home. I had a Belfast granny, and was brought up to believe that not to just get on with things is to allow a form of victory to the bad guys – I’m sure all Northern Ireland readers will be familiar with that sentiment. I visited Belfast all through the seventies, and went shopping in the city centre regularly. Was it foolish of my mother to subject me to such ghastly risks? I think the attitude I have grown up with is healthier than that of the young patient whose mother cancelled her operation this week on the grounds that the hospital might be unsafe – we have every policeman in the West of Scotland here at the moment!

To go back to 2005, my concessions to the terrorists were to always get off at the first stop on the underground – AAGBI headquarters is about midway between two stations – and to carry a small torch in my bag. I flew to London six days after the attempt on Glasgow airport, and decided to go as soon as it was announced the car parks were open, and it was more or less business as usual. It's an interesting philosophy – I’m sanguine about being blown to bits (if it’s got your name on it, so be it), but the thought of having to get up earlier in the morning to get to the airport by another means, or even worse, the thought of being left hanging about an airport for hours (I do far too much of that already) was enough to make me cancel my journey!

I hope to give a fuller version of events at some point, but that will have to wait, for reasons that I am sure are obvious.

This month, the Honorary Secretary reports on three matters – two of importance to us all, and another of supreme importance to a small but growing subgroup within the Association – the old-enough-to-know-better bikers. Membership of this group is free, but not without expense, as ever more impressive toys and accessories seem to be under discussion every time I come across more than one of its members gathered together. Also under discussion are efficiency in anaesthesia (and how to prove it), and Clinical Excellence Awards – both issues that exercise us all, or should. However, the imprint of the editorial stiletto is on the backside of anyone attempting to contribute to Anaesthesia News who forgets that CEAs are an English thing! The Hon. Sec’s advice is applicable to other formats in use – only the terminology and the timetable may differ.
Also in this issue, Ranjit Verma (who must be one of the very few people who understands it) unravels the complexities of the NHS IT system, and at least lets us know what it is trying to achieve. Commercial operations allow us to buy books, order groceries, book flights, and do virtually anything online, but every time a public body tries to use IT efficiently, it seems to go pear-shaped. If anyone knows why this should be, could they let the Government know? Even if this system is set up successfully, the frequency of the cry, “Is the internet down again?” in my hospital doesn’t fill one with confidence that it will all work!

Finally, a subject dear to my own heart – the Association’s Overseas Anaesthesia Fund. Money has been rolling into this since its launch a year or so ago, and we are extending the range of projects which will make a real difference to the provision of quality anaesthesia in the developing world. Ellen O’Sullivan updates us on a recent initiative. Please keep giving generously!

Hilary Aitken

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Sir Geoffrey Organe (1908-1989)

Born in Chennai, India and after local schooling he came to Taunton School, Somerset in 1919 as a boarder with his younger brother. He studied medicine at Christ's College, Cambridge, transferring to the Westminster Hospital for his clinical studies and qualifying in 1933. After local house jobs he went into general practice in Bushey with Patrick Shackleton but took a trainee post in anaesthesia at the Royal Berkshire Hospital, Reading in 1936. He took the DA in 1937 and Magill invited him to return to the Westminster Hospital the same year. Organe rapidly moved up the career structure becoming a registrar in 1938 and the following year becoming an honorary Consultant. Being a protégée of Magill and Rowbotham would have done him no harm. He wrote an MD thesis on intravenous thiopentone, having watched Lundy using the drug at Madison. Organe had been diagnosed with colonic cancer and underwent a bowel resection and was thus exempted from military service at the outbreak of World War Two. He devised new ways of determining the potency of muscle relaxants including the short acting decamethonium and was one of the first to try the new ganglion blocking effects of pentamethonium when it was shown that it had little muscle relaxing properties but potent hypotensive ones. When a new Chair in anaesthesia was created in 1966 at the Westminster by London University, Organe was a natural choice for the position. He had held most of the important political roles in anaesthesia; elected to the AAGBI Council in 1947 he became Honorary Secretary in 1948 and then President in 1953. He was President of the Anaesthetic Section of the RSM in 1949 and was closely associated with the opening of the Copenhagen Training Centre in anaesthesia organized by the WHO in 1950. With the setting up of the WFSA in 1955 Organe became its first Secretary-Treasurer, a post for which his previous travels through over 40 countries had ably prepared him. He was Dean of the Faculty of Anaesthetists from 1958-61 having previously served as an Examiner for both the DA and FFARCS. He became WFSA President at the 3rd Congress in 1964. His travels and influence continued as he strove to ensure the WFSA developed, and his skills were recognized by the awarding of Honorary membership to over 20 national anaesthetic societies. He was adviser in anaesthetics to the Chief Medical Officer. In 1968 the World Congress came to London and in the same year Organe was knighted. He retired in 1973 and moved to Dorset and subsequently to Calne in Wiltshire.

Professor Sir Gordon Robson (1921-2007)

Born in Stirling, he attended Stirling High School before going to Glasgow University where he qualified in medicine in 1944. After 6 months of an obstetric house job in Stirling he joined the RAMC and became an anaesthetist in Nairobi while at the same time working in the local maternity hospital. After returning from the war in 1948 he worked as a Senior Registrar in anaesthesia in Glasgow’s Western Infirmary for four years before transferring to Durham, working as First Assistant under Pask. He was appointed Consultant Anaesthetist to Edinburgh Royal Infirmary.
in 1954 but after two years he moved to the Wellcome Chair in Anaesthetics at McGill University, Montreal. Here he studied the action of anaesthesia on the brain and respiratory control. He returned to the UK in 1964 to be the Professor and Chairman in anaesthetics at the Royal Postgraduate Medical School and Hammersmith Hospital. One of his first successes was to separate the department of anaesthesia from that of surgery! He was to stay in this post for the next 22 years until he retired in 1986 aged 65. He revolutionized the department into one of the most successful research departments of anaesthesia. He was also willing to take on a series of political roles. He became Anaesthetic Advisor to the Chief Medical Officer (1975-84), Dean of the Faculty of Anaesthesia (1973-76), Master, Hunterian Institute (1982-88), Honorary Secretary, Conference of Medical Royal Colleges (1976-82), President of the Scottish Society (1985-86) and the RSM (1986-88). He was appointed CBE in 1977 and then knighted in 1982.

*See note about Sir Gordon Robson’s memorial service at the end of this article

**Professor Sir Keith Sykes (1925-)**

Brought up in Devon and Yorkshire he studied medicine at University College, London, and Magdalene College, Cambridge and qualified in 1949. After house jobs in London and Norwich he joined the RAMC for two years’ national service undertaken with the British army of the Rhine in Germany. During this time he trained as an anaesthetist in Hamburg and on returning to the UK he went back to UCH where he subsequently took his DA and FFARCS. His first real experience with anaesthesia research took place during a year as Rickman Godlee traveling scholar to Beecher’s department at the Massachusetts General Hospital, Boston. Returning to the UK Sykes took a post at the Royal Postgraduate Medical School and Hammersmith Hospital in 1958 where he stayed until 1980. During this time he spent six months in Durban studying the efficacy of IPPV during tetanus on both children and adults. Back in the UK he set up a resuscitation service, a blood gas analysis service, and opened a recovery unit in 1960 which evolved into the first general intensive care unit in the UK. His research interests encompassed rebreathing during anaesthesia, respiratory changes during thoracic surgery, extracorporeal circulation, the physiology of mechanical ventilation, the causes of hypoxia during anaesthesia and the effects of drugs on the pulmonary circulation. In 1980, he left his personal Chair to become the third holder of the Nuffield Chair of Anaesthetics at Oxford. Here he established a laboratory for experimental studies in pulmonary blood flow and in particular the influence of drugs used in anaesthesia and intensive care medicine on that circulation. He published what was to become the standard text on clinical measurement and was instrumental in the introduction of patient controlled analgesia to Oxford. He was made Advisor in Anaesthetics to the Chief Medical Officer in 1986, a post he held until 1992. He was knighted in 1991. He now lives in Budleigh Salterton in Devon.

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**Professor Sir Donald Campbell (1930-2004)**

Born in Rutherglen, near Glasgow he was educated at Hutcheson’s Boys Grammar School before qualifying in medicine from Glasgow University in 1952. After local house jobs he moved to Montreal and then to Edmonton, and finally to Lethbridge, Alberta, where he was trained in anaesthesia. In 1956 he returned to Glasgow and after further trainee positions at the Royal Infirmary and Stobhill Hospitals he gained his FFARCS and was appointed Lecturer to the University Department as well as Consultant Anaesthetist at Glasgow Royal Infirmary in 1960. He was appointed to the Chair in 1976 where he remained until he retired in 1992 and was Dean of the Medical School for four years (1987-91). He was instrumental in setting up the respiratory intensive care unit at the Royal and still found time to write numerous papers and two textbooks as well as being much in demand as a visiting lecturer both nationally and internationally. He was an examiner and then Board member of the Faculty of Anaesthetists before becoming its Dean in 1982 for a 3 year term. He then became a vice-President of the Royal College of Surgeons of England having already been a Council member and then Vice-President of the AAGBI and President of the Scottish Society. He later served as President of the Royal College of Physicians and Surgeons of Glasgow, and was Chairman of the West Glasgow Hospital University Trust. He was awarded a CBE in 1987 and a knighthood in 1994.

There can be little doubt that these great men deserved their recognition but were there not others who might have been recognized? There are rumours that some (like Derek Wylie) refused such honours; who knows for sure?
Anaesthesia has been practised in the UK since 1846. In that time period, from my basic researches I believe some 317 surgeons have been knighted in comparison to our 9. What does that say about our speciality and how it is perceived? I suspect that we are ‘below the radar’ for most of the time and also that perhaps we do not know the right ways of putting names forward for appropriate recognition. This has to change.

So well done Sir Peter, but surely our speciality deserves and should receive more?

David J Wilkinson,
Boyle Department of Anaesthesia,
St. Bartholomew’s Hospital, London

Sources:
Maltby JR. Notable names in anaesthesia. 2002 RSM Press. London
Thanks also to the many personal contacts who supplied information contained in these articles.

*A memorial service for Sir Gordon Robson is being held on Thursday 6 September 2007 at 2.00 pm in St Clement Danes Church, Strand, London. Please contact Miss Charley Wainwright at the Royal College of Anaesthetists (020 7092 1500) for further details.
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Details of events and meetings will also be listed free of charge on the AAGBI website: www.aagbi.org
Contact: Claire Elliott on 020 7631 8817 or e-mail: claireelliott@aagbi.org

Seminars at Portland Place

The Association of Anaesthetists of Great Britain & Ireland

NEW SATELLITE INDUSTRY SEMINAR ORGANISED BY FANNIN HEALTHCARE

Anaesthesia News September 2007 Issue 242
British Medical Union to run NHS

From our correspondent Scoop O’Lamine

In an astonishing sequence of events the Government has decided to hand over the running of the NHS to the BMU. Following a number of public workshops “How should we lead the NHS?” run by the Department of Health, the government followed public advice to delegate the day to day running of the NHS to the BMU.

“This is a very exciting opportunity for the BMU”, explained a spokesman from the Senior Medical Specialists Committee. “We have set a number of priorities to get the NHS back on track. There is no doubt that the government has put a lot of extra money into the NHS over the last decade, but due to a number of inappropriate targets and initiatives, little of the money has ended up where it belongs, much of it going directly into providing patient care. We shall correct this in three phases.”

Phase one involves making all NHS Trust managers redundant and moving into their offices. In addition Boards of Directors will be appointed from senior surgeons and physicians. “Other specialties will be able to concentrate on clinical roles and follow instructions of the appointed clinical leaders”. All nurses will all be required to return to uniform and work on the wards. Practitioners and nurse consultants will be phased out over at least 2 weeks.

The consultant contract will be renegotiated by the BMU with the BMU. “Although this might initially seem a little odd to negotiate our pay and conditions with ourselves, it is clear that government has made such a mess of previous negotiations that it is only the BMU that understands the true worth of doctors. Account will need to be taken of the extra management responsibilities of all doctors.”

Phase two will include the implementation of the new contract. Everyone will expect to lose two clinical sessions to be replaced by two management professional activities (MPAs). These extra sessions will provide doctors dedicated time in their contracts to manage services properly, promoting more efficient patterns of working. “The basic contract will be 5.5 DPA, 2MPA and 2.5SPA which will reduce some clinical activity, but allow employment of higher numbers of doctors to run the service at an increased efficiency. Base pay rates of consultants will double to correct historic underpayment, and in addition all consultants will retire with a gold CEA award.”

Phase three will deal with the temporary drop in capacity from the new contract implementation and restore the differential between the private and NHS sector. Undercapacity in the NHS will be addressed by allowing waiting lists to get longer for non-urgent elective procedures. Patients who would rather not wait will be freely permitted to elect to go a doctor of their choice and pay for immediate treatment. “We believe this is more development of choice, and believe that both patients and clinicians will be thrilled to see that we have maintained the freedom of patients to choose their clinician.”

In order to improve training and experience in new consultants, a new grade will be created – the specialist clinician. When asked if this was a reversal of their previous opposition to a sub-consultant grade, a spokesman explained that with consultants having to manage as well as work in both the NHS and private sectors, it was clearly an opportunity for younger colleagues to spend some time gaining much-needed clinical experience. “This is not a sub-consultant post; it is a non-consultant post”.

Consultants have reacted to the proposed changes enthusiastically. “We can definitely run the NHS and look after ourselves! Thanks to the BMU, the NHS is safe again, and medicine is back to a profession run by professionals” exclaimed a BMU supporter.
It will not have escaped your notice that there has been a vast amount of activity relating to information technology in the pursuit of our profession over recent years. All this stems from a vision that the Government had back in 1998, when the NHS Information Authority published its strategy in a document entitled “Information for Health”; also dubbed the “Information Highway” and later the “Information Superhighway”. The purpose of this initiative was to enable patients to receive the best possible care by providing the information that health professionals needed, wherever they were, to enable them to deliver that care. It also sought to involve patients in the care they received.

In 2000 the National Programme for Information Technology (NPiT) was launched which focused on how this improvement in patient care and services would be delivered in England. NPiT only applies to England. There are different programmes for Scotland, Wales, and Northern Ireland. The National programme is now being delivered by Connecting for Health (CfH). It is the biggest non-military IT project in the world with an escalating budget to boot.

So what is the programme supposed to deliver? There are several elements to the national program:

**Picture Archiving and Communication System (PACS):** A system to capture, store, distribute and display digital medical images. Local roll out started in 2005 and by the end of 2006 all hospitals should have been using PACS. Does your hospital still use X-ray films or are all images available on computer screens? 90% of hospitals now use a PACS system - it has been one of the more successful procurements in the NHS.

**Choose and Book:** A service in which appointments and bookings for investigations, outpatients and surgery will be organized electronically. The patient should be offered a choice of up to 4 hospitals/clinics for referrals. They will be able to choose the place, date and time to suit them. Although it was supposed to be 90% completed by March 2007, it is experiencing delays, but should be fully in use by 2008.

**Electronic Prescription Service (EPS):** This system enables electronic transfer of prescriptions (ETP) from the GP to the pharmacist. As a consequence this makes dispensing medication safer, more efficient and convenient. Widespread availability is expected by the end of 2007/8

**The NHS Care Records Service:** This includes Electronic Patient Records in hospitals and other primary care systems, a Summary Care Record, and a Web-based Patient Access to summary records through My HealthSpace. The summary care record and the electronic patient record are both secure electronic infrastructures that should enable confidential patient information to be transmitted between healthcare professionals.
One of the fundamental concepts of the program is that all patient records will be kept electronically and accessed electronically independent of geographic location. Hence a hospital in one part of the country would be able to access the records of an individual who comes from some other part of the country electronically. Furthermore, this record would be maintained from the moment an individual is born to the time they die, the so called ‘cradle-to-grave’ record. For the jobbing anaesthetist there are clear advantages. You are required to give an emergency anaesthetic in the middle of the night to an individual who is unable to give you an adequate anaesthetic history. You can, with a few keystrokes, see their ‘potted’ medical history on the screen, irrespective of where they come from or which parts of the country they have lived over the years. The linearity of the record is likened to a spine into which data is added as episodes occur and information is pulled off this spine as and when necessary.

The summary care record (spine) is thus a subset of the patient’s full medical record and contains basic information about the patient such as their name, address, NHS number as well as simple drug and allergy history, and some clinical details. This information will be visible to the patient on a read only basis but available to all clinicians with permission.

The Spine is scheduled to be available generally by the middle of 2008 and the care record services by 2010.

New National Network (N3): To enable the IT developments to happen, and to cope with future needs of the NHS, a new network is required that will have sufficiently robust infrastructure and broadband capacity to cope with the anticipated traffic. It will need to be reliable and secure. It is now available in almost all hospitals, but may need greater bandwidth as time goes on.

Contact: This is a secure central e-mail directory service (NHSMail). It will allow exchange of clinical information, encrypted and mostly within the NHS environment.

As sure as eggs is eggs when projects of such magnitude are undertaken two things are assured. Firstly the initial budget will be hopelessly inadequate (the final cost being many times more than anyone could possibly have imagined) and secondly, the time scale will inevitably slip. In addition other problems in commissioning, software development, testing, training and implementation are inevitable.

Initially, in 1998, a budget of £1bn was approved. This increased to £2.3bn, then £6.4bn and is now said to be around £12.4bn. The final cost may yet be higher and is conservatively estimated at over £20bn. In the early stages the money was used to ‘wire up’ the NHS including hospitals, GP surgeries and pharmacies. Money is required not only for setting up the system in the first place but also for maintaining it in the future. The government have funded the very basic functionality, and trusts and PCTs will probably have to fund the running costs, and add-on components. Watch this space….

Dr Ranjit Verma
Chairman, SCATA
Council member, AAGBI

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10th Anaesthesia, ICM and Pain Forum
Da Balaia, The Algarve
1-4 October 2007

19th Anaesthesia, ICM and Pain Update
Val d’Isere, French Alps
4-7 February 2008

www.doctorsupdates.com
Tel.+44(0)20 8725 0018    Fax.+44(0)20 8725 3135
New GAT Chairman

The GAT Chairman just got taller! Chris Meadows took over from Sara Hunt as GAT Chairman at the GAT ASM in Brighton in June. A full report will follow in the next issue of *Anaesthesia News*.

Why every anaesthetist should join AAGBI

Benefits of AAGBI membership:

- Receive: *Anaesthesia* and *Anaesthesia News* every month
- AAGBI guidelines
- Other publications for specific membership categories
- GAT handbook
- SAS Handbook
- Life insurance cover for patient transfers
- Discount on textbooks from Blackwell and OUP
- Preferential registration rates for AAGBI meetings and seminars
- Eligibility to apply for research and travel grants
- Access to “members’ only” section of AAGBI website
- Be part of an organisation representing over 90% of anaesthetists in the UK and Ireland

Details at http://www.aagbi.org/aboutaagbi/membership.htm
Enquiries to the membership department on 020 7631 8801 or email members@aagbi.org

Needle Nightmare!

*Is this how kids view anaesthesia?*

**Anaesthesia Information for Children Project Update**

We would like to thank all readers who responded to the “Needle Nightmare” request, published in the December 2006 issue of *Anaesthesia News*, for children’s anaesthesia information resources to be sent in to the project team.

Phase 1 of the project is now complete and has looked at several aspects of information resources for children. With your help, we were able to identify and examine 22 locally produced booklets and photo-stories, 6 short films and 11 websites. None of the examples of information sent to us contained a comprehensive explanation of the process of anaesthesia beyond induction. There is clearly a gap in resources which this project will aim to address. We have also examined published children’s literature to identify books which might be recommended for pre-operative reading, and we have been consulting with groups of children with regard to the style of illustrations they prefer in leaflets.

We are now in a position to tackle Phase 2 and, with the assistance of play specialists around Great Britain, we will soon be undertaking a further, nationwide consultation with children to identify the themes and issues which cause them most concern about anaesthesia. The information we gather will then be used to aid in the design of bespoke information resources for different age groups of children. We hope to create leaflets and interactive web-based resources which will be available for use throughout the NHS.

This project is supported by the Royal College of Anaesthetists and the Association of Paediatric Anaesthetists of Great Britain and Ireland.

For further information, please contact:
Dr Josie Brown, josie.brown@leedsth.nhs.uk or
Dr Judith Short, Judith.short@sch.nhs.uk
Seminars at 21 Portland Place

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

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

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

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

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

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

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

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

To be placed on the waiting list, please e-mail Gemma Williams, Events Administrator gemmawilliams@aagbi.org Tel 020 7631 8804.

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.
Seminars Calendar

**GAT: THE CONSULTANT INTERVIEW**  
*Wednesday 10 October 2007*  
Organiser: Dr M Parris, London
- Criteria for a good CV
- Preliminaries to the interview
- How to be number one choice at an interview
- Practice interviews - with a selection panel followed by debriefing and analysis
- Hot topics and interview skills workshop

**ULTRASOUND FOR ANAESTHETISTS VASCULAR ACCESS & ICU**  
*Monday 15 October 2007*  
Organisers: Dr N Moore & Dr A Gaur, Leicester
- Ultrasound - basics
- Vascular anatomy and techniques
- Sono anatomy and sono techniques re vascular access
- Ultrasound in ICU
- Ultrasound scan on volunteers
- Hands-on experience on phantoms

**AAGBI HISTORY OF ANAESTHESIA SEMINAR THEME: MILITARY ANAESTHESIA**  
*Tuesday 16 October 2007*  
Organisers: Dr A G McKenzie, Edinburgh  
Dr C N Adams, Suffolk
- Military anaesthesia before World War I
- Anaesthesia in World War I
- Military anaesthesia in World War II
- Film footage of anaesthetic practice in the two World Wars
- Military anaesthesia in the aftermath of World War II and beyond
- Anaesthesia in the Gulf Wars

**MMC UPDATE – LATEST NEWS AND VIEWS**  
*Tuesday 23 October 2007*  
Organiser: Dr V Bythell, Newcastle upon Tyne
- New structure of training
- Best practice in recruitment and selection
- Practical exercises in recruitment
- Changes to the training curriculum, assessments and examinations
- Who is going to do the work?
- Manpower & discussion

**NEUROANAESTHESIA & NEUROCRITICAL CARE RECENT ADVANCES**  
*Thursday 25 October 2007*  
Organisers: Dr E J da Silva & Dr J Sturgess
- Awake craniotomy – anaesthetic input
- Depth of anaesthesia – recent advances
- TIVA – drugs and new equipment
- Interventional neuro-radiology – (Thrombosis in coiling/ Ca²⁺ blockage infusions)
- Radiology input into neurotrauma and critical care
- Optimising conditions for brain recovery in intensive care

**DIFFICULT AIRWAYS**  
*Wednesday 31 October 2007*  
Organisers: Dr M Stacey & Dr T Turley, Penarth
- Prediction of the difficult airway
- Anaesthetising the airway
- Practical awake fibreoptic intubation
- Management of the difficult airway in children
- Difficult intubation in adults
- Failed intubation in obstetrics
- Extubation

**MANAGEMENT & FINANCE SEMINAR**  
*Thursday 1 November 2007*  
Organisers: Dr R Alladi, Lancashire & Dr M Martin, London
- What do you really need to know about management? Overview
- Difficult colleagues – issues and some solutions
- Life outside anaesthetics
- How to rally support and make your voice heard
- Maximising your benefit from the NHS Pension
- Tax efficient savings
- Property – important information that you may not know
- Wills, intestacy and simple Inheritance tax solutions

**SEMINAR AT THE ROYAL COLLEGE OF PHYSICIANS**  
**ULTRASOUND GUIDED REGIONAL ANAESTHESIA - INTRODUCTION OF ULTRASOUND INTO CLINICAL PRACTICE**  
*Monday 12 November 2007*  
Organiser: Ultrasound interest group RAGBI / AAGBI  
Sponsored by:
- Introduction - application and limitation of ultrasound
- Anatomy - ‘You only see what you know’ – the importance of anatomy in clinical ultrasound
- The perfect block!! - Upper limb
- Peripheral nerve stimulation – ‘dead and buried’ or ‘alive and kicking’
- Ultrasound – the evidence
- Abdominal blocks – an alternative to epidurals
- How to introduce ultrasound into clinical practice, training & assessment of competency

**AWARENESS AND DEPTH OF ANAESTHESIA**  
*Wednesday 14 November 2007*  
Organiser; Dr J Andrzejowski, Sheffield
- A sceptic’s guide to depth of anaesthesia
- KIS/Si: The isolated forearm technique
- Neuropathology of depth monitoring made simple
- Bispectral index (BIS) monitoring
- Learning in your sleep? The psychological impact of awareness
- Beyond the BIS - best of the rest?
- Medicolegal aspects of intraoperative awareness
BLEEDING, CLOTTING AND HAEMORRHAGE - AN UPDATE

Please note new venue: The Royal Society of Medicine

Tuesday 4 December 2007  Organiser: Dr R Rao Balkady, London

Supported by an educational grant from Novo Nordisk

Please note fixed rate for all attendees: £120

Open to all Anaesthetists, Intensivists and Haematologists. Places are limited, so early application is advisable.

We regret we cannot accept telephone bookings.

- ‘Normal haemostasis: current models’
- The complex nature of coagulopathy in massive bleeding in trauma/surgery
- “Monitoring coagulation during haemorrhage to optimize the haemostatic intervention”
- Can we avoid blood transfusion?
- Massive bleeding in trauma/surgery: hematological management
- Antiplatelet therapy – pre, intra and post operative implications
- Interesting Case discussion:
  1. Bleeding Trauma Patient
  2. Leukemia patient with neutropenia and thrombocytopenia
  3. Post cardiac surgery bleeding

LUNG ISOLATION AND ONE LUNG VENTILATION

Please note new venue: Royal Institute of British Architects

Tuesday 20 November 2007  Organiser: Dr D Duthie, Leeds

Delegates will be divided into two groups for the day. One group will have lectures for the morning whilst the other will take part in practical workshops. In the afternoon the groups will swap so that everyone has a day consisting of 1/2 lectures and 1/2 workshops.

During the workshops delegates will watch demonstrations and isolate lungs themselves using double lumen tubes, bronchial blockers with flexible and rigid bronchoscopes.

Lectures:
- Physiology of one-lung ventilation
- Lung isolation and one-lung ventilation in clinical practice
- Complications of lung isolation

Workshops:
1. Robertshaw double lumen tubes and clinical confirmation of lung isolation
2. Bronchocath double lumen tubes and fibreoptic correct positioning
3. Arndt and Cohen blockers 4. Univent tubes
5. Rigid bronchoscopy

ANAESTHETISTS AND THE LAW

Wednesday 28 November 2007  Organiser: Dr S Yentis, London

Part I – How it works & what it means
- The courts and their structure
- The different types of law
- Lawyers and legal references

Part II – How you might encounter it:
- Prosecution under various Acts
- Assault, battery, negligence, manslaughter & murder
- The GMC
- Keeping out of trouble

PAEDIATRICS SEMINAR

Thursday 29 November 2007  Organiser: Dr B Bingham, London

- What's new in resuscitation/airway management?
- Clinical dilemmas on the day of surgery
- Paediatric sedation
- Managing the "difficult child"
- Optimal analgesia for paediatric day case surgery
- Minimizing PONV in children
- Optimal peri-operative fluids in children

RESUSCITATION

Tuesday 11 December 2007  Organiser: Dr J Nolan, Bath

- Mouth-to-mouth ventilation is redundant
- Defibrillation – state of the art
- Airway management for CPR - above or beyond the larynx?
- Controversies in advanced life support
- Life support courses - do we need them?
- Post resuscitation care

Joint meeting run by the AAGBI and NSUKI to be held at 21 Portland Place
Please note fee for AAGBI & NSUKI members
£120 (retired members £60)

AN INTRODUCTION TO SPINAL CORD STIMULATION

Wednesday 30 January 2008  Organiser: J M Valentine, Norwich

- Physiological basis of SCS and its clinical relevance
- Clinical indications for SCS & how to select the right patients
- Patient information and consent
- Percutaneous systems & trial stimulation
- Surgical leads & basic surgical skills
- Complications: how to avoid them & how to manage them
- Data collection and maintaining best practice
- SCS programming skills

Joint meeting run by the AAGBI and NSUKI to be held at 21 Portland Place
Please note fee for AAGBI & NSUKI members
£120 (retired members £60)

AN INTRODUCTION TO INTRATHECAL DRUG DELIVERY

Thursday 31 January 2008  Organiser: Dr F Luscombe, Plymouth

- An overview and indications for Intrathecal Drug Delivery
- Management of Severe Spasm with ITDD
- Management of Cancer Pain with ITDD
- Management of Chronic non malignant pain with ITDD
- Organisation and setting up a service
- When to use ITDD and when to use SCS

Please note that some of the SEMINARS LISTED have been previously advertised and may already be fully booked – please check our website for availability: www.aagbi.org
Booking a Seminar

Title of seminar

Date of seminar

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

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

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

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

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

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

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

Please debit my credit card (Visa/MasterCard/Delta) or Switch Card:

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

Autumn Scientific Meeting
In conjunction with the
Scottish Society of Anaesthetists
Friday 19th / Saturday 20th October 2007
The Malton Hotel
(formerly Great Southern)
Killarney, Co. Kerry

Speakers: Prof. Pierre Foex, Dr. Liam Plant,
Dr. Geraldine O’Sullivan, Dr. Mike Henry,
Dr. Thomas Aherne, Dr. Seosamh O’Riain.

Topics: Percutaneous Coronary Interventions and the
Perioperative period. Complex Renal Dysfunction
and Major Abdominal Surgery. Medical Problems
Associated with Pregnancy.

Workshops on Hypertension. Optimisation of Respiratory
Disease. Update Perioperative Diabetes
Management. Education and Anaesthesia.

Presentation Prizes. Gala dinner.

Details: email - danielmullane@eircom.net
Registration/Accommodation/Travel:
email - emurphy@jorireland.com.
CME Credits: College of Anaesthetists, RCSi

For further information please contact:
AIM 2007, Anaesthetists in Management, 21 Portland Place, London, W1B 1PY
Tel: 020 7851 8991, Fax: 020 7851 4503. Email: aim@aim.org.uk
Further details will be available from www.amtob.org

CME points have been applied for.

University of Cambridge
Department of Anaesthesia

Cambridge Fibreoptic Endoscopy
Course
Addenbrooke’s Hospital, Cambridge

Two day workshop
Dates for 2007/2008:
19/20 Nov 2007
10/11 March 2008
9/10 June 2008
17/18 Nov 2008

Includes:
• Care & sterilisation of endoscopes
• Demonstration of awake fibreoptic intubation
• Experience of anaesthetising airway for awake
  fibreoptic intubation
• Practical experience of fibreoptic endoscopy

Cost: £300 for participants
£350 for observers

Suitable for consultants and trainees – places limited to 8 per course

Approved for 10 CEPD points

For further details and application form contact:
 Helen Smith
Dept of Anaesthesia
Box 03
Addenbrooke’s NHS Trust
Cambridge CB2 2QQ
Tel: 01223 217697 email: helen.smith@addenbrookes.nhs.uk
Anaesthetists are frequently involved in the care of patients who lack mental capacity. However the old rule that ‘no individual can consent’ on the behalf of a mentally incompetent patient and the dictum that decisions have to be made by health professionals in a patient’s best interest, have been completely revised in the Mental Capacity Act (MCA) 2005 which, in part, came into effect on 1st April 2007 with the remaining elements to become law on 1st October 2007. This Act applies to England and Wales only; Scotland has its own legislation, the Adults with Incapacity (Scotland) Act 2000, and Northern Ireland is currently governed by common law.

In essence, the Act provides a statutory protection and legal framework for the ethical principles that govern current medical practice including respect for a patient’s autonomy and the best interest principles. In the NHS environment the Act will primarily affect mentally incompetent patients (aged 16 or above) requiring care, treatment and/or intervention by healthcare professionals, including anaesthetists. The five key principles around which the whole Act revolves are:

1. All patients must be assumed to have mental capacity to make decisions unless proved otherwise and
2. All practicable steps must be taken including provision of appropriate help and support to patients before establishing that they lack capacity.

3. Patients should not be considered mentally incompetent merely because they make an unwise decision.
4. Any decisions made on behalf of patients, any treatment provided or intervention undertaken should always be in their best interest.
5. Restraining patients is only permitted provided that there is risk that an incapacitated patient may come to significant harm and that its use is proportionate to the likelihood and seriousness of the harm.

From 1st April 2007, breach of these principles by anaesthetists while providing anaesthetic or medical care to incapacitated patients could be regarded as ill treatment or neglect and, if convicted, a doctor could be imprisoned for up to five years. However, health care professionals should be protected from any legal liability provided all necessary steps to establish incapacity and best interests are taken a priori.

New safeguards have been introduced to empower people with impaired capacity to make their own decision wherever possible: these include;

- Lasting Power of Attorney (LPA) – An adult, while mentally competent, may appoint another adult to consent or refuse, on his/her behalf, treatment or intervention, if and when he/she becomes incapacitated.
- Court Appointed Deputies – The Act empowers courts
to appoint a deputy or deputies with legal authority to make certain health and welfare decisions on behalf of an incapacitated adult, if an issue can’t be otherwise resolved.

- **Advance Decisions to Refuse Treatment (ADRT)** – The Act provides statutory clarification as to the validity and applicability of advance refusals of treatment(s) 4.
- **Independent Medical Capacity Advocates (IMCA)** - NHS Trusts are legally obliged to request the appointment of an IMCA to represent ‘un-befriended’ incapacitated patients who lack any family members, unpaid carers or close friends, when major decisions are to be made on their behalf.
- **A detailed ‘Code of Practice’** to translate the Act into clinical practice has been published.

The practical application of the Act will be tested by precedent. However, management of unconscious patients in A&E, general or orthopaedic surgery in old and frail patients with dementia or Alzheimer’s, decisions whether to accept or refuse admission to ITU, or decisions about life support treatments in the critically ill are examples of the type of situations which will offer anaesthetists the challenge of providing appropriate care whilst complying with the Act.

**Mental Capacity Act 2005 in A & E**

Anaesthetists are vital members of hospital trauma and resuscitation teams and are first responders to any trauma or resuscitation call outs from A & E. The Act recognises and supports the simultaneous management and assessment approach to critically ill patients brought into A & E. In emergency situations it will be impractical rather than unreasonable to withhold resuscitation or treatment until a formative assessment of mental capacity is completed. A&E admissions may have variable conscious levels; ideally an assessment should be delayed until the patient is stabilised. However, in many cases, resuscitation and stabilisation may of itself lead to an improvement in or restoration of the patient’s mental capacity. A hypoxic, hypotensive and confused patient may become totally lucid once resuscitated with oxygen and intravenous fluids.

The Mental Capacity Act requires the use of a 2-stage ‘decision specific’ test for assessment of mental capacity;

**Stage 1:** Is there an impairment of, or disturbance in, the functioning of the person’s mind or brain? If so then

**Stage 2:** Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision at that time?

Stage 2 requires the assessor to establish that the patient can:

- Understand in broad terms and simple language what decision they need to make and why they need to make it. Similarly, the consequence of making or not making this decision must be understood.
- Understand, retain and weigh up the relevant information pertinent to this decision
- Can communicate the decision by any means including the help of an appropriate specialist (e.g. speech therapist, interpreter) and/or equipment.

A multi-professional approach may reduce the burden of the decision carried by a single person but the final responsibility remains with the senior professional caring for the patient. Once ‘incapacity’ is established all the decisions on the patient’s behalf should be made in his/her best interest but every effort should be made to identify the patient’s past and present wishes, feelings, beliefs and values. These may be sought from family members, friends and/or anyone involved in the care of or interested in the patient’s welfare.
Mental Capacity Act 2005 and Intensive Care

Admission of critically ill mentally incompetent patients to an intensive care unit may involve consideration of an ADRT, particularly in patients with chronic progressive disorders such as motor neuron disease or muscle dystrophies. An ADRT may be verbal or written (best practice), and must specify treatment(s) to be refused and circumstance(s) in which the refusal will apply.

An ADRT only applies to refusal of treatment(s) and no patient, or their representative, can demand specific forms of medical treatment, if an intensivist considers the treatment(s) to be clinically unnecessary, futile or inappropriate. An ADRT cannot require a doctor to perform anything that is unlawful, including any action taken with the intent of ending a person’s life. Additionally, an ADRT cannot be used to refuse basic care e.g. personal hygiene, warmth and the offer of food and water by normal routes.

Although mentally competent, sedated and ventilated patients requiring a specific intervention or procedure e.g. tracheostomy, will become a dilemma. Intensivists have to balance the risks of waking up the patient for consenting purposes against proceeding with the intervention following the best interest principle. However, obtaining the understanding of the patient’s family and relatives will be important if the latter option is followed. The existence of a valid LPA may be helpful in such situations.

Elective Surgery in Incapacitated patients

Frequently patients with learning disabilities, dementia, Alzheimer’s or following a stroke are anaesthetised for curative, palliative or orthopaedic procedures. Many such patients are cared for in a nursing, residential or sheltered homes. The act places a legal duty on such institutions to involve an IMCA whenever a question arises about an ‘un-befriended’ patient’s mental capacity, provided the patient has been in a care home for eight or more weeks or whenever a serious medical treatment is proposed. It will then be the responsibility of the clinicians, including anaesthetists, to consult the IMCA before proceeding with surgery. Although the IMCA cannot consent on a patient’s behalf they can request a second opinion or challenge decisions formulated by clinicians. Only life saving emergency treatment may be given to such patients without IMCA representation. The existence of a valid LPA for any patient exempts the need for the appointment of IMCA.

MCA 2005 and Do Not Attempt to Resuscitate (DNAR) orders

An ADRT does not equate to a DNAR order unless in writing, signed, witnessed, and includes an express statement that no life-sustaining treatment “even if life is at risk” is to take place. A verbal ADRT about DNAR should be regarded as a patient’s wish and may be taken into consideration while setting up a DNAR order. In the cardiac arrest situation, it will be reasonable to initiate or continue with CPR if the existence of an ADRT cannot be confirmed or the resuscitation team has any reasonable doubt about its validity.

Key Concept

Anaesthetists should continue to make decisions in a patient’s best interest but efforts must be made to determine if any LPAs, court appointed deputies or advance directives are in place and that family members or an IMCA have been consulted, even though they are unable to consent on the patient’s behalf. Finally, if there is any doubt, dispute or conflict between health professionals and the patient’s representatives, then an independent clinical and / or legal opinion should be sought but actions must be taken to prevent the death or a serious deterioration in patient’s condition until such time as the court reaches a decision.

Acknowledgement: I am grateful to Dr R Knight for his help and guidance in the preparation of this article.

References:
British Association Of Indian Anaesthetists
6th Annual Meeting, Saturday 27th October 2007
The Marriott
Forest of Arden Hotel & Country Club
WARWICKSHIRE

The scientific programme will include lectures and discussions from Dr. Judith Hulf, President of the RCOA, Drs. Julian Bion, Gordon Lyons, Bhaskar Tandon, Devendra Patel, Ian Smith, Nick Sutcliffe, Roop Kishen, Professors Rajinder Mirakhur, Chandra Kumar, Ravi Mahajan, and other eminent speakers.

The meeting is open to all anaesthetists. Anaesthetists in training presenting papers are eligible for prizes. The deadline for abstract submission is 15th October 2007.

CME 5 Points

Chief Guest: Prof. M. Ravishankar, JIPMER Pondicherry

For further details, contact the Organising Secretary
Dr G. Raghuraman
Consultant Anaesthetist
Birmingham Heartlands Hospital
Tel: 07780 611969
E-mail: raghulatha@hotmail.com
Website: www.baoia.org

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Closing date for applications: 12 October 2007

Association Educational Awards are only open to members of the Association of Anaesthetists of Great Britain and Ireland
Dear Editor...

Editor’s Choice letter

Let sleeping cats lie

Like most candidates I didn’t find it too hard to find excuses not to revise for my Primary (that kettle desperately needed a clean, oh and the rug needed hoovering, absolutely...) But I thought I would show you my main obstruction to my books! Harry the cat made it clear how fascinating he found the pharmacokinetics of thiopentone...

Sarah Cowman
Anaesthetics SHO, Margate

P.S. I did actually pass !

Allergic to allergies

We receive periodical alert notices from our nurse led assessment clinics. By and large these are thorough to a fault.

Today I received one such which I felt merited sharing with a wider audience. It included within it a conscientious listing of the patient’s reported allergies. eg. Iodine – skin reaction (fair enough, must remember to tell Sister), Feldene – abdominal bloating (yes, I can see that), Ether – confusion (er! Sorry!), lignocaine – NUMBNESS (really? you don’t say!).

I wonder whether any of your other readers have been similarly enlightened recently.

Andrew Stoddart
Conquest Hospital,
St Leonard’s on Sea.

Problems with the split tube technique for NG insertion

I am writing in response to the letter from Drs Swinton and McCormick regarding the use of a split endotracheal tube for nasogastric tube placement (Anaesthesia News, July 2007, page 27).

Like the editor, I was taught the technique of nasogastric tube placement using the split red rubber endotracheal tube. I would like to draw readers’ attention to a potential complication of this method, oesophageal perforation. I know of one case of this occurring with a red rubber tube, and this resulted in the practice being stopped in that institution.

The more modern endotracheal tubes, being stiffer, may be more likely to cause this serious complication.

David Quick
Consultant Anaesthetist
Dorset County Hospital
**Micromanaging the Health Service**

The management antics ably described by Gas Flo in July’s edition (page 36) are extraordinary. Or are they?

When this Government came to power in 1997 it soon became apparent that the ‘managed health care’ devised by the previous government was not to be undone but strengthened and raised to a new, as yet undreamed-of level of refinement. Today we have reached the absurd - but in management terms entirely logical - stage where a phrase like ‘skill-mix too rich’ does not really elicit much excitement. It’s just the normal meaningless management-speak that we have got used to and accept without batting an eyelid.

Even far away in Africa, where I was at that time, the few remaining expatriate doctors were surprised when International Development Secretary Claire Short, far from reversing market-driven trends and bringing in ‘sensible’ new ideas for improving health for Africa, actually embellished the strategies of her predecessor, Baroness Lynda Chalker and continued to freeze out health professionals. The management-orientated, privatising, ‘cost-recovering’ people at the former Overseas Development Administration under the Conservatives were not fired by Labour - they were promoted. These strategies have today contributed - alongside many other adverse forces, it must be said - to the virtual demise of the public sector health service in Africa.

Two years earlier, the year 1995 - which I had thought then to be the nadir in the balance between supply and demand in African health - is now revealed by the shifting tides of market forces to have been the high ground before a gentle, slippery slope.

If there ever had been a ‘right’, ‘good’ or ‘sensible’ way to conduct a health service, say 20 years ago, there is certainly no such way in 2007. Today such words have little meaning. The managers probably say ‘employment’ or ‘promotion’ instead, the politicians use ‘empowerment’ - out loud - while thinking to themselves ‘control’. A case of Quot homines, tot sententiae. Or, as Nigel Molesworth would have it: ‘Tot quot, clot?’

Who is responsible? Some people voted for Labour in 1997. And on two further occasions. They voted when all the evidence to show where the management plans were going was plain to see -including those costly plans for health IT which has enabled the doctor-controlling MTAS. Some voters, in all probability, will have been a few everyday folk in a small hospital up North.

It may seem like a crazy way to run a health service but it is on a predictable, logical path and apparently chosen by the majority.

Too bad for Africa, by the way, but that is just a footnote today.

Paul Fenton
Locum Consultant Anaesthetist
France

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**Who am I?**

As recent correspondence has illustrated (1) the public perception of the training required to become an anaesthetist seems somewhat misplaced. Recently I found myself in a similar situation when conducting a pre-operative visit. On approaching the patient she peered quizzically over her spectacles and enquired "are you the doctor or the anaesthetist?". Both, I replied much to her bemusement.

Ian Thomas
SpR in Anaesthesia
Bristol


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**SEND YOUR LETTERS TO:**

The Editor, Anaesthesia News, AAGBI, 21 Portland Place, London W1B 1PY or email: anaenews@aagbi.org

The Editor’s Choice letter every month will win a prize.

*Due to the volume of correspondence received, letters are not normally acknowledged.*
Having recently returned from the European Society of Anaesthesiology (ESA) meeting at Munich it’s a good time to update you on European matters. Details of motorcycling antics and other exploits will be covered elsewhere in the newsletter, whilst this contribution focuses on engagement with European bodies.

Anaesthetists in Europe live and work in widely varying circumstances. There are only 2.5 anaesthetists per 100,000 head of population in Bulgaria (contrast to UK 11, Holland 14). Low salaries and migration are an issue for Poland although there has recently been some success in getting salary increases for anaesthetists who remain. Doctors in general and anaesthetists in particular are an altruistic breed and there is real impetus amongst the European anaesthesia community to improve patient care and anaesthetists’ working conditions across Europe. UK and Irish anaesthetists engage in European matters in various roles and through several organisations. This article provides a brief update on what has been going on within the last year.

Section of Anaesthesiology of UEMS

Within the Section and Board of Anaesthesiology of the UEMS (European Union of Medical Specialists), AAGBI members (and indeed all UK and Irish anaesthetists) are represented by our President, David Whitaker and the Convenor of the AAGBI Irish Standing Committee, Ellen O’Sullivan. At the recent Munich meeting of the UEMS anaesthesiology section, Ellen O’Sullivan was elected secretary which will further strengthen UK/Irish input.

The Safety and Quality subcommittee has produced a document entitled “Quality and Safety in Anaesthesia” which was published in the June edition of the EJA. The anaesthesiology section has a good relationship with the main body of the UEMS and feeds information and ideas in the general direction of the European Union. The next meeting is in October 2007 when the focus will be on developing consistent minimum monitoring standards, the collection and publication of anaesthetic mortality data, and the European credit transfer system for educational activities. In addition a symposium will be held on Patient Safety.

ESA Council

Robert Sneyd (UK) and Anthony Cunningham (Republic of Ireland) are elected ESA council members. In the past year Council members undertook discussions in electronic sub-groups supported by an all day meeting in Munich. We recommended that ESA continue to provide comprehensive coverage of anaesthesia as well as topics in pain management, critical care medicine and emergency medicine. This reflects the diverse roles that anaesthetists play in different European countries, which in many cases are very different to typical UK consultant jobs. We recognise that many of our members participate in teaching either of medical students or junior doctors and will consider expanding support for teaching and learning at future congresses. Like the AAGBI, ESA is experimenting with e-learning and is making slide presentations from meetings available online. One interesting point was the enthusiasm for e-learning from eastern Europe where access to postgraduate activity may otherwise be severely limited.
ESA engages with another body, Foundation Européenne d’Enseignement en Anesthésiologie, FEEA (www.euroviane.net), to support a standardised CPD curriculum of postgraduate anaesthesia meetings which follow a fairly detailed template and have been very popular within eastern Europe and throughout the world. ESA contributes speakers, encouragement and some funding to this initiative and anticipates continuing to do so in the future.

The decision by ESA to focus its development activities within Europe (and mainly to the east) complements the AAGBI commitment to Africa. There is a need for good communication and appropriate collaboration to make the best use of people, learning materials and money.

ESA encourages collaboration between different centres, including ESA Fellowships which allow a young specialist from eastern Europe to visit another country to develop their clinical experience and specialist interests. In the current round Fellows will be received within the UK in Liverpool and London.

**ESA National**

ESA National (formerly the ESA National Anaesthesia Society’s Committee NASC) allows input to ESA from AAGBI and other societies. AAGBI officer Alastair Chambers is on the ESA National Committee and during the last year ESA National has supported the fellowships mentioned above and made other practical contributions to education and training given by ESA within member states. Crucially, ESA National leads ESA projects supporting eastern Europe.

ESA National has sponsored a number of training programmes in the last year including a six month course for trainees in Moldova – to date a total of nine trainees have taken part in this, two of whom were sponsored by WFSA and seven by ESA National. A very successful ‘teaching the teachers’ course has been run in Bratislava with participants from five countries (Serbia, Moldova, Poland, Slovakia and Bulgaria). The aim is to create a network of enthusiastic young teachers and the course covers scientific principles, organisational issues and geographical topics. Feedback from those who attended has been very positive.

ESA National supports participation by outside speakers in national anaesthesia society conferences and on request will suggest speakers for a session and may sponsor travelling costs. To date ESA National has primarily supported speakers to meetings in Eastern Europe. AAGBI has discussed the possibility of an ESA session at one of our major meetings and this may feature in the future.

**European Diploma**

The European diploma, EDA, has never been popular in the UK as we have a well-developed examination system of our own. In contrast, uptake continues to grow in other parts of Europe. This is an area where the well developed thinking of the UK training and examination system gives us a lot to offer our European colleagues and this is reflected by the strong role played in the EDA by UK anaesthetists.

Robert Sneyd

Acknowledgement: Thanks to colleagues named above who contributed elements of this report.

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**HELP FOR DOCTORS WITH DIFFICULTIES**

The AAGBI supports the Doctors for Doctors scheme run by the BMA which provides 24 hour access to help (www.bma.org.uk/doctorsfordoctors).

To access this scheme call 0845 920 0169 and ask for contact details for a doctor-advisor*. A number of these advisors are anaesthetists, and if you wish, you can speak to a colleague in the specialty.

If for any reason this does not address your problem, call the AAGBI during office hours on 0207 631 1650 or email secretariat@aagbi.org and you will be put in contact with an appropriate advisor.

*The doctor advisor scheme is not a 24 hour service.
SAS Audit and Research Prize

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) invites applications for the SAS Research and Audit prize. This is exclusively for SAS doctors to encourage them to undertake research and audit. Entries will be judged by the Research Committee of the AAGBI. All SAS doctors who are members of the AAGBI are eligible to apply for the prize.

An audit project should be carried out under the supervision of a consultant and have also been approved by the Trust. A research project should also be supervised by a consultant and approved by the local ethical committee and Trust.

Applicants should submit a summary of their audit or research of no more than 1000 words, 3 figures and 3 tables. It should be presented in the style of the journal Anaesthesia.

The winning entrant will have an opportunity to present their work at a national scientific meeting held by AAGBI. Other entrants may be asked to display a poster at the same meeting (as judged by the Research Committee of the AAGBI).

Please email entries along with full contact details of the author to secretariat@aagbi.org

If you have any additional enquiries, please contact Chloë Smith on 020 7631 8807.

THE CLOSING DATE FOR ENTRIES IS 11TH JANUARY 2008

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The grant is to enable a department of anaesthesia to pursue a research project either by the purchase of equipment or the part funding of a salary for medical or technical help or other support.

Further information and application forms are available from the Association website:

www.aagbi.org

or Chloë Smith, Association of Anaesthetists of Great Britain and Ireland,

Direct Line: 020 7631 8807, or email: secretariat@aagbi.org

Closing date for applications: 12 October 2007

Association Educational Awards are only open to members of the Association of Anaesthetists of Great Britain and Ireland
Overseas Anaesthesia Fund (OAF) Fellowship Scheme

During a recent visit by UK anaesthetists to Uganda to assist with the 2007 refresher course, we learned that anaesthetic training posts in the country are unpaid, so there is difficulty in attracting the next generation of anaesthetists.

Originally we felt that OAF would be mainly for items of equipment, but after our visit this year we realised that what was needed most were more anaesthetists to drive the politics of anaesthesia delivery which will promote safer anaesthesia and help to unlock funds. There are identifiable good training schemes in Uganda and we feel that supporting fellows, who will commit to staying, is good use of our OAF funds. Accordingly, the Council of AAGBI has agreed that OAF will fund one fellowship for a two to three year period to improve efforts to attract trainees into anaesthesia in Uganda.

I am pleased to let you know that the Council of the Association of Anaesthetists of Great Britain and Ireland has agreed that OAF establish, with Mbarara University Postgraduate Anaesthesia MMed programme, a fellowship worth £3000 per year for a Ugandan postgraduate to undertake anaesthesia studies for 2-3 years. Part of the requirement for the fellowship will be that the postgraduate undertakes to remain in Uganda for 3 years after the period of fellowship.

In addition we are delighted that a candidate whom we met while in Uganda has been chosen to receive this fellowship award. He is an excellent trainee and we are delighted to support him. Dr Sarah Hodges has written a short summary of the recipient, Dr Arthur Kwizera. We congratulate him and look forward to following his progress in his anaesthetic career.

Ellen O’Sullivan
Co-ordinator, Overseas Anaesthesia Fund

Arthur Kwizera

Arthur trained at Makerere University and Mulago Hospital in Kampala and graduated in 2002. He is just completing the first year of his postgraduate anaesthesia specialization and the Overseas Anaesthesia Fund will be sponsoring him through the next two years of his training, also at Makerere and Mulago.

After graduating from medical school in 2002 Arthur did his surgical internship at Hoima Regional Referral Hospital in the centre of Uganda and then returned to Mulago for six months’ medicine. His interest in anaesthesia started as an undergraduate when he excelled in the subject.

Whilst on an elective in Sweden he met a Ghanaian anaesthetist who inspired him as he worked with him both in theatres and on the Intensive Care Unit. He realized that only anaesthetists seem to fully understand physiology and pharmacology and therefore are the only “true physicians”.

His long term ambition is to be an intensivist and he would like to develop critical care services in Uganda. With this assistance for his training from the AAGBI, Arthur will work in the same unit as Dr Sarah Hodges for at least three years after completing his training and help develop the anaesthetic services including the HDU.

Arthur is 29 years old. He went to a top rugby-playing secondary school where he played scrum half and fly half. He also managed to achieve good enough grades to go to medical school and continued to play scrum half for the university and for the local “MTN Heathens” reserve team.

Since starting his studies in anaesthesia he has had much less time to train and has had to give up playing to such a high level but is now the doctor for the Uganda national team.

Anaesthesia in Uganda

It needs a courageous doctor to embark on a career in anaesthesia in Uganda. As most anaesthetics are given by non-physicians the specialty has little kudos amongst doctors. Anaesthesia has a small voice in the circles of influence, so very little investment is made and the specialty has not progressed especially in the fields of critical care and pain management.

Sarah Hodges
AIM is continuing to prosper and grow as a Specialist Society for all anaesthetists who are involved or interested in medical management or leadership, in the broadest possible terms. We are aiming at those who lead, manage, chair or direct services in anaesthesia, operating theatres, pain management and critical care; those with aspirations to do so in the future; anaesthetists with an interest in health policy; anaesthetists interested in their own career development, including those in training posts and career grade doctors. Leadership roles are seen outside what is generally termed “management”: in tutorships, which involve organising and overseeing education; in audit lead roles, which also include much organisation; and in heads of clinical services and departmental sub-specialities. In short, we offer something for all anaesthetists, as all anaesthetists are actual or potential leaders, whether they realise it or not.

AIM started life at a meeting in Manchester in January 2001 at which 30 or so Anaesthesia Clinical Directors were brought together to discuss the challenges they faced. AIM members now come from all over the UK, and work in the different health services of the devolved countries, as well as the Republic of Ireland. Further details of the history and philosophy of AIM are to be found on the website www.aimgbi.org.

We have evolved the Strategy Group into a formally constituted Committee, elected by the AIM members, and including colleagues from most of the UK and Ireland, together with representatives for GAT (Michael Parris) and SAS doctors (Ramana Alladi). The Chairman is currently Pamela Bell, from Belfast, supported by the Treasurer (Barbara Thornley); the Secretary; the Education Lead (Pieter Bothma) and other committee members, and by the Association of Anaesthetists Specialist Societies team. For up-to-date details of all the committee, please refer to the website. We meet three times per year at AAGBI headquarters in Portland Place, to discuss future events and educational needs; how we can support anaesthetic colleagues and how we can continue to gain sponsorship to progress with our plans.

The AIM Annual General Meeting, for all members, takes place during the autumn annual conference, this year on 29th November at the Royal College of Anaesthetists, London.

We are committed to developing management training for all anaesthetists. Increasingly consultant candidates are expected to have management knowledge at interviews, and the College sees management as a part of the trainee curriculum. We have produced a statement on the management training requirements of anaesthetists, available via the website.

We run popular day Seminars at Portland Place for the Association of Anaesthetists, most recently on June 19th 2007, which had the theme of personal and departmental.
effectiveness, with presentations on: negotiating skills; dealing with complaints; conflict resolution; success in committees; your role in a team; what the clinical director expects; leading a clinical team; developing a business case; and understanding change in the NHS.

We have established our annual conference as an event for the autumn at the Royal College of Anaesthetists in London. At our conference we invite leaders in healthcare management, legal and other disciplines to join us as we look at the hot topics of the moment. “Making sense of changes in the NHS” was the theme of our 2006 conference, which also introduced a trainee essay prize, with the winner from a number of excellent submissions making an “impressive presentation” ( quoting the feedback) at the conference on management competencies she will need as a consultant.

Following this success, we are looking ahead to our 2007 conference on 29th November at RCA London, with the general theme of “Departmental Governance: Maintaining a Safe Service”. As well as the trainee essay prize-winner’s presentation (on governance issues), the topics will include: improving the links with non-medical management; managing SPAs; managing a failing doctor; Hospital at Night; planning for 2009 and the 48-hour week; managing intensive care services; and the nightmare of workforce planning. There will be time for questions and discussion, and opportunity for networking with colleagues. Our website gives more details, and a downloadable registration form.

We have run satellite workshops on management issues at some of the recent AAGBI Annual Congresses, in Bournemouth, Cardiff and Manchester, and we are planning ahead for 2008 in Birmingham. We have also been involved in SAS doctor updates on management topics, for example at Aberdeen in 2006.

We have developed a website www.aimgbi.org to help disseminate information and to publicise our work. Along with details of AIM and its committee, and future events of interest to leaders in anaesthesia (whether run by AIM or not), there are links to various websites of interest (we are always looking for suggestions of new sites), a growing resource of presentations that have been made at past AIM events, and the ability to download application forms for AIM membership and AIM events. We plan to develop an on-line discussion board where members can post their problems and suggest possible solutions for others.

We have recently developed a newsletter, to be published 2-3 times per year, with articles of interest to medical managers, details of forthcoming events, and a full report on the latest conference. This is sent individually to AIM members on publication, and is then available to download from the website a month or so later. Each issue now has a Sudoku competition, which is a challenge to all, but as yet this does not carry a prize.

Other benefits of AIM membership include advance notice, and priority booking, of AIM events; the possibility of seeking direct advice on problems from fellow AIM members and officers; and the possibility of involvement in the running of AIM. We are always seeking to welcome new members, and especially those who want to contribute to the organisation of AIM activities, with their knowledge, skills and experience, or just their energy and willingness to help out. Either download an application form from the website, or contact Busola Adesanya-Yusuf, the Specialist Society link at the Association or via aim@aagbi.org

AIM is an anaesthetic Specialist Society like no other, in that its interests apply potentially to all anaesthetists, pain specialists and critical care doctors, whether they realise it or not. Management may have become a dirty word to many clinicians, but on the other hand many anaesthetic leaders have found that these responsibilities are thrust upon them, sometimes at short notice, and they would benefit from the support of an approachable, friendly network of colleagues who will have faced similar problems.

Dr Bill Rawlinson, Consultant Anaesthetist Hon Secretary of AIM
Can I ever get my patient for 8.30?!  
101 reasons why not

It is a ritual for me almost everyday to sit on the window-sill with a cup of tea looking at the Glossop hills for at least half an hour in the morning, waiting for the first patient. The list is supposed to start at 8.30am. I am not sure what 8.30 means i.e., whether it is the time to send for the patient or for the patient to be in the anaesthetic room, or in the operating theatre, or for the surgeons to commence the operation.

It amazes me every day that there is a different reason why I cannot get the patient for 8.30am. So one day I started keeping a note of the reasons to see if I ever exhaust the list. They are nearly all avoidable, and they happen all the time up and down the country. I feel that looking at the issue seriously and finding a way to deal with the reasons effectively will save the NHS millions of pounds.

I am not very good at counting but I believe the number of reasons comes to 101! It really amuses me when I am asked at 8.40am, ‘Is it all right to send for the patient, doctor?!’ If I say, ‘What do you think I have been doing here for the last twenty minutes?’ it will only get me into trouble for being sarcastic. What am I supposed to say?

Read on…

**Patient Reasons**
- Patient rang but did not turn up yet
- Not sure if the patient is coming or not
- Rang to say that she/he is NOT coming
- Patient is taken ill
- Patient is on holiday
- Not aware of the operation or appointment
- Got the date of operation wrong
- Not fasting
- Patient was told that the operation will be performed under local anaesthetic and hence not fasted

**Diabetic and not on sliding scale yet**
- In the toilet
- In the shower
- Cannot find the patient in the ward
- Has just gone out
- Patient is walking and has no dressing gown or slippers
- Arrived late
- Changed mind about operation
- A child patient and refuses to come to theatre
- Missed routine medication e.g., anti-hypertensives

**Consent**
- No valid consent
- Outdated
- Incorrect

**Not brought medication- not available in the ward**
- No theatre gowns for patients
- Requesting pre-medication
- Patient is too heavy- no appropriate staff or trolleys
- Patient’s case notes missing or can not find it
- Patient is dead!
Wrong side
Patient not marked
Trainee doctor not available
Trainee doctor not answering bleep
Not sure of the nature of operation
Consent taken after pre-medication or opioid analgesia
Child's parent not available

Operating list
Theatre list is not available
Order of the list is changed or not known or not clear
No list was made – surgeon or secretary was on holiday
Computer crashed

Surgeon
Surgeon is late
In the trauma meeting
Doing rounds
Held up in A&E
Lecturing
Not aware of the list
A locum - starts at 9am
Not answering the bleep
Awaiting second opinion
Not happy to perform operation unsupervised
Cannot find the surgeon

Anaesthetist
Not arrived
Not seen the patients
Not happy about the investigations
No assistance
Attending resuscitation in A&E
Needs second opinion or assistance
Cannot find the patient
Patient not available to be seen
Not happy to anaesthetise
Up all night

Theatre
Does not know where the patients are
Not sure of the order of the list
Air-conditioning not working
Fire alarm gone off
Instruments not available or not suitable or not arrived
Trolley not available
Trolley broken down or brakes not working
Canvas not available
No anaesthetic staff
No scrub staff
No porters
Drug keys not found or not available
Anaesthetic equipment faulty
Staff rang in sick
Having morning refreshment: cannot find the anaesthetic staff
Lack of communication between anaesthetic nurse, anaesthetist and surgeons e.g., presence in theatre
Cannot send for the patient till the surgeon is in theatre changed
Case notes missing

Investigations
Bloods not done
Not ready
Results not available
Xray staff come at 9am
Blood is available only after 9am
Xrays are missing

Patient in Xray
Patient needs Xray

Organisation
Beds not available
Patient in reception, waiting to be collected
No ward staff
Nurses on hand-over
Trainee doctor only comes after 8.30
Patients are not clerked
Patient needs further explanation
Do not know where the patients are
Patient is in a remote location, awaiting transport
Surgeon wants to see the patient before anaesthetic and he is not present
No theatre gowns

Well, there you are. How about passing on missing reasons? I shall add them to my next edition!

Ramana Alladi

Editor’s note
Ramana has missed out water coming through the theatre ceiling and power cut, both of which have happened to me - send any more he's missed to anaenews@aagbi.org
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