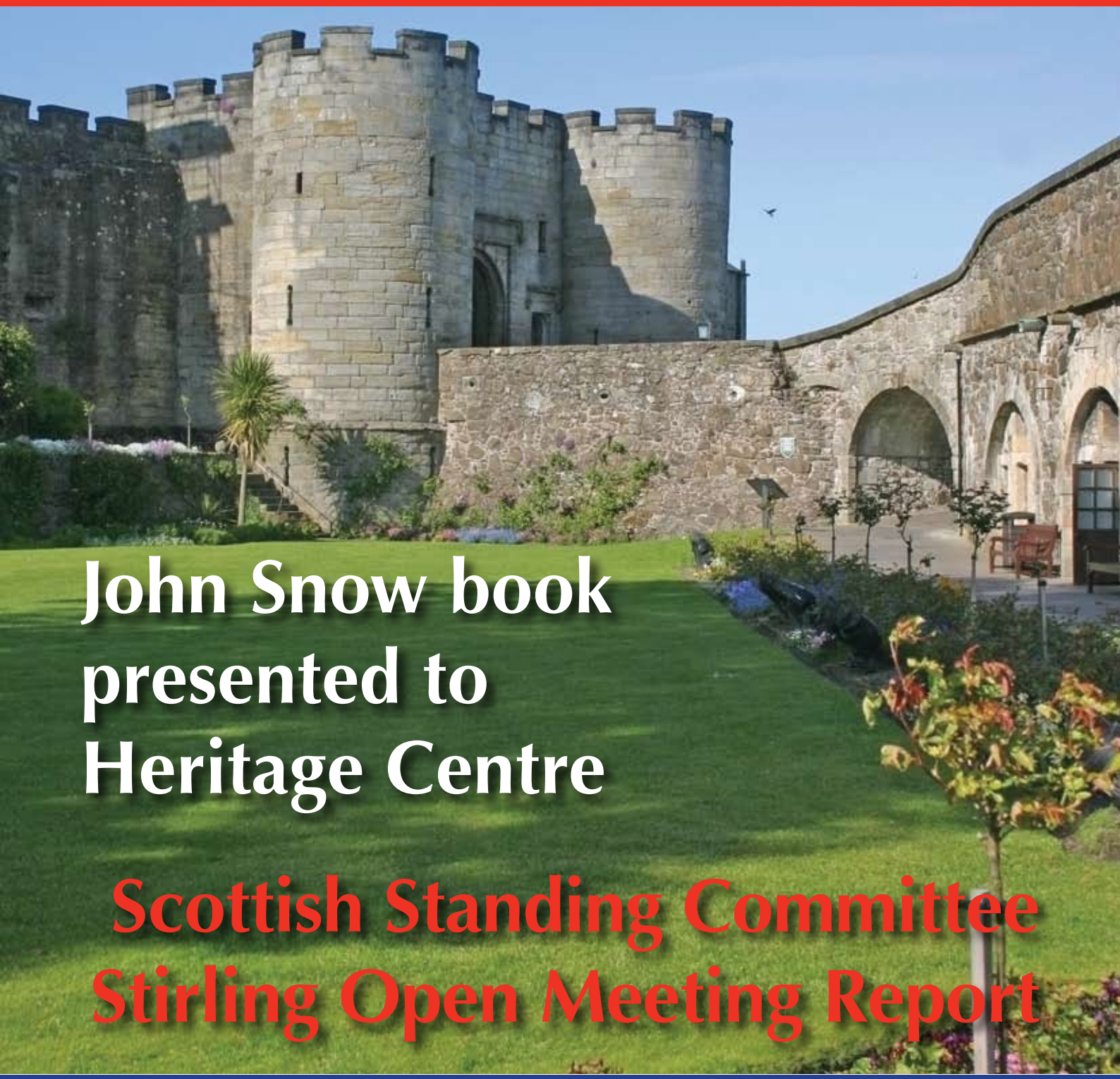
Anaesthesia News

No. 238 May 2007

The Newsletter of the Association of Anaesthetists of Great Britain and Ireland. ISSN 0959-2962



John Snow book presented to Heritage Centre

Scottish Standing Committee Stirling Open Meeting Report

21 Portland Place, London W1B 1PY, Tel: 020 7631 1650, Fax: 020 7631 4352, Email: anaenews@aagbi.org, Website: www.aagbi.org

THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

GAT 2007

27-29 June 2007

The Corn Exchange, Brighton

Annual Scientific Meeting of the Group of Anaesthetists in Training (GAT)

Not to be missed for its highly topical and educational scientific programme

For more information:
meetings@aagbi.org
www.aagbi.org/events

BOOK YOUR STUDY LEAVE NOW

REGISTRATION FEES

	Members before the 27/04/07	Members after the 27/04/07	Non members
One day	£140	£190	£280
Two days	£210	£260	£350
Three days	£260	£310	£410

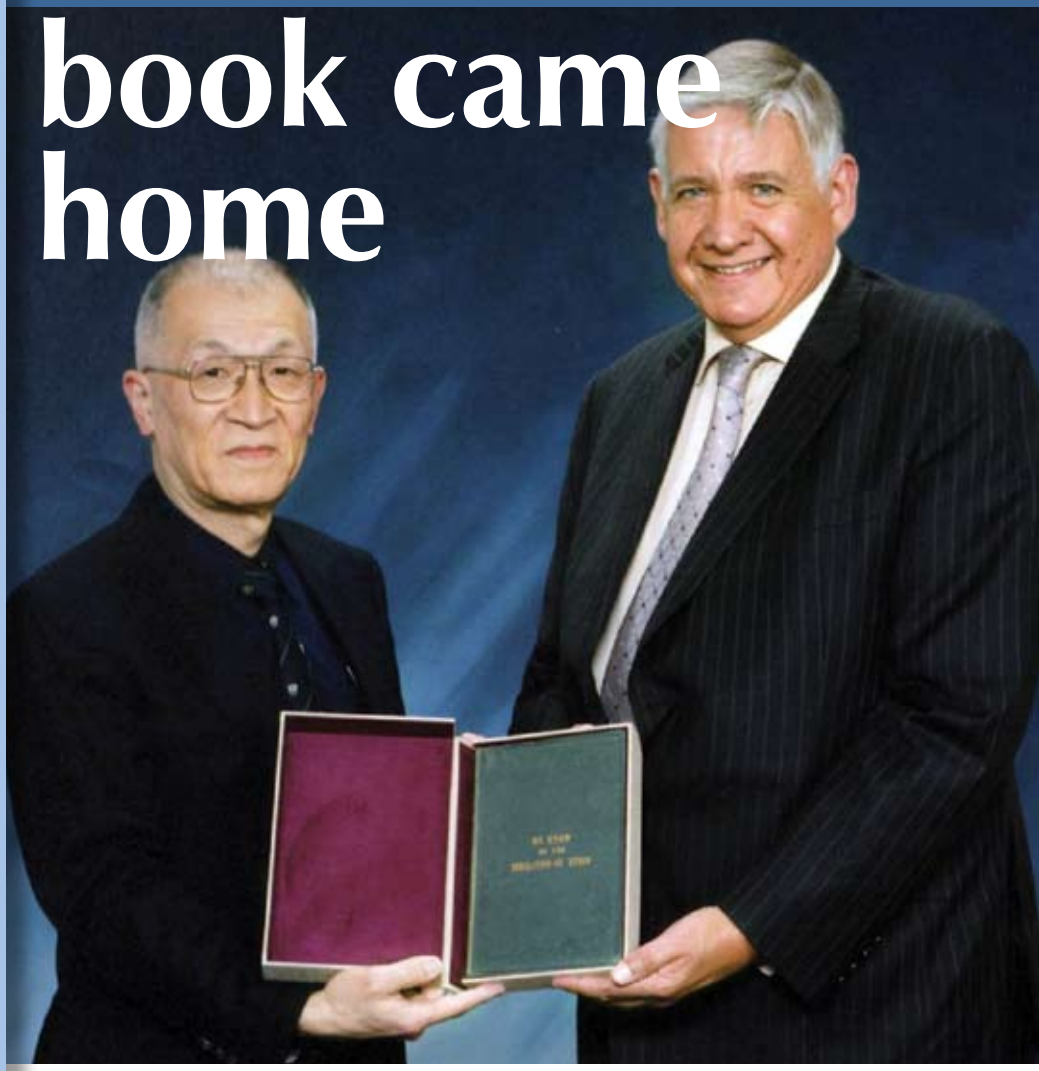
Contents

The Association of Anaesthetists of Great Britain and Ireland
21 Portland Place, London W1B 1PY
Telephone: 020 7631 1650
Fax: 020 7631 4352
Email: anaenews@aagbi.org
Website: www.aagbi.org

Anaesthesia News
Editor: Hilary Aitken
Assistant Editors: Iain Wilson and Mike Wee
Advertising: Claire Elliott

Design: Amanda McCormick
Pips Design, Telephone: 01604 642263
Printing: C.O.S Printers PTE Ltd – Singapore
Email: terence@cosprinters.com

It's time the book came home

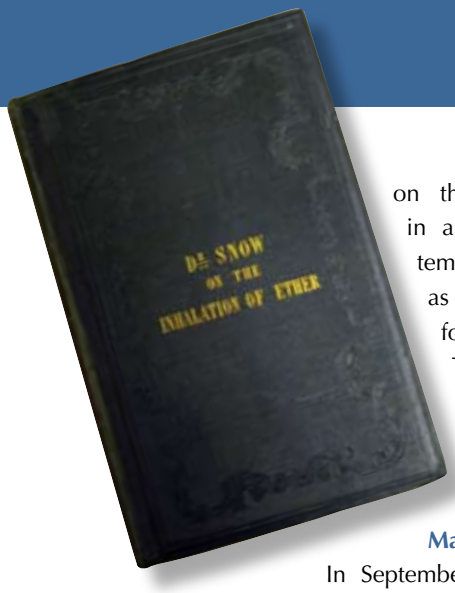


Beginnings

In July of 2006 I received an email from a Professor of Anaesthesia in Japan. Professor Akitomo Matsuki and I had met at several history of anaesthesia meetings over the years and we had last talked at a dinner in Japan some 3 years previously. The e-mail told me that he had retired two years ago to Hakodate in northern Japan where he was continuing to research and write about history. He told me how for many years he had tried to found what he called a *"Museum Library of Japan Anaesthesiology"* but that this had failed for economic reasons and also because of *"the poor understanding for the importance of history in our speciality by our Executive members."* Then came the statement *"So, I would like to have your frank opinion about my donation of John Snow's book with his autography that I have, to your Association's library."*

The book

John Snow's "On the inhalation of the vapour of ether" was published in September 1847 and is a delight. Snow describes in his preface how he wanted to produce a practical book to assist fellow practitioners and how he was sure more superior works would appear in future on the topic. He describes, in detail, five stages of ether anaesthesia, which he said enlarge and augment those suggested by Plomley, Longet and Flourens earlier in the year. He advocates an understanding of the concentration of ether administered and gives detailed descriptions, with illustrations, of his own ether inhaler. There is much detail



on the concentration of ether in a fixed volume at different temperatures and sound advice as to how to position a patient for different operations. There are a large series of specific case presentations and discussion of animal experiments.

Matsuki's copy

In September 1980, Professor Matsuki attended the 7th World Congress of Anaesthesiologists which was held in Hamburg. One of the sessions, entitled 'Anesthesiology: past and present', chaired by Professor Frey, had as a speaker Sir Robert Macintosh, who at the age of 83 spoke with great clarity and impact. During his description of the pioneers of English anaesthesia, Macintosh eulogised the importance of Snow's monograph on ether anaesthesia and stated that every anaesthetist in the world should read it at least once. Matsuki was mulling over these words as he walked back to his hotel in Hamburg and on the way wandered into a medical bookshop. He asked to see an old book on a shelf whose spine had no writing and when it was retrieved and handed to him he was astounded to find it was the very book he had just been hearing about at the Congress.

This copy is unique in having the words 'from the author' inscribed on the title page. It is an edition sent in 1847 to Dr Oppenheim, the Editor of *Zeitschrift fur die Gesammte Medicin,* for review purposes. How it came to the bookseller is unknown.

Facsimile editions

The Wood-Library Museum in Chicago had produced a facsimile in 1959 and in the preface they suggested that there were only 6 copies of the book in the world. Ole Secher from Copenhagen had produced a facsimile copy in 1985 which he circulated to his friends as a Christmas gift. Professor Matsuki realised that few anaesthetists will have had the opportunity to read the book, so produced his own facsimile edition in 1987 with the desire that it should receive widespread distribution in Asia and Oceania; in addition he made available a copy to every registrant to the Second International Symposium on the History of Anaesthesia held in London in July 1987. He presented a paper on his discovery at that same Congress.[1]

Matsuki's facsimile contains a preface from Tom Boulton, a copy of a letter written by James Robinson who was the first to use ether in the UK, a copy of a letter from a patient whom Robinson anaesthetised describing his sensations, a copy of Snow's death certificate, a copy of the review written by the German editor to whom the book was sent and a picture of Snow's grave in Brompton cemetery. His own researches have suggested there may be around 12 copies in various libraries and of course the number in private collections is unknown. The Association would be interested to hear from members if original editions are available in libraries near them and whether the listing shown is correct.[2]

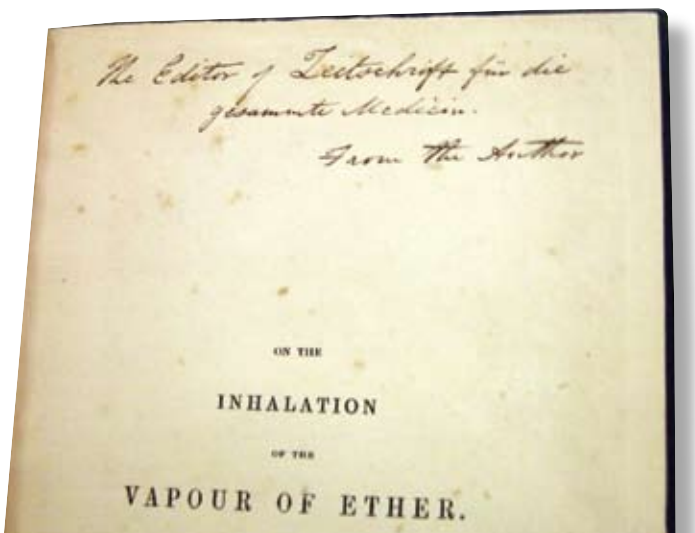
To accept or not?

I had no doubt that this unique book would be a great addition to our Heritage Library and I at once contacted the then President, Professor Michael Harmer. After discussions with the Executive and members of the Archive Committee, I was authorised to accept the donation on behalf of the Association. I emailed Professor Matsuki and told him that the Association would be delighted to receive this gift and by return he offered to put it in the post to me! I was certain that this was not a good idea and decided to go out and collect it. The Association kindly sponsored a short trip and the book was collected in November 2006.

It was apparent to me and to the new President, David Whitaker that it would be appropriate to present Professor Matsuki with a symbolic gift to recognise his extraordinary generosity. A new award was initiated by Council, The Charles King Award, presented to those who have made a special contribution to the heritage of anaesthesia; Professor Matsuki is the first recipient.

An exchange of gifts

I was met at Hakodate airport by Professor Matsuki. A special ceremony took place at a local hotel, recorded by a professional photographer, where the professor first presented me with the book and then I presented him with his Charles King Award. The following day he drove me around the sights of Hakodate, a very historic city which was one of the first to have outside consulates in the late 1850s. I was put back on a plane to Osaka (where I was reunited with my luggage which had been left in Frankfurt


The Editor of Zeitschrift für die gesammte Medicin.
From the Author
ON THE
INHALATION
OF THE
VAPOUR OF ETHER.

David Wilkinson presents Professor Akitomo Matsuki with the inaugural Charles King Award

the previous day!) to fly home. The book was delivered to the Association library the same week and was highlighted by the President during his address at the Winter Scientific Meeting in January.

Final thoughts

Professor Matsuki's generosity to our Association is truly wonderful. He has given us a treasure that can be consulted and valued by present and future generations. It is arguably the most important textbook of anaesthesia ever written and when I asked him why he had decided to donate it to us he simply said, "David, I thought it was time the book came home."

It is home safe and will be kept that way for ever. Thank you again to Professor Matsuki for all his work and scholarship in anaesthesia and for a gift beyond value.

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

The John Snow book is currently being assessed for conservation work. To contact the Anaesthesia Heritage Centre, please call 020 7631 8811 or email irismillis@aagbi.org

References;

1. Matsuki A. John Snow (1813-1858) and his book 'On the inhalation of the vapour of ether in surgical operations'. In: The History of Anaesthesia. Atkinson RS and Boulton TB (editors); Royal Society of Medicine Services, 1987: 498-500.

2. Personal communication Matsuki A. It is believed that the following libraries have original copies of Snow's book:: Royal Society of Medicine, London; University College, London; AAGBI museum library, London; British Library, London; Library of the Physicians and Surgeons of Glasgow, Glasgow; University library, Newcastle upon Tyne; Library of Edinburgh University, Edinburgh; University of Birmingham library, Birmingham; Boston Medical Society, Boston USA; Wood Library Chicago, USA; Medical library of University of Texas, Galveston USA.

Anaesthetists in Literature

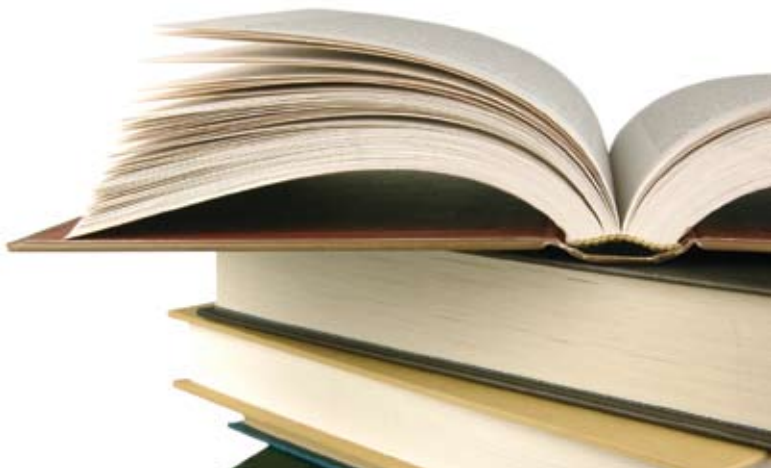
On holiday last year, one of my sunlounger books was "Quite Ugly One Morning" by Christopher Brookmyre. He's an author I enjoy anyway (seriously sick black humour) but what I particularly liked about this novel was that one of the main characters is an anaesthetist; indeed, Dr Sarah Slaughter is the nearest Christopher Brookmyre gets to having a heroine. The interesting thing is that her being an anaesthetist is not essential to the plot – it's important that she's a doctor, but it's just that she happens to be an anaesthetist. It's also a portrayal that we would all acknowledge and be flattered by: she's strong and capable, takes no nonsense from the surgeons, and has a great fund of anaesthetic one-liners, at least one of which I hadn't heard before and am saving for future use.

All is explained by the knowledge that Christopher Brookmyre's wife is an anaesthetist, so not only does he have impeccable source material, but he'd be in trouble if it was an inaccurate picture which resorted to clichés.

This got me thinking about other anaesthetists in other books. There aren't too many I can think of. I think there are some in Michael Crichton's "Coma" – from memory most of them are dunderheads too thick to work out what's going on (or indeed to react appropriately to a critical incident of unknown aetiology), and I have a feeling one of the chief baddies was an anaesthetist.

They turn up in other medical – based novels such as Samuel Shem's "House of God" and "M.A.S.H.", but don't often feature in general literature, compared with the number of doctors in some other specialties. (I can't claim to have done any scientific research, but if anyone wants a publication in the Christmas BMJ, it will be enough to thank me in the acknowledgements.)

In the recent past, I was a screening panellist for the Romantic Novel of the Year award (don't ask) and surgeons in particular seemed to pop up regularly as the glamour boys (nearly always boys) in romantic fiction. Knowing lots of real surgeons, I found it laughable really – funnily enough, I don't recall too many scenes in the books where the toys came out of the pram because the laparoscope wouldn't work properly. The category I read for specifically excluded Mills and Boon, and they have a whole genre of doctor/nurse romances. How many of the dark brooding heroes are anaesthetists? If anyone wants to write and tell me, I will guarantee anonymity! In more serious fiction, Ian



McEwan's "Saturday" has a neurosurgeon, Sebastian Faulks's "Human Traces" has a pair of psychiatrists, and Pat Barker's "Regeneration" trilogy also has psychiatrists – clearly the glamour boys of literary fiction. Doctors are, for the most part, white, middle class men.

So doctors in general are seen as interesting, often glamorous people; good topics for serious or light fiction – but anaesthetists aren't. Before I get too paranoid, I should remind myself that I haven't come across too many dermatologists, occupational health doctors, radiologists and many other specialties in books. Pathologists of course, have the whole genre of gruesome murder mysteries to themselves. So we should be thankful to Christopher Brookmyre (and Mrs Brookmyre) for giving us one book to call our own. If you spot any more (realistic) anaesthetists in books, let *Anaesthesia News* know – if Richard and Judy can have a book club, why shouldn't we?

This month in *Anaesthesia News* we have a report on Scottish matters – the Scottish Standing Committee Open Meeting in Stirling is now in its sixth year and continues to maintain a standard of excellence and interest hard to find elsewhere. The combination of clinical and political makes for a good day away from the office, and there is always something to tell non-attending colleagues about the following week.

In this month's issue we also have not one, but two genuine scoops. David Wilkinson recently travelled to Japan to collect an anaesthetic heirloom kindly donated to the Association's Heritage Centre, and another ancient treasure, Mike Harmer, has recently been appointed as Deputy CMO for Wales. We wish him well in his new role.

And continuing our "history" of *Anaesthesia News*, John Ballance and Stephanie Greenwell bring us through the turn of the century and early noughties, and almost up to date. Since becoming editor, I have realised that *Anaesthesia News* is read and enjoyed by anaesthetists everywhere – I'm always being buttonholed (mostly in a good way) at meetings about something I've written or published. I hope that in another twenty years *Anaesthesia News* will still be entertaining, amusing, and occasionally annoying you.

Hilary Aitken

Going Over to the Dark Side

The expression 'going over to the dark side' has become embedded in the English language as if referring to an ancient occurrence. Yet, its origin appears to be the George Lucas film 'Star Wars' and relates to the transition of the good guy, Anakin Skywalker, into the evil Darth Vader. The full story behind this transition is told in the subsequent films and anyone interested should visit one of the many websites devoted to Star Wars where the whole story is told in detail. Of course, in the end Darth Vader comes good again and saves his son's life.

So what has all this, as interesting as it is, to do with anaesthesia? Simply that it was the response of a colleague when I told him that I was resigning from the NHS to take up the job of Deputy Chief Medical Officer for Wales. Although he meant it as a joke, there is perhaps an element of truth in that it might reflect the view held by many, perhaps myself included, that such people are somehow divorced from the real world of medicine and potentially destructive. So given that, what on earth persuaded me to consider such a move and what could I hope to achieve?

I have to admit to not knowing too much about Chief Medical Officers (and their Deputies) but have always seen them as rather distant public health people of dubious importance. My first misconception of the role of the public health doctors (and by inference, CMOs) came in my interview for medical school back in the 60's. There I was being interviewed by the great and the good in the Great Hall at Barts. Professor Sir Bodley Godley (or something like that) threw out the question: 'In an average size city, who is the most important person with regard to public health?' Of course, if I was to be asked that nowadays I would know that the panel would be thinking medical, but in those days, I innocently suggested 'the dustmen'. The universal raising of eyebrows generated a near gale only for it to be countered by the sharp indrawing of breath. Perhaps the panel felt that I argued my case well, or perhaps they were just short of applicants that day, whatever; they offered me a place. From then until last year, I have to admit that I had not given such roles much thought apart from looking at various reports and living with imposed changes, and wondering on which planet these people live.

Towards the end of last year, I was looking at what the future might hold for me. I had held one of the most important roles in our specialty as President of AAGBI. Anything else in anaesthesia was now going to seem either 'more of the same' or an anticlimax. The time spent as President had allowed me to look at broader issues outside anaesthesia such as workforce and developments in healthcare. It was clear to me that troubles were looming and the constant changes in health targets and political interference was making things difficult for everyone. This also coincided with my having held the Chair in Cardiff for 10 years and a feeling of the need for change before I became stale. A single unexpected telephone message started the process.

Mike Harmer

The Welsh Assembly Government was looking for a Deputy CMO and someone thought that the job might interest me. My initial response was one of surprise as I have no public health background and had in the past been quite vocal about political interference in healthcare. But what they were looking for was someone who had a long experience of working in Wales (and so knew the health system) and particularly of working in secondary care. Suddenly, things looked different and after a deal of thought, I decided to throw my hat in (albeit some 4 weeks after the official closing date for the post). I expected to hear nothing more and was surprised to be called for an initial interview. Hereby started my initiation into the Senior Civil Service recruitment process!

I was summoned to an initial interview in Birmingham – which was changed to London on the morning of the interview. This was a 'sounding' interview lasting two hours in which I was asked for examples of 'civil service' skills. Even after the interview, I was not quite sure what these were but it seemed to be seeking experience in decision making and supporting colleagues. It was an interesting experience, and I thought that would be it; but was subsequently invited to complete two on-line questionnaires and attend for a second interview.

The on-line questionnaires were actually a personality profile and a motivation questionnaire. Having done similar things many years ago when the department was into personality profiling in the selection process for trainees, there was no great surprise or threat. The motivation questionnaire was slightly more bizarre and seemed to keep asking the same questions but in different settings. At the end of it, I really had no idea whether I would come over as a dedicated clinician or a money-grabbing ogre. On finishing the questionnaires, I was given details of the next stage of the interview process: a two-hour written test of literacy, numeracy and logic to be followed by a one-hour interview with a psychologist.

On arrival at the second interview, I was shepherded into a small room and given the literacy paper. This involved reading a number of short articles and then answering questions on the meaning of words and phrases used. There was 30 minutes allowed for this and after years of speed reading as an editor, I was finished the exercise within 25 minutes and thought it was all a doddle! The second session was numeracy. This time a document was provided that pertained to departmental sales within a large store. Absolutely nothing to do with medicine but wanting to know such things as 'what would have been the impact on profits from toy sales if the inflation rate predicted for the previous year had been half that expected?' Just the sort of thing that worries us in everyday clinical practice! The fact that they provided a calculator suggested that this needed more than a guess. I was about half way through the 40 questions when the invigilator came in and delivered the dreaded words 'stop writing and pens down'. It took me back years and I suddenly realised that I could have been sitting my 11+. Hmm, not so strong on the numeracy front, so bring on the logic. This consisted of a series of patterns and how do other patterns fit into the various groups. This was all pretty straightforward and the type of thing that you see in IQ tests. There were a total of 80 questions to be completed in 30 minutes. I roared through the first 30-40, easily seeing the shape patterns, then 'hit the wall'. The next 10 questions seemed to make no logical pattern at all and it came as a relief when the 'stop now' was sounded.

There then followed the interview with the psychologist. In front of her were the results from the on-line questionnaires. The results were expressed as points on a line with a central band that implied 'normality'. It was a bit worrying to see a number of my points sat outside the comfort of normality. However, all was not lost and in fact these outliers were seen as positives as they recorded good characteristics such as loyalty, decisiveness and determination. That all seemed to go well and then the psychologist produced my results from the '11+'. Here my scores were compared to a cohort of high-ranking managers and civil servants. For literacy, I scored at the 90th centile line (chest pushes out with pride), for logic I was

exactly on the 50th centile (chest moderately deflated) and for numeracy, I was on the 35th centile (head drops in shame). So here I was as a literate, moderately logical, numerical dunce!

Again, I assumed that that was the end of the journey but not so; I had made the final interview where the short list was down to five. As part of the interview, I was asked to give a 7-minute presentation on the topic of specialist paediatric services. I spent some time researching all the relevant documents and managed, I thought, to put together an irrefutable argument for moving everything to Cardiff! I was the last candidate of the day. On sitting down and about the extol the virtues of my master plan for paediatrics, the CMO settled me with the words 'before you start the presentation, the previous candidates seem to have misunderstood what we wanted them to discuss and I hope that you have not been similarly confused'. Clarification confirmed that I had also 'missed the point'. It did seem odd that all five candidates had been unable to guess what the CMO was looking for, but then we were clinicians trying to best guess a civil servant. After the faltering start, the interview went reasonably well but as civil servants they kept looking for key words. It was clearly important to slip in words such as 'leadership', 'teamwork', 'vision' and 'cost neutrality'. With the interview over, I was informed that they would be making their decision later that day and would notify me in the next few days of the outcome.

On arriving home, my wife enquired how it had gone. 'On the strength of that interview, I would not appoint me!' was my response. After eight days, I had not heard a word and so assumed that I had not been successful. I sent off a polite email thanking the CMO for considering me and pointing out that it had been 'an interesting experience'. Almost as I hit the 'send' button, my wife rang to say that the postman had just delivered a large envelope from the Welsh Assembly – they wanted to offer me the job. The Dark Side beckoned!

So here I am about to leave clinical practice to take up a new challenge. The Deputy CMO in Wales has a portfolio that includes responsibility for all the hospitals, and the ambulance and blood transfusion services. Given the recent problems in all three, this seems a pretty poisoned chalice. As the time approaches to move into the post, it is odd how you view newspaper and media reports in a different light, as you know you will have to deal with the aftermath.

I suppose it still begs the question 'why do it?'. It really comes down to a challenge. I have loved my clinical career and I have been fortunate to be able to have done so many things: to have edited *Anaesthesia,* to have held a university chair, to have been an elected member of the College council, to have been President of AAGBI. But what more could one do apart from seek something new? I hope that my move to the dark side may in some small way provide some enlightenment for the 'dark forces' and perhaps help us all to work together to improve healthcare. Perhaps I can leak out a 'view from the dark side' in due course.

Mike Harmer
Immediate Past President

MERSEY- THE AINTREE WAY
FINAL FRCA VIVA REVISION

2.00 pm Friday 8th - 4.00pm Sunday 10th June

The Aim of the Weekend
is to
Suffuse the Candidates with so much Exposure
to
The Viva Challenge
that, on the day,
They will be Immune
to the Stress & Stupidity
that so often & unnecessarily leads to Disaster

MENU
Master Class in the Subtleties of the Viva Encounter
Long Case Booklets
Short Case Booklets
Clinical Science Booklets
Six Formal Viva Sessions
(Under as near Examination Conditions as can be mustered)
Review of Past Experience

'Quite ingeniously organised.'
'Fantastic course'
' Definitely the <u>best ever intense</u> viva practice that one can have in the limited time!'

University Hospital Aintree, Liverpool.

£250
(Including Breakfast, Lunch & On-Going Refreshments 08.00 – 20.00)

<u>IMPORTANT NOTES</u>

This course will only be of value to those candidates who have earned an invitation to London following the SAQ & MCQ papers.
(Applicants who fail to 'get a viva' will not be penalised – Cheques will be destroyed)
Thus candidates will be expected to produce the appropriate evidence.
Interested candidates are asked to consult the Mersey Website
(www.msoa.org.uk – Classes & Courses)
for
Full Feedback & Details of the Administrative Mechanism.

Postscript
Best Viva Result to date – 86%
Worst Viva Result to date – 79%

Continuing the series of articles written by the former editors of Anaesthesia News. This month, John Ballance and Stephanie Greenwell bring us up to date

The three surviving former editors – (L-R) John Ballance, Stephanie Greenwell and Ed Charlton

John Ballance

Editor, *Anaesthesia News*
1999-2003

Some time in 1999, the Board of *Anaesthesia News* decided, in its wisdom, to name a successor to the second editor, the very successful Ed Charlton. Ed had taken 'The Bugle' from a means of removing Association notices from the 'grown up' journal to an informative, provocative and interesting newsletter. Clearly a hard act to follow!

I was selected from a wide field of applicants (actually, I was the only one!) and set about lining up what I hoped would be as good as Ed's Bugle, but different, and, because I lacked Ed's desktop publishing skills, I had to find some friends to help me.

Jane Meakin was 'lent' to me as Editorial Assistant and Lesley Ferguson, recently taken on as Public Relations Officer, made the beginnings of the new team. Accordingly, Jane and I travelled North, to the *Anaesthesia News* office, then Ed's back room. Having braved the attentions of the much published Hoover the Cyberspaniel and Deefer, we got to grips with the work involved in the handover. Jane was succeeded when she left by Metin Enver and then Claire Elliott.

The next move was to involve an expert in graphic design, publishing and the handling of electronic material. I was fortunate to have worked with Matthew Carr of Eyekon Design previously, so I asked for a tender and some specimen layouts. These were submitted to the Board (which was to meet roughly twice a year, to keep an eye on the new Editor) and approval was gained. Advertising rates were also set, the idea being that 'small ads' would be preferable, with the accent on informing the membership of what was going on in the Association, its committees and specialist societies. As the Editor of *Anaesthesia* was a member of the Board, it was ordained that no advertising should be taken that would clash with the requirements of the main journal. This was only changed

later when Intersurgical Ltd. kindly took a repeating full page advertisement and guaranteed to continue to advertise in *Anaesthesia*.

The concept of a term of office for the Editor was introduced and the Board decided that I would be too exhausted or reactionary after three years, so that a successor would be appointed after this time. The rule of having the copy checked at the last minute was also introduced, to avoid embarrassment to the Association. So, as the presses were about to roll, the President had to check. This proved interesting, on occasion!

September 1999 saw my first edition which contained a lead article from Lesley Ferguson on an Association stand in the House of Commons and the important introduction of insurance cover for Members when travelling in ambulances as a membership benefit.

I inherited a splendid back page column, "Tales from the Back Line", by Paul Fenton from Malawi. When Paul left Africa he was replaced by the wonderful Ruth Hutchinson, with "Letter from Zimbabwe". Ruth and two colleagues continued through thick and thin, at no small risk to themselves, surviving confiscation of vehicles, theft of a phone line and a disruptive election - copy was always ready on time.

Other regular contributors were the acerbic GasFlo and the challenging Dr Ruxton, both of whom are still contributing today. Mention must be made of the splendid support from GAT, the Independent Practice Committee, a regular History page and several guest editorials. *Anaesthesia News* would have been very much poorer without the regular missives from the late John Zorab. Forever pointing out errors and taking contributors (and the editor) to task for suggested lapses of etiquette or dress, he is sorely missed.

Over the four years there were many fascinating, interesting and challenging letters. Only one, I remember, took me to task. It was right at the end of my tenure and upbraided me for mentioning that, for my last list, I had chosen and was given, an attractive (female) SHO. I was accused of single-handedly setting back the recruitment of trainees. Fortunately, said SHO replied with a letter which ended, "I'm sure Dr Ballance will continue to offend long into what I hope is a very happy retirement."

I hope I am doing my best.

Stephanie Greenwell,
Editor, *Anaesthesia News*
2003-2006

Shortly after John Ballance took over as Editor of *Anaesthesia News,* he decided to take an assistant and I was easily persuaded to take on this role as I enjoy writing and had done a few articles for the newsletter. I helped with the editing, put the occasional edition to bed when John was on holiday, and wrote and commissioned regular articles. Otherwise, being Assistant Editor was a pretty easy job. John always made the editor's job look effortless. When he handed over to me, he gave me to understand it would not be too onerous apart from the run up to the print deadline. What he hadn't told me was that being the editor of a monthly with an incredibly literate, demanding readership actually changes your life - and that of your family.

For a start, your holiday plans have to be based entirely on the editorial schedule.

I became a complete liar with regard to deadlines. Very few authors actually believe you when you give them a date. Even with repeated nagging they will run you right up to the brink, when you will inevitably have a difficult all-day operating list and no trainee. This will result in a laptop on the anaesthetic machine and a grouchy surgeon or a spell of editing lasting deep into the night and a very grouchy husband!

I became a complete pedant with regard to spelling and grammar (particular personal hates are 'less' instead of 'fewer' and the common misuse of the word 'myriad' - *it's not a noun!)*. It is also quite a revelation to discover that greatly respected colleagues with brains the size of planets cannot spell or punctuate, necessitating hours of diplomatic editing. Sadly, I started to sleep with a copy of Fowler's Modern English Usage beside the bed!

I spent the whole of the first year in a constant state of anxiety that there would not be enough copy for the next edition. Putting each month together is a bit like doing a scrapbook except that you have to exactly fill all of the pages. I commissioned several regular slots (President's Report, Naked Gasman, Scoop etc.) so that I had a bit of a comfort zone. If there wasn't enough copy, I'd lean on Council and colleagues to do an emergency piece, or ghost write something myself. I soon learned to print controversial views to encourage indignant correspondence. I would also hoard possible articles for a rainy day – nobody writes anything over Christmas or in the summer holidays so

March and October can be arid months. As time went on I got so much good copy the newsletter had to expand – from 24 to 36 pages in fact.

What was almost worse than having too little copy was when, at the last minute, a member of Executive would send in a worthy document that not only had to go in, but needed a prominent place near the front, and a headline. This would inevitably have at least three thousand words and displace one or two interesting articles that you had promised faithfully to print; with a subsequent phone call or angry email from the authors!

However, my life was made much, much easier by two major players; Claire Elliott our Editorial Assistant, who did all the adverts, and Amanda McCormick the designer. At the same time as I took over from John in 2003, it was decided that the printing of *Anaesthesia News* would be put out to tender. Matthew Carr had done a great job but the newsletter was rapidly expanding both in size and readership. Arkle Print was currently printing the AAGBI stationery, fliers and programmes. At a meeting held at Portland Place in 2003, just before I took over as Editor, we met Amanda and Chris Hodgson of Pips Design and Arkle Print, and looked at examples of what they could produce. I was very impressed, and hit it off immediately with Amanda when I realised how talented she is. I rapidly developed a successful partnership with Amanda in which she intuitively built up a style and layout with which I was comfortable. She frequently waved her magic wand over out-of-focus photographs (famously adding snow to one front page to make it look seasonal!), and was miraculously capable of shoe-horning lengthy articles into tiny spaces and making sparse ones look opulent. When the printing was transferred with that of *Anaesthesia* to Singapore in 2006, I was sad to lose contact with Arkle Print and Chris Hodgson who had shown great flexibility and given a superb service, but fortunate indeed to be able to retain Amanda as the designer.

I must not forget my Assistant Editors, Ranjit Verma, Mike Wee (who took over from Ranjit), Iain Wilson and Hilary Aitken (who of course is now Editor). Four pairs of eyes are always better than one when it comes to editing and my job was made much easier by their help each month. They also, each in their own way, brought extra quality to the newsletter, commissioning and writing editorials and articles. Ranjit is remembered for his photos, crosswords and sudoku puzzles (which were nearly always solvable!); Iain for his humour and overseas connections that brought in so many spectacular articles; Mike for his meticulous editing and thought- provoking editorials;

The editorial dress sense has improved over the years – Stephanie Greenwell and Hilary Aitken

and Hilary for her enthusiasm, superb grasp of English and the ability to spot a flying apostrophe at a hundred paces (brought about no doubt by a superior Scottish education) and, of course, agreeing to take over as my successor with only one arm twisted up her back!

There are days when I miss all the fun and the constant pressure of the production schedule – but decreasingly few. It is wonderful to have the freedom to write when I have something to say, and to look forward to the surprise of each new edition of *Anaesthesia News* without already having read it several times over!

EuroSIVA

European Society for Intravenous Anaesthesia

10th EuroSIVA Meeting
on
Intravenous Anaesthesia

Hotel Bayerischer Hof, Munich, Germany

June 8-9, 2007

Friday June 8, 2007

Session 1: New applications of PK/PD models on drug delivery and control.
Speakers: *E Olofsen (NL), C Nunes (P), D Westenskow (US)*

Session 2: Mechanism of Hypnosis
Speakers: *P Pandin (B), M Maze (UK), G Schneider (G)*

Session 3: Modifying the Outcome by Anaesthetic drugs?
Speakers: *S Himmelseher (G) T Fuchs-Buder (F), J Raeder (N)*

Session 4: Pharmacokinetics for special patient groups.
Speakers: *K Grathwohl (US), S Schraag (UK), F Engbers (NL)*

Saturday June 9, 2007

Session 5: Workshops: Interaction & Hands on

For details & registration: www.eurosiva.org

16th & 17th November 2007

A JOINT MEETING
OF

THE NEUROMODULATION SOCIETY OF UK & IRELAND (NSUKI)

&

THE BRITISH STEREOTACTIC & FUNCTIONAL NEUROSURGERY GROUP

at the

ROYAL YORK HOTEL
CITY OF YORK

Featuring: international speakers; presentations on the most recent studies in Neuromodulation and Free paper presentations as well as industry sponsored symposia.

For further details, please contact Busola Adesanya-Yusuf,
Executive Secretary, NS(UKI)
Tel: +44 20 7631 8894 or by email at
Neuromodulation@aagbi.org

Are you a General Anaesthetist covering on call Intensive Care sessions?

Intensive Care

infomed
Research & Training Limited

Modular conference for busy, hands-on Consultant, Registrar and Career Grade **Intensivists** and **Anaesthetists**

at **The Royal College of Anaesthetists**, organised by **Infomed Research and Training**, on **Monday 11 and Tuesday 12 June 2007.**

RCoA, Churchill House, 35 Red Lion Square, Holborn, London WC1

DAY 1: Trauma Critical Care

☑ Haemostasis and Thrombosis Issues in Trauma ☑ Thoracic Trauma Pearls ☑ Endpoints of Resuscitation: Pre-Intra and Post-Operative Standards ☑ Case Scenarios: Resuscitation ☑ Management of Traumatic Brain Injury in the District General ITU ☑ Mea Culpas ☑ Practical Tips for Anaesthetists/Intensivists Providing Out of Hours Trauma Lead ☑ Case Scenarios: Multiple Trauma Patients in ITU

DAY 2: Advanced Practical Update

☑ ARDS: A Practical Update ☑ Getting the Most Out of Your CVP and Doppler ☑ Obstructive Airways Diseases ☑ Case Scenarios: CVP and Doppler ☑ Microbiological Dilemmas and Solutions in ICU ☑ Acute Liver Failure ☑ Critically Unwell Children: Diagnosis, Stabilisation and Transport – Tips for the Adult Intensivist in the DGH ☑ Case Scenarios: Critical Unwell Children Transfers

FACULTY OF LEADING CONSULTANTS

➢ **Dr Geoff Bellingan**, Consultant Intensivist, University College Hospital, London ➢ **Dr David Swann**, Consultant in Anaesthesia and Intensive Care Medicine, Royal Infirmary of Edinburgh ➢ **Dr Bruce Taylor**, Consultant in Adult and Paediatric Intensive Care Medicine, Portsmouth University Hospital ➢ **Dr Julia Wendon**, Consultant in Intensive Care Medicine, Liver Intensive Therapy Unit, King's College Hospital, London ➢ **Prof Tim Hodgetts**, Hon Professor of Emergency Medicine and Trauma, University of Birmingham ***plus*** eight other leading practicing Consultants

Course fee
£465 (inc. VAT) **for the two days.**
£300 (inc. VAT) **daily rate.**
Your Trust can be invoiced…

10 CPD points.

Queries and bookings: **020 7190 3410**
For full programme: **www.infomedltd.co.uk**
Email: **conferences@infomedltd.co.uk**

CONFERENCES & EVENTS

Centre for Anaesthesia, UCL and associated groups

on-line booking link and further details for all events can be found at:

www.ucl.ac.uk/anaesthesia/meetings

2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007 ~ 2007~ 2007

4th Paediatric Sedation: How to do it Safely

IET/Savoy Place, London, 7th & 8th June 2007, Chair: Dr Mike Sury, GOS, London

CALL FOR ABSTRACTS

We invite you to submit abstracts of audits in relation to Paediatric Sedation, either prospective or retrospective, in particular those featuring new care plans, treatment protocols and the use of Ketamine vs. other sedation agents vs. no sedation! Any work is acceptable which has not been accepted for publication in peer review journal by the abstract deadline of 31st January 2007. Submission should be a maximum one A4 page and emailed to SiobhanMythen@btinternet.com by 31st January 2007. A number will be accepted for poster presentation and finalists will be asked to present at the Paediatric Sedation Conference 2007

6th EBPOM: Evidence Based Peri-Operative Medicine Conference

Savoy Place London, 5th and 6th July 2007. Chairs: Dr Mark Hamilton & Prof Monty Mythen, UCL, London

- **Professor Lee Fleisher,** Assessment and reduction of cardiac risk in non-cardiac surgery
- **Professor George Hall,** Anaesthesia and modulation of the stress response
- **Mr Alan Horgan,** Colorectal surgery: Improving care through optimising and auditing my practice.
- **Professor Gavin Kenny,** Remifentanil: The perfect peri-operative opiod
- **Dr Ross Kerridge,** Implementation of peri-operative systems: an international perspective
- **Professor Henrik Khelet,** Enhanced surgical recovery: simple steps to improve surgical outcome
- **Dr David Lubarsky,** Pharmacological protection for AAA surgery
- **Professor Mervyn Maze,** Anaesthesia: A molecular conundrum
- **Professor Don Poldermans,** Peri-operative medication
- **Dr Andy Rhodes,** Anaesthesia for bariatric surgery
- **Dr Neil Soni,** An ideal peri-operative fluid
- **Professor Matt Thompson,** Vascular surgery: improving outcomes and changing practice
- **Professor Jean-Louis Vincent,** Epidemiology and prognosis of organ dysfunction after major surgery

Provisional agenda, venue and booking details available at www.ucl.ac.uk/anaesthesia/meetings

(Did you know 2007 Tour de France is scheduled to start from London on the morning of Saturday 7th July?)

"Dingle 2007": 9th Current Controversies in Anaesthesia and Peri-Operative Medicine

10th-14th October 2007, Dingle, Co. Kerry, Ireland

CALL FOR ABSTRACTS: £1000 in prizes

We invite you to submit work for poster presentation. Selected finalists will be invited to give an oral presentation in Dingle on Friday 12th October 2007. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 30th June 2007. Abstracts should emailed in the form of one A4 side of printed text and in word or PowerPoint on or before 30th June 2007 marked clearly with your name, address, telephone number and email address.

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

E-mail: SiobhanMythen@btinternet.com

Seminars at 21 Portland Place

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

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

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

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

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

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

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

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

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

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

The Association of Anaesthetists
of Great Britain & Ireland

Seminars Calendar

PLEASE NOTE THAT SOME OF THE SEMINARS LISTED BELOW HAVE BEEN PREVIOUSLY ADVERTISED AND MAY ALREADY BE FULLY BOOKED – PLEASE CHECK OUR WEBSITE FOR AVAILABILITY: www.aagbi.org

WORLD ANAESTHESIA - CHALLENGES, SUCCESSES AND OPPORTUNITIES

Wednesday 16 May 2007

Organisers: Dr M Bill, Belfast & Dr K Henderson, Brighton

Anaesthesia in a war zone: Iraq
Surgery in a war zone: Afghanistan
Disaster anaesthesia: Darfur, Sudan
Developing services: Ethiopia
Teaching: Long term: Malawi
Teaching: Short term

This seminar is run by the World Anaesthesia Society whose aim is to encourage the development and support the practice of anaesthesia in developing countries

ANNUAL UPDATE ON THORACIC ANAESTHESIA

Thursday 24 May 2007

Organiser: Prof F Gao, Birmingham

What can we learn from the UK pneumonectomy outcome study?
Anaesthesia for thoracic spinal surgery
Anaesthesia for paediatric thoracic surgery
Anaesthetic management for oesophagogastrectomy
Thorocoscopic lung resection
Post thoractomy chronic pain syndromes
Case discussion: elective and emergency thoracic surgery

ULTRASOUND IN ANAESTHESIA AND CRITICAL CARE

Monday 4 June 2007

Organisers: Dr B Nicholls , Taunton & Dr O Weldon , Newcastle upon Tyne

- Physics of ultrasound
- Machines / optimising image / needling techniques
- Vascular access
- Ultrasound in critical care
- Ultrasound guided regional anaesthesia
- Focused echocardiography
- Ultrasound training – assessment / competency lessons. Emergency medicine

SAFE TRANSFER OF CRITICALLY ILL PATIENTS

Wednesday 6 June 2007

Organiser: Dr P Farling, Belfast

- Safe transfer of patients with brain injury
- NICCaTS - A centrally based transfer service
- Transfer and the ambulance service
- Paediatric transfer
- Air transfer

ANAESTHESIA FOR MAJOR SURGERY – AN UPDATE

Tuesday 12 June 2007

Organisers: Dr R Rao Baikady, London & Dr P Farquhar-Smith, London

- Preoperative assessment for major surgery
- Perioperative fluid management and monitoring
- Perioperative pain management after major surgery
- Anaesthetic dilemmas: Choice of anaesthetic/ monitoring / temperature control
- Management of massive haemorrhage
- Postoperative optimisation of high risk surgical patients and surgical intensive care

AIM Seminar EFFECTIVE LEADERSHIP

Tuesday 19 June 2007

Organiser: Dr M Jones, Bridgend

- 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 the business case
- Understanding change in the NHS

PERIOPERATIVE BLOOD MANAGEMENT

Thursday 28 June 2007

Organiser: Dr V Brown, London

- The state of the UK blood supply – SHOT report
- Physiology of blood components and clotting
- Clinical aspects of coagulation, transfusion triggers and anaemia
- Monitoring of coagulation and platelet function, TEG – the present and the future
- Blood conservation techniques
- Pharmacological methods - the debate continues
- Autotransfusion, cell salvage, factor VIIA and surgical outcome

PLYMOUTH SEMINAR TO BE HELD AT THE ROBBINS CENTRE, UNIVERSITY OF PLYMOUTH

ANAESTHESIA FOR PATIENTS WITH ENDOCRINE DISORDERS

Wednesday 4 July 2007

Organisers: Professor J Hunter, Liverpool & Dr M Coates, Plymouth

- Anaesthesia for patients with diabetes mellitus
- Anaesthesia for patients with thyroid disorders
- Anaesthesia for patients with disorders of the parathyroid glands
- Anaesthesia for patients with a phaeochromocytoma
- Anaesthesia for patients with endocrine disorders of the pituitary gland

GAT: THE CONSULTANT INTERVIEW

Wednesday 11 July 2007

Organisers: Dr M Parris, Northampton & Dr P Johnston, Belfast

- Criteria for a good CV
- Preliminaries to the interview
- Communication skills for interview
- Practise interviews - with a selection panel followed by debriefing and analysis
- Interview workshop

THE 7 DAY WEEKEND: ENCOURAGING YOU TO PREPARE FOR, AND ENJOY YOUR RETIREMENT

Thursday 19 July 2007

Organiser: Dr M Martin, London

- Maximising your benefit from the NHS pension
- What does a retired anaesthetist do?
- Private pensions – what do I do with them now?
- Understanding investments
- Preparing your assets for retirement
- Simple and effective inheritance tax planning

ANAESTHETISTS AND THE LAW

Wednesday 28 November 2007

Organiser: Dr S Yentis, London

Pt I – How it works & what it means

- The courts and their structure
- The different types of law
- Lawyers and legal references

Pt II – How you might encounter it:

- Prosecution under various Acts
- Assault, battery, negligence, manslaughter & murder
- The GMC
- Keeping out of trouble

Directions

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

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

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

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

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

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

Travel advice can be obtained from www.transportforlondon.gov.uk where you can download underground and bus maps and also view the latest travel updates. To check latest national rail information go to www.railtrack.co.uk

Booking a Seminar

Association Seminars: you choose them, we run them

To book a place on a seminar, please complete this form and return to: David Williams, Association of Anaesthetists, 21 Portland Place, London, W1B 1PY or fax to: 020 7631 4352.
For availability, see website www.aagbi.org or telephone 020 7631 8862/8834. We regret that we cannot accept telephone bookings.

Title of seminar .....

Date of seminar .....

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

Surname .....First name……

Address .....

…….. ..... Postcode ..... ……

Daytime phone ……Post held .....

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

Special dietary requirements.....

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

Please debit my credit card (Visa/MasterCard/Delta) or Switch Card:	**Member** **£120.00** ❒	**Non-member** **£240.00** ❒	**Retired Member** **£60.00** ❒

Card/Switch Number .....

Card Security Code ..... (The last 3 numbers printed on the signature strip on the back of your card)

Expiry date .....Start date/Issue no (Switch only) ……

Cardholder's name ..... ……

Cardholder's signature ..... Date ……..

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.

Dear Editor...

A Change of Practice

Shoulder arthroscopies and subachromial decompressions can be painful procedures. Without the use of regional anaesthetic techniques, pain and opioid usage is likely to lead to a postoperative inpatient stay with its consequent costs. We devised a plan to save our trust money and enhance patient satisfaction by moving the shoulder list into Day Surgery. To do this, a number of anaesthetists had to be trained to perform interscalene blocks. Our ODPs, and theatre and recovery staff needed to see the benefits to the patient and discuss the logistics of how a list with multiple interscalene blocks could run.

There are many courses available for a single anaesthetist to learn how to perform interscalene blocks but none to train a whole department. With help from Abbott and B Braun we organised our own block day. Five shoulder cases were booked onto an all day list; all had agreed to an interscalene block and to be involved in training. On the evening before the list, Dr Martin Herrick from Addenbrookes Hospital, Cambridge lectured us on brachial plexus anatomy and block technique.

During the block training day, two anaesthetists sequentially performed the blocks under Dr Herrick's supervision with a further five anaesthetists and many ODPs, theatre and recovery staff observing. The day was a great success and over the following weeks a new day surgery shoulder list was instigated without much difficulty and with high patient satisfaction.

Bringing a trainer into the department to teach all the staff groups involved is an efficient and relatively cheap process compared to ad hoc study days for individuals. I commend this practice to a wider audience.

Dr Clive Duke
Consultant Anaesthetist
West Suffolk Hospital
Bury St Edmunds

Welfare Dilemma – no easy answer

Anaesthesia News No 236 March 2007, page 38-39

This question of a "drunken colleague" is always a troubling situation. If a policemen suspects that you are driving while under the influence of alcohol, he has a certain procedure to follow. He cannot take the law in to his own hands and change the procedure depending on "ifs" and "buts" etc. He will offer you a breath test and if it is negative you are free to go. If it is positive or equivocal he wants you to take a blood test. Refusal of any of these would put you at risk of arrest and time in custody until someone bails you out.

But in NHS practice, there is no specific procedure to follow and the hypothetical answers given by different consultants and the actual action taken show that you can take actions ranging from ignoring it altogether, to total destruction of the person concerned.

How can you judge if someone is drunk? Can you accuse someone of being drunk just because you think the person smells of alcohol? When I went to a PLAB exam in 1985 one of the examiners in my VIVA smelled strongly of whisky even from across the table. Was he drunk and not in a position to make a correct judgement of my answers? Someone may be also drunk without smelling of alcohol. What blood alcohol level is considered to be dangerous for operating on a patient? Is it the same as the level for safe driving, less or more? Can you actually make a complaint about someone being drunk without a positive breath test or a blood test?

The Solution?

I think the best course is to have breathalysers available in hospitals. If you have any doubt you could offer the person concerned a breath test. There is no need for anaesthetist to confront the surgeon or vice versa. If the most senior person in theatre has any doubt, then that person should offer the breath test to the doctor. If it is negative then the matter rests there. If positive then send the person home and make a report to the line manager. If a breath test is refused, the conclusion should be "drunk" by default and take the action as above.

Dr Lakshman Bandara
Locum Consultant Anaesthetist
West Cumberland Hospital
Whitehaven

What about the patient?

It seems to me that all the Consultant responses to the welfare dilemma are reasonable.....however it would be obvious to the patient if things were being covered up by the "surgeon is unwell" tactic. Surely the surgeon has just consented the patient?

Or are we still led to believe that the anaesthetist consents for the procedure because it is in his best interests to do so!!!!!!

Dr G Biswas
Consultant Anaesthetist
Buckinghamshire NHS Trust

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

Due to the volume of correspondence received, letters are not normally acknowledged.

Scottish Standing Committee Open Meeting

Dr Andrew Vickers delivers the first lecture

The last Friday in February and all roads lead to Stirling. Even the sclerotic M80 which appeared to have sunk into terminal gridlock the day before miraculously cleared to allow passage to the 2007 meeting of the Scottish Standing Committee of the AAGBI. This was the 6th such annual meeting and dare we say it, it has now imprinted itself on the anaesthetic collective consciousness. This year's meeting, held again in the Education and Conference Centre of Stirling Royal Infirmary, was the usual eclectic mix of clinical and political topics delivered in a variety of styles ranging from expert lecture to polarised debate. It ended with a rather disturbing analysis of NHS finances as the longer term effects of PFI debt repayment kick in. Professor Allyson Pollock looks altogether too reassuring to be a harbinger of doom yet her message might just push global warming off the top of things your children hold against you.

Keynote speaker Professor Allyson Pollock

In sporting parlance, the start was delayed ten minutes to allow for latecomers – did someone mention hospital parking? So it was after nine thirty when Neil Mackenzie welcomed one and all to the meeting. He introduced the Association president David Whitaker who promptly hung a gong round Dr Mackenzie's neck. No, he was not to be the next provost of Stirling - the office of Convenor of the SSC was being recognized officially with an insignia in the way that the Irish equivalent has long enjoyed.

The first session started with Dr Andrew Vickers bringing us up-to-date with paracetomol. This everyday drug continues to defy pharmacologists' attempts to unravel its mysteries yet its effectiveness as a pain killer is not in doubt whether taken alone or in combination. The advent of the intravenous preparation has increased its use and put the altogether more unreliable rectal route in the shade, so to speak. Dr Vickers argued that iv paracetamol worked faster than the oral preparation but because of the comparative costs the latter route should be the first choice where possible. He left us with some recently published evidence of an antinociceptive, analgesic effect of gabapentin, the chronic pain doctors' favourite drug.

Professor Mark Bellamy overcame the initial indignity of having the chairman forget his surname and delivered an enjoyable talk on the anaesthetic problems when surgery intrudes on the inflated world of the morbidly obese. He introduced us to a new classification of "front loaders" and "side floppers" as descriptors of what happens when gravity meets an overlarge horizontal pannus. He then took us through the pathophysiology and risk factors linked to high BMIs, and finished with a "how to" guide for anaesthesia and bariatric surgery. Many of the usual suspects were there including difficult intubation, altered pharmacodynamics and good postoperative care. My only surprise was the relatively easy post op pain control, largely

David Whitaker presents SSC Convener Neil Mackenzie with the new chain of office

managed with PCAs, but then there had to be some good news and the prospect of needling the back of a behemoth is the stuff of bad dreams and not to be countenanced.

After an all-too-short coffee break we entered the wonderful world of Dr Gordon Todd who described his experiences of 30 years administering dental anaesthetics mainly to young impressionable Glaswegians. A case of "gallus" senior meets "gallus" junior. Dr Todd dedicated his talk to the memory of Dr Donald Braid, doyen of Glasgow dental anaesthesia and a close colleague, who died recently. Gordon straddles the period between GOH (gas oxygen halothane for younger readers) with FOP (finger on pulse) monitoring and the modern realms of conscious sedation in a new unit at the Royal Hospital for Sick Children. In between times he regaled us with stories ranging from voyeurism of the Art School's still life class through to the messy estrangement of a punter from his indwelling dentures. On a more sombre note, there have obviously been major changes in the way dental anaesthesia has been managed, often in response to anaesthetic disasters. Gordon's talk rightly concentrated on improving safety with better teaching, more resources and centralisation of dental anaesthesia.

The debate on physicians' (the apostrophe has real significance) assistants in anaesthesia brought contrasting styles to the podium. Dr Neil Smart, like a trapeze artist performing without a safety net, spoke without any help from Powerpoint. He argued that this new breed should be seen in the context of a changing anaesthetic workforce with fewer and less experienced juniors, that far from challenging the consultants' role, their very presence would allow a more flexible working pattern in and out of theatre and that there was little evidence that patient safety would be affected. Dr Gerry Keenan expressed a number of fears and reservations about the assistants' potential role, remembering that a majority of anaesthetists had opposed their introduction in a recent AAGBI survey. He felt they may present a threat to the anaesthetists' role despite initial assurances to the contrary, the public and patients might be (more) confused about anaesthetists' status, and informed preoperative consent for patients might have to include information regarding who exactly was administering anaesthesia.

If that was the pre lunch *aperitif* then the *digestif* appeared in the guise of the now traditional Open Forum – a sort of Question Time but without the lady in the pink jumper in the third row. The David Dimbleby role was taken by Neil Mackenzie, who chaired a panel comprising David Whitaker, Ian Johnston and Henry Robb. Amongst the topics raised were the work of the Association, the implications of the Health Department's letter on intrathecal injections for anaesthetic departments, the fate of non European Union doctors with highly skilled migrant worker permits who are entering the MTAS process, and where APs sit in the scheme of organising departmental resources. The audience at various stages appeared mollified, reassured or uncertain. Their consolation is that we are all in this together.

There then followed a debate on "Two sides of appraisal and job planning". The protagonists were Drs Henry Robb and Cameron Howie who focused on the respective roles of consultants and managers in improving the NHS and making the world a better place. Both speakers, in their own inimitable ways, managed

to tease out some valuable points. The consultant contract has delivered big pay cheques but no increase in output at a time when, in some indebted English Authorities, private companies are bidding to deliver some standard health services. Apart from staying in Scotland, closing your eyes and hoping our system functions well enough, the best advice was to approach job planning with a clear idea of what you want, state (and prove) your case and be co-operative.

In the final session, Neil Mackenzie introduced our guest speaker Professor Allyson Pollock from the Centre for International Public Health Policy at Edinburgh University. Professor Pollock's talk was "Will Scotland's NHS go the English route?". She has, as it were, looked over our neighbour's fence and seen unwelcome plants growing in the English physick garden. Worse, she sees signs of spread into our patch.

In England there is evidence that the PFI debt burden is adversely affecting health services. Some in primary and secondary care are now being privatised and losing their accountability. Should we be worried in post devolution Scotland? Yes, because of the number of new PFI hospitals being built here. The same impact on Health Board finances is likely here and her future financial projections caused many in the audience to swallow hard. Clearly some of our services may be vulnerable to privatisation. However we have a golden opportunity to publicise our concerns, because elections to the Scottish Parliament are looming.

At the end Professor Pollock was presented with a crystal decanter and 4 glasses from the Society. She would not have missed the allusion to the local fondness for resolving debates with a drop of *uisge beatha*.

Gavin Gordon

Competing interests…very definitely. With the help of Jim Dougall I organised the meeting and, mea culpa, was also the forgetful chairman.

10th Stevenage Anaesthesia Society Workshop

Friday 15 June 2007

Education Centre, Lister Hospital, Stevenage, Herts.

Supported by Herts & Beds Critical Care Network
www.hertsandbeds.com

and the Bedfordshire and Hertfordshire Postgraduate Medical School

PROGRAMME

08:45–09.00	Registrations and Coffee	12.15-13.45	Lunch
09:00-09.10	**Welcome** Dr Rajan, Consultant in Anaesthesia & Intensive Care Lister Hospital, Stevenage	13.45-14.15	**"Reducing Ventilator Associated Pneumonia in ICU"** Eva Joelsson-Alm, Clinical Nurse Specialist Intensive Care Unit IVA, Södersjukhuset AB, South Stockholm General Hospital
	Quality and Safety in Anaesthesia and Critical Care		**"The Sheila Willatts Lecture"**
09.15-10.15	**"Lessons Learnt in Implementing Health Care Improvement Programmes around the World"** Dr Vahe Kazandjian, Centre for Performance Sciences Inc, USA	14.15-15.15	**"Following the Evidence"** Professor Jean-Louis Vincent Head Dept of Intensive Care Erasme Hospital, Free University of Brussels
10.15-11.00	**"Pre-operative Team Briefing - Improving Safety in Theatres"** Dr L Lingard, Associate Professor Department of Paediatrics, University of Toronto	15.15-16.15	**"Non-technical Skills and Patient Safety in Anaesthesia and Critical Care"** Dr Tom Reader Postgraduate Research Student School of Psychology, University of Aberdeen
11.00-11.15	Tea Break		
11.15-12.15	**"The Safer Patients Initiative – Transforming Safety in Critical Care"** Dr Brian Tehan, Divisional Clinical Director/Consultant Anaesthetist Conwy & Denbighshire NHS Trust	16.15	Questions and Close of Meeting

Meeting Organised by Dr Thiagarajan, Consultant Anaesthetist, For further information please contact: Sarah Holmes – Co-ordinator, Tel: 01438 781086, e-mail: sarah.holmes@nhs.net (Approved for 5 CPD points)

PANG

Pain and Nociception Group

London Acute Pain Symposium

Churchill House,
Red Lion Square, London. WC1R 4SG

Friday, 8 June, 2007

Neurophysiology of pain
Acute pain in the complex patient
The case for neuropathic pain therapy
NSAID's what's left?
Organisation of acute pain services
Pain management in critical care units
Pain in the elderly
Paediatric pain management
Postoperative nausea and vomiting

Registration: £195

Further information: **Mrs S Welham**
PANG Administrator
7 Dover Road, Sandwich. CT13 0BH

Tel/fax: 01304 612520 **Mobile: 07801 930370**

(Approved for CEPD)
(Concessionary rates available)

www.pangmeetings.com

THE ASSOCIATION OF ANAESTHETISTS

of Great Britain & Ireland

ANNUAL CONGRESS 2007

DUBLIN

ROYAL DUBLIN SOCIETY

12-14 SEPTEMBER 2007

- Three parallel streams of didactic lectures
- Scientific sessions, current issues and update sessions
- Workshops on Difficult Airways, Regional Anaesthesia, Independent Practice, Finance and many more…
- Eponymous lectures
- Keynote speakers
- A full and varied social programme, partner day tour programme
- Annual Dinner
- Satellite Symposia and Industry Workshops
- Extensive trade exhibition

CALL FOR ABSTRACTS

Abstracts are invited for case scenarios, oral or poster presentation. Papers accepted for presentation will be published in abstract form in the journal *Anaesthesia. Prizes for the best free papers, as judged by a panel of experts. Closing date for submission 1 June 2007.**

**The Editor-in-Chief reserves the right to refuse publication.*

	MEMBERS BOOKING BEFORE 21/7/2007		MEMBERS BOOKING AFTER 21/7/2007		NON MEMBERS	
	£	€	£	€	£	€
One Day	180	252	225	315	280	392
Two Days	260	364	310	434	380	532
Three Days	340	476	395	553	475	665

FURTHER INFORMATION

CONTACT: +44 (0)20 7631 8808/5 meetings@aagbi.org www.aagbi.org

THE FINAL FRCA EXAMINATION

Prospective Examination Candidates are
Invite to Join

The Mersey SAQ Writers Club

Membership of the Club will Expose You to the
Intricacies of the Short Answer Question Paper

As a Number and not a Name, You will be Expected
To Address under Examination Conditions
One Twelve Question Paper per Fortnight

You will be expected To Set Questions & To Mark Answers

Through such Intimate Involvement with the Short Answer Challenge
You will become that much more Able to Cope

CLUB TWO
Opens on July 1st
Registrations Close June 31st

Interested trainees are invited to attend

'Introduction to The Mersey Method'

Saturday 16th June
11.00 – 16.00
Aintree Hospitals

One Fee for Membership of £400* will entitle the Member to
Remain in the Club and to
Attend the Introductory Meeting & the Mersey SAQ Weekend Courses

Free of Any Further Charge

until

Successful in the SAQ Paper Examination

For Registration & Club Rules
please see

msoa.org.uk

"In the Discipline Lies the Reward"

***Applicants who attend the Introductory Meeting but who subsequently choose not to join the Club will be charged £75, which charge will include the cost of Lunch.**

CHAIRMAN'S MESSAGE

2006 was an exciting year for the SAS committee of AAGBI. The launch of the SAS handbook was certainly a highlight and I am very pleased that it has turned out to be a useful document for SAS doctors up and down the country. I should thank Dr Les Gemmell, Chairman of the working party and the editing team for their efforts.

We managed to increase the SAS membership during the year but there is still a lot to be done. We have had several requests for the SAS handbook from non members - joining the Association is the best way to ensure that you receive all the publications as soon as they become available. The Association has plans to introduce a special introductory subscription for SAS doctors wanting to join in this, its 75th anniversary year. Please watch this space.

It is more than a year since the negotiations for a new SAS contract started and I have been waiting patiently for the result as there is a lot of uncertainty. We all want to see the outcome and organise our jobs accordingly. I have been getting regular queries about all aspects of job planning. Members have requested guidance on the number of operating lists and clinical sessions to be done in a week, on on-call commitments, sessional allowance for CPD, pre and post-op work, study leave and professional leave, teaching and administration duties and on how to get re-graded to associate specialist grade from staff grade. The SAS committee has already prepared a draft of the new SAS Glossy that includes guidance on all these matters based on the present contract. However, as the new contract is believed to be imminent, we have been holding back publication.

Looking at the introduction of MMC and its effect on manpower issues, I believe that there will definitely be a need for an SAS grade to accommodate doctors that do not fit into the system. For example, doctors who opt for anaesthetics as their career but cannot get into MMC scheme due to lack of places, those that are not successful in postgraduate exams or do not want to do them, those that go through specialist training but do not get consultant jobs (or have to wait for one), and those that do not want to take up the responsibility of a consultant for whatever reason will all have to resort to SAS grade jobs. The only other options available for them are to change their speciality, drop out or go abroad.

Already the number of applicants for consultant jobs has increased and it is becoming increasingly difficult to get these posts. Several consultants due to retire are remaining in post because they fear the vacant post will disappear during reorganisation of Trusts. Looking at the plans of the Department of Health, the government seems to be looking for cheaper options and creating specialist jobs or jobs requiring limited accreditation. For whatever reason, the SAS grade is going to expand enormously. It is inevitable. There is also a danger of Trusts creating jobs such as Trust Grades which do not conform to any national terms and conditions which is deeply concerning.

Several private or quasi-NHS small hospitals are coming up. I fear that these hospitals will be staffed by SAS doctors or doctors from overseas on a service-only basis. There is a lot of uncertainty and the next few months will be critical.

On a different note, may I remind you all about some important events coming up in the next few months? The joint SAS Review day (AAGBI and RCoA) is being organised by the Association this year and is held on 10th May in the Association headquarters at 21 Portland Place. Based on suggestions made by the participants in the SAS survey, we have organised an interesting and academic programme dealing with current and relevant topics for SAS doctors. I do hope that you all try to attend.

As usual we are going to have a separate SAS session at the Annual Congress in Dublin in September (12th – 14th) this year. Please make a note in your diary and try to attend. I am planning to organise a seminar on management for SAS doctors, and would appreciate your thoughts on such a seminar with suggestions for topics.

PMETB has raised hope among SAS doctors that it will provide a pathway to CCT through article 14. Many have found it to be a laborious, expensive and disappointing experience. However I am happy to note that some have managed to achieve success.

I would like to remind you all about the research grant of up to £5000 for SAS members of the Association. Council has been generous in allocating that money exclusively for SAS doctors. Those of you who are interested in doing research please do apply.

Finally may I request you all to get in touch with me at the Association if you have any suggestions or ideas you would like us to consider. I promise that every idea and message will be taken seriously and acted upon. I would also like to thank you for all your suggestions and cooperation during the past year.

Ramana Alladi
Chairman SAS Committee

I'm free! The Mysterious Art of the Free Paper Revealed

David Bogod

Here's a scenario you might recognise. Lured by the programme, the thought of some juicy CME points, the chance to meet up with old friends and maybe the possibility of a few drinks, you sign up for the Association's Annual Congress. The morning after the gala dinner, when the friends and the drinks took temporary precedence over the points, you find yourself wandering distractedly around the tortuous corridors of the conference centre, looking for the difficult airway workshop. Hearing noises from inside a break-out room, you open the door, to be confronted by a large number of chairs, a small number of suspiciously youthful-looking delegates (one or more of whom may be breast-feeding infants), a harassed audio-visual chap, and three men with grey suits and matching hair. In the air is the whiff of tension that only really comes when people at the top of their game are in direct competition with each other. Gentle reader, you have stumbled into the free paper session.

But wait. Do not back out, muttering imprecations and hiding your badge. Tarry awhile, and discover the secret world of the stopwatch, the amber and red lights and the eight-minute time limit! Wonder at the arcane topics which can be explored by a trainee with a 250-quid grant, a consultant supervisor with a bee in his bonnet and a spare three months! Be amazed at how an eminent professor can completely miss the point and then be put firmly in his place by a second-year SpR who knows her brief backwards!

Those in the know about free paper sessions often regard them as the best part of a conference. Not for them the first-class-flown Californian superstar giving the same lecture for the twentieth time or the elderly worthy telling how much better it was in the days of rags, bottles and Von Recklinghausen (these are entirely fictitious examples of their type and are not meant to refer to any particular speaker, alive, dead or retired). And they are often absolutely right. If you want to know what's exercising the minds of today's bright young stars and tomorrow's clinical champions, where the future of monitoring lies, and which new drugs will be big next year, the free paper presenters will tell you. And if the current topic is not your cup of tea, there will be another one along in 10 minutes or less, and another one after that. The free paper slot is a tapas bar compared to the plenary session's five-course meal with a dull dinner companion, and is the tastier, fresher and more entertaining for it.

A read through the abstracts published at intervals in *Anaesthesia* will give you a flavour of what you have been missing. In Aberdeen in 2006, we heard, *inter alia,* about the use of ultrasound in rectus sheath blocks, the fastest way to achieve fibreoptic intubation, whether being left-handed has any influence on our ability to wield a bag and mask, how many of us actually use the Sonosite when placing internal jugular lines, and a new connector for preventing cross-over errors between intravenous and neuraxial administration of drugs. The overall winner, Dr Ewan Jack from Glasgow, produced an eye-opening analysis of how long it actually took to achieve cardiovascularly stable anaesthesia after apparently reaching a steady state with TIVA, a paper with huge implications for future research in this burgeoning field.

But why stop at coming along to listen? Free papers really are a free-for-all, and are certainly not just for trainees. This is the perfect forum for you to tell an audience about your own pet topic that you've been informally working on, or the audit project you completed. Perhaps you've been fed up with theatre delays and, having analysed the situation, found that you could increase throughput for minimal cost by having unpremedicated patients walk to theatre instead of ride. Maybe you've reduced the incidence of poor epidural blocks in your

obstetric patients by doubling the volume and halving the concentration of your first dose. You may even have found a way to solve the Nobel prize problem of anaesthesia – how to get a nasogastric tube down an intubated patient first time. If you have, please come and share it with your peers; by doing so, you will probably have a greater impact on clinical anaesthetic care in the UK than any ten eponymous lecturers you could name.

Last year's free paper winner, Ewan Jack

And don't be put off by imaginary obstacles. The free paper process is designed to be as open and unrestrictive as possible, and to make submission quick, easy and non-threatening. Visit http://www.aagbi.org/events/annual%20congress/docs/congressabstractform07.doc to do the whole thing electronically and, if in doubt, call Chloe Smith at the Association or e-mail her at chloesmith@aagbi.org – she doesn't bite! If accepted for presentation, you will have to put together an eight-minute summary on Powerpoint and be prepared to answer two minutes of gentle questions (the days of the aggressive academic out for self-promotion at the expense of the poor presenter are now long gone). And that's it!

If the thought of standing up on your hind legs still fills you with dread, then there is another alternative, the poster. Instead of putting your grand idea into a series of slides, you take them along to your audiovisual department, who will help you to display them on a very large, glossy sheet reminiscent of a movie billboard. You transport this to the meeting in a long cardboard tube which, if you are unfortunate enough to be flying, will certainly attract the attention of a phalanx of security guards ("take this plane to Cuba or I'll hit you over the head with my cardboard tube; you won't be fatally injured, but it will make a scarily resonant 'bong' sound"). Once at the conference centre, you will be directed to a distant corner of the trade exhibition, where you will meet a large number of other people with identical tubes. Your poster will be pinned to a display board where it will be resolutely ignored by all right-minded delegates for the duration. At some point in the proceedings you will be asked to stand by your poster, and three old fogeys will wander up to ask you rambling questions, rather in the style of Prince Philip on walkabout ("Have you come far?"; "What do the pink dots on the graph mean?"). At the end of the meeting, you take your poster down, put it back in the cardboard tube, and take it home, where your spouse will discard it a year later, having despaired of you doing anything about it.

If the thought of a monetary prize and publication in *Anaesthesia* is not enough to whet your appetite, just come along for the fun anyway; the free paper session is a surprisingly good source of anecdote. I co-chaired a session at the European Society of Anaesthesiology a few years back, in which a trainee from the Balkans presented a rather complex study in halting English. A Greek delegate in the front row asked a very long question in English that was not so much halting as stationary. My Italian co-chair looked at me, and I had a go at rewording the question. The presenter looked nervous and muttered "I must ask my professor". He then proceeded to engage a very large, heroically-mustachioed woman sitting in the back row in a protracted and completely incomprehensible conversation, while Marco and I looked nervously at the clock and the audience watched in mute fascination. After what seemed like 20 minutes, the presenter turned to face his questioner and, with a beatific smile and in a triumphant tone, said "The professor, she say 'yes!'". How we applauded!

David Bogod
Editor in Chief of "Anaesthesia"

COUNCIL

News & Announcements

Scottish Standing Committee Membership

At the recent elections to the Scottish Standing Committee, the following candidates were successful:

Dr Ken Barker (Inverness)
Dr Alastair Michie (Ayrshire)

They will replace Drs Heather Hosie and Pete Alston, who have completed their terms of office.

Dr Kathleen Ferguson replaces Heather Hosie as secretary, while Neil Mackenzie and Gavin Gordon continue as Convenor and treasurer respectively.

20% Discount on Textbooks for AAGBI Members

Two major publishers of Anaesthetic textbooks, Oxford University Press and Blackwell, offer members 20% discount on their books, when purchased direct via their respective websites.

To purchase Blackwell books at a discount:
Visit the website at www.blackwellpublishing.com/medicine and click on "books" to browse the full catalogue of titles from Blackwell publishing. To claim your 20% discount use the discount code **AAGBI20** when prompted in step 2 of 4 in the shopping cart.
The discount is available on the full Blackwell catalogue.

To purchase OUP books at a discount:
Visit the website at www.oup.co.uk/promotions/medicine/websoaagbi to browse for books and place your discounted order online.
The discount is available on the full range of OUP books apart from some of the general reference works.

Pilot Internet Lecture from the Scottish Standing Committee of the Association of Anaesthetists.

Log on to http://forth.mvm.ed.ac.uk/gbdlecture/ before 18.30 on the 29th May 2007.
Dr Gordon Drummond will deliver a lecture entitled 'Extending your senses -free extra information from your monitor screen'. The lecture will be hosted by Dr Peter Alston from the Royal Infirmary of Edinburgh.

This is a pilot internet lecture to explore a new way of delivering information to the membership. As such, anything may happen! This lecture depends on the use of Macromedia Breeze which is hosted on a server at the University of Edinburgh. Be very aware that for many reasons, it is highly unlikely that you would be able to view this internet lecture on a computer connected to the NHS network. If you have a ADSL broadband line for your home computer then you should (theoretically!) have no problems accessing the lecture. There may a limit to the number of viewers who log on so first come, first served. It is hoped that the lecture will be interactive. You will be able to put instant message questions to Gordon Drummond throughout his lecture. You may also be able to ask them verbally but you will require to have a microphone and headphones plus or minus a video camera to do so.

If you require further information please email Peter Alston at peter.alston@ed.ac.uk.

International Relations Committee Travel Grants

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

Dr A. Cowan (Southampton) *Liberia*
Dr V. Clark (Edinburgh) *Brazil**
Dr A. MacFarlane (Glasgow) *Brazil**
Dr P. Stone (Glasgow) *Brazil**
**Combined grant given*

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

Difficult Airway Day

A one-day Symposium and Workshops for Anaesthetics Trainees and Consultants

Thursday 21st June 2007
The Walkers Stadium, Leicester

Practical Sessions to Include

Oxford Box & Tracheobronchial Tree

Oral/Nasal Endoscopy

Intubating LMA

Intubating through an LMA with Aintree intubating catheter

Checking of the double lumen tube

Trans-tracheal Ventilation & Percutaneous Tracheostomy

Sim man (simulator)

Bullard Laryngoscope

5 CPD Points Awarded from the Royal College of Anaesthetists

Registration fee: £120 inc Lunch and Refreshments

Course Organisers: Dr M Mushambi and Dr P Ali, Consultant Anaesthetists

Contact Sam Thurlow, Conference Co-ordinator
Tele 0116 2502305
Email sam.thurlow@uhl-tr.nhs.uk

British Society of Echocardiography
Affiliated to the British Cardiac Society

Association of Cardiothoracic Anaesthetists / British Society of Echocardiography

There will be one sitting of the Transoesophageal Echocardiography Proficiency Examination in 2007

Thursday 11th October 2007
(prior to the BSE Edinburgh meeting)

The 2007 Accreditation Pack and registration forms for the exam can be downloaded from www.bsecho.org

Registration forms should be posted to:
BSE Accreditation Administrator, Executive Business Support Limited, Suite 4, Sovereign House, 22 Gate Lane, Boldmere, Sutton Coldfield B73 5TT

14TH ANNUAL PAEDIATRIC ANAESTHESIA UPDATE

Friday 22nd June 2007
The Manchester Conference Centre
Organiser: Dr D Patel
Manchester Children's University Hospitals
Department of Anaesthesia

PROGRAMME

Managing children with heart murmurs and cardiac devices
Dr Gordon Gladman, Liverpool

Postoperative fluid management for Children
Mr Anthony Landers, Birmingham

Debate: General Anaesthesia is preferable to Sedation for radiological procedures in children
For: Dr Jonathan Smith, London
Against: Dr Oliver Dearlove, Manchester

Paediatric resuscitation guidelines: what's new?
Dr Russell Perkins, Manchester

Paediatric pain management in the A&E
Dr Briar Stewart, Liverpool

Management of a severely injured child
Dr Henrik Hack, Manchester

Course Fees £165 ~ Approved for 5 CME points

All enquires should be directed to:
Christine Taylor
Department of Anaesthesia,
Royal Manchester Children's Hospital
Hospital Road, Pendlebury, Manchester, M27 4HA
Telephone / Fax Number: 0161 922 2439
Email: christine.taylor@cmmc.nhs.uk

University of Oxford *Nuffield Department of Anaesthetics*

Courses on

Anaesthesia for Developing Countries

Oxford (Friday July 6th 2007)
Uganda (October 29th - Nov 2nd 2007)

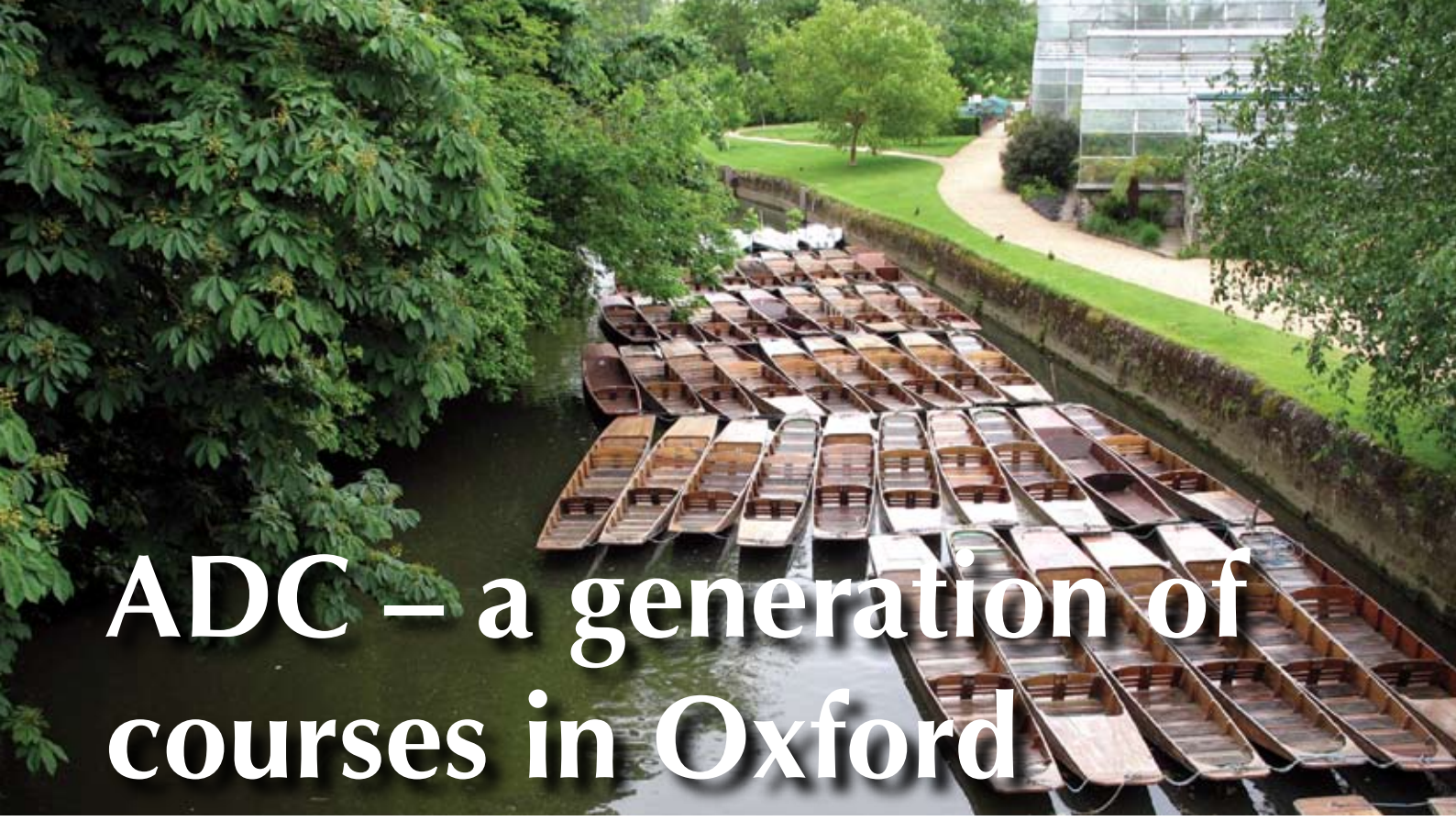
Courses will be held in 2 centres this year:

The July (Oxford) one-day primer course will cover the basic clinical and logistic features of working in a Developing Country, including hands-on technical demonstrations.

The October (Uganda) course will complement and amplify this in a clinical setting, with additional teaching on Draw-Over, Ketamine, Oxygen Concentrators, Logistics, Obstetric & Paediatric Anaesthesia, Trauma management, Drug supplies and Training Issues

For further details & booking form contact Mrs. Pat Millard, Nuffield Dept of Anaesthetics, John Radcliffe Hospital, Oxford OX3 9DU. Tel 01865 221590 Email: pat.millard@nda.ox.ac.uk

or see website www.nda.ox.ac.uk for further details & application



ADC – a generation of courses in Oxford

It's a feature of impending senescence to look back – in this case to 1981. Anaesthetists of today may wonder to hear of the daily use of drugs such as Althesin, Fazadinium, methohexitone, or (then just introduced) Enflurane – alleged to be a superior inhalational anaesthetic, its use limited by high cost.

In the same year we started a little course in Oxford for a "minority interest" group – "Anaesthesia for Developing Countries" (ADC), a subject regarded by most as denoting "old-fashioned" anaesthesia. None of the "modern" drugs mentioned above got a look in. The aim was to address the practicalities of providing safe anaesthesia in those countries of the world (128 of the 156 countries listed by the World Bank) where infrastructure and anaesthetic training cannot be taken for granted. In these countries oxygen does not grow in pipes, nor drugs in cupboards, and many of them have only a handful of physician anaesthetists.

Oxford, the spiritual home of draw-over anaesthesia, seemed a good place to start – we already had a group of anaesthetists trained in the locally in the mysteries (actually simplicities) of appropriate safe techniques that could be relied on in the absence of compressed gases and electricity. We had no idea if anyone would come on the first course – fortunately about a dozen did. We had a hugely enjoyable time teaching one another, and resolved at the end to do it again. So far we have done it again 24 times.

What has been the attraction of these courses? Without any doubt, it has been the participants. They have come from far and wide (the first year someone came specially from Fiji; we had an anaesthetic nurse who raised her own funds to come from Malawi one year); they have brought with them priceless experience and knowledge, which they have shared with each other (and us) in the rather monastic atmosphere of a residential course on which the presence of "significant others" was actively discouraged!

Without a doubt, the part of the course most appreciated has been the clinical demonstrations. The fact that we have been willing (with the patients' permission) to take groups of up to 6 people at a time into the anaesthetic room, and perform anaesthesia in front of them, seems to have convinced doubters over the years that such eccentricities as making your own oxygen in the anaesthetic room are not only possible but effective. It goes without saying that these have been the most difficult bits of the course for the faculty – not because the anaesthesia is difficult – quite the contrary, but because of the difficulties of crowd control, finding 20 extra sets of theatre blues, and dealing with surgeons to whom our presence always came as a complete surprise, in spite of all the letters and phone calls in advance of the event!

There is much more to it than giving the anaesthetic – we have encompassed training issues, logistics, how to make your own IV fluids, and how to service your own vaporizer, along with a lot of other useful stuff that is missing from UK specialist training. The course has given birth over the years to 2 daughter courses – Bristol and Hobart – both started by people who came through

the Oxford course, and to the World Anaesthesia Society. We also have two "grandchildren" – *Update in Anaesthesia* (together with its web & CD versions) and *Primary Trauma Care*.

Two things that particularly encourage us are the number of former "students" who have worked overseas following their participation on the course, and now are among our panel of lecturers; and the way the course fills up every year without much effort on our part to advertise it – mostly by word of mouth. It has kept going because it's so enjoyable to run – no one is there because they have to be, or to get through an exam – they come because they are interested in the subject, think it relevant and want to talk about it. Someone asked me once how *I* became an *"expert"* but after a moment I realised it was because these people had come from all over the world, and had taught me everything I know about the subject. On the first course, by the fourth day, I felt that every last possible word on the subject had been spoken – now we get through about 20% of what we could say. Maybe I've just become a slow talker!

Althesin and its companions are no more, and no doubt one day draw-over will follow them into the sunset (not just yet – it's still going strong in Indonesia, India, Nepal, Uganda, Malawi and many other places – now including Basra!). With or without draw-over, it is unlikely that our message to the rest of the anaesthetic world should be "Imitate us and our £30,000 workstations" – I hope there will still be a place for travel to broaden the anaesthetist's mind (and skills), and that courses like ours will continue to equip people to work beyond the confines of the NHS.

Seminar in progress

Anyway, after 25 years (things move pretty slowly in Oxford) we are changing the format. This year we are splitting the course into a 1-day primer course (in Oxford, July 6th 2007) and a 5 day field course in Uganda (details on our website www.nda.ox.ac.uk)

Mike Dobson

The first course delegates

Ever wondered how the Department of Health and the Government generate such snappy titles for reports and white papers?

Now you too can produce dynamic document titles with the Harrop-Griffiths Patented Healthcare Title Generator©!

It couldn't be simpler!

Titles consist of two or three couplets, followed by an optional subtitle. Look below and you will see three couplet generators and a subtitle generator. Choose a word or phrase at random from each column in Box A to produce a couplet. Then go to Box B or Box C and choose a word or phrase at random from each column to produce one or two more couplets. When you have your couplets, arrange them in random order and then decide if you want a subtitle and then put them all together. The result: a catchy and dynamic title for a report that really looks as if you are going to do something about the utter disaster that is the National Health Service.

Some quotes about the Harrop-Griffiths Patented Healthcare Title Generator©:

"I wouldn't have got where I am today without the Title Generator!" (Sir L D, London)

"Better titles, higher ministerial positions!" (Mrs P H, London)

BOX A

Protecting	Patients
Promoting	Safety
Assuring	Health
Securing	Cleanliness
Safeguarding	Trust
Strengthening	Care
Focussing on	Confidence

BOX B

Preventing	Tragedy
Learning from	Errors
Avoiding	Mistakes
Minimising	Accidents
Investigating	Cock-ups

BOX C

Safer	Patients
Better	Nurses
Cleaner	Healthcare professionals
Friendlier	Managers
Vilifying	Doctors
More caring	Wards
More knowledgeable	Environments
Happier	Trousers

SUBTITLE BOX

An organisation with a	Future
A healthcare system with a	Memory
A profession with a	Present
A culture with a	Past
A plan for the	Problem
A hospital with a	Mop

A FITTING SOLUTION

Following Dr David Zuck's case report in the January 2007 edition of Anaesthesia News, Dr Michael Corfield has submitted another, and wonders if an anaesthetist working now would be allowed to do this!

Some years ago it would have been unusual to find an anaesthetist at work anywhere much outside an operating theatre. How their skills came to be valued (or not valued) by other clinicians is thus of interest, as new paramedical and other subspecialties continue to emerge.

A tipping point occurred in the early 1950s following the twin epidemics of paralytic poliomyelitis and barbiturate self poisoning, as it did more recently, somewhat similarly, in the on-site management of road traffic accidents. Physicians at that time had not seen, and therefore did not believe, that IPPV could not only maintain life but save it, while diagnosis and investigation could wait, at least until the appropriate experts had been roused from their beds.

Anaesthetists were better placed. They knew only too well about hypoxic crises and already cuararisation, rather to their regret, had greatly extended safe operating times. Yet "artificial respiration" as it was then called was still generally perceived to be the province of the first-aider – with some truth, as I will relate.

The message, as I recall it, came not from the above, but from the Antipodes, and not on the road to Damascus, but one of North London's drearier suburbs.

As a novice SHO, my registrar was a much respected Australian lady, as it happened directly descended from the founder of the hospital. One evening, luckily it was she who was on call when the fourteen year old son of a local pharmacist was brought in suffering from severe convulsions. He had, mistakenly or not, swallowed 1.5g of his father's strychnine, a fatal dose.

Recalling how medical students in Denmark had saved paralysed polio patients by "bag squeezing", why not, she thought, do the same for this lad. Gastric emptying was impossible. Just to touch him produced a convulsion, though fully conscious; so she bravely anaesthetised him with thiopentone and set up a suxamethonium drip. Ventilated over the next twelve hours, he rapidly excreted the poison and the next morning was ungrateful enough to complain of a sore throat and back.

After a few days of ward observation in case convulsions recurred, he was returned, probably in disgrace, to his parents and quite possibly flourishes in 2007.

Suppose instead things had turned out badly. Visualise the scene. There is public interest, with cameras perhaps. Expensive Counsel is hired. "So doctor, your treatment for this child, poisoned by a lethal substance, is to administer another, related to an arrow poison, I believe?" "Well, yes" "And how many such cases have you treated in this way before?" "None". Murmurs arise in court or, more likely, at the GMC.

Serious questions however do arise. Why did this remarkable feat pass almost unnoticed? Countless patients throughout the world continued to succumb to barbiturate overdose, when all they needed was oxygenation, nursing and a prolonged siesta.

Subliminal resentment at the work and expense caused by self-harm cannot be ruled out. It is echoed strongly in many modern lectures on smoking, obesity and addiction. Maybe it is time indeed that the Hippocratic injunction to do no harm was extended from doctors to their patients.

But accountability is no excuse for lack of imagination. Could it be that protocol driven medicine will save the ninety and nine, but stifle the intuitive initiative that could save the extra one?

Michael Corfield
Retired Anaesthetist
Crewkerne

GAS FLO

NOTES FROM A SMALL HOSPITAL
A TALE OF EVERYDAY FOLK IN THE NORTH

Education, education, education – or a moving experience?

Like many departments of anaesthesia, mine devotes one morning or afternoon each month to clinical audit. We co-ordinate this with the surgeons and do no elective operating so we can all get on with it relatively undisturbed. Recently however, management has expressed deep concern with what we do in the time and instructed us to spend less on clearly unimportant clinical affairs, pointless audits and morbidity/mortality stuff, and devote at least a third of the time to solid, evidence-based, mandatory CNST (Clinical Negligence Scheme for Trusts) training and documentation.

In the last few months, we have received diversity training in how not to discriminate on the basis of gender, race, disability, age and sexual orientation; cunningly spot an abused child and report it; work a defibrillator; wash our hands properly; know what to do in the event of a fire and, this month, move and handle patients.

The Trust actually doesn't give a stuff about our ability to do any of this. The purpose is to earn discounts on indemnity payments by reaching NHSLA level 2, and weasel out of any injury or disability claims from staff or patients on the basis that training has been delivered and documented. This applies to all CNST training. Ask yourself: does anybody ever test to see if the training has been effective? No, since clearly this is not the objective. There is not a shred of evidence that it reduces risk, or if the exercise actually costs less than it saves. Perhaps we should audit it!

All of our instruction has been delivered by ex-nurses who are almost delirious with happiness at no longer having to work unsociable hours looking after patients, and who now have a mandate to boss doctors about. These women (they are nearly all women, the blokes seem to choose less esoteric stuff such as resuscitation training) love their job so much that time is nothing to them. They are fearless in the face of an audience of medics (a minority group, notably not covered by diversity training and therefore fair game for anyone). They are completely unafraid of stating the bleeding obvious – and do so; plodding steadfastly on to the end of their spiel in the face of yawns, snores and improvised urgent bleeps and summonses.

This month, the whole department of anaesthesia was required to report to an empty operating theatre to witness a demonstration of lifting (oops can't use that forbidden word) moving and handling patients. We were shown a variety of cunning devices designed to make life easier, all of which are kept at the far end of the hospital behind locked doors. There was a memorable demonstration on how to move a morbidly obese patient off the floor. Closely followed by a display of how to transfer an unconscious patient from trolley to operating table; turn said patient into the lateral position, and slide them up and down using a nifty, slidey tube thingy. This revolutionary device is very slippy indeed. My colleague, who pluckily offered to assist in the demonstration, was shot neatly onto the floor at the far side of the operating table. Unlike an unconscious patient, and quite agile, he was able to escape serious injury. He bravely jumped back aboard so we could be shown another similar device designed to be left under the patient during surgery to assist with interoperative positioning. We watched with poorly suppressed glee as the table was tipped head-down and my colleague slid slowly, with all the grace of a ship being launched, head-first onto the floor. The moving and handling trainer was unmoved. The rest of us were in stitches. This stuff definitely beats work any time!

Moreover, it was a great comfort to learn that, in the event of a patient regurgitating unexpectedly and an immediate need for the head-down, left-lateral position, this specialist equipment can be readily obtained from the Moving and Handling Department at any time - providing it is not already in use on one of the wards and the key can be found.

It was also reassuring (but not to my husband) that being female, I can no longer do the weekly shop as I should not lift more that three kilograms from waist height. This hitherto little-known fact also gets us out of the urology list girls – hurrah!

I was sternly admonished for saying, when moving a 'patient', "right chaps, on three - one two three" as it can apparently be confusing to the nursing staff, who may be doing an instrument count. I must, from now on, fall in with correct protocol, and say, "right chaps; ready, steady, slide". (I pass this on to all of you may not have such an efficient CNST training department and be unaware of the problem. Probably better not say "chaps" however, as it could be regarded as gender sensitive.)

Finally, those of us who spent any time at all at our desktop workstations were urged to order special chairs and desks to avoid the inevitable back strain that would undoubtedly occur in the fullness of time. I wonder how much this would cost if we all took our instructor at her word, and what the CEO would think?

I'm left wondering what next month will bring. How to make a cup of tea without scalding yourself perhaps; or Running safely with scissors? I can hardly wait!

Gas Flo