The Newsletter of the APA

T-Piece

No. 1 January 2012

APA

Association of Paediatric Anaesthetists of Great Britain & Ireland

The President of the APA, Dr Kathy Wilkinson and Dr Gill Lauder pictured at the ASM in Torquay

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A New Year message from the President.

Welcome to the new APA newsletter (the title of which Tony Moriarty produced in an inspired instant!).We wish you a really happy and successful 2012.You will have heard from us recently about the Birmingham ASM, and I hope that you have had chance to look at the programme. This has been designed specifically to accommodate the interests and needs of as many members as possible in all types of setting. With this aim in mind there will be 2 parallel streams on day 1 from which you can "pick and mix". We recognise that Study leave expenses are very hard to come by and so we have not increased delegate fees for several years. We have also included a free reception on the evening before the meeting commences, as to get best value from the conference many will need to stay for 2 nights. The social event at Edgbaston promises to be really excellent, and I am personally very happy being both a cricket and curry fan. Don't be put off if you are neither, as I am assured that none of this will be overpowering! We have the facilities of a very large and exciting venue in Birmingham and I really hope you are able to attend.

Money, money, money…! Like the rest of the world this has been a preoccupation of Council officers over the last 6 months. We would very much like to offer more support to Research, Governance and Educational activities, but our expenses are rising annually. In order to better achieve our aims we are in the process of an appraisal of expenditure and we will present an annual report to you prior to the AGM in May.The survey of members was returned with enthusiasm by many of you, and our thanks to all who completed it. We are endeavouring to provide a response to your views by communicating more often and almost always electronically. We also need to find ways of better supporting paediatric anaesthesia networks. Whilst we know that emails are a constant source of additional work, please let us have your thoughts and views personally whenever possible.

Kathy Wilkinson

Peninsula meeting 2012.

Drs Simon Courtman and Anna Johnson enjoy a light refreshment while successfully organising the Annual Scientific Meeting

The Association of Paediatric Anaesthetists of Great Britain & Ireland

39th Annual Scientific Meeting
10th and 11th May 2012

The International Convention Centre
Birmingham UK

- Parallel Streams, Specialist and Generalist Paediatric Content
- Paediatric Trauma Session
- International Speakers
- Workshops – Airway, TIVA, Ultrasound Vascular Access and Human Factors
- Debate Session "Competency Based Training"
- Social Programme
- CPD Accreditation
- Meeting website now open

For information and registration
visit **www.apagbi2012.co.uk**

Results of the Members Survey undertaken in 2011

Question 1. What was the grade of repliers

Consultant	186	75%
Trainee	41	16,7%
NCCG	2	0.8%
Overseas	26	6%

2. Where do people work?

1. Specialist children's unit	33.3%
2. University hospital with specialist children's unit	35.0%
3. University hospital without specialist children's unit	5.7%
4. DGH with specialist children's unit	8.5%
5. DGH without specialist children's unit	13.8%
6. Single speciality surgical centre	3.7%

3. What do you think the APAGBI needs to concentrate it's time/resources on? please rate answers 1 lowest rank to 6 highest rank.Highest ranking in order

Professional standards e.g. guideline development	4.55
Educational resources and training	4.50
High quality Meetings	4.49
Scientific research and national audit	3.99
Patient centred projects e.g. patient/parent information	3.82
Developing world initiatives	3.43

Rank is out of five.

4. Which areas do you think we could improve upon? Highest in order

a) Involvement in College/training issues

b) Providing more educational resources to assist revalidation

c) Involvement in national health service issues

d) Provide more information about Council business e.g. publish minutes

5. How can we improve communication to the members?

a) Website	74%
b) Increased email correspondence	54%
c) Newsletter	22.9%

6. How can we improve the website?

a) more educational materials	(70%)
b) more guidelines	(65%)
c) Discussion forum	(35%)
d) patient information	(30%)
e) more newsletters	(17%)
f) website is ok	(10%)

7. Member satisfaction score

Specialist anaesthetist	92% positive
Non specialist anaesthetist	47% positive
Trainees	55% positive
Overseas	50% positive
Retired member	9% positive

8. Peer review

Members who have undergone peer review	24%
Of which percentage found it useful	67%
Would like process	67%

9.Education and training

Which of the following would help with CPD and Revalidation?

a. Courses run by the Education & Training Committee covering areas for revalidation

23.9%

b. Resources developed by the Education & Training Committee to be made available for members to use to run courses locally themselves 20.9%

c. Both 74.1%

10. The Education & Training Committee are currently developing resources to improve our website for members. What additional information would you as a member value:highest responses in order

a) suggestions on how to optimise training in paediatric anaesthesia for trainees

92.8%

b) details of paediatric anaesthesia courses in the UK and how the course content links in to the revalidation matrix

92%

c) suggestions on how to keep up to date with paediatric anaesthesia as a consultant

91.8

d) cases to support learning

91.3

e) suggestions on skills needed for anaesthetists to support paediatric intensive care outside a Children's Hospital and how to acquire and maintain them 85%

f) more detailed information on revalidation 77%

g) medical students 45%

Science and meetings

11. Please prioritise your views on how the Scientific Committee should direct efforts and funds.Highest responses in order

a) To support multicentre research initiatives commissioned by the APA

3.94

b) Towards high quality basic science related to paediatric anesthesia

3.4

c) To support small scale clinical studies within the membership

3.0

d) To undertake relevant surveys from the membership/ commissioned by the APA

3.0

e) To participate more fully within the National Institute of Academic Anaesthesia

3.0

12. Please indicate your views on how the content of the Annual Scientific Meeting could be improved

a) More Educational topics	60%
b) More emphasis on quality issues and professional standards	46%
c) More topics for Generalists	36%
d) More Scientific topics	30%

13. Would you like us to run occasional one day single or core topic meetings?

76% yes

14. Which days are best

Weekdays Thur/Fri	70%
Mixed Fri/ Sat	14 %
Weekend Sat/Sun	11%

Networks

15. Do you have a local paediatric anaesthesia network?

Yes	54%
No	22%
Don't know	24%

16. What does the local network provide?

Educational meetings	85%
Sharing of protocols and guidelines	53%
Local management issues/meetings	26%
CPD visits to the nearest tertiary centre	24%
Social events	22%

I would personally like to thank anyone who replied to this survey, It is already helping us to shape the Association for the future.

Results of the Election to Council.

We were pleased to receive replies from over 60% of the electorate able to vote and as usual the outcome was decided by a handful of votes. On this occasion Dr Colin Dryden (Alder Hey) was elected to council.

The Royal College of Anaesthetists & The Association of Paediatric Anaesthetists of Great Britain and Ireland

SAFEGUARDING CHILDREN:

Level 3 training for anaesthetists

19 APRIL 2012

RCoA, London

PROGRAMME

09:00 – 09:30	***REGISTRATION & REFRESHMENTS***	
09:30 – 09:45	**Introduction and Welcome**	*Dr Kathy Wilkinson, Norwich*
09:45 – 10:15	**Recognition and response to safeguarding concerns**	*Dr Alison Mott, Cardiff*
10:15 – 10:45	**Legal aspects of safeguarding**	*Mr John Paul Garside, Norwich*
10:45 – 10:55	Discussion	
10:55 – 11:15	***REFRESHMENTS***	
11:15 – 11:45	**Multi-agency working: what is it?**	*Ms Deborah Hodes, London*
11:45 – 12:15	**What happens when a child dies**	*Ms Sarah Steel, Norwich*
12:15 – 12:30	Discussion	
12:30 – 13:30	***LUNCH***	
13:30 – 13:50	**CASE SCENARIO**	

Rotational Workshops: *all groups rotate through each station*

	13:50 14:20	**14:20 14:50**		**15:10 15:40**	**15:40 16:10**
Workshop 1 Communication with the child/young person and their family *Lead: Dr Liam Brennan*	Blue Group	Green Group		Orange Group	Purple Groups
Workshop 2 Communicating with other professionals *Lead: Dr Alistair Cranston*	Green Group	Blue Group	**BREAK 14:50 - 15:10**	Purple Groups	Orange Group
Workshop 3 Next Steps: presenting the information to professionals in various forms *Lead: Dr Hilary Glaisyer*	Orange Group	Purple Groups		Blue Group	Green Group
Workshop 4 Supporting the role of safeguarding anaesthetist *Lead: Dr Kathy Wilkinson*	Purple Groups	Orange Group		Green Group	Blue Group

16:10 – 16:30	**Case Scenario Revisited**	Drs Liam Brennan and Alistair Cranston
16:30 – 17:00	**Summary**	
17:00	***CLOSE OF MEETING***	

APA position statement on the NCEPOD report in perioperative deaths in children 2011

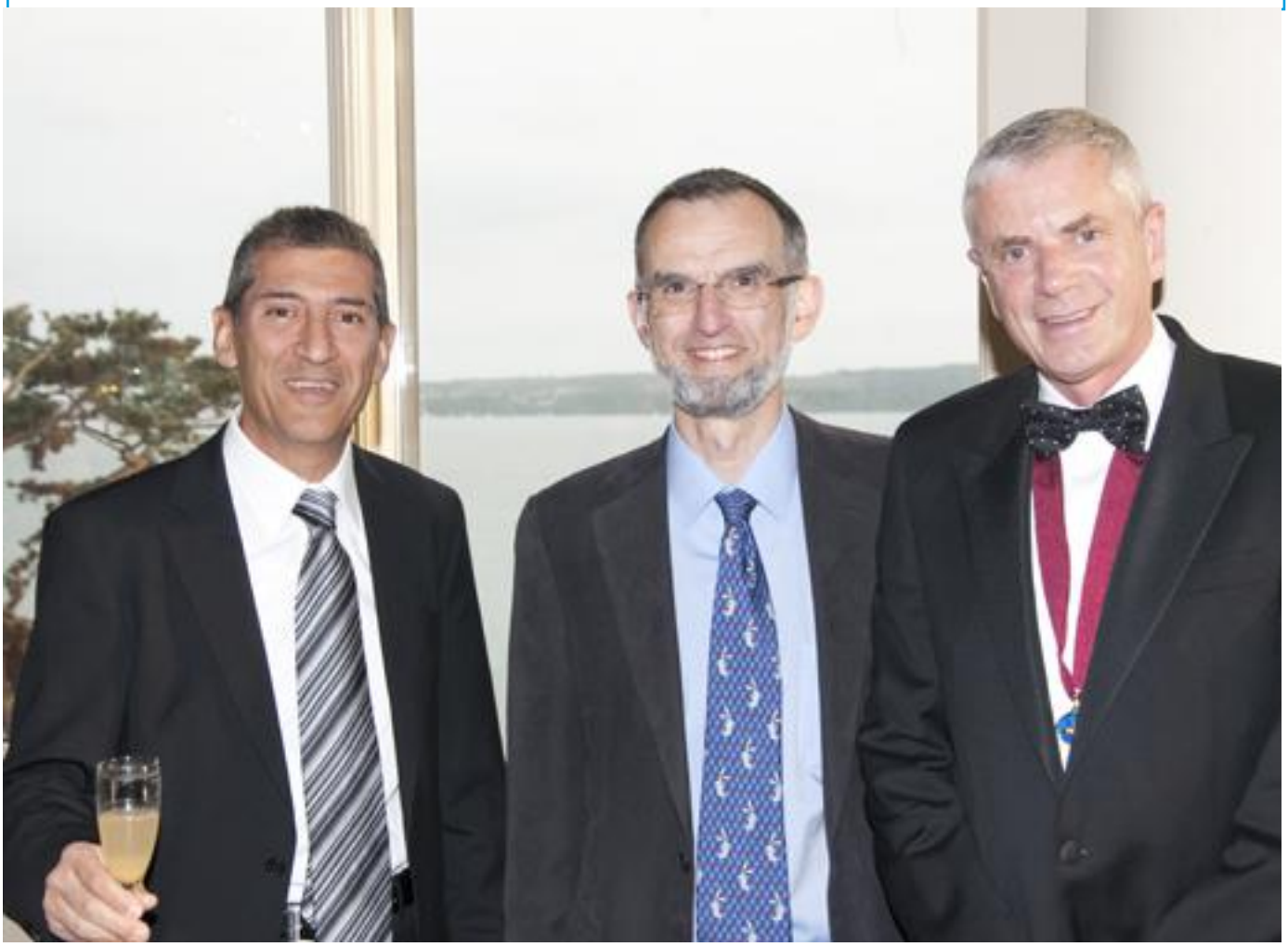
The 3rd NCEPOD report into outcome and death in surgery and anaesthesia in children was launched at the end on October 2011 (http://www.ncepod.org.uk/2011sic.htm). This report provided peer review of the case notes of 378 children aged 17 years and under, who died within 30 days of surgery, between 2008 and 2010. It also undertook a detailed organisational survey of hospitals providing surgical care of children.The headline result of the peer review section of the report was that care was good or satisfactory in 71% of cases, and there was room for improvement in 24%. In 3% of cases care was unsatisfactory. Whilst this is a better result than in other (adult based) NCEPOD reports, the overall response rate was just 63%. Therefore firm conclusions cannot be made, other than that there is certainly room for improvement in terms of participation.In those cases that were reviewed anaesthetic care was judged as generally good – most of the children who died were extremely sick and being cared for appropriately, by a consultant anaesthetist in a specialist centre. As in many areas of medical practice, information, record keeping and consent were not adequate in many of the cases and require more attention.Cardiac surgery (n = 62), neurosurgery (n = 36) and cases of necrotising enterocolitis (n = 103) accounted for 64.6% of the 378 deaths.The 2 specific conditions that merit further discussion, are necrotising enterocolitis (NEC) and acute neurosurgical emergencies. NEC cases were managed in specialist centres and the clinical care was generally good but there were difficulties in decision making which could be improved. It was felt by authors that improved care for this condition could be informed by the development of a national database, which would provide clinicians with more information on the potential for successful interventions.Head injury and other acute neurosurgical emergencies present particularchallenges.

"It is hoped that local services will be examined against the report's findings and if areas of deficiency are identified, they will be addressed"

There was a higher incidence of unsatisfactory care in this group of patients, and this reflected on both networks of care to facilitate timely referral, and on specialist centres where senior clinicians were not always involved in decision making and delivery of care. The 'Safe & Sustainable' review of paediatric neurosurgery is examining this area of practice and is due to make recommendations in 2012(REF).

In relation to organisational care here was much that could have been improved. In particular, the existing recommendations, to develop networks of care for sick children, don't seem to have been implemented in many regions and where they are present, they do not always include both anaesthetists and surgeons. Whilst the responsibility for formal, properly funded networks is officially with the NHS commissioning bodies, APAGBI strongly supports the development of local and regional networks and we are happy to offer advice and support through our 'Linkman' scheme and via established regional networks for anyone wishing to develop or improve services in their locality.Another area of care that could be improved is the recognition and early management of the sick child. In 18.5% of hospitals performing surgery in children, there was reported to be no formal policy for the recognition and treatment of the deteriorating child. APAGBI recommend that scenario based training for medical and surgical emergencies should be made part of annual training, and should be both relevant to local provision of care and, if possible, multidisciplinary (http://www.apagbi.org.uk/sites/apagbi.org.uk/files/PEDIResusTrainingFORanaes4.pdf). Using simulation, to rehearse the management of the sick child is a useful way of identifying areas of difficulty and for developing protocols in areas where sick or injured children

present rarely. Track and trigger systems or early warning scores are also helpful for identifying a deteriorating child at an early stage and are by no means universal.Transport policies were available in 93% of hospitals that performed surgery in children, but may not always have resulted in timely intervention and did not universally include recommendations for the transfer of the family. How can we respond to the report? The NCEPOD website contains a 'toolkit' which includes a summary of the areas where improvement may be needed and an audit tool to facilitate local audit against these recommendations (http://www.ncepod.org.uk/2011sic_toolkit_full.php?). It is hoped that local services will be examined against the report's findings and if areas of deficiency are identified, they will be addressed.In summary, management of surgery and anaesthesia in children is perhaps better than some elements of adult practice, but considerably more that needs to be done before we can say that it is excellent, or even satisfactory, in all cases. As mentioned, simple measures applied locally will make a difference but the APAGBI needs also be active in both supporting local initiative and in lobbying centrally. We strongly support the development of anaesthetic and surgical networks and will be working closely with partners to advise and assist the development of these in any area. In particular, we are encouraging the continued training of both surgeons and anaesthetists in the management of the common surgical conditions of childhood so that children can be safely and accurately assessed and, where appropriate, treated locally.



Familiar faces at the meeting in Torquay, Drs Dr Walid Habre, Dr Francis Veykemans and Dr Peter Crean

lifebox

Saving lives through safer surgery

Lifebox

Reports of anaesthesia and surgery practice in resource-poor parts of the world commonly include accounts describing shortages of personnel, equipment and drugs, limited access to surgical care, and patients who present late with high severity of disease (1). Not surprisingly, outcomes from anaesthesia in these settings are often poor – in some parts of the world, anaesthesia-related mortality is 100 to 1000-fold higher than in the UK (2).

Many of you will be familiar with the WHO Safe Surgery Saves Lives Programme, which aims to improve outcomes from anaesthesia and surgery through the adoption of the WHO Surgical Safety Checklist checklist, developed under the leadership of Atul Gawande, renowned surgeon, writer and public health researcher. Around 234 million operations are performed each year and these are associated with 1 million deaths and 7 million serious complications, half of which are likely to be preventable (3).

When piloted in a variety of settings, the checklist resulted in a greater than 30% reduction in mortality and morbidity (3), and preliminary results from pilot studies in Moldova and Zambia suggest that the effect is even greater in poorer settings where anaesthesia monitoring is not available.

One of the essential requirements of the checklist is that a pulse oximeter is used during surgery. Oximeters were introduced into practice in the early 80's; they transformed our ability to monitor our patients, and quickly spread to every area of the hospital. Without doubt millions of lives have been saved due to the widespread introduction of pulse oximetry.

For colleagues working in developing countries the situation is very different. Many are working without access to pulse oximeters and are required to monitor their patients using clinical assessment with a precordial stethoscope and a finger on the pulse. There are significant price barriers to the introduction of pulse oximeters and difficulties in replacing components such as probes and batteries. Recently it has been estimated that at least 70,000 operating rooms no not have a pulse oximeter (4), but the overall need for oximeters in healthcare is much greater. Oximetry has been shown to improve the outcomes from childhood pneumonia (5) (one of the major causes of death in the under 5's), and in areas where oxygen is used

unmonitored, to prevent retinopathy in the newborn.

'Lifebox' (www.lifebox.org) is a new charity formed by Atul Gawande in partnership with the Association of Anaesthetists of Great Britain and Ireland (AAGBI), the World Federation of Societies of Anaesthesiologists (WFSA) and the Harvard School of Public Health. The aims of Lifebox are to promote the use of the WHO Surgical Safety Checklist in developing countries and also to make available a good quality pulse oximeter for use in hospitals anywhere in the world.

Following a tendering exercise conducted by the WFSA, a contract was awarded to Acare Technology Limited Taiwan to supply a pulse oximeter that is robust, high quality, and battery or mains powered and has a monitor with an audible tone, waveform and adjustable alarms. It is particularly suited to the difficult conditions found in operating rooms in low-income settings. This oximeter can be purchased or donated via the Lifebox website and sent to any clinician or non-profit making hospital in low- or low-middle income country for only $250. Replacement probes are only $25 and include a universal finger probe (1 yr to adult) and reusable infant wrap around probes (more details are available on the Lifebox website – all enquiries welcome!)

What can members of the APA do to support our colleagues working under such difficult conditions? Many of you have been involved in anaesthesia outreach for many years and have established long-term partnerships with hospitals overseas. Lifebox works to ensure that pulse oximeters are only delivered to clinicians or hospitals that have completed appropriate screening. Our preferred way to distribute pulse oximeters is to work through locally based clinical colleagues who will help us undertake training in the use of pulse oximetry and also the WHO Surgical Safety Checklist, and we would be very pleased to work with you and your partner hospitals. Additionally, local clinicians are often able to help with customs clearance and further distribution within the country.

In July 2011 the AAGBI donated 80 pulse oximeters to colleagues working in Uganda and a team travelled from the UK to deliver the oximeters and provide checklist training at Mbarara University Teaching Hospital. The Lifebox team has been following up the students and oximeters and we have been delighted to hear about the many critical incidents identified and lives saved with the device. Additionally the checklist is proving useful where it is taken up, but there is more work needed on this, as is the case in our own hospitals!

Lifebox would welcome donations to purchase oximeters and also partnerships in hospitals in countries where oximetry is not used. Our target is to ensure no patient undergoes anaesthesia without a pulse oximeter, and no surgery is undertaken without the use of the WHO checklist. Can you help us?

Dr Isabeau Walker(a) Dr Iain H Wilson
AAGBI Executive and Lifebox Trustee
President AAGBI and Lifebox Trustee

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2. Walker IA, Wilson IH. Anaesthesia in developing countries – a risk for patients. Lancet 2008 371: 968-9
3. Haynes AB, Weiser TG, Berry WR, et al A surgical safety checklist to reduce morbidity and mortality in a global population. N Engl J Med 2009 360: 491-9
4. Funk L, Weiser T, Berry et al. Global operating room distribution and pulse oximetry supply: an estimation of essential infrastructural components for surgical care. Lancet 2010 376: 1055-61
5. Duke T, Subhi R Peel D et al. Pulse oximetry: technology to reduce child mortality in developing countries. Ann Trop Paediatr 2009 29: 165-75

The *Association of Paediatric Anaesthetists* and the
Neuroanaesthesia Society of Great Britain and Ireland
in conjunction with the Royal College of Anaesthetists

The second meeting of the

Paediatric Neuroanaesthesia Network

date:

Friday, January 27th, 2012

venue:

The Royal College of Anaesthetists
Churchill House, 35 Red Lion Square
London, WC1R 4SG

CPD applied for

Neuroanaesthesia Society of Great Britain & Ireland
NASGBI

APA
Association of Paediatric Anaesthetists of Great Britain & Ireland

Safety in Paediatric Anaesthesia

The APA is one of the advisory members of the Safe Anaesthesia Liaison Group (SALG), which is an organisation that has been formed between Royal College of Anaesthetists, Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the National Patient Safety Agency (NPSA) (with Scottish patient safety representatives) to encourage active learning from patient safety incidents. Members of SALG review patient safety incidents reported to the NPSA to produce a quarterly Patient Safety Update, and promote specific safety campaigns such as the 'Stop Before You Block' campaign to reduce wrong site blocks in anaesthesia. As I am sure you are all aware, the NPSA will be closing in 2012, but the incident reporting function, the National Reporting and Learning Service (NRLS), will be transferred to the new NHS Commissioning Board in April 2012. We would like to encourage you to continue reporting patient safety incidents, especially during this interim period. There are two methods of reporting to the NRLS – either through your local Risk Management Service, or through the anaesthetic e-Form, which provides a direct portal to the NPSA to report anaesthesia related incidents (http://www.nrls.npsa.nhs.uk/resources/?EntryId45=65359). Recent patient safety incidents highlighted to SALG include:

- Errors with intravenous paracetamol – incorrect dose, failure to document doses given in theatre, and duplication of intravenous and oral doses continue to be reported. Paracetamol has been the subject of a previous alert from the NPSA (http://www.nrls.npsa.nhs.uk/resources/?EntryId45=83757).

- Failure to flush residual anaesthetic drugs from intravenous cannulae. This continues to be associated with serious adverse events in paediatric practice (http://www.nrls.npsa.nhs.uk/resources/?EntryId45=65333).

- Infection control in anaesthesia – this was the subject of a recent Medical Device Alert (http://www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts/CON129213).

- Problems with the Auxiliary Common Gas Outlet in GE anaesthetic machines, which is a particular problem in paediatric practice as we commonly use both the T-piece and the circle system during cases (http://www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts/CON137664).

As the deadline for implementation of the NPSA alert on safer neuraxial connectors approaches (http://www.nrls.npsa.nhs.uk/resources/?EntryId45=94529), the Presidents of the national anaesthesia organisations, including the APA, are in discussion with the NPSA about how to facilitate testing of these new devices before introduction to the NHS. Information will be updated on the APA website as it becomes available.

Isabeau Walker Chair Safety AAGBI
AAGBI representative to the APA

New year's message for Trainee Paediatric Anaesthetists

Dr Alyson Calder
Trainee representative APA

As APA trainee members we have the opportunity to contribute to the Paediatric Anaesthesia community. There are lots of different ways to do this, and the APA is here to help you. It's possible to be involved at any training level and the more you put in, the more you get out of your experience; like learning a language you will become fluent in 'paediatric anaesthesia'. By getting more involved you will become a more learned anaesthetist, boost your CV and ultimately secure that training/ fellowship/ consultant post you are aiming for. Everybody likes a countdown, so here are your top 5 ways to get involved this year.

5 Things for Trainees to do this year!

1. Submit an abstract for the APA meeting in Birmingham (10-11th May, 2012)

Go to www.apagbi2012.co.uk, have a look at the programme and register. The sessions look excellent, whether you plan on being a full-time, part-time or occasional paediatric anaesthetist. Our Trainee Session will share fellowship experiences from around the globe, particularly invaluable for those planning an Out of Programme Training year. Even better than simply attending the meeting, submit an abstract. You have until the 2nd of March 2012 to do this. Nine abstracts will be selected for oral presentation and the others will be presented in poster form. If you have never submitted an abstract before, it is easier than you think. Step by step instructions on how to do this are at www.apagbi2012.co.uk. For those of you who have presented at meetings before, there should be nothing stopping you! And, of course, there are prizes for the best.

2. Submit a 'Best Bet'

The next time you come across a clinical question (e.g. "Should we apply cricoid pressure for rapid sequences in infants?" or "When should I use and avoid muscle relaxants in paediatrics?"), expand upon your cursory Google search and spend an evening (or two) writing a 'Best Bet' for publication on the APA website. A Best Evidence Topic (BET) takes a specific clinical scenario and uses evidence to answer your clinical question. You define what your clinical question is, perform a literature search, critique the papers you find and

then produce an answer to your original clinical conundrum. Guidance on how to complete this process is available at www.apagbi.org.uk/content/how-guide ('How to submit an APAGBI Best Bet'). Team up with a consultant or senior registrar willing to provide guidance and help with the write-up. The final product will inform you for future similar clinical scenarios, will familiarise you with literature searching and provides an instant presentation to deliver to your department. Lastly, it will help your anaesthetic colleagues around the globe through publication on the APA website. More about this process can be found out by contacting alysoncalder@doctors.org.uk.

3. Write an article for the newsletter

We all know that anaesthetists enjoy reading newsletters more than scientific journals. The process of writing and submitting an article for newsletters is easier than writing for a journal. We would be delighted for you to share your experiences with us (e.g. your experience on a fellowship/elective/sabbatical/hospital visit/at a meeting/in your hospital). Or perhaps you have opinions on a clinical or management topic (e.g. competencies, simulation, assessment, rotas). Sit down at your desk with a cup of tea, open up the laptop and get writing! Send your questions/ideas/articles to alysoncalder@doctors.org.uk or tonymoriarty@me.com.

4. Do an audit

It comes to us all, our favourite question at the ARCP meeting: "have you done any recent audits?" The key is to find a topic that will allow you to carry out a USEFUL audit. The best way to approach this is a) choose a subject you are interested in and b) identify an area of local interest. Speak to your colleagues about difficult clinical or organisational issues that they would like quantified or investigated. 'Raising the Standard: A compendium of audit recipes', a Royal College of Anaesthetists publication, is another good place to find audit ideas. It contains an entire chapter of Paediatric Anaesthesia audit standards (www.rcoa.ac.uk/docs/ARB-section9.pdf). Choosing a topic of relevance to your local hospital/trust means that it is likely your department will be keen for you to present your findings at a hospital meeting. You are also more likely to get involved in local management (e.g. developing a protocol/assembling a list of equipment/applying for funding for equipment you have identified as desirable). This, of course, ticks the 'Management' box for you and will be invaluable experience for when you become a consultant. The APA is keen to hear about audits you plan and is willing to offer advice. You should submit your findings as an abstract for future APA meetings. Audits are published on the APA website (http://www.apagbi.org.uk/professionals/audits-best-practice-presentations). Please contact alistaircranston@apabgi.org with your audit questions.

5. Get in touch!

I am keen to hear from trainee members, in particular if you have any questions or perhaps some ideas/requests for how the APA could serve you better. What resources would you like from the APA? Would you be interested in organising a local meeting, perhaps an evening seminar on a paediatric topic? Do you have ideas for what we could be doing better? Please drop me an email on alysoncalder@doctors.org.uk. If I am unable to help directly, I will find someone who can.

In terms of our new year's resolutions at the APA, two of the main areas we aim to improve for trainee members are the website and the production of the 'APAGBI TRAINEE HANDBOOK OF PAEDIATRIC ANAESTHESIA: Guidance for those planning a career in paediatric anaesthesia'. Watch this space.

Dr John Inkster

One of the first paediatric anaesthetists.

John Inkster, who died on the 10th September, was born one of twins in Middlesborough in 1924. His father was a physician and his mother a Great Ormond Street-trained nurse. He was educated at Epsom College because, as he said, his father had discovered that as a doctor he would get a £10 reduction in the fees. He went from there to study medicine at the University of Aberdeen and graduated in 1945. John became a house physician at New End Hospital in Hampstead where he gave his first anaesthetics in the afternoons when the (real) anaesthetists had left to work elsewhere. This started an interest in anaesthesia that would last the rest of his life.

After New End John joined the Regular Army for 31/2 years where he expressed an interest in being trained as anaesthetist. The Army, in its way, ignored this and made him a Regimental Medical Officer. It was only after a serious motor bike accident, which left him unconscious for three days, that the Army decided that he was unfit to be a Regimental Medical Officer but fit enough to be an anaesthetist. His father, however, was unimpressed by John's career choice and did not speak to him for the next three years.

When he left the Army John applied for a job in Newcastle, mainly to be with Professor Edgar Pask whose First Assistant he eventually became. Pask was a hard-working and irascible task master but John developed a great respect for him and inherited Pask's ability to design and produce pieces of anaesthetic equipment to fill the gaps left by the manufacturers.

John's interest in paediatrics developed as he sought ways of dealing with what to him were difficult and alarming anaesthetics. He learned some of his skills in the Hospital for Sick Children in Toronto as well as in Melbourne, Cape Town and Great Ormond Street Hospital. He was appointed as a consultant at the R.V.I. in 1958. At that time in Newcastle most of the general surgery carried out on infants and small children was at the Babies Hospital, three large houses near the Royal Victoria Infirmary that had been knocked together. John gradually took over the anaesthetics here, working largely with John Scott who had come from the Middlesex Hospital to become Newcastle's first paediatric surgeon. Both of them later moved to the Fleming Hospital for Sick Children in nearby Jesmond and the Babies Hospital closed.

The Fleming had two operating theatres and a small intensive care unit which provided the stimulus for John to produce several innovative pieces of equipment. Together with Dieter Hoffman of the Design Unit in Newcastle University he designed a fluid-logic, neonatal ventilator which was unusual in that it delivered fully-humidified gas at the correct temperature and all the parts that were in contact with the baby could be autoclaved. He adapted two different adult ventilators for use in the operating theatre as well as devising a heating and humidifying system for them. He also had made a kit to allow an oesophageal probe to act as a set of E.C.G. contacts so that monitoring could be rapidly achieved. Perhaps his best known invention was the system of 8.5 mm tracheal tube connectors and matching T-piece that was more convenient to use on small infants than adult-sized equipment. These were originally made in metal but were taken up by Portex as the plastic MiniLink system which could also be used for long-term ventilation.

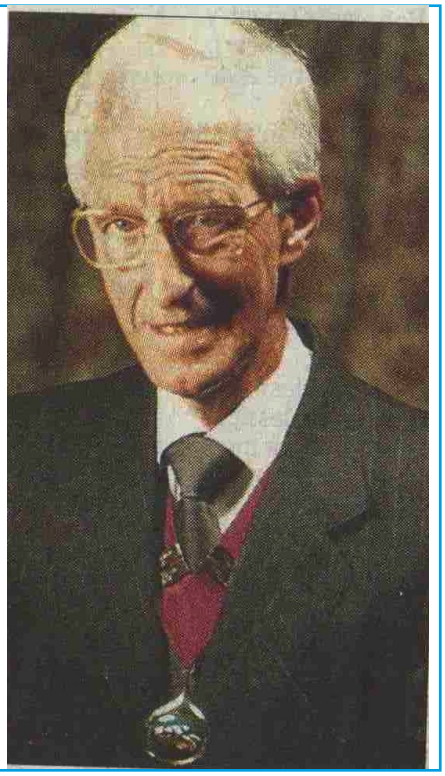
Arguably John's greatest gift to anaesthesia and intensive care was the invention of P.E.E.P., which he called Residual Positive Pressure. This was published in the proceedings of the World Congress of Anaesthesia in 1968 and slowly entered mainstream practice throughout the world

although he received little credit for it.

John was a founder member of the Association of Paediatric Anaesthetists with Bob Cope, Jackson Rees and Gordon Bush and was its President from 1982 to 1985. He retired in 1985 but continued to attend the annual meetings of the Association until ill health made it impossible. He, and his second wife Lynda, were a great help to their successors when the A.P.A. held its annual meeting in Newcastle in 1999.

John Inkster was a man of enormous intelligence and organisational ability but he was most of all a practical man and a great clinician. His hard work and clarity of thought was an inspiration to all those who worked around him.

R. J. Bray



TIVA for Tots

A paediatric intravenous anaesthesia study day

Meeting awarded 5 CPD points

Registration Fee: £150
(£85 for Anaesthetists in Training)

To register, visit:

www.TIVAforTots.co.uk

(online registration and payment of registration fees via the secure servers of WorldPay)

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Meeting hosted and organised by RPD Publications (Europe)
www.RPDpubs.eu

In the new look format of this newsletter, and in response to the request in the members survey for more communication between the APA council and members, We intend to produce this e-newsletter at least quarterly.

I would welcome all submissions from members, interesting cases, audits, original articles or just observations related to paediatric anaesthesia. Future versions will incluse updates, guidelines and topics of interest.

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