NEW ELEPHANT FOR Bristol Zoo
Following a long gap since the death of Wendy, North Bristol was proud to announce the safe arrival of Brunel, a rare white elephant, in Bristol this May. In response to reports of developmental delays, Brunel’s keeper, Caril Lion, pointed out that Brunel is still very young and teething was always going to be a difficult period. Replying to complaints that Brunel had had several episodes of incontinence, sending members of the public running for cover, Caril Lion asked for patience as “all youngsters need potty training, even if they cost £350 million, just look at Balotelli.”

See also:
• Code Brown for Danger
• Aerospace News

AAGBI Cycle Ride For Guy

• Critical mass of Lycra hits Harrowgate- concerns raised about possible chain reaction!
• Read the Bristol Flyers blog inside- relive every turn of the cranks!
• Hear a Belgian Waffle!

Basic precautions in the state of the art operating theatres.

Aerospace News
Concerns that a construction firm recently active in Bristol were branching out into the aerospace industry were allayed when a spokesman suggested that it was unlikely that anything they built would actually succeed in leaving the ground.
THE SOCIETY OF ANAESTHETISTS OF THE SOUTH WESTERN REGION

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## Contents

<table>
<thead>
<tr>
<th>Vol 47 No 2</th>
<th>Autumn 2014</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Editorial</td>
<td>Richard Dell</td>
<td>3</td>
</tr>
<tr>
<td>Future meetings of the Society</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>News of the West</td>
<td>Linkmen of the Region</td>
<td>6</td>
</tr>
<tr>
<td>Examination successes and honours</td>
<td>Ben Walton</td>
<td>26</td>
</tr>
<tr>
<td>Spring Scientific Meeting report</td>
<td>James Pittman</td>
<td>27</td>
</tr>
<tr>
<td>AAGBI Cycle Ride for Guy</td>
<td>Rhys Davies</td>
<td>31</td>
</tr>
<tr>
<td>Ross Davis Adventure Bursary Report</td>
<td>Kate Reeve</td>
<td>40</td>
</tr>
<tr>
<td>Severn trainees Anaesthetic Research Group (STAR)</td>
<td>Kate Reeve</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Chris Newell</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ronelle Mouton</td>
<td></td>
</tr>
<tr>
<td>SASWR Spring Meeting Poster Prize</td>
<td>Fran Smith</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Quentin Milner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Corinne Hayes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Matt Greening</td>
<td></td>
</tr>
<tr>
<td>The Wine Column - Chianti</td>
<td>Tom Perris</td>
<td>49</td>
</tr>
<tr>
<td>OOPE Extremes from A to Z</td>
<td>Mark Pauling</td>
<td>51</td>
</tr>
<tr>
<td>Poem - French Leave</td>
<td>Robin Forward</td>
<td>55</td>
</tr>
<tr>
<td>Ross Davis Adventure Bursary</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Crossword</td>
<td>Brian Perriss</td>
<td>57</td>
</tr>
<tr>
<td>Prizes and bursaries</td>
<td></td>
<td>58</td>
</tr>
<tr>
<td>Notice to Contributors</td>
<td></td>
<td>59</td>
</tr>
</tbody>
</table>
Welcome to this ‘Winter is Coming’ edition of Anaesthesia Points West. If you are not familiar with the phrase, it is quoted repeatedly in the TV series Game of Thrones, not that I watch it myself, you understand, although my children find it a useful educational resource combining sex education and medieval torture in a handy smartphone-friendly format.

In this edition I am very pleased to announce that there is virtually a full complement of reports from around the region in the News of the West section, so thank you to all the Linkpersons for collecting all the news and gossip.

There is also a report from the Spring Scientific Meeting, held this year in the Headland Hotel in Newquay, during a spell of glorious weather and five feet of perfect surf. Cyclists also had perfect conditions, with empty roads and amazing scenery so I’d recommend next year’s meeting in May in Plymouth for more of the same.

While on the subject of cycling, Rhys Davies has written a hilarious account of the experiences of his cycling crew as they rode to the AAGBI meeting in Harrogate as part of the Ride for Guy. If you have an interest in cycling, and quite frankly road-biking is spreading like a cross between Ebola and Stepford Wives around here, then you’ll be able to empathise with their adventures. If you’d rather take the train, then there is plenty of Class A evidence in the account to back up your position.

Our foreign correspondents in this issue are Mark Pauling and Kate Reeve. Mark Pauling compares working conditions in Australia to the more economically deprived but culturally infinitely richer Zambia. Kate Reeve, who features twice in this issue, was the winner of the Ross Davis travelling bursary, and travelled to Africa, New Zealand and Asia. I wonder how these intrepid travellers re-acclimatise to life in the NHS, with entirely different pressures to deal with, and less spectacular views out of the window.

From the regular contributors, Tom Perris reminds us of the summer with a tour of Chiantishire in his wine column, and gives suggestions for some red wines to drink with those winter roasts and Robin Forward gives us something to mull over with his poem ‘French Leave’. Brian Perriss provides his regular brain-teasing crossword.

Why ‘Winter is Coming’? Because the common themes from the News of the West contributors is the chronic all year round lack of beds, along with Trusts running up debts, with those debts being compounded by fines imposed when operations are inevitably cancelled secondary to bed shortages. Worrying about winter bed pressures seems to be a luxury for when the usual battle for beds hits a temporary lull. Extra NHS spending, £8bn quoted most recently, is probably not the long term answer. It’s difficult not to be a conspiracy theorist, but using my soapbox on the grassy knoll for a moment, I have a theory. I suspect that once Trusts hit the financial buffers, Monitor is going to
step in and alleviate Trusts from the burden of providing a full gamut of services, and much of the elective work being presently hived off to the independent sector in what seems like a temporary arrangement is going to become a more permanent feature of the health provision landscape. That would leave the NHS as a provider of non-elective services, requiring a work force prepared or contracted to work seven days a week, which oddly enough, is at the core of the negotiations the BMA are currently bogged down in.

Bring on the summer.

Richard Dell
Future Meetings of the Society

**Autumn 2014**
North Bristol NHS
M Shed, Bristol
27-28th November

**Spring 2015**
Plymouth
14-15th May

**Autumn 2015**
Bath
Dates to be finalised

**Spring 2016**
Overseas Meeting
News of the West

This is where you are kept up-to-date on all the news and gossip from each department in the South Western region. The name of the correspondent appears at the end of each contribution and he/she is also the SASWR LINKPERSON for that department. Anyone wishing to find out about more about SASWR, or wishing to join, should search out the local link person, who will readily supply details and an application form. In addition to other benefits, each member will receive the twice-yearly edition of APW- free!

Barnstaple

I was gazing perhaps a bit too deeply into a hospital skip en route to my car, wondering why one would bin perfectly good timber and if there was something that could be put to good use at home, when one of my Gynaecology colleagues drove past in his Mercedes with a smirk on his face. I then began to reflect on what my response should be to his predictably sarcastic appraisal of my compromised position. At the same time, I remembered that the deadline for the SASWR newsletter was approaching and perhaps I was looking in the wrong place for inspiration.

The CQC came to visit, and a team of nearly 60 investigators descended on us for three days. We seemed to come out OK with an open and friendly attitude etc, some areas of excellence mainly in community services I didn’t know existed. All I can see is that we need to do is pull up our sleeves... it appears that not everyone has bought into the ‘bare below the elbows’ mantra.

No one has retired since the last newsletter but we have been awash with locums as HR are usually a few years behind in filling predictable gaps. Laurie Marks has resigned in order to spend more time in Zimbabwe supporting his ailing relatives and we are sad to lose him, as he has always been a very enthusiastic, friendly and resourceful colleague. Perhaps he might start writing his letter from Zimbabwe for Anesthesia News again!

Rubina Ahmed, our chronic pain champion, has added another string to her bow by passing the American chronic pain fellowship at the same time as running the service here singlehanded. One has to be careful not to answer Alison’s phone when she is out of the office or one could be in for a lengthy conversation.

Nick Love started with us at the beginning of September, which coincided with a rather busier than usual Intensive Care Unit and on his first on call was handed over ten patients in what should be a six bedded unit. Start as you mean to continue!

We managed to claw back the darts trophy from the ODP’s in a winner takes all finale. This was thanks in no small measure to Mark Cartmell’s finely tuned manual dexterity (colorectal surgeon), perhaps he mistook bulls eye for brown eye!

On the trainee front we have a bright new bunch galloping their way through their competencies towards the IAC. They are Harriet Daykin, Marc Brown, Martin Paul (or is it the other way round?), Laura Squire and Christian Mertes.

Catherine Dore is now in Exeter buffing up her CV and Matt Casemore is back in
Plymouth. Rebecca “how do you pronounce that” Skrypczsak left us, and Anesthesia and headed for the big smoke. Anna Wamsley and Nick Ledlie are both doing Medicine elsewhere in the Trust and no doubt miss the security of ITU. That leaves us with James Bickley, Eleanor Quinn and David Robertshaw, now grown up CT2’s and beavering away at the Primary. Monika Hanko had a little boy earlier this year and her hands must be full with Balasz doing a chronic pain fellowship halfway across the country. Balasz Ittzes has returned as a locum consultant. (Editor’s note: different Balaszs, or whatever the plural is). Giza did a stint with us before heading back to family in Hungary and Vinod Gupta has become a regular, helping us out in times of need. Most of our middle grades have spent a considerable time in ambulances ferrying patients as far as Graves End Manchester and Truro. Joerg Kuehne, who professes not to have any hobbies except transporting patients from A to B, has done more than his fair share of transfers, but if that is not enough he frequently flies off to more distant corners of the globe, including Toronto a few weekends ago!

Tony Laycock has become something of a local celebrity, featuring in the North Devon Journal for his heroic efforts to correct cleft palates for operation SMILE this time in South America. You may be fooled into thinking that he is lured into this by the promise of a holiday in an exotic location away from the wife with stimulating female company. It’s hard work I tell you!

Cecily Don has stepped up to be our next Clinical Lead, or should I say taken up the reins to extend a horsey metaphor given her equestrian bent. No doubt she will have things whipped into shape before the sun sets over the stables.

If you ever have an emergency then Tim Cobby is your man as he spends a considerable amount of time playing with plastic dummies, ALS, EPLS, ATLS, Foundation simulation, OSCE practice and Neophyte simulation for Anaesthetic Trainees.

Andy Walder, never one to ignore a gadget or two, pioneered the use of the Novolung on our unit and cured a young lady of a fate worse than death. She is now raising money for our unit and popped around to deliver a thank you cake. “Periphery of excellence” as one of our trainees once chimed.

Enough for now, my head is aching.

Guy Rousseau

Bath

We are all professional purveyors of somnolence. That is what we do, day in and day out (for seven days a week if Sir Bruce gets his way). The irony therefore does not escape me how many of us are currently having our nocturnal shut-eye interrupted.

It is with considerable empathy that I congratulate Drs Andy Georgiou, Clare Hom-
mers (ergo myself), Sarah Hudson, Sarah Warwicker, Justine Barnett and Clinton Lobo on the safe arrival of Alex, Evie, Jessica, Charlotte, Thomas and Coralie. We wish Katie Patton and Charlotte Battle well on their forthcoming maternity leave too. Rumours that Dr Goodwin has secured funding for a condom vending machine to be fitted in the department are unconfirmed and quite frankly improbable. There appears to be no funding for anything at all. Besides, he is now too busy ‘appraising’ all of us and therefore does not have the spare time to write a business case for a prophylactic spewing metal box on the wall. Which brings me to the topic of appraisal. We are all scientists and even I understand the fundamentals of robust scientific endeavour. Is it not therefore peculiar that we are all scurrying around collecting supporting evidence to disprove the null hypothesis that we are all lazy, poorly performing doctors with no plan for our personal development?

The closest analogy I can think of for non-medical people is the DVLA giving up trying to catch people speeding and instead requiring all motorists to prove that they don’t speed instead. That and everyone having to file an annual ‘trip plan’ and getting feedback from other drivers every 5 years or so.

Maybe I’m just suffering from chronic lack of sleep and it will all seem so much better when Evie sleeps through the night. When she was born Andy Georgiou sent me a mammoth pack of disposable ear plugs.

Never a good time to take these out, once they’re in…

If there are any left once she is sleeping through the night, I might send them to my colleagues at NBHT to help mute the sound of seagulls and breaking glass. My hope is that they will have had their sewage issues sorted by then and can send me their nose plugs. That seems fair now that they have all the exciting vascular surgery and I’ve had to re-invent myself as a colo-rectal anaesthetist.

While I may be constantly thinking about my next snooze, Professor Cook has also been caught NAPping. He has recently helped usher in NAP 5 and is to be congratulated for doing so. I was somewhat perturbed to see the increased risk of AAGA with TIVA. Fortunately all of our brand new anaesthesia machines include a depth of anaesthesia monitor as standard and so recommendation 7 is an easy win. However, I am confident that those advocating starting pEEG monitoring prior to induction of anaesthesia (recommendation 56) have never placed the electrode on themselves. I have inadvertently brought tears to the eyes of a strapping male trainee doing so and when he returned the favour
I concurred that it wasn’t particularly pleasant. Drs Lesley Jordan and Rachel Awan also deserve special mention for winning their Patient Safety and Care Award 2014. Together with one of our ODAs, Tracey Booker, they attended a five star event in London to collect their award. Contrary to popular belief, they were not part of a charades playing troupe miming “I’m a little teapot...”

Our cherished Fiona Kelly, together with Melanie McDonald and Genevieve O’Farrell won the MPS and AAGBI safety prize at the AAGBI annual conference in Harrogate for their difficult airway tea trolley (a tea trolley touring theatre to entice anaesthetists to be educated about difficult airway management - an easy sell really).

Anyone for tea?

Mel also won the Audit Poster Prize at the same meeting and placed second at the POAG/CoMma Regional obstetric meeting in Taunton for her oral presentation.

The elder statesman of the department, Dr Stephen Hill, has finally confirmed which side of the laid back/ don’t give a damn line he is slumbering on and will now retire. In his own inimitable way, he has eschewed a formal dining out dinner, opting instead for a long walk. This is being organised by Dr Monica Baird (not during SPA time) and I am concerned that some of us might not make it back!

I first worked with Steve as an SHO and have fond memories of house sitting his beautiful home, drinking his wine and being entertained by him in numerous departmental meetings. As a consultant colleague I have benefitted...
from the Bath Anaesthetic Group which he founded, I have been enthralled reading his preoperative anaesthetic clinic letters and I have enjoyed being entertained by him in meetings!

He has been a stalwart of the department of anaesthesia, intensive care medicine and chronic pain management for decades and his laconic style and irrepressible good humour will be sorely missed.

I am confident that his next career as an eccentric inventor will be a fruitful one. The plane he built and then modified to take diesel rather than the more traditional avgas only had a few episodes of ‘engine silence’ and is now flying well.

I wish him many happy hours tinkering in his shed, walking his dog and enjoying his retirement. With Steve gone, I don’t think the department will ever see another blind nasal intubation!

Malcolm Thornton

Cheltenham

Now that an exasperated email from Richard Dell has finally made it past my spam filter, I have been shamed into submitting an update for Cheltenham. Given that our last contribution appeared some years ago, many will have assumed that we had either been taken over, Crimea-fashion, by the Great Bear of neighbouring Gloucester, or that we had been reallocated to another region. For a town that boasts Midlands Today as its regional magazine programme, this uncertainty is understandable. We don’t like to shout from the rooftops up here, but we are back. This all begs the question of what has happened since we last declared anything, and with apologies to all the excellent people with their laudable achievements who have passed through our hands, I frankly haven’t much of a clue – but will phone a friend before I reach the end of this page. I did recently notice that Southmead’s Chris Thompson, who we like to claim as our own because he started out here around the dawn of the millennium, has published a bona fide textbook, Applied Anatomy for Anaesthesia & Intensive Care (apologies to the other authors), and a supreme effort it is too. Hats off Chris, you are now the most famous anaesthetist to come out of Cheltenham.

We continue our deeply entwined relationship with our Junction 11 cousins at Gloucestershire Royal, with most of our number crossing over for cameo appearances in the other. This has led to embarrassing instances of wrong site surgery, an occupational hazard for those
of us with alternating commitments. In the new world of fast-changing service reconfiguration, we also find ourselves – somewhat unexpectedly – a “vascular centre”. The bridleway from Swindon has rarely seen so much nocturnal traffic (dogging on Crickley Hill excepted) and those who (mistakenly) assumed this quaint outpost to be a cushy number for on-calls have had to revise their opinions in the light of the tsunami of atheroma from over the Wiltshire border.

Mandy Rees has assumed the role of College Tutor. With her effervescent people skills, it is the role she was born to play, much like Morgan Freeman with Mandela. She has embraced it with characteristic enthusiasm, and embraced anyone who has entered her office. Except me. Just a brisk handshake. Mel Cockroft, Emily Buckwell and Natalie Grey were the latest of our fine young people to pass the Primary hurdle and have recently moved on to bigger and better things. Natalie also found time to have a baby, so double congratulations; other recent new parents are Madelina Riba and Raj Giriyappa. This very correspondent also tried to divert attention from his imminent 50th birthday by entering the family stakes for the first time. And finally, another of our old SHOs has returned in long trousers, the gentleman farmer/ITU consultant that is Dave Windsor. With his chiselled good looks, organic home-grown sausages and metaraminol infusion, he is what the girls call “the full package”.

Trevor Johnson

Exeter
The past few months have been a time of change in Exeter. We have said a sad farewell to Matt Rucklidge, who has moved permanently to Perth. During the past 10 years he has served the department well with his interests in obstetrics and difficult airways. As befits such an occasion we held a farewell party hosted by Paul Thomas. It proved the ideal opportunity for Paul and Chris to unleash their homebrew on the unsuspecting public. The four brews were apparently all delicious, but even the weakest brew induced some serious Dad dancing. Marina underestimated the power of hardly any homebrew, and cycled home. She was almost home and dry, when the episode with the dog occurred. A few “too ugly to come to work“ leave days later, plus some expensive dental work, and she is as good as new. Al Martin unleashed his drone on the party, and this time I don’t mean Fiona. Despite endangering the lives of all present, as it swooped and soared above the crowd, it did take some pretty spectacular pictures. We wish Matt success for the future, and secretly hope he will return.

The three stooges

As always at this time of year, lots of the trainees who have worked hard during the past few years have moved on. We wish them good luck in their new posts. Just
beware of TINDER – you know who you are! Many congratulations to Ben Ivory and Tom Clark, who have both been appointed to consultant posts in Torbay, and to Geena Mathew who has a consultant post in Southend. Also, hot off the press, congratulations to Alex Mills, Cathryn Matthews and James Simpson, who have all been appointed to consultant posts within our department. We look forward to you joining the gang.

Welcome to Graham Simpson, who has started as the newest pain consultant, and only took a week of unpaid leave in August, and to all the new trainees who started with us in August.

We have had some sickness. Nick Batchelor seems to be recovering well from his injury. It seems his main mistake was to have been too sober at the time.

Also I wish David Conn a speedy recovery from his recent major surgery. Luckily he had a real anaesthetist who was able to give a proper (general) anaesthetic, and is now recovering well.

Lauren seems to think she is the Queen, having two weddings and of course two honeymoons. The first was a small affair on a beautiful day in Dartmouth. The second was a big knees up in Woodbury, with the Sux Pistols making a comeback, and lots of vigorous dancing. A good time was had by all.

There have been lots of babies. Rachel had Margo, Libby Fontaine had Theo, James Lloyd had Jack and Mark Jackson had Evie. Well done to all of you. At least half of you hardly felt a thing. Congratulations to Megan who is expecting her first baby.

We have sailed through August, without me having to sell my soul or beg anybody to do extra work – thanks to locums Fran Smith, Alex Mills, Andrew Woodgate, Tom Woodward, Dom Smith, Peter Valentine, and Catherine Dore (who has yet to emerge from ITU). Job planning has gone fairly smoothly, judging by John’s still full and glossy head of hair. There were a few winners and losers, but mostly same same. The Trust seems to be appointing new surgeons daily, despite no vacant theatre slots. Evenings and Saturdays are becoming the norm. And somehow we already have a bed crisis in September. So, that’s about it until next time, other than to say well done to Mel Hawkins for rendering Teabag speechless when she revealed her former life. Maybe more of that next time.

Pippa Dix

Gloucester

Greetings from Gloucester. We have had a busy few months with several new appointments, marriages, births and parties! Alex D’agapeyeff has been appointed as Speciality Director for Anaesthesia for Gloucester and Cheltenham. As one of the youngest members of the department we are all very grateful to Alex for stepping up to the plate. He is doing a fantastic job and has particularly enjoyed spending his summer job planning for all 57 consultants!

We are delighted to have appointed Henry Murdoch and Owen Bodycombe as new consultant colleagues and Caroline Price from Oxford as a locum consultant. We had the customary drinks and curry night to welcome them to the department which was great fun as always. There has been a fair bit of sporting activity over the summer. Belinda
Pryle, Louis Khor and Charles Rodriguez have all run the Cheltenham half marathon in fantastic times and Sarah Bakewell participated in the Cheltenham triathlon.

Congratulations to Ian Crabb on the birth of his fifth child, a daughter called Iris. Also to Tanya Brookes who has just returned from maternity leave following the birth of her son. Tim Cominos has recently got married and been to Costa Rica on his honeymoon. Finally, Vicky Lewis is due to tie the knot this November.

We were sad to say goodbye to Joe Cobbe who retired this summer. He has been a member of the Gloucester anaesthetic department for about a million years and will be greatly missed.

Our trainees have been busy as always. Jonathon Lightfoot has been appointed as a locum consultant in Gloucester before pursuing his interest in music. Emma Clow has been appointed as a locum consultant at the BRI and is hoping to travel later next year. Hamish Breach is studying for an MSC in regional anaesthesia at the University of East Anglia. It is a three year programme which is online distance learning. He highly recommends it to anyone with an interest in regional anaesthesia. Liz Hood and Catherine Bryant are shortly off to Uganda for three weeks to do some Obstetric anaesthesia. Nicola Stewart is currently cycling from St Malo to Bordeaux with a group of girls called ‘the pink ladies’. They are cycling for the Anthony Nolan trust and challenge adventure charities. We wish them all a safe return from their travels. Not to be outdone by our trainees travelling around the world, a large cohort of the consultant body are currently packing their suitcases in preparation for the Doctors Update in Portugal. It is a shame that we have to travel to a club med hotel, where I believe we can play tennis and golf, in order to keep up to date with current best practice in anaesthesia. I will report back in the Spring addition!

Claire Gleeson

North Bristol

It would be fair to say that over the last few months it’s been rather an interesting time at North Bristol. Things, despite years of feverish planning haven’t quite gone as smoothly as one might have hoped but we’re now firmly installed in the shiny new Southmead Hospital and to quote Mr Vandross “there ain’t no stopping us now”. It’s difficult to know where to begin but suffice it to say that there have been one or two teething difficulties that have tested the patience of many and have shown just what a resourceful department we are. Even the local seagulls conspired against us by mistaking the nice round white pebbles installed on our flat roofs for eggs, which they then picked up and dropped on the £4000 panes of glass breaking several in the process. We do now have a resident falconer to watch who provides weekly viewing from our rather lovely 5th floor staff canteen that we are frequenting all too often when there’s yet another delay in theatres. Much of the fire fighting during the more than turbulent early days, was done by the anaesthetics department. At times it felt like everything that could possibly go wrong did and then just when all those were sorted it was time for the things that were impossible to go wrong to malfunction as well. Still, most of it is sorted now and all that is left to do is work out a way of making things work a little quicker. During this process moral
has taken a real hammering, particularly amongst our nursing colleagues and there has been quite an exodus to other local institutions. The rota writers have been working feverishly to keep all the lists covered. How they have done this is astounding as most of the time no one quite knows which lists are happening let alone where. There are frequent pleading e-mails asking for last minute substitutes and it’s a credit to the department that all requests have been met. I suspect patience may now be starting to wear thin though as a particularly benign anaesthetist (not Dr Leigh) recently returned to the department muttering that if (insert name of a neurosurgeon) told her one more time that the last case was “just a quick one” only to be there 6 hours later they would personally see to it that the last brain that particular surgeon saw was their own. Talking of anaesthetic departments our living space is quite frankly amazing. It even has its own balcony which we’re not allowed to use with the doors to it having been firmly locked. Don’t think for a moment that that has stopped certain members of the team from displaying worrying evidence of a misspent youth and happily we now have outside living space once more. Our secretaries are keeping the ship afloat and amusing themselves by taking updated photos for the wall of shame – much evidence of hair brushes in use prior to said photos being taken with the exception of Drs Whittle, Hooper, Lewis and Thomas who didn’t have to worry.

Those in ITU have been having an easier time of things. Teething troubles were far fewer and all members of staff who were lost and given up for dead have now been found somewhere in the unit’s vast expanse. We still have more beds than staff but now have more staff than we’ve ever had before. To celebrate the opening of the Guy Jordan Seminar room on the Unit we managed to have the first cake and alcohol rave in the new hospital. The “no alcohol on the premises” policy was well and truly flouted aided in part by one or two Victoria sponges finding their way into the security office. Guy’s dad, Gareth Wrathall and the new Chief Executive all gave excellent speeches and we all felt the room was properly christened. There have been a raft of new appointments recently with Dr’s Burrows, Care, Darweish, Davey, Davies, Goswani, Janssen, Nickols, Thompson and Whittle all joining the fray.

Dr Whittle’s retirement from active service with the RAF means we are down to two military personnel embedded with us but both have more than made up for the shortfall with one in particular recently bouncing into the department and letting all who cared to know that she’d just brought a gentleman back from Sierra Leone with a little more than a cold. Never have so many moved so fast in the opposite direction to her route of travel! With the appointments of Drs’ Carey and Davies A joining with Drs’ Tolchard and Davies R we now have a full compliment of what have become fondly known as “the Four Northmen of the Apocalypse”. We also welcomed back Dr Thornton from her holiday in Swindon and will shortly be welcoming back Dr Harris (R) from his holiday at the Children’s Hospital. We said a sad goodbye to Dr Chris Johnson after many years of service. Being an expert in wilderness medicine Chris came back for a brief last hurrah that involved leading tours of the new hospital.
His was always the most popular tour as there was an absolute guarantee that no one would get lost and if they did would be found, fed, watered and airlifted to safety before anyone had noticed.

Out of work activities abound, mainly involving bicycles and horses. Dr Dunne won a prestigious dressage competition and then promptly fell off her horse and became yet another member of the Anaesthetics department to experience life on the inside.

Dr Shinde persuaded a few colleagues to cycle to Harrogate from Bristol for the AAGBI conference and then wisely decided to cycle from London herself instead. Clearly, what happens on Tour stays on tour but the odd bit of gossip filtered back including tales of heroic mountain ascents (Dr Burrows), rousing motivational speeches (Dr Martindale) and sore bottoms (Dr Carey).

A full unexpurgated version appears elsewhere in the journal.

Three new babies to report, named Alexander, Joseph and Ruby being the works of Drs Thomas (M), Marsh and Tolchard respectively.

Lastly, trainees who are too numerous to mention but are invariably excellent and have adapted far better than many of us to the new environment. Lots of exams passed as always.

Ben Walton

Plymouth

Richard Struthers has continued to fight our corner and has shown infinite patience in the ever more Kafkaesque job planning. The beautiful summer has distracted most of us from the ongoing saga, with half of the department still waiting to have their job plans signed off – but it’s only mid-September. This has led to a frustrating delay in the official confirmation of a new record for the shortest time to change a job plan after starting work. Matt Ward shattered the previous record of a couple of weeks by altering his job plan on Day 4, before he had even done any clinical work. The new starters (Michelle Barnard, Paul Margetts and Jess Welbourne) could only look on in wonder at the nimble footedness of Matt as he realigned his job plan to lay the groundwork to take over as college tutor (and more kite-surfing). He has now taken over the role from Andy Rushton and has some big shoes to fill. Andy has done a superb job and we are all extremely grateful for his hard work and dedication to the job. Good luck, Matt.

In the post summer elation we have the delight in welcoming new appointments and we look forward to welcoming Ruth Treadgold, Kim Chishti and Robert Tonko to the department...as soon as possible, please! The new and returning trainees...
have settled in and are making us all feel a little older – “Oh, you’ve been away for two years” really translates as “what have I done in the last two years?” A particularly warm welcome to Penny Geens who is over from Christchurch, New Zealand. She has enabled some fond reminiscing of time spent in New Zealand, right down to living in the same house, albeit one of us pre- and the other post-earthquake.

After a great farewell bash of tapas and fine wine, Mary Elphinstone left in May for the long trip to Saint Helena. Unfortunately they hadn’t restocked with Vin de Constance since Napoleon was there, and the thought of long evenings without a quality dessert wine led to a quick decision to return to a more civilized life. There are some things that one simply can’t live without. Unfortunately Mary has decided that she isn’t coming back to the anaesthetic department and she remains sorely missed. The only other person who is pretending to leave is Colin Fergusson who is giving up Anaesthetics to concentrate his remaining years on ICU.

There was a good turnout from the department to support Mel and Sam, who were shortlisted for “Non-clinical team of the year in the hospital’s Star Awards. After much excitement Mel and Sam were unlucky not to walk away with the prize. Rumours that Sam didn’t manage to find the venue because she had been tipped off that they weren’t going to win are completely unfounded. Magnanimous in their defeat they paid tribute to the people that make smoothies on Level 6. (They are damn fine smoothies.)

The department has seen four recent weddings with Juleen Gill (now Fasham), Sarah Droog, Matt Boyd and Mark Pauling all marrying people outside the department – it was much easier when the Brown’s were here.

The better weather has seen a return to the departmental commitment to gain a better understanding of all that is labour ward. The proud, but tired, new parents are Ross Vanstone (baby girl in April), Steve Copplestone (baby girl in April) Juliet Barker (baby girl in May), Laurence Hullatt (baby boy in May), Matt Ward (baby boy in July), Dave Viira (baby girl in August) and Rich Reed (baby girl in August). Anybody wanting some kite-surfing kit should contact Matt Ward directly. The majority of new fathers decided that the statutory parental leave was sufficient. Ross Vanstone’s wife however was keen to have a bit company at home. So eager was she that she sent Ross out on their three year old’s skateboard and then pushed him off. Not having thought it all the way through she hadn’t realized that having an arm in plaster for six weeks would mean no nappy changing for him. Frustrated by his incapacity she kicked him out every morning and to his credit he managed to get in to the hospital on most days, despite being unable to drive.

Other landmark occasions have involved Mel having a birthday and Sam stopping having any more birthdays. The south west exam courses continue with the success for which has become routine. For the AWSoME course 9/10 SW trainee’s passed and for the DAFT course 9/10 SW trainee’s passed. The organisers would like to say a big thank you to all those who continue to support these courses. Summer training has been going on apace and the difference between the regions rugby teams has had some knock on effects in the local hospitals. The transferable skills from the respective rugby teams
have shown benefit in some nimble footed manoeuvres in the anaesthetic and HR departments. Locally the majority of the departmental elite athletes have had a summer off, meaning that none have required time off to recovery for injury. There has of course been almost compulsory participation in Tour de Moor. There have been a few hardy souls that swam around Burgh Island whilst others paddled a variety of craft around with them. The idea of support crew seemed alien to most and it is unclear if the swimmers expected to be cut-up and cuffed over their becapped heads with an assortment of paddles. Oh and it wasn’t a race …allegedly. The only really insane sporting achievement was Pete MacNaughton who completed the Tenby Ironman in 12:50:24 and came home in an extremely creditable 6th place in his age group. These exploits, however, pale compared to the character of some. Dave Birt has shown the fortitude, strength of character and cheerfulness in the face of adversity that typifies his approach to life and for which he has been admired by all in the department since he arrived 15 years ago. In between bouts of chemotherapy Dave is repeating his Commando challenge from 25 years ago. He will be yomping 30 miles across Dartmoor following his original course from a few years ago. Among others accompanying him will be his son, Harry, and Andy Burgess. If you would like to support Dave in his fundraising for the Pancreatic Cancer Research Fund his fundraising page is - https://www.justgiving.com/Birtie We have no doubt that Dave will successfully complete the yomp but the jury is out on whether Andy Burgess will make the cut off.

**Swindon**

Zeus was an angry god who liked to do his own thing so, like Hal, he had to go. We now have Perseus, son of Zeus. I like Perseus. He’s straight with me, not too clever for his own good and, by pressing the ‘Consultants Only’ button, will turn the Gorgon surgeon to stone – a nice Drager innovation. Very German. Although not formally gagged, your scribe has agreed to craft his language on his opinion of Zeus. I hear a deafening silence.

As July gives way to August; the evenings draw in and the signal is raised that ‘tis time our trainees make haste back up the M4 to base camp to make way for new blood. Twelve new recruits ranging from CT1 to ST7 duly arrived on 6th August. No strange names this time: Rhys Rhidian the nearest to qualify – must be Welsh. Sky, odd name winner 2013, turned out to be an excellent fellow.

It is not just our trainees that jumped ship. Your scribe devotes the rest of his prose to two of our lifers.

Mike O’Connor will be well known to the Bristol old lags. A Bristol graduate, MOC came to Swindon as a registrar in 1986, returning as a consultant in 1989. Mike was appointed to assist Mike Tattersall (NOTW, Autumn 2012) to develop the embryonic pain service, establish an acute pain service and, when not engaged in this, to do his thing on the ICU. It is rumoured that MOC soon realised ICU was not for him when some of his patients got better – he dropped ICU to concentrate on pain, a proper challenge. One would think this enough to keep MOC occupied, but wait, there’s more: Mike found time to be an FRCA examiner as well as Trust Director of Medical Education. And, even as I write, although MOC has put away

Matt Hill
his laryngoscope for good, he is still at work, part time, ‘supporting doctors’ at the Deanery. A couple of MOC curios to titillate SASWR readers: a Birkenhead boy, MOC was a direct contemporary of Paul O’Grady at school. Will Lily Savage one day make a surprise appearance at the SASWR dinner? And there’s still more; MOC’s wheels have always been a sporty soft top; but, as far as we are aware, no-one has ever seen the lid down.

The other lifer, having administered to the sick and worried well of Swindon for many years, is Faz Rahmani. The gold standard associate specialist, Faz got on with the job. He never came seeking advice or to cancel a case. Nor do I remember him getting into difficulties with his charge. . . just the occasional ‘crem form’ (only joking). Faz was quick too. His ODP had to be nimble if he was to apply any ‘monitoring’ before the patient was rendered insensible. Surgeons loved him.

Although your scribe has worked in the same department as Faz for 16 years, he realised he knew little about the man. An e-mail was dispatched. This is Faz’s reply, which your scribe felt worthy of addition to his report in unabridged form:

I was born in Tehran. When I was three years old, my father was appointed by the newly formed “Iran Air” to head its office in Kabul. We were in Afghanistan for the next seven years and I have very pleasant memories of my childhood there. My later schooling was back in Tehran and luckily I managed to get the right grades for entrance to Medical School. There was, however, a twist as I decided to do my medical education in Pakistan. In the mid 60s there was a regional cooperation agreement between Iran, Turkey and Pakistan. This included a student exchange programme, and as medicine in Pakistan was a five year course as opposed to seven years both in Iran and Turkey, my mind was made up! Starting Medicine in Karachi in the late sixties with limited knowledge of English and having to pass an exam every other week was not fun!

It was during my third year that I had my first taste of charity work. Villages I had visited in Sind, near Karachi, had no water, electricity, health facilities or even schools. The majority of the population were what were then called Untouchables. Their living conditions made a permanent mark on my life. A little pond with dirty water was used for bathing humans and animals, the same being used as the only source of drinking water. I had enough money to plan construction of a shower room and get fresh water piped from a nearby village. A couple of months later, visiting the village, I discovered that the fresh water was merely topping up the dirty pond. I learned early that effective charity work is more than just hand outs!

My arrival in the UK in 1972 was a big change indeed. My first SHO post was in Dewsbury in Yorkshire. My boss, a senior Consultant Anaesthetist, was doing a study on the use of apomorphine to empty gastric contents prior to Caesarian Sections. Imagine women rolling and screaming in pain while my boss and I added to their misery by giving these unfortunate mothers apomorphine with all too predictable results. I have always wondered what happened to that study and did any hospital use it as their technique of choice!

Over the next few years I was, to some extent, a wondering minstrel of anaesthesia, mostly
in the UK, but with a couple of sojourns abroad. In 1975, I was in Nigeria, where a retired Irish Professor and I managed the Anaesthetic Department at the Ile-Ife University Teaching Hospital. Professor Sheila Kenny claimed that she had been first to recognize Malignant Hyperpyrexia, I never got to establish the validity of this claim! In 1981 a job offer at Montego Bay, Jamaica, was all too tempting. However my two year contract was terminated by me after one year due to non-payment of wages due to the ‘financial difficulties’ of the Jamaican Government!

In early 1983, having returned to the UK after my Caribbean experience, scanning the BMJ I noticed an advert for a two day locum job at Princes Margaret Hospital, Swindon. I was ‘interviewed’ by Drs Peter Babington and Mark Jackson (NOTW, Autumn 2010) for the post and the rest is history: Swindon became my place of work for the next 31 years. Both professionally and socially, it has been a truly enjoyable 31 years of my life.

Although he has never mentioned it to me, your scribe knew that Faz was involved in charity work, but had no idea this went back 40 years, or of the extent of his work, both in the Caribbean and Africa. Readers who would like to know more about Faz’s current projects should look at www.zambiangems.com. Your scribe is humbled.

Doug Smith

Taunton

Our department has seen plenty of comings, goings and retirements over the past year. We have welcomed Fiona Dempsey as our new intensivist, Nicky Campbell and Abigail Hine, both of whom are Taunton graduated trainees, and Rurai Moulding who joined us from Weston Hospital. This year we also saw two of our departmental heavyweights (in seniority, not BMI!) leave – Dr Richard Desborough who put down his propofol syringe the week before his 70th birthday, and Dr Andy Daykin who has been enormously influential in our department over his distinguished career. Both will be enormously missed. We are also sadly going to be saying goodbye to Jonathon Alper, a fantastic staff grade who has been with us for 10 years but has retired due to ill health. Dr Jasmine Lucas, another of our senior consultants will be retiring at the end of the year and will also leave a big void in the department. Steve Harris has temporarily left us on a career break to surf the shores of Auckland. Finally we reluctantly said goodbye to Matt Ward who defected to Plymouth – something about the choice of delicatessens being better further south?

The Taunton junior anaesthetic team of the future has also expanded as we welcomed babies for Dr Julie Lewis (Joseph) and Nicky Campbell (Oliver).

We have another lovely bunch of trainees with some great exam successes - Lindsay Arrick passed the Final FRCA on her first attempt and Adam Carpenter passed his primary FRCA in a similar fashion.

In job news, Jane Thurlow has taken over as director of medical education in our trust and Richard Gibbs has been elected to the ICS board. Barry Nicholls continues to be on the board of AAGBI and secretary of ESRA. Stuart Collins now oversees the final FRCA question setting as well as being an examiner for the RCOA. Dave Creasey is our current excellent clinical lead. Mike Walburn has been working with the IHI in America and now has several qualifications.
in Healthcare improvement science. Nick Kennedy (our theatres clinical director) continues to be president of SOBA, on the South Gloucester commissioning group and on the CPD board for the college in overseas training.

The Hospital opened its new multimillion pound Jubilee Building in Spring this year. This is a 128 bedded, 3 floor surgical bed block with all single, en-suite rooms. The nurses with pedometers report walking more than 5 miles on each shift but the patients love it. We are about to lose our chief executive – after 6 years she has decided to hand over to someone willing to stick us out for the next hemi-decade. We are also now the only bid in place for a take-over of Weston Hospital. We will find out before Christmas if our bid is successful or not. Much change ahead!

On the social front, Taunton anaesthetic department lycra uniform is still out in force with too many cyclists, triatheletes and Iron men to mention. We hold our regular cyclopuffathons which have more to do with beer than cycling but still pull in the crowds. We had a fantastic retirement do at Hestercombe House for Andrew Daykin in June, attended by about 150 of his inner circle of colleagues, and a great departmental Barn Dance in February which illustrated why we all chose medicine over dance as a career choice!

Helen Hopwood

Torbay

What a glorious end to summer the last couple of weeks have been- warm, sunny days with misty mornings the only sign that autumn is not far around the corner. What a shame for the holiday makers that it rained from the minute the schools broke up to the day they went back. Especially after they spent millions repairing the train line at Dawlish in time for the summer hoards. Still, what is the best way to keep cool during this Indian summer? Surely, it has to be ‘the ice bucket’ challenge! We have not been immune to this internet craze here at Torbay, certainly a more healthy option than Ebola if you are going to go ‘viral’. Just think of all that money raised for charity (ahem…) and be thankful we haven’t got a hose pipe ban when you’re filling up those buckets.

But I digress. Let me tell you what is new here in sunny Torbay. Firstly, at the top of the tree, our chief executive has resigned (see previous column for the story behind this) and our medical director John Lowes has admirably stepped into the breach to provide temporary cover. David Sinclair is now our medical director and we also have a new chairman of the trust too- Sir Richard Ibbotson.

In our department Nuala Campbell is enjoying her own Indian summer with a 4th year in her term as Clinical Director and Andrew Gunatileke has the unenviable task of replacing Tas Ali as the new chairman. Tony Matthews has stepped down after 6 years as College Tutor to be replaced by yours truly and we also have 3 new ICU consultants due to start over the next few months- Richard Eve, Ben Ivory and Tom Clarke. We look forward to welcoming them into the department with the (now traditional) ice bucket challenge. Steve Stamatakis continues for the time being as a locum consultant, and Cathryn Matthews having only just started as a locum, has already been poached by Exeter (boo, hiss!).

There has been an active anaesthetic social programme this summer. Thanks to Richard Hughes for organising a paddle down the river Dart from Stoke Gabriel to
Tuckenhay, perfectly timed to coincide with good weather and an outgoing tide to help us home after a few pints of beer in the Maltsters arms! Then there was the equally glorious evening paddle around Burgh Island off Bantham Beech. Again, thanks to Richard for reminding us why this part of the country is such a beautiful place to live.

Finally, most recently we had the department summer BBQ. Once again John Carlisle played host to a fantastic afternoon of hog roast and garden games. Rumours that Tod Guest was brought up in a travelling circus as a Diablo performer are apparently unfounded.

As far as meetings and conferences go, Torbay has also been doing its fair share to keep everyone’s CPD points ticking over this year. In July, we hosted the annual scientific meeting of SOWRA (South West Regional Anaesthesia group) and enjoyed a full day of lectures and workshops including an excellent presentation on suprascapular blocks from UBHs' own Simon Lewis (Editor’s note: some confusion here, surely that should be the Spire’s own Simon Lewis? He’s not called the Monarch of the Glen for nothing). Then later this year (5th December to be precise) Torbay will be hosting the annual scientific meeting of SWAMS (South West Airway Management Society). So if revalidation is looming and you still haven’t cracked the matrix, then Torbay could be the place for you.

As always at trainee level we have had to say goodbye to a number of people and hello to a (hopefully) equal number. Two of those to have recently moved on achieved some kind of record by spending over three years here and the department is considering erecting some kind of garden bench in their honour. Certainly Dan (Quemby) and Dom (Smith) would have enjoyed sitting on it for long periods of time had they still been here.

It was also goodbye to Claire Attwood, Andrew Biffen, Kat Tober, Martin Dore and Ailee Pigott which meant hello to Iain Robinson, Kat Mahoney, Tim Warrener, Anna Perham, Carlen Reed-Poysden, Sandeep Kusre, Steve Copplestone, Adam Revill, Theresa Hinde and Danielle Franklin.

So by the time you read this will some of the ‘great’ have one out of ‘Great Britain’ or will it have been good riddance to the whingeing Scots at last? That depends on your point of view I suppose. Seeing as the deadline for this article is the day of the referendum I can only speculate.

Until next time…

Andrew McEwen

Truro

It’s as fantastic as ever down here. We have had a wonderful summer in Cornwall (I speak for myself, and when I say Cornwall I like to think that Brittany is an annexe of said county).

Of course it started so well with the spring meeting here at the Headland Hotel in Newquay, and the sun has been shining ever since.

“So if I’m not doing my list in the morning, who is? Oh…You!”
It was fantastic to see those of you who managed to make it down, an excellent effort at a busy time. Those who did were rewarded with erudite and entertaining speakers, and wonderful weather in a lovely setting. We managed to persuade a very small selection of our ODP’s to come too, and we were lucky enough to enjoy their company for aperitifs on the terrace watching the sunset over the Atlantic followed by a delightful dinner. I think the mistake came in letting Duncan get competitive at the bar, trying to taste every whisky (with an Irishman - der).

We all saw sense and left them to it, a lucky escape. Thank you again to Ruth and Paul for organising the whole thing.

Now I shall move onto the usual matters. I think I am right in saying that we have had only one departmental delivery since last time. Patrycja Jonetzko has had a baby, we haven’t seen her since but hope they are all doing well and look forward to her return next year. We have very recently appointed two new Intensive Care Consultants; Dave Ashton-Cleary got “his job” as he called it, and we look forward to meeting Matt Holand who comes to us from Wolverhampton and is a “very nice bloke” apparently. Hopefully by
the time this is published we might have three more anaesthetic consultants too. We have more trainees to add to our collection and, of course, have waved a few off to further a field. Anthony Bradley is now a substantive consultant in Bristol Children’s, which is fantastic news.

Last week Megan Thomas won first prize for a presentation at the AAGBI Annual Congress, presenting a piece of work produced by Will Rutherford and SWARM. Anna Ratcliffe is presenting, as I write, at the British Blood Transfusion Society Annual Conference, with Cathy Ralph there to support. Cathy and John Faulds head our blood conservation team, which is acknowledged nationally to be one of the leaders in the field.

Another proud moment is hearing that Roger Langford and Dave Ashton-Cleary have had a book published, ‘Key Clinical Topics in Anaesthesia’. I am sure it’s a fantastic read, and in addition to this may have prevented Roger having a 5th baby? On to the departures lounge, Richard Page has officially retired but has come back to do his preferred lists (just ECT?) and did NOT want a party, so has NOT had one. I am missing his lovely presence in the place, the familiar schlepping of his shoes along the corridor and his Eyeore – like-but-spot-on comments. We have seen Ding, in some unlikely places. And she looks fantastically well and relaxed, even when fending badly behaved children off her basket weaving. Of course Adrian Hobbs and Lars Jakt are missed by us all, the OSU have been having a field day. “Dr Hobbs didn’t do it like that….”

Treliske, as of today, needs a …new Chief Executive. Well fancy that! I have a couple of potential candidates lined up below.

Note they both are well prepared with life jackets (sinking ships and all that).

So pretty much same old/same old down here; losing money hand over fist, no beds, no “actual physical” beds, not even a trolley for some patients. Electronic prescribing is
now established, with masses of foibles. I am blaming it for unscrewing the bottom of my O2 flow meter on the side of the anaesthetic machine this week, it’s the only explanation I have.

I shall end on a positive note. Cornwall is beautiful and the hospital staff are as entertaining and hard working as ever. So in conclusion, we are lucky to be here.

Georgia Brooker

UHB

This time I must be brief to allow the necessary column inches for our friends at North Bristol to recount their tragi-comic stories of moving hospitals with you. How we cried! How we laughed! Our hats are off in admiration to those involved in what must have been a hugely stressful exercise. Here at University Hospitals, we’ve had our new ward block open with a few less significant hitches, although the ITU are going to have to wait a bit longer to go across. The paediatric team have moved into a lovely new office in which to consume caffeine and look busy.

Speaking of hiding, we’ve all been doing our utmost to avoid the inspectors from the Care Quality Commission who were stalking us last week. This involved careful manoeuvring of oneself around the building, maintaining high levels of suspicion when confronted with strangers, and judicious booking of annual and study leave. The managers told us to be “honest but not naive”, whatever that’s supposed to mean. Presumably they don’t read Points West. Look out for the results of the inspection on the CQC website, or if it’s not gone well, the Daily Mail.

To be honest, it’s getting harder to hide now drone activity is on the increase. This was in evidence at the late summer BBQ organised by Becky Aspinall, where the whole department was ‘papped’ by a drone flown by Ben, Charlotte Steed’s husband.

‘Does this thing come with Hellfire missiles?’

A friendly game of softball ensued, but it turns out we only play hardball at UHB.

A friendly game of softball

The general anaesthesia team have been fortunate to attract some lovely new consultant colleagues in Kaj Kamalanathan, Ruth Murphy, Ali Johnstone and Sarah Saunders. Great to have you - now get on with it! Our Leader’s words, not mine.

In the ITU team Richard Eve has moved to Torbay, and John Hadfield is already showing signs of mellowing as a new dad. Claire Dowse and the ladies organised a fine evening for the hospital consultant’s
committee. Local anaesthetists’ pop group “Debbie Does Dallas” provided the tunes while the girls made shapes on the dancefloor. Provenance of the band’s name can be easily Googled, in case you were wondering. Rachael Craven has once again been risking her life in the studio of the Radio 4 Today programme, and also treating refugees in war-torn Syria. Rachael’s years of selfless service overseas was recognised by the AAGBI who awarded the Pask Certificate of Honour. We are all full of admiration for you, Rachael. [historical note: Prof E A Pask was the chap who allowed himself to be anaesthetised via a Bain circuit and thrown in a pool to test lifejackets during WW2]

Finally, some news from the SASWR website. We’ve tentatively moved into the arena of social networking with our Twitter account @SASWRorg. Please make us look popular and join in the conversation by following us - no one else will! The best tweets including our hashtag will be published on the website...perhaps. We successfully deployed electronic registration for the last meeting and we are keeping it for the future. There is also the option to pay a year’s subscription as a one-off if you’ve let your subscriptions lapse - please check. Membership entitles you to big savings on meeting registration. We look forward to seeing you all in Bristol this November.

Ben Howes

Weston-super-Mare
Regarding Weston, we are nearly there to hear the news about ourselves(!). Who knows whether Weston will be part of Bristol or Taunton? Having said that this kind of excitement comes and goes. It has been going on for a long time. Important thing is the hospital looks good. Front make over is done. Costa Coffee welcomes at the entrance of Weston hospital. Of course bit of a squeeze and crunch on WRVS shop.

Summer is gone and autumn is here. It was time for the famous five (boys) Emil, Alex, Paul, Ed and Jon to move on from Weston. Not baby anaesthetists any more. Welcome to our new bunch of trainees Amy, Katie, Kathryn, Mohammed and Lauren all enthusiastic and talented. We have already seen some good talent there (liking baking cakes).

All in all a good summer at Weston. Some of us went away, some stayed back to make life (rota) greener.

Guru Hosdurga
Examination Successes and Honours

Primary FRCA
Adam Carpenter
Mel Cockcroft
Emily Buckwell
Natalie Grey

Final FRCA
Lindsay Arrick
Libby Fontaine

FICM
Lorna Burrows
Keith Davies
Ian Kerslake
Emma King
Alex Middleditch
Ed Scarth
Sarah Sanders
Reston Smith
David Windsor

Society of Anaesthetists of the South Western Region Prizes

Poster Prize: Fran Smith

Miscellaneous examinations

Please accept the apologies of the editorial team if your success has not been mentioned above. We can only print the names supplied to us by the college tutors and linkmen from around the region.
A select number of SASWR members last May took destiny into their own hands and ventured into the independent minority state that most of us thought was the county of Cornwall. This was at the invitation of the Truro Anaesthetic Department who were hosting the spring’s Society meeting. Ruth Taylor and Paul Waterhouse had taken on the organisation of the meeting and chosen The Headland Hotel in Newquay to be the venue.

and mountain bikes and it was clear that the meeting was going to provide more than just CPD. Was SPA to be renamed - surfing and peddling activity?

The dynamic organising duo of Ruth Taylor and Paul Waterhouse
The hotel sits virtually on the beach and looks out over one of the better surfing beaches this country has to offer. It instantly became obvious why the Cornish would like to keep this part of Britain to itself. It was stunning. Glorious sunshine, turquoise water and perfectly formed waves. We had hit the jackpot. As the delegates arrived the usual array of overnight bags were supplemented by wetsuits, long boards

Gold coast? No, the Cornish coast
The meeting was opened by the President, Dr Chris Johnson, who welcomed us all and thanked the organisers for all their hard work and skill in arranging the
meeting. He extended his thanks to the representatives from the pharmacological and medical devises industry that had kindly supported the event. The first academic session was then chaired by Dr Claire Preedy and themed on ‘Innovations in Medicine’. First up was Dr Rob Searle who discussed outcome measures of quality, particularly the value of using the web based ‘my clinical outcomes’ software for this purpose. If you had not heard about the ‘Epidrum’ before this meeting, its inventor Dr Jim Roberts was able to use its development to discuss the processes and pitfalls that exists in designing a new product for medical use. His Innovation centre at UCL is trying to improve the way this is done as it is far from easy. Dr Gary Minto then talked us through what new advances in patient management have come from the recent published literature. It re-affirmed that is very unclear which half of what we know is actually true.

Dr Geoff Wigmore then tackled the tricky issue of the Mental Capacity Act, how to make a decision of ‘best interest’ for a patient and the issue of patient restraint. Dr Rebecca Mawer then followed up with how to minimise the ‘negative experience’ of the anaesthetic room for the difficult child. The long-term behavioural consequences of a distressed child in the AR need to be better appreciated and she described many useful strategies on how to keep everyone calm.

Lunch followed and was notable because many of the delegates spent the meal longingly looking out to sea imagining they were characters from the film ‘Point Break’. The organisers had to skilfully corral the delegates back into the lecture theatre for the next session, lest some of them were tempted to put on their speedos and make a dash for the water.

The next session was all about Paediatric retrieval and we were very fortunate to have Dr David Lutman from Great Ormond Street Hospital giving us an update.

David is the paediatric retrieval lead for this famous hospital and has seen it all: Local, regional, national and international retrievals. By using a series of case studies, he took us through what to do in some of the tricky aspects of stabilising and transferring very sick children. He was honest enough to admit that on one trip, the ambulance he was on had actually knocked over a child on route to a retrieval. This made his service truly self-sustaining! There was then a demonstration of the EZIO and an update on its use in clinical practice. Finally Fergal O’Malley, who had previously been on the retrieval team at GOS and who is now a Nurse Practitioner in Plymouth, went through what to do in some more paediatric clinical scenarios.

The final lecture of the day was given by the charismatic Lieutenant Commander Andy Watts.
He talked to us through the evolution of air sea rescue, particularly its development in the Southwest. He clearly has a passion for helicopters. Like so many public sector services the air sea rescue service is being contracted down, at the same time as our seas and beaches are getting busier. This briefly caught the attention of the surfers before they were again transfixed by the breaking waves on Fiscal Beach. LC Watts then described a number of dramatic rescue missions, including some at night whilst he was using night vision goggles. It is amazing what you can see going on in public car parks after dark.

The meeting closed for the day and delegates dispersed to swim, surf, run, cycle or make use of the Spa. I sat in the sun having a relaxing drink with those not desperate to squeeze into neoprene or latex. We all then reconvened later that evening for the drinks as the sun went down and then had a very good dinner in the hotel.

Friday morning’s lectures were started by Mr Bob Hendry from the Medical Protection Society. Difficult things happen and will happen to us during our challenging careers: Mr Hendry reassured us that the professional organisations are there to advise and protect us. However some unacceptable situations are self-made and unprofessional and the MPS won’t be able to help. In his experience it is those who offend early on in their careers who often go on to be at high risk of further problems later in their careers. The high risk category is the male doctor, who was naughty at medical school, is in their 50’s and has a high volume clinical practice. Sound familiar! Mr William Westlake, a local Ophthalmic Surgeon and husband of Dr Sam Banks, followed on and gave an excellent review of the ocular complications of eye anaesthesia and the complications that can befall the eye during general anaesthesia. This Medico-Legal session was concluded by Dr Emma Heap, a doctor turned Barrister. Emma’s advice was if you have a problem , run towards it rather than away. When things go wrong it is the dishonesty afterwards
that gets people into trouble. Be careful out there.
The next session was on blood conservation and was kicked off by Mr John Faulds who gave a 10 yr history of the service in Truro Hospital. This has evolved at the same time as there has been a dramatic decrease in blood donation. Dr Catherine Ralph then presented her ground breaking work on the use of cell salvage in the Obstetric Department. She discussed the risks and the notable benefits of using autologous vs. allogeneic blood in patients having caesarean section. Her group is now looking at the use of cell salvage techniques in vaginal deliveries. Mr Rob Holmes, consultant obstetrician, finished the session with a series of cases of massive obstetric haemorrhage and their management.
After lunch we were treated to a session on Trauma. Prior to this Dr Fran Smith was awarded the trainee poster prize by the President. The first talk was given by Dr David Ashton Cleary who is at the forefront of the developing speciality of Pre-hospital Care. He was able to give us a comprehensive update on how the service and training in this area is evolving. It is still in its early stages but momentum is building. The last lecture in this Trauma session was given by Dr Giles Nordman who spoke on damage limitation surgery and when to stop.

Our final and guest lecture was given by Mr David Venn who is a retired Brigadier and now a consultant in hostage negotiations. He gave us a fascinating insight into the usually very secretive world of getting the safe release of kidnap victims in some of the most unpredictable and unreliable parts of the world. Dealing with Somalian pirates is not an easy day job. It is a complex game dealing with people who don’t have rules. I thought this lecture may have some relevance to negotiating with surgeons but even they do not compare with Mexican drug gangs. This ended a very successful meeting and we drove away from a sun drenched Cornwall thinking that we must never give the Cornish the chance of a vote of Independence: it is too nice to lose!
“So why are you cycling to Harrogate” It’s not an unreasonable question. Two weeks ago my wife cycled to Paris, no one questioned her about that, they just asked what charity they were doing it for. Last year Guy Jordan, a friend to many of us, was killed whilst out cycling, and given there is a regular cycle to the annual conference from London it was a natural thing to do to cycle from Bristol too. Over the last few months there has been chatter about it in the department, not least as Sam Shinde, a cycling novice, had decided to cycle from London and was furiously training. A plan slowly came together led by Sarah Martindale. When she knows I am going to the conference she points her finger at me and says “You’re cycling aren’t you?” and that is it, I am roped in. Wim volunteered to drive a support vehicle. He was keen to be involved in supporting both ourselves and our cause. Over recent weeks maps have been strewn around the department. I spoke to Sarah about the trip, who is reassuring; “I think it should be a nice easy route, no more than 80 miles a day to ensure we all enjoy it” Next thing I know we have a route with a couple of stages reminiscent of the Tour de France “It’ll be fine,” she said, “but we’ve got to do the Peak District.” Preparation is key, I know this, but my wife has pinched all the training opportunities for her ride to Paris. The move from Frenchay to Southmead has shortened many of our commutes, which is bad. I am left with a couple of training rides on my old commuting bike affectionately know as ‘The Iron Horse’ by members of the anaesthetic department. My proper bike is stuck in the shop needing a new drive train.

Cycling is a bit like medicine, full of terms unfamiliar to lay people. If you want to know what is like to be a patient on the receiving end of medical jargon, have a chat with a bike mechanic. Drive train = the bits that make your bike go. A new chain, rear cogs and bottom bracket are required. It’s hard not to just pretend you know what they are talking about. Still, when I get it back three days before the trip it feels like a new bike. Thank you BW cycles. It doesn’t help me hearing how many rides everyone else has been on in preparation. Wim and I are at opposite ends of the organisational spectrum I feel. He has printed out copies of the route for all riders, got everyone’s contact details, provided us all with B & B details, and arranged a phone tracker to follow the riders.
My final bit of preparation is to get Sarah to strap a bar bag onto her full carbon bike so she can map read. It is a bit difficult to persuade her this will speed us up as all she can see is a rather unaerodynamic box that will slow her down. Eventually she relents, and we are all set to go.

Day 1: Cotswold Crunch

72 miles
Bristol to Moreton in Marsh

Bristol crew:
Sarah Martindale
Helen Johnstone
Anthony Carey
John Warwick
Juliet Learner
Lorna Burrows

Joined later by:
Ted Rees & Rhys Davies

Support crew:
Wim Blanke

As I understand it, according to Sarah M, the Bristol crew ‘all met up on time, had no problems leaving, had a perfect ride without any issues at all and arrived in Moreton on Marsh exactly as planned.’ Getting lost on the outskirts of your home city doesn’t look good or inspire confidence in those following you, so how she explained them going up the same street in Winterborne several times 3 miles in to the trip I have no idea. Apparently the extension of the route from 60 to 72 miles was ‘a minor problem’. As was discovering that part of the route was actually more mountain bike than road bike and had to be altered. All was forgotten by Lorna producing her fantastic Millionaires Shortbread which kept everyone going. However, there was a suspicion that not as much came out of the car second time as went back in. Anything to say Wim? Ted, with superb local knowledge, guided them in with sat nav to avoid the horrible A-roads and they arrived safely before night.

Personally I had a hell of a day. I had to fit in seeing my youngest christened (he’s 2 years old but you forget you haven’t done things like that by the time you are on to your 3rd). Then I left my wife and relatives clearing up whilst I cycled up to meet the rest of the gang (Sounds like a perfect day. Editor). I am very worried about this trip, I have been unwell for 10 days, to the extent that I have been on antibiotics for 48 hours and, though feeling a little better concerned I might not be in good enough shape. Over dinner, I try to explain this. The fact I have lost 2 kilos merely results in the response “well it’ll be easier to get up the hills then”. In fact it is then suggested I’m cheating a bit. That’s what friends are for! Anyway, off to bed with Wim. It’s a small room with twin beds pushed together, a bit Morecombe and Wise like. We separate them slightly.

Bristol’s finest

As I understand it, according to Sarah M, the Bristol crew ‘all met up on time, had no problems leaving, had a perfect ride without any issues at all and arrived in
What are the rules of sharing a twin room with a Belgian, I wonder?

Night Wim, can I be Eric?

Day 2: Holes, hills, gravel and carrghhs!

105 miles
Moreton in Marsh to Matlock Bath

Cycling today:

Rhys “Sick boy” Davies,
Anthony “Cake boy” Carey,
John “The mechanic” Warwick,
Lorna Burrows “Queen of the Mountains”,
Helen Johnstone “Over enthusiastic girl”
Sarah Martindale “The Navigator”
Juliet “grrrrrrrrhhhh” Learner

Before we set off I have another insight into how organised Wim is. “Wim, Have you got a pair of scissors?” He gives three options; two pairs of scissors or a pair of wire cutters “Have you got a highlighter please to mark the map?” “I think so”, and then produces a new packet of six. He’s got everything you can think off including full medical kit, an orange flashing light, megaphone, food and water and 2 sat navs in case it gets a bit tricky. He’s also i-gel positive. Wim is a massive i-gel fan, in fact, combined with his love of pre-hospital care we have decided as a group that if any of us want to lie down at any point, we need a wing man to stop us ending up with one shoved down us.

We head off and after only three miles we have had two chains off and then Juliet stops because her bike won’t change gear.

She is somewhat reluctant to carry on with her now single speed bike. Now you should never leave a man behind, but it takes Sarah all of about two minutes to leave her friend to the elements. “Come on we need to get going” “We need to get on.” Anthony kindly offers to swap bikes with Juliet, but she declines.

‘Never leave a man in the field’, but OK if it’s a girl, apparently

Super Wim is called into action. We plough on, expecting to see her soon. Today’s planned route is 90 miles of mainly B-roads punctuated by a series of homes out of Country Living. We stop for coffee in Warwick and discover Juliet has a problem with her shifter that will require most of the day to solve, she is, to put it mildly, gutted. Anthony is not happy, it is beginning to dawn on him that I might have misrepresented the ride to him. I might possibly have given him the impression he is on a cake tour between Bristol and Harrogate, punctuated with a bit of pedalling. Prior to the ride he also took his bike into his local bike shop in Stroud, for a tune up. Well it definitely is musical, and there is a lot of banging when he changes gears, and he’s already had to reset the derailleur. Mind you, if you go to a bike shop called Noah’s Ark what do you expect?
The rest of the morning is glorious, every now and then we have to get on an A road for a bit, which reinforces how nice the B roads are. The only problem is we do get a little bit more lost as they are more tricky to navigate, still what’s a few more miles between friends. It takes up to lunch to arrive at the site of the battle of Bosworth and we have ridden 48 miles.

The Battle of Bosworth

Pasty chips and beans all round, gert lush! Sarah wants to buy a lance to keep as all in order!

We are joined on this trip by John Warwick from Oxford. He’s already helped out with mechanicals yesterday, but two things strike me about him. First, he is a bit of a demon descender on the hills, secondly he has fallen into the trap of buying a pair of white bib shorts. I did this once, and proudly showed them off at work on their arrival. I was told in no uncertain terms to send them back and get black ones. “Why?” “Because often they are worn without underwear, hairs stick out, and you are neither blond nor grey!” I was then given three options; A: change for a black pair B: dye my nether regions blonde or, and this was a bit left field, C: apply ‘Veet for Men’ to the same area. I ordered a black pair straight away. I’m not sure we know John well enough yet to hand him a bottle of Veet. (Editors’ note: see http://www.amazon.co.uk/product-reviews/B000KKNQBK for the reason why)

The women I work with can be a bit intimidating (if any of you are reading this, then it’s not you obviously, it’s the other ones, you know…her). Here on the roads it’s worse. I’m with a GB triathlete, one who climbs like a mountain goat on EPO, one whose a formidable mountain biker, only held back by the fact she has a Chemie Alcott knee, and one who looks like she has about three gears she hasn’t even bothered with yet. Most of them go on tour cycling in the alps, and some go winter training. Thank god for Anthony. One of the problems of being behind is, however, all you have to stare at is behinds. I’m not sure whether to say anything or not, but one of the girls’ bib shorts are really rather thin. Eventually I point this out, but now feel compelled to ride in front of her, this is much harder, and I wonder if it looks like I’m trying to not let her get in front of me. It is solved rapidly as she ups the tempo and cruises off into the far distance.

Our route planning has referenced ‘Google Cycles’ which is good, but occasionally gives you a bike path that could be terrible or amazing.
After lunch we have a short gravelly one which causes Lorna to have a small melt down, “THIS IS NOT ROAD CYCLING”

A complex system of hand signals exists for cyclists to warn each other of danger. However it seems we are either unsure of some or are inventing new ones. Lorna doesn’t like this, it’s against the rules, so we just shout instead. “Holes”, “gravel”, “car”, “clear”. The girls are really good at shouting. Who’d have thought it. She is, however, open to the idea of new hand signals, so we spend some time trying to invent ones for different types of road kill.

Next note to self - when cycling through a city don’t refer to it loudly as ‘a bit of a hole’, sorry Coventry.

Then we hit Derby, we have to either take a horrible A-road or chance a bike path. We opt for the bike path, and what a joy it was, 12 miles of fantastic, well maintained well signposted car free paths.

Now I would like to give our route to Steve Yentis (Chief Editor of Anaesthesia) and let him do some stats on the number of places we went through with ‘hill’ in the title today. I am keen to see how many standard deviations away from the norm it would be. Unsurprisingly they all had one hill, apart from ‘Mount Pleasant’ (it wasn’t). Sarah seems drawn to them, it’s all a challenge to her.

We end the day with some big hills as we approach the Peak District. As we tire a little it is young Helen who seems to have all the energy, and her relentless enthusiasm for every new sight has been amazing. Looook Windmill (she’s Scottish), Looook rabbit, amazing, Looook reservoir. Tractor. She was also aware to all hazards, and “caargh” was shouted relentlessly and enthusiastically from dusk till dawn.

Anthony chips in after a particularly nasty hill “we seem to have done a lot of up and no down” I force feed him a gel and make him drink some water, and he picks up a bit, Lorna looks as fresh as she did at 8am. Cue the steepest longest descent I have done in a long time into Matlock Bath, our destination for today. I had a massive grin on my face for the first bit and then it got scary.

Matlock Bath has illuminations to guide us in, then, just to add insult to injury, The Temple Hotel is up a little kicker of a hill. Wim and Juliet are there to greet us. Sarah upsets the hotel owner by trying to sneak her bike into her room, but order is restored quickly. They serve some interesting beer here.

We head out for a curry which hits the spot perfectly, then it’s a hike up hill to bed.
P.S. Favourite moment for the girls was spotting the number plate PMT II. Helen; “she must have permanent road rage”

Go to bed with thoughts of the Col de Bradfield awaiting us tomorrow.

Tour de France to Tour de Farce

Day 3 Matlock Bath to Harrogate

I didn’t sleep well last night for a combination of reasons, one was pain down my left arm, but I’m not telling Anthony as he’ll whip out his Pajunk block needle and have me pinned down so he can numb my arm (he’s a purist is Anthony, there’d be no sedation) This is bad, but it does allow my to conduct a sleep study on Wim (it’s OK, no OSA). Yesterday we did 105 miles, it was supposed to be 90. I’m not sure if Sarah is deliberately underestimating, getting us lost, or (and I suspect it is this one) she wanted us to have done more miles than the London crew. She tells us today is about 80 miles. This is clearly a lie, Google quotes 90 miles minimum, we have all stopped believing her.

Wim dishes out Belgian waffles to fuel us during our first stint on the road and off we go. It is impressive that we have left on time yet again. Mainly this is down to the fact we are all scared of Sarah who is becoming more unhinged about timings as we go on.

Two minutes in and we are lost. We look around and of course it is the massive hill we need to head up. We go through Chatsworth estate, and have some lovely descents. After one very steep one, we are about to head off when we realise Juliet is missing. We send Lorna back up, turns out Juliet was busy taking photos of alpacas and missed a turn. I decide this could be a tactic to slow Lorna down. If we can get her doing hill repeats on the steepest descents she might end up as tired as everyone else.

More coffee and cake
There is plenty of hill climbing too, but John has done something to stop Anthony’s bike sounding like it has a family of mice living in it and is bit happier when I explain most of the big climbs will be done by lunch. Our coffee/cake stop is in Hathersage in glorious sunshine, Wim catches us up a having had to pick up my wallet that I left in the hotel, what would we do without him.

The more we get into the Peak District the better it gets, the grass gives way to bracken and heather. We stop at the top of a hill where a couple are bird watching. “What are you looking at?” shouts Sarah. “Red grouse” the wife whispers back. “Shall we leave you to it?” shouts Sarah, “That’d be nice.”

Too late, as we leave the bird takes flight. I’d like to think that he got the perfect shot as it took off and that we ‘helped’, but am not convinced. Wim overtakes us all on another long and lovely descent, cheering us all on. We pause near the top of another steep climb and I shove food at Anthony, “What are you doing. We only just ate cake?” says Sarah. We have to gently remind her we are not all 60kgs, and some need to eat more often “I’m in pain” says Anthony. “Pain is just weakness leaving your body” she says, hopping back on her bike and, with superb timing, falling off and cutting her elbow. “Is that painful Sarah?” says Anthony, quietly.

We are also getting closer to a section with two arrows on the map. This is worrying as it means a hill of 20-30%. That’s a bit bonkers, and we are working out if we need to skirt around it.

Carey with a drink, not a whine for once

Before we know it, there is writing on the road and we are in Tour de France territory.

Tour signs
Go Cav, Vroom Froome, and repeatedly Jens Voight’s famous phrase of “shut up legs”. Famed for attempting heroic, stupid, crazy breakaways this is what he shouted to himself when he was trying to carry on.

Then disaster strikes, we swoop down, turn a corner and there is a wall of a hill. What is going on, this shouldn’t be here. We shout and puff and blow up it. I’m shouting “shut up legs” to see if it helps, bizarrely it does. John falls off this time. That was bonkers. We rest halfway, then push to the top. Exhausted we turn round and see a ‘25%’ sign. We have done a double arrows climb, and we are chuffed. So much so that we don’t feel the need to do the next one and skirt around another glorious reservoir.

We lose Lorna temporarily as she disappears off ahead the wrong way - I think she just wants to do a few extra miles. Then we head to Penistone for lunch. We are a bit late, have done 42 miles and 5000 feet of climbing. Sarah still insists we only have about 40 miles to go. Lunch is delayed slightly due to a lack of pastry tops to the pies, Sarah is muttering - “I knew we shouldn’t order pies”

There has been lots of talk about aching muscles and pains. Helen yelped for the first hour or so today with a sore bum. Sarah is now complaining of sore inner thighs Lorna “ Ooh do you mean the virgina preservalis muscle?” Everyone turns to look at her in anticipation. “You know, the one that keeps your legs together.” Not sure which medical school she went to but someone was having her on in anatomy. Arriving off the train is Sarah Love-Jones, who has somehow started a pain session in theatres early, finished it and managed to get up here from Bristol for 2.15pm. She is a bit lacking in training having first fallen off a climbing wall and breaking her ankle, and then had a nasty collarbone fracture mountain biking. In fact in recent years in addition to this, the anaesthetic department has had one hip fracture (Brown) and two pelvic fractures (Marsh, Pettifer). Also finger fractures, a radial head fracture (Walton) and facial injuries. The trauma surgeons are rumoured to have tried to put bisphosphonates in the water in our department to reduce the number of broken bones.

We get ready to leave, Sarah is almost frothing at the mouth as I say I need a wee before we leave. Why didn’t you all stagger it, go when we arrive, if you all go now we’ll be even later leaving. I quietly suggest I might need to get something out of Wim’s van before we leave. This is met with scathing looks from Sarah. We eventually leave. The afternoon is glorious, we really have had good weather. The pace slows a bit an it becomes clear we are going to struggle to arrive before night fall.

“Ohhh it’s all proper Yorkshire. Just like Coronation street”, exclaimed an anonymous female.

I don’t have the heart to tell her it’s the wrong side of the Pennines. The girls seem to need a few more wee stops than us fella’s. They are obviously a bit more tricky. Thoughts turn to whether they
could use one of Wim’s i-gels as a she-wee. They are so competitive they devise a points scoring system with extra if you can wee through the gastric port.

As Sarah gets more worried, her navigation gets a bit worse. We go the wrong way down a dodgy cycle path. Then she goes right and everyone else goes straight on. We end up back where we started.

“We’ll if you’d listened to me we’d be alright” says Sarah with a big smile. We eventually get around Leeds on some A-roads. We are on the last stretch, what could go wrong. It goes dark and we are tiring. Fortunately Wim is waiting as we round a corner. We have a final break and then head on. There is no way now to shorten our route. Wim sits behind us as we head towards the fantastically named Kirby Overblow.

As we do so it’s as if God is reaching down and randomly flicking our lights off. Helen’s go, then Sarah’s too. We redistribute them but it is becoming dangerous now. Finally we see signs to Harrogate. We hit the last few hills with Wim driving behind with orange light flashing to protect us. At the finish of Le Grand Depart, the first stage of The Tour De France, there are still bicycles all over the place. In shop windows, sticking out of buildings etc.

Finally we arrive, as we turn a corner a massive cheers goes up from the restaurant where the AAGBI linkmans dinner is happening. It is a great moment.

We are invited in, given champagne and then kindly invited to sit down for a meal. They did stick in a corner next to the balcony to keep the smell down though. The inevitable question is asked- where is the AAGBI conference next year? Shall we cycle there?

After a delicious meal, we slowly drift away to our accommodation.

Miles done today 100
Feet of ascent 9000.

*President’s reception*

*Dedicated to the memory of Guy Jordan*
In 2013, I was awarded the Ross Davis Adventure Bursary towards my year abroad after CT2b ACCS Anaesthesia in Severn. I had planned an exciting and varied year away starting in Northern Tanzania for nearly two months experiencing some anaesthetics and tackling the heights of Mount Kilimanjaro and then onto New Zealand to work in Middlemore Hospital’s Anaesthetic Department and Starship Hospital’s Paediatric Intensive Care and Retrieval Service.

Northern Tanzania

A few years ago I volunteered in Kenya working with the AMREF flying doctor service and various charity projects and was keen to return to east Africa to experience their anaesthetic services. I decided to split my time in Tanzania between one of the four major national hospitals, Kilimanjaro Christian Medical Centre (KCMC) and a more remote hospital up in the foothills of Mount Kilimanjaro, Machame Hospital.

KCMC is a 450-bed referral hospital for more than 11 million people in Northern Tanzania. It is associated with a school of anaesthesia, which helps train doctors, nurse anaesthetists and intensive care nurses. Anaesthesia is provided largely by nurse anaesthetists and assistant medical officers.

In Tanzania, with a population of 34 million, there are few medically qualified anaesthetists and most of those are reaching retirement age. In KCMC, two senior doctors and two trainee doctor anaesthetists were present. KCMC has five main operating theatres, as well as theatres for Urology, Obstetrics, ENT and Ophthalmology at different sites. Within the main theatres the nurse anaesthetists would be expected to anaesthetize a huge variety of cases including on one list with one surgeon: a V-P shunt in a month old baby, a Burr Hole for traumatic Subarachnoid Haemorrhage and a Partial-Hepatectomy. The general surgeons were incredibly skilled and adapted easily to the wide variety of patients.

The anaesthetic equipment used was mostly familiar including re-used single use endotracheal tubes, Mapleson Circuits (taped to fix holes), and some modern anaesthetic machines, mostly donated by American sources. Laryngeal masks were available for emergencies but the nurse anaesthetists were not comfortable using them and had mostly never used one in practice.

Monitor use throughout theatres was variable. Three theatres had working pulseoximeters, two had working ECG monitoring and BP monitoring was rarely used. Nurse anaesthetists valued highly the pre-cordial stethoscope and ausculted almost continuously.
Prior to leaving for Tanzania I contacted the Lifebox organization as I thought reviewing monitor availability and giving teaching sessions on monitor use and critical incidents would be achievable during my visit. I took out three pulsoximeters to donate, reviewed available equipment and did small group teaching sessions with the nurse anaesthetists.

I was surprised to find that KCMC had a plethora of broken, misplaced donated equipment in corridors and cupboards, which unfortunately were not in use. Utilisation of the medical engineers of the hospital was limited and often involved copious amounts of paperwork. We spent one afternoon gathering leads and probes from abandoned machines and had fully working ICU monitors by the end of the day.

Limited drugs were available including halothane as the only inhalational, suxamethonium and pancuronium for muscle relaxation, and thiopentone and ketamine for induction. Lidocaine was used for the majority of spinal anaesthetics due to the cost and availability of bupivacaine. Analgesic options for the majority of operations included pethidine for day one post-operatively, tramadol orally for day two and paracetamol thereafter. Multimodal analgesia did not exist and unfortunately morphine was not available. The two anaesthetic trainee doctors were incredibly eager to learn about different peripheral regional blocks, appreciated their potential benefit in patient care and had started performing simple blocks in the months before my visit.

Lifebox pulsoximeter being used in a general theatre at KCMC.

Machame Lutheran Hospital on the slopes of Mount Kilimanjaro started its life in 1906 with German missionary doctors and grew to be one of the main hospitals in Northern Tanzanian. Currently it is a 130-bed medical-surgical community hospital, whose main referral centre is KCMC. Machame’s workload is a mix of general, orthopaedic and obstetric surgery with two different theatre complexes and five theatres. The hospital’s anaesthetic services were provided by three nurse anaesthetists, one with 35 years experience, one with 5 years and another just out of training. Between the three nurses they would provide 24-hour cover, with mostly caesarean sections occurring overnight.

The theatres had an exceptional level of cleanliness, staff worked in harmony and were mostly let down by resource availability. Orthopaedic theatre had an old anaesthetic machine with halothane available, whereas the general theatres used EMO draw-over vaporizers with ether. The available induction agents and analgesic drugs were similar to that in KCMC. I again explored monitoring practices and undertook a Lifebox Survey and training. In all theatres prior to induction the three nurse anaesthetists ensured all
monitoring was attached and working, including BP, ECG and Pulsoximeter. There were five theatres and three pulsoximeters, meaning they had to retrieve pulsoximeters from different theatres.

One unforgettable morning I came into theatre mid-induction of a 50-year-old obese lady and the nurse anaesthetist had no chest movement with endotracheal tube placement and a rapidly desaturating patient. The situation developed over the next ten minutes. The tube was in the correct place with a Grade 1 view, the EMO circuit was concluded to have a leak and to my horror the ambu bag had an irreparable slit. The theatre had an oxygen concentrator and no piped or tanked oxygen. Needing a circuit and oxygen, but having nothing to hand, made me feel totally useless, no algorithm or DAS guideline had prepared me for this. With the nurse anaesthetist blowing into the endotracheal tube, eventually a circuit and oxygen cylinder were found and the patient’s saturations were quickly 100%. Attempts to fix the EMO circuit failed. The patient did not have her surgery, was observed closely overnight and thankfully made a complete neurological recovery. I will never take for granted ODPs and the ease with which we have equipment to hand. Before leaving Machame, the nurse anaesthetists and I made sure that all theatres had an emergency kit bag of working equipment and petitioned to the Clinical Director for emergency oxygen cylinders in all theatres. Numerous oxygen cylinders were kept in the ICU, however, being a different directorate they could not simply be moved.

Whilst in Northern Tanzania we took the opportunity to explore the plains of the Serengeti and the Ngorongoro Crater. On Safari we saw four leopards, countless lions and had a rather close encounter with an angry bull elephant.

Whilst staying on the Mountain it would have been rude not to summit and so we did the six day trek, via the Machame gate, and reached the summit at 5,895m (19,341ft) at dawn with only a smidge of altitude sickness.
Middlemore Hospital, Auckland

For the following nine months we worked and played in Auckland, New Zealand. I spent the first three months in Middlemore Hospital, one of the largest tertiary teaching hospitals in New Zealand. It is the national centre for orthopaedics, plastics, burns, renal dialysis and spinal surgery. I was based in theatre and got to experience a wide variety of cases including complex ENT, orthopaedics, acute paediatrics and tertiary obstetrics. Patients from the Maori and Pacific Island population often had very high BMIs, made up a large proportion of the patient mix and posed the obvious anaesthetic challenges. It was not unusual for a list to have numerous 150-200kg patients. Genetically the population has large jaws and easy airways, however I still treated all patients with a healthy amount of caution and preparation. In Middlemore, the highest patient weight in which a classic LMA was used was 220kg. Remembering my best day on-call, I helped anaesthetize a 9 month old for an orthopaedic procedure, a 97 year old lady with aortic stenosis for a neck of femur fracture, a 270kg man for debridement of abdominal wall sepsis (no LMA used!) and a man with pan-facial fractures who had an awake retrograde fibroscopic intubation.

Paediatric Intensive Care unit (PICU), Starship Hospital, Auckland

Starship Children’s Hospital has the only specialist PICU in New Zealand, has approximately 1,000 admissions each year and provides the National Paediatric Retrieval Service. The unit is a combined cardiac and general intensive care facility with capacity for 16 ICU beds and 6 HDU beds. Around 45% of overall admissions are cardiac, providing support for pre- and post-operative children commonly with congenital cardiac conditions and rheumatic heart disease. The general case-mix is varied including liver transplantations, neurosurgical cases and complex spinal surgeries. During my time at Starship, I saw some miraculous recoveries but also dealt with some incredibly sad cases that will always stay with me. The learning curve for working in PICU was immense and I thoroughly enjoyed my time there and learnt a lot from the PICU Consultants, my colleagues and the nurses.

Retrieval work involved covering the entire country, often with long transport times and involved a mixture of helicopter, fixed wing and land transports. Depending on the referring hospital the retrievals varied greatly with some hospitals having little paediatric experience and equipment. A memorable shift towards the end of my placement involved a helicopter retrieval of an 8-month-old boy with severe bronchiolitis. On entering the referring hospital I saw a blue baby with unrecordable saturations and blood...
pressure. After successfully resuscitating the child, helped by adrenaline and an excellent PICU nurse, I realized how much I had learnt during my time in Starship. On getting ready to leave they asked me to review another 9-month-old bronchiolitic who was not looking good. I stabilized the second child, flew back to Auckland with the first and swiftly returned to transport the second. It turned our to be a long shift but both boys made excellent recoveries.

Helicopter retrieval from Hamilton on a beautiful day in Auckland.

I also cannot forget to mention the transport shift when returning from Christchurch with a child intubated, ventilated and on high levels of inotropic support. Suddenly the plane rapidly filled with smoke. Thankfully we were only minutes from the nearest airport, however, I was struck with the thought “Fire safety protocol on a plane whilst looking after a critically ill child… nothing springs to mind”. When not flying around the country for work, we scratched the surface of what New Zealand has to offer and trekked in Mount Cook and Mount Aspiring national parks, went sea kayaking in the Abel Tasman and walked the 43km Tongariro Circuit.

Laos/Vietnam/Cambodia

We took the long route home from New Zealand and visited various parts of South East Asia during the six weeks before starting in August in the UK. The theme of hill climbing and interesting locations continued as we explored the mountains and hill tribes of Northern Vietnam and then ventured across into Northern Laos. After an eventful 14-hour night bus to Luang Namtha we ventured out into the Jungle, which was an incredible experience. We continued our journey by visiting the temples of Cambodia, cruising the Mekong Delta and exploring the Vietnam coastline.

I am incredibly grateful for the support of the Ross Davis Adventure Bursary for helping me experience developing world anaesthesia and explore the fantastic country of the long white cloud, by land and air. I will endeavor to maintain my links to Tanzania and I hope to maintain the relaxed Kiwi attitude to life as well as their thirst for adventure.
Background

Across the country a revolution in Anaesthetic and Intensive care trainee research is occurring. After the development of the National Institute for Academic Anaesthesia (NIAA) in March 2008, there has been increased focus on academia within anaesthesia. Over the last two years, eleven regional groups have successfully been set up in an effort to increase trainee exposure and involvement in research and audit. The South West Anaesthesia Matrix\(^1\) (SWARM) was the first group in the series, has had numerous successes and has led the way for the rest of the country. UK surgical trainees have previously proven the concept of collaborative work at both regional and national levels and have to date conducted successful national multi-centre trials, including the ROSSINI\(^2\) randomised controlled trial.

STAR was ‘born’ in early 2013 from the frustration of accessing research opportunities within the region at a junior level and the possibilities for continuing projects whilst rotating to different hospitals. After attending the Autumn SASWR meeting in 2012, the existence of SWARM encouraged us to try and create a group in Severn. Collaborative trainee-led groups have actually already existed in the Severn region, including ‘Regional Trainees in Intensive Care Severn ’ (RTIC), which generated some considerable successes\(^3\), however with some of the proactive founding members reaching the end of their training the group lost momentum.

The Severn region has a wealth of research availability and experienced consultants involved in national and international level research but with regular rotations around the region it can be difficult for trainees to continue projects or perform high-quality projects in short periods of time. Through STAR Group we hope to improve the experience of research and audit for Severn trainees and also offer research training opportunities. By performing large, multi-centre projects we also hope to attract national funding and grants to the region. It is hoped that with a network of interested trainees, projects can be completed, repeated as necessary and access to research and audit increased. By conducting research across the whole region, higher impact studies will be produced and be more applicable nationally.

STAR’s structure is made up of a central committee of trainees and consultant
supervisors who coordinate the group and its activities at a regional level, ensuring project completion and group momentum. Currently the committee is formed of trainees who have expressed an interest in STAR and who were initially keen and enthusiastic about the concept. In the future, committee elections will occur at our annual AGM and we currently welcome expressions of interest for committee positions. Every Trust has both a trainee and consultant lead who coordinate projects within each hospital. In total STAR currently has around 40 trainee members across all 7 Trusts in the Bristol School of Anaesthesia. Ultimately our aim is to involve all trainees from the school. More information on committee positions and on your hospital leads can be found on our website (http://anaesthesiaresearch.org).

Completed Projects

Our first audit project ‘Lower limb amputation: a multicentre audit’ was successfully run across 4 trusts and was presented at the Autumn SASWR meeting 2013; practice is currently undergoing quality improvement strategies and will be re-audited in the near future. We have also conducted multiple surveys including a survey into intraosseus access use at cardiac arrests, which was presented at GAT ASM 2014 and a peripheral nerve block follow-up survey which was presented as a poster at the AAGBI Annual Congress, September 2013. Results from this survey are being used to help devise a follow-up programme for regional blocks and a peripheral nerve injury pathway in North Bristol. As a group we have also been involved in the RUH Bath project “Residual anaesthesia drugs – silent threat, visible solutions”, for which STAR members, have recently been awarded The President’s Prize at the RCoA Annual Congress 2014 as well as earning the Palladium Patient Safety Prize.

Contribution to International Research

In addition to performing regional projects, STAR Group has been involved in data collection for both a national and an international study. ISOS4 (International Surgical Outcome Study) is an international observational 7-day cohort study of complications following elective surgery. It was run in the UK in late May 2014. STAR Group was registered as an official collaborating body and under leadership from Alex Looseley, led the data collection for the region. Across six Trusts and nine hospitals, 15 trainees successfully collected data for over 500 patients; we look forward to seeing the results from this landmark study.

STAR Group was also involved in SNAP-1 (Sprint National Anaesthesia Project) which was the first in what is hoped to be an exciting new initiative of projects involving anaesthetists and hospitals throughout the UK. These SNAPs are intended to provide a ‘snapshot’ evaluation of clinical activity and patient centred outcomes. SNAP-1 was a research project which involved a two day evaluation of patient reported outcomes after anaesthesia: specifically, patient satisfaction after anaesthesia and patient reported awareness. STAR Group led the involvement of hospitals across the region in all 8 Trusts, through 20 active trainee leads. North Bristol NHS Trust alone recruited 180 patients into this study.
RAFT

The Research and Audit Federation of Trainees\(^6\) (RAFT), endorsed by both the NIAA and RCoA, was set up as an umbrella organization by the regional anaesthetic trainee groups across the country. This collaborative network aims to produce high-quality national projects designed and run by trainees. RAFT first came into existence after a meeting of the different regional groups in December 2013 and by the time you are reading this will have completed its first national project in Summer 2014, looking at the perioperative use and availability of cardiac output monitoring.

The Future

Our success within the first year clearly displays the possibility for great things. Trainee collaboration in Severn and across the country means that we can conduct quick, high quality research and audit over multiple sites. Trainee projects therefore have more continuity and can be re-audited, improve patient care and are applicable nationally. We hope that though multi-centre audit and research, trainees in Severn can become a huge part of striving to improve patient care both within our region and nationally.

STAR Group’s next AGM will be held at the SASWR meeting in Bristol in November 2014. At this time we hope to discuss future project ideas and elect much needed positions to the committee, including an IT lead. Hopefully reading this article will highlight the possibilities for your involvement, whether trainee or Consultant.

If you are interested in becoming a member, local lead or have any exciting ideas or questions please get in contact.

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Twitter: [@Staresearch](https://twitter.com/@Staresearch)

1. [www.ukswarm.com](http://www.ukswarm.com)


5. [http://www.niaa-hsrc.org.uk/SNAPs](http://www.niaa-hsrc.org.uk/SNAPs)

6. [http://raftrainees.weebly.com](http://raftrainees.weebly.com)

Dr Kate Reeve
Dr Christopher Newell
Dr Ronelle Mouton
An Audit of Bleomycin Alert Documentation in the Notes of Paediatric Patients

Dr Fran Smith, Dr Quentin Milner, Dr Corinne Hayes, Matt Greening
Royal Devon and Exeter NHS Foundation Trust

Bleomycin is a chemotherapeutic agent derived from *Streptomyces verticillus* in 1966 and used successfully since the 1970s for the treatment of germ cell tumours, lymphoma and squamous cell tumours of the head and neck. It is highly effective and damages DNA by free radical formation and lipid peroxidation. Bleomycin can also cause pulmonary damage in up to 20% of recipients, by unclear but similar mechanisms ultimately leading to fibrosis. This may be fatal and the administration of oxygen may induce or exacerbate this process. Fatal pulmonary toxicity following the use of perioperative high-flow oxygen (HFO) in bleomycin-treated patients was first highlighted by Goldiner in 1978. The clinical presentation was similar to respiratory distress syndrome, and this was supported by post-mortem findings. Administration of lower FiO₂ and judicious fluid administration led to better outcomes. In Goldiner’s paper, ideal FiO₂ was felt to be <0.28, levels as high as 0.45 were associated with harm. There have been case reports describing pulmonary toxicity associated with oxygen administration many years following bleomycin treatment, implying a life-long risk.

Patients treated in childhood may be unaware of the agents they have received and their implications. Indeed many healthcare workers may be unaware of the potential hazards of oxygen therapy in such individuals. It is essential therefore, that previous exposure to bleomycin is both clearly documented and easily accessible in patient records, along with an explanation of the risk.

Objectives
- to examine the documentation of bleomycin exposure, and its accessibility
- whether or not specific alerts were made regarding the use of oxygen
- whether or not the use of a specific alert card for the patient to carry for reference would be advisable

Methods
We identified patients previously treated with bleomycin from the trust paediatric oncology register. The notes were examined to see if an alert was present on the external cover plus an explanation on the immediate inside cover. In the absence of this, we examined the notes to see if documentation existed elsewhere.

Results

**Figure 1.** Circle graph showing only 38% of notes had alerts in the correct location. 25% of notes had no alert at all

**Figure 2.** Circle graph detailing specific instructions regarding High Flow Oxygen (HFO) only present in half the notes

Discussion
Not all patients and healthcare providers are aware of the risks of the combination of bleomycin exposure and oxygen therapy, which can occur many years after bleomycin treatment. Thorough documentation is essential in these circumstances as patients may not recall what they have received or many not be in a position to communicate this. However documentation alone maybe insufficient, i.e. when the notes are unavailable, and in this situation an alert card would be a sensible solution.

Conclusion
As a result of our findings, documentation is to be standardised for paediatric patients:
- an alert on the outside front cover of the notes
- bleomycin treatment documented and a recommendation to avoid high-flow oxygen on the inside front cover
- a letter detailing all the information above in the main patient notes, plus a copy for the patient

In addition, following a consultation with pharmacy, an alert card has been developed for patients to carry at all times.

References
No prizes for guessing where I’ve been on my holidays this year. By some serendipitous coincidence, I have to produce an article shortly after returning from the annual family sojourn. And since I insist on taking my vacations in parts of the world sufficiently civilised to produce fine wine, I usually write about where I’ve just been.

Now, the observant amongst you will have noticed my use of the adjective “fine” in the previous paragraph and that, until recently, may have been considered optimistic at best and even misleading. For Chianti had sunk in both quality and reputation so far as to be considered the worst type of plonk: The Raffia-wrapped, squat bottle being only fit for lampshade support in Italian restaurants. But, as the title happily suggests, this is no longer the case: Or at least not universally. Like many wine producing areas around the world the good folk of central Tuscany have had to wake up to an over-subscribed wine market, a removal of subsidies and stand on their own two feet. And as in, for example, the south west of France or Spain in general, quality is rising fast.

Chianti Classico is the area that lies in the hills between Florence and Sienna in Tuscany: A spectacularly beautiful landscape that was fought over by the rulers of those two cities for centuries which accounts for the predominance of fortified hilltop towns in the area. The wine growing area was delineated in 1726 (by Grand Duke Cosimo the Third, fact fans) making it the oldest designated wine region in Italy. Subsequent expansion of the Chianti region now means it extends all over Tuscany as far as Pisa on the north-west and down to Montalcino in the south. These peripheral areas can’t use the “Classico” tag on their labels though which is helpful, because a lot of their stuff is still pretty ropey.

The predominant grape is Sangiovese and the original regulations insisted on each bottle containing 80% of this blended with a few other local grapes including the insipid white grapes Malvasia and Trebbiano. Not surprising then that the resulting wine was thin, acidic and lacking in fruit flavour. Just about adequate for swilling down the tomato sauce and pasta but distinctly wimpy compared with many of Italy’s more celebrated reds such as Barolo or Barbaresco.

Dismayed by the stifling rigidity of the classification regulations that forbade experimentation and limited quality, several growers threw the rule book out the window in the 1970’s and started the “Super-Tuscan” movement. More a marketing tool than an indication of style or quality, it meant that by declassifying their wine and including any grape that would add quality some superb wine was made. Some still based on Sangiovese blended with Cabernet and Merlot and some abandoning Sangiovese altogether. Whatever the mix, these are powerful
delicious wines that re-established the reputation for quality wine in Tuscany and, for a time, commanded super high prices to go with their cult status. The recession has seen off most of this excess but the wines are still being made, and happily, are a bit more affordable these days. Also fortunate is that the subsequent relaxation of the rules and the investment in technology and quality has meant that Chianti is a different thing entirely than in the recent past. It can still be a light, sharp, cherry-scented wine which partners well with many foods but increasingly, it is a more intense, structured wine resembling the better offerings from Bordeaux. If it says “Reserva” on the label, it will have been aged for at least a couple of years, probably in an oak barrel, and will be this more substantial style. If you leave it hanging around in your cellar / cupboard / garage for a few years longer than usual, that cherry fruit will turn into something more redolent of leafy forests and mushrooms. Rather fabulous with those slow cooked dishes you may be seeking out in the recipe books as the seasons turn again. Why not give it another try?

**Perris’s Picks.**

*The Society’s Exhibition Chianti Classico. 2011.* The Wine Society. - £11.95

This is exactly what I’ve been on about! New, voluptuous style with abundant fruit, bouquet and charm. Top stuff!

*Poggiopiano “Il Ruspato” Chianti. 2009.* Marks and Spencer - £11.94

Made by the same people as the Society wine above, but from a more selected parcel of vines. This is oak-aged, rustic and fruity. Would go well with some of that Italian roast pork you were thinking of cooking this weekend

*Antinori, Tiganello 2011.* Berry Bros and Rudd - £45.50

One of the original “Super-Tuscans” and certainly one of the best. Packed full of dark fruit. Very young and tannic currently, but give it a few years...and considerably cheaper than previously, it is superb stuff and (I would suggest) worth the outlay for a special occasion.

Enjoy!
Waking up on day one of my two-year career break, I was filled with mixed emotions: the excitement of stepping off the training treadmill and ‘cutting my own path’, tempered by trepidation at the thought of no pay cheque this month, uncertainty of whether my plans would come to fruition, and already missing Musgrove Park’s homeliness. My place on the tropical medicine diploma was secure, but I still had no visa for Australia, and no idea then that my wife would have us heading off to Zambia in little over a year.

The Diploma in Tropical Medicine, Hygiene and Health is a three-month course, covering tropical medicine, entomology and public health (PH). We studied the spectrum of diseases encountered in the developing world, from venomous snakebites to Japanese Encephalitis; however the greatest emphasis was placed on malaria, HIV and tuberculosis. Entomology covered the vectors of tropical diseases, from mosquitoes to blowflies, whilst the PH module covered international aid, health system models, management of outbreaks and even how to build a latrine. The course equipped us with knowledge and skills that were invaluable for what we would later deal with, but also set realistic expectations of what can be achieved in a resource-poor setting.

We proceeded to move to Western Australia where I had a senior registrar post in the 15-bedded ICU of Fremantle hospital. The resources at our disposal were staggering compared to what I was used to; daily procalcitonin levels on all patients, levosimendan, dexmedetomidine, and out-of-hours MRI and EEG availability were just some examples of the plenitude of Australian health care.

However, there were aspects of the medical culture that were difficult to rationalise: the propensity to over-investigate, for example, and the public/private divide, which made me miss the NHS. Fremantle also has a large Aboriginal population, and the interface between the two cultures was fascinating to experience.
The lifestyle we were able to enjoy was fabulous, exploring this most captivating and breath-taking country during the course of our time there.

Beachside living and gin-and-tonic fuelled sunsets over the Indian Ocean were particularly pleasant.

It therefore came as a surprise and some spillage of my sun downer that I absorbed my wife's declaration, on her return from work, that we were off to work in Zambia.

St Francis Hospital is a 350-bed mission hospital in the eastern province of Zambia, 600km from Lusaka. Zambia is the 26th poorest country in the world, with a life expectancy from birth of 52 years for its population of 14.6 million. With an HIV prevalence of 12.7%, infant mortality rate of 66 deaths/1000 live births and maternal mortality rate of 440 deaths/100,000 live births, the demographics alone showed some of the challenges we would face in our work there.

The medical staff in the hospital consisted of seven overseas doctors, two permanent Zambian doctors, multiple temporary Zambian registrars and six permanent medical licentiates. Medical students on their elective were an invaluable additional resource. It was crucial that we worked together effectively, despite the melting pot of backgrounds, languages and cultures within the team.
I was employed as a senior registrar in anaesthesia and general medicine. My duties comprised working in theatres three days a week plus a 1:3 on call for theatre emergencies, with the remainder of my time spent on the male medical ward, outpatients and occasionally paediatrics.

Our clinical practice was unsupervised, and the volunteers really had just each other for advice and help.

My first task in theatres was to tease out the working equipment from the stores and establish an ordered stock of emergency drugs (adrenaline and atropine), cannulas, drugs and fluids (saline and Hartmann’s). The two anaesthetic clinical officers were vastly experienced, and provided a lead in utilising the available equipment. Delivering safe anaesthesia was a unique challenge, using halothane and trilene delivered through Oxford Miniature Vaporisers connected to an oxygen concentrator, without gas analysis. Patients were manually ventilated using a bellow, and given that pancuronium was our only non-depolarising muscle relaxant, it didn’t take me long to start using regional techniques when possible! We used 5% lignocaine in spinals, using cannulas as spinal needles. Shorter procedures were performed under sedation, using a mixture of ketamine and diazepam. Our only monitoring was a pulse oximeter I had procured before leaving Australia, and a manual sphygmomanometer. Equipment was in short supply, with stocks of suxamethonium, giving sets and blood all temporarily running out in the course of my time there. Power cuts could plunge the theatre into darkness at any time, with mobile phones offering light until the back-up generator whirred into action. The contrast from Australia was stark.

Theatre lists began at 8am and typically had 12-20 patients per list over the three theatres; general surgery, obstetrics and gynaecology and trauma. The turnover was extraordinary: patients queuing at the door wrapped in bed sheets, next to trolleys of post-operative patients in the recovery position, with a single recovery nurse overseeing them prior to their return to the ward.

Mortality was unfortunately a routine part of working in the hospital, to which we had no choice but to adapt. Deaths on the table were particularly traumatic for me. Patients presented in extremis, only seeking help when their pathology was advanced. Sepsis, wound infections, burns and malignancies were frequently in advanced stages prior to presentation. However, the resilience of the patients was extraordinary, and the satisfaction of helping them immense.

The working conditions on the medical wards were no less trying. We could have up to 50 patients on each adult ward at any
one time, all of whom presented late and unwell. My wife (not a paediatrician) did a paediatric ward round of 90 patients one Saturday. There was a vast amount of HIV and its associated complications, as well as TB, malaria and trauma. Malnutrition on the paediatric ward was particularly hard to witness. Each ward had an ‘intensive care unit’, which comprised a single oxygen concentrator given to the patient with the lowest saturations, and a doubling of observations from 12hrly to 6hrly. Having to ration our resources was stressful and at times frustrating, but also absolutely necessary.

The pharmacy had chronic drug shortages, at times running out of antimalarials and antibiotics. The laboratory facilities at best could provide a full blood count, CSF analysis and MC&S, but also suffered from lack of reagents. The nursing staff showed incredible resilience in dealing with such harsh working conditions.

Despite the hardships and challenges, this was a job with unparalleled levels of satisfaction. It was a privilege to work with motivated Zambians whose efforts did not wane despite the harshness of the conditions. The patients expressed enormous gratitude for their treatment and were a pleasure to look after. It was a joy to practise pure medicine largely unencumbered with extraneous bureaucracy or politics. It was particularly humbling to spend time with the Zambian staff and local people in the village, whose joie de vivre was really inspiring. Long walks, slow dinners and guitar practice replaced fast bike rides, quick internet and TV, and I miss the pace of life there. Zambia also has some of Africa’s best national parks, whilst Victoria Falls was an absolute highlight of the whole trip.

The opportunity to work overseas is one I would recommend to anyone with an inkling for adventure, and has undoubtedly been of great benefit to me, both personally and professionally. The worldwide transferability of our skills in medicine is a privilege and something to embrace, and we’re lucky to work in a deanery which affords us these opportunities to enhance and share our experience and explore the world at the same time.
French Leave

A seemingly empty village, steep roads of cobblestone. Behind the enigmatic doors is anyone at home?

The only shop, a small boulangerie; baguettes and croissants. Afternoon it shuts at three.

The buildings push upwards, forever striving for the sky. Opposite out living room a gigantic barn with a square eye.

In its wall, too far up and far too small to climb through, yet with single upright bar. As for its purpose, I’d no clue.

Finally, redemption; between those concrete monoliths a sudden sunlit view of vine fields, as the mist lifts.

Robin Forward
The Ross Davis Adventure Bursary

Available for exciting endeavours in anaesthesia!

Up to £1000 to be awarded annually
Open to trainees in anaesthesia from Peninsula, Severn and Wessex Deaneries
For OOPEs, meetings and other educational and adventurous pursuits

Applications to be made to the Society of Anaesthetists of the South Western Region (SASWR) by May 1st 2015

Well-rounded CVs essential!

Further information available from: www.rosswindsurf.co.uk
                                           www.saswr.org.uk
CROSSWORD
Brian Perriss

Clues Across

7. Small restaurant would make money by lake. (9)
8. Have respect for the delay. (5)
10. Guards an organized group of workmen. (6)
11. Yet it can provide single-mindedness. (8)
12. Take over a market in cereal despite hesitation. (6)
14. Proprietors put new distribution in alternative places. (6)
16. Incline to take care of. (4)
17. Wine in Brazil yes? No, Spain. (5)
18. Study concerning commercial. (4)
19. Area visited by Reginald and I on bikes. (6)
21. Be friendly at the party. (6)
24. Children's holiday left out, avoid hurt. (4 - 4)
26. The consequences of goods brought in from abroad. (6)
27. In three-quarters of an hour, two hundred take place. (5)
28. Visit in luxury cars for checks on attendance. (9)

Clues Down

1. Support for two. (5)
2. A hormone to give you a heavenly body. (8)
3. Logically, concerning a son is evident. (6)
4. Sounds like this weather by-passed us. (4)
5. Exist as a prisoner, a guiding light. (6)
6. Old soldier devastated Turin once. (9)
9. Fine wool from Bangor area. (6)
13. These birds came to rest in castles. (5)
18. Come out again to gather fruit. (8)
20. Flood in development. (6)
22. Vegetable that sounds opposite to what it is. (6)
23. Sifts through square buns. (6)
25. Backroom for Othello, perhaps. (4)

Solution to Crossword in Spring 2014 APW
Prizes and Bursaries

Details of all prizes, rules, and entry deadlines can be found at www.saswr.org

There are several bursaries and prizes available to members of SASWR:

The SASWR Intersurgical Trainee Prize
Two prizes, of £750 and £250 respectively, are awarded annually at the November Scientific Meeting of the society. Entries of up to 2000 words maximum in the form of an essay or short paper on any topic related to anaesthesia, intensive care or pain medicine should be submitted electronically to the Honorary Secretary of the Society (honsec@saswr.org), by 30th September each year.

The three best entries will be presented orally at the SASWR meeting in November, and the prize awarded at that meeting. Any entrants who do not make the shortlist will be invited to enter the poster prize at the meeting. Please note that you must be registered for the meeting in order to present your work, and you may not enter both this and the poster prize.

SASWR Poster Prize
The Spring and Autumn scientific meetings will have a poster prize of £250 awarded to the best poster presentation. To enter, submit your work as an abstract or poster to the Honorary Secretary (honsec@saswr.org) by 30th September each year for the Autumn meeting and 31st March for the Spring meeting. You will need to be registered for the meeting and be able to present your poster to the judges during coffee.

The Ross Davis Adventure Bursary
Annual awards totaling £1000 in memory of Dr Ross Davis, are presented by his family and friends, to trainees of ST3 or above from the Wessex, Peninsula or Bristol deaneries to support ‘exciting endeavours in anaesthesia’. Further information can be found at www.rosswindsurf.co.uk and applications should be directed to the Honorary Secretary of SASWR (honsec@saswr.org) by 1st May each year. The successful applicant will be invited to accept their award at the following November meeting of the society, although the award may be released before then!

The Feneley Travelling Fellowship
This cash bursary is awarded to any member of the society to support a ‘mission abroad’. Applications, to the Honorary Secretary of SASWR (honsec@saswr.org), are welcomed throughout the year.
Notice to Contributors

All articles should be sent by email to the editor (see below for address). Scientific articles should be prepared in accordance with uniform requirements for manuscripts submitted to biomedical journals (British Medical Journal 1994; 308: 39-42) i.e. as used by Anaesthesia. Please ensure that references are complete and correctly punctuated in the required style. The approved abbreviations will be used for journal titles. Photographs should be sent as separate attachments. The deadline for submissions is usually 10 weeks before the next meeting of the society. Submission of articles to Anaesthesia Points West implies transfer of copyright to the Society of Anaesthetists of the South Western Region. If an article has been previously published elsewhere, permission to use the material should be sought from the editors of that journal before submission to Anaesthesia Points West. Submissions will be acknowledged on receipt and notice of acceptance/rejection/need for corrections will be sent as promptly as possible.

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