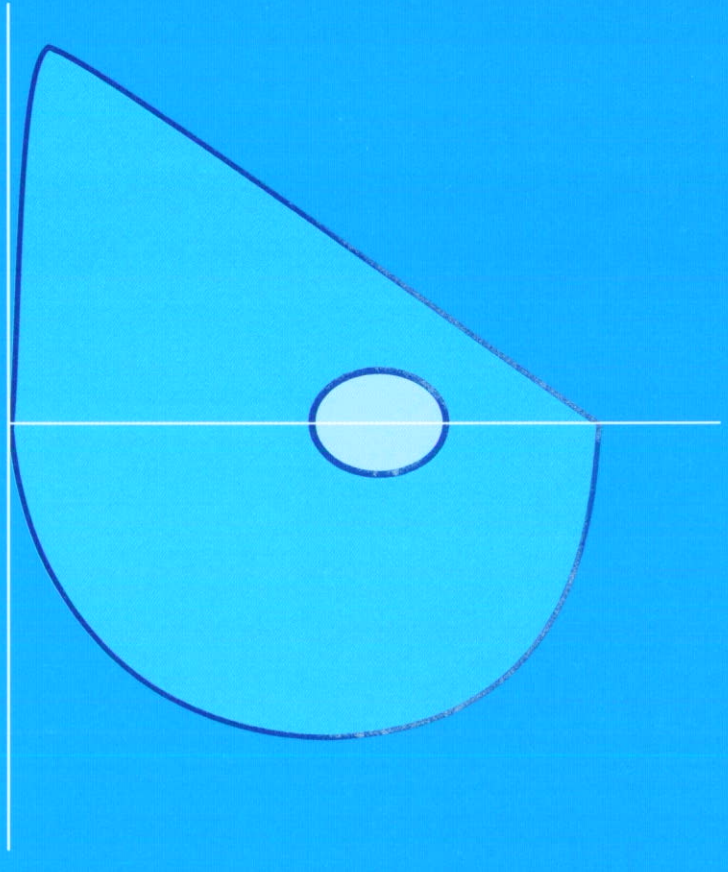
Vol. 5 No. 3 Dec. 2003

Inspire



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The Official Journal of the Association for Respiratory Technology & Physiology

FINAL WORD

Welcome to the winter edition of Inspire. Some great and thought provoking articles this time. Go back in history with the equipment of the past, as humorously related by Mike Saunders in his article on Lung Function Measurements in 1960 – if your Head of Department says they don't remember the kit they are lying about their age! Also Georgina Martin from Leeds has written the "alternative" ERS report. Anyone not stirred by its content cannot have oxygenated blood in their arteries! And, true to his usual style, an entertaining article by Brendan on the ARTP/ ARTI joint meeting in Dublin with, surprise surprise, many references to a certain liquid refreshment.

This will be my final word as, with regret, I am giving up my ARTP Executive and editorial role. It is a decision forced by ever increasing clinical and non-clinical workloads - a situation many of us are in. I have really enjoyed being part of such a dynamic and professional team. Thank you to everyone over the past few years who has made my job easier with contributions to Inspire. Please keep sending in the articles.

Merry Christmas and a Happy New Year to all ARTP members. Hopefully we will see many of you at the Annual Conference in a few weeks time. It promises to be another superb event.

Gill Butcher
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Belvedere Road
Burton-on-Trent
DE13 0RB

CONTENTS

THE REGISTRATION COUNCIL FOR RCCP CLINICAL PHYSIOLOGISTS

Dear Colleagues,

Re: Clinical Physiologists Petition to the Health Professions Council

I am delighted to announce that RCCP on behalf of your profession, have successfully petitioned for regulation under the Health Professions Council [HPC], with the Council giving an overwhelmingly positive vote.

We have yet to receive the official notification, as our presentation to the HPC council only took place on 8.10.03. But I am reliably informed that the HPC will be making a provisional recommendation to the Secretary of State.

The reasons for the recommendation being provisional are twofold:-

1. HPC anticipates that a number of aspirant groups will seek regulation over the next four years. A number of the groups within Healthcare Science may have broad similarities and clinical physiologists are likely to be one of these.
2. Parliamentary timetable will probably mean that changes to the Health Professions Order 2001, relating to Healthcare Scientist aspirant groups will not be made until early 2005.

The HPC will therefore make final recommendations on all aspirant groups in Healthcare Science area, who are ready for regulation, in late 2004. For those who take longer to develop a voluntary system a further group should go forward in 2006. HPC expect that clinical physiologists will be in the first group to go forward for statutory regulation in 2005.

This is only the first phase albeit an essential one. The next phase involves RCCP working with the Regulation Branch of the Department of Health, who will begin the long process of crafting the legislation and a document for issue as part of the public consultation exercise.

Therefore I estimate that our voluntary registration system has between 16 and 18 months of operation under its present form. Once again I would **urge all potential registrants to apply to the voluntary register NOW.** It will be a more straightforward and less expensive process [estimated costs for future grand-parenting under HPC are over £200]. As ever help is available via your professional body representative and their contact details appear on our web site at www.rccp.co.uk.

May I take this opportunity to thank all of registrants for their continued support in our endeavour to achieve statutory regulation of practice, soon to be realised. I also would like to thank on your behalf your professional body representatives who have worked so hard to achieve this objective on behalf of all of our professions.

Yours sincerely

Anne Burge - Hon Chair RCCP

Inspire

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BURSARY INFORMATION

Bursaries are available to ARTP members, which can be used to support attendance at National ARTP, BTS or STS meetings. Other relevant respiratory meetings or approved training courses will also be considered. Bursaries are available to student, associate and full ARTP members of any grade. They can be used for partial or total funding of registration, travel and accommodation costs for the whole or part of the meeting/course. All bursaries are considered by the ARTP Executive Committee on the reason for the request and the commitment to an article for *Inspire*.
For further details or an application form please contact: **Gill Butcher (Bursary Secretary), Cardiorespiratory Unit, Queen's Hospital Burton, Belvedere Road, Burton on Trent, DE13 0RB. Tel: 01283 566333 Ext 5334 or via e-mail: bursary@artp.org.uk**

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Price £65 to ARTP members, £80 to non members
Contact Jackie Hutchinson ARTP Administrator to order
admin@artp.org.uk or telephone 0121 241 1611

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CORRESPONDENCE: admin@artp.org.uk

URGENT REMINDER

REGISTRATION FOR THE ARTP ANNUAL CONFERENCE 2004 IS NOW WELL UNDERWAY. IT IS NOT TOO FAR AWAY SO PLEASE ENCOURAGE YOUR DEPARTMENT MEMBERS AND RESPIRATORY COLLEAGUES TO REGISTER AS SOON AS POSSIBLE. CPD POINTS (11 IN TOTAL) HAVE NOW BEEN AWARDED FOR THIS MEETING.

AGENDA

ARTP Conference 2004
29 – 31 January 2004
The International Centre, Telford

The ARTP Conference provides the ideal environment for practitioners in respiratory physiology to come together to learn about current techniques, latest research and innovations and meet other like-minded practitioners. Eleven CPD points have been awarded for this meeting.

Thursday 29th January 2004

18:30 Keynote Speaker – Professor Milic-Emili, Canada
19:15 ARTP Open Forum
19:45 Manufacturer's Reception

Friday 30th January 2004

Plenary Session – Chairs: ***Respiratory Exercise Testing Session, Dr Lawrence McAlpine & Dr Roger Carter***

09:45 Breath by Breath Exercise Testing – Professor Hans Folgering, Netherlands
10:10 Traditional Exercise Testing – Professor Chris Cooper, USA
10:25 The Future of Full Exercise Testing – Dr Lawrence McAlpine (TBC)

11:00 Refreshments & Poster Viewing

Plenary Session – Blood Gas Testing – Chairs: ***Dr Will Kinnear & Miss Julie Lloyd***

11:30 Physiology of Blood Gases – Professor Mike Hughes, London
11:55 Methods of Measuring Blood Gases – Miss Rachel Holt, Nottingham
12:20 Interpretation & Clinical Applications – Professor John Gibson, London

12:45 – 13:45 Lunch & Poster Viewing

13:00 -13:40 Lunchtime Workshops

Simultaneous Sessions

Respiratory Technology – Chairs: ***Dr Bill Tunnicliffe & Mr Nigel Clayton***

14:00 Which CPAP - Dr Adrian Kendrick
14:25 The Nose in OSA – Measurements and practicalities – Dr John Kiely, Drogheda
14:50 Advances in Respiratory Measurement – Mrs J Shakespeare

Respiratory Physiology – Chairs: ***Professor Milic-Emili & Dr B Cooper***

14:00 Control of Ventilation – Mrs Sandy Jack, Aintree
14:25 Advances in Lung Mechanics – Dr Neil Pride, London
14:50 The background to the TLCO: What are we actually measuring - Professor Mike Hughes, London

15:15 Refreshments & Poster Viewing

15:45 Guest Lecture: Professor John Gibson, Newcastle upon Tyne
19:00 Drinks Reception & Gala Dinner

Saturday 31st January 2004

09:00 AGM
10.00 Poster Session

Plenary Session – Update on Lung Diseases – Chairs: ***Mr Nigel Clayton & Mrs A Evans***

11:30 Sarcoidosis – Dr Brian Harrison, Norfolk & Norwich
11:55 Connective Tissue Diseases – Dr Sheeran, Cannock
12:20 Obliterative Bronchiolitis - Dr Andrew White, Birmingham (TBC)

12:45 Close of meeting

For further information please contact: Association for Respiratory Technology & Physiology
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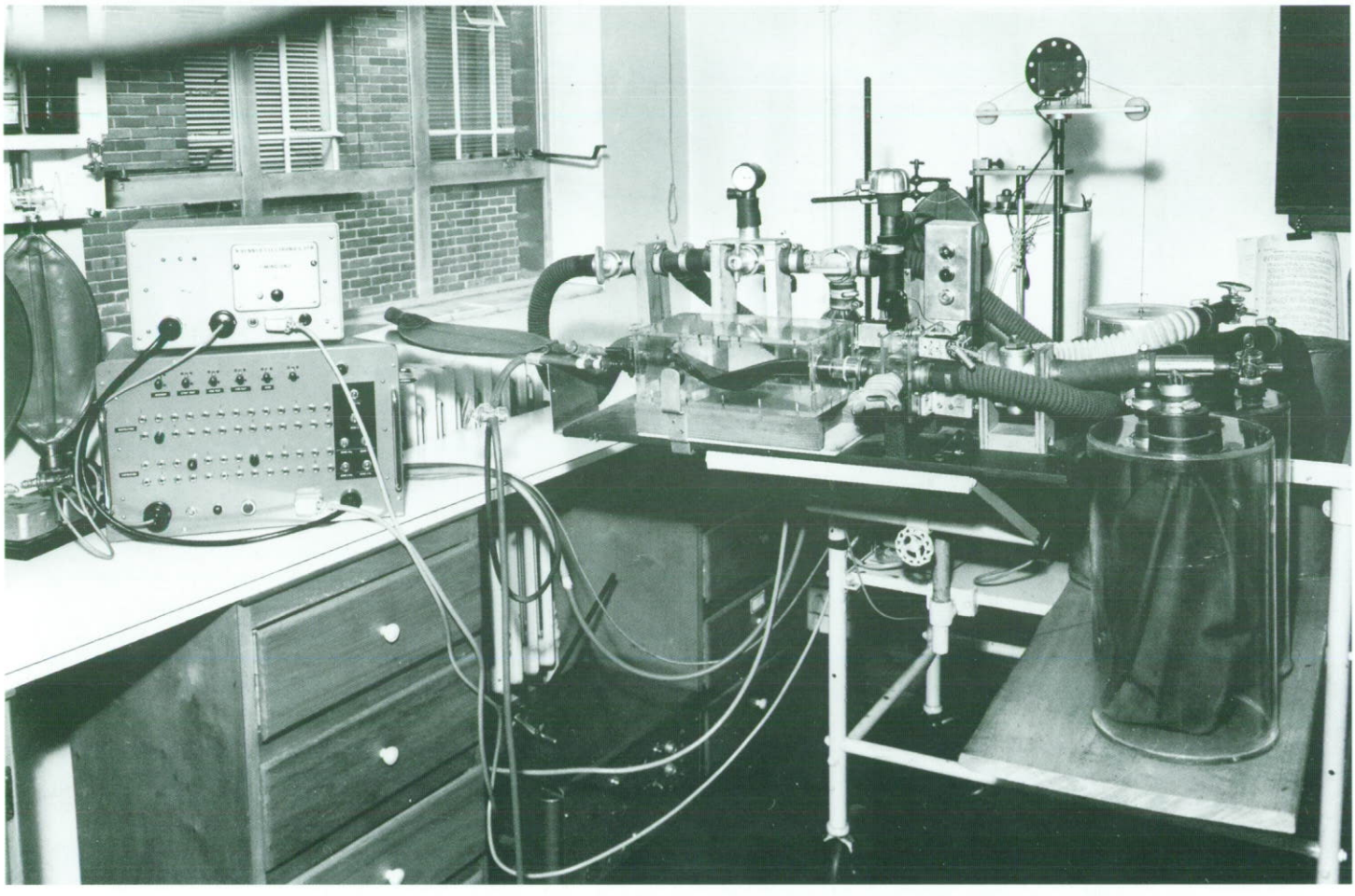
Email: admin@artp.org.uk Website: www.artp.org.uk

LUNG FUNCTION MEASUREMENTS IN 1960

by Mike Saunders



Mike Saunders has recently retired after spending 42 years in Lung Function Departments. He spent 25 years working for the Medical Research Council with Dr John Cotes until his departure to Newcastle and 17 years working for the NHS as the head of Lung Function at Llandough Hospital. He has sent in this article which should be of great interest both to "mature" ARTP members who may remember with fondness (or otherwise) similar looking equipment and to the "younger" members who will probably breathe a sigh of relief that their daily duties do not include calibrating and maintaining such beasts! The 1960s equipment and methodology would probably be rather carefully scrutinised by Health and Safety officials of today.

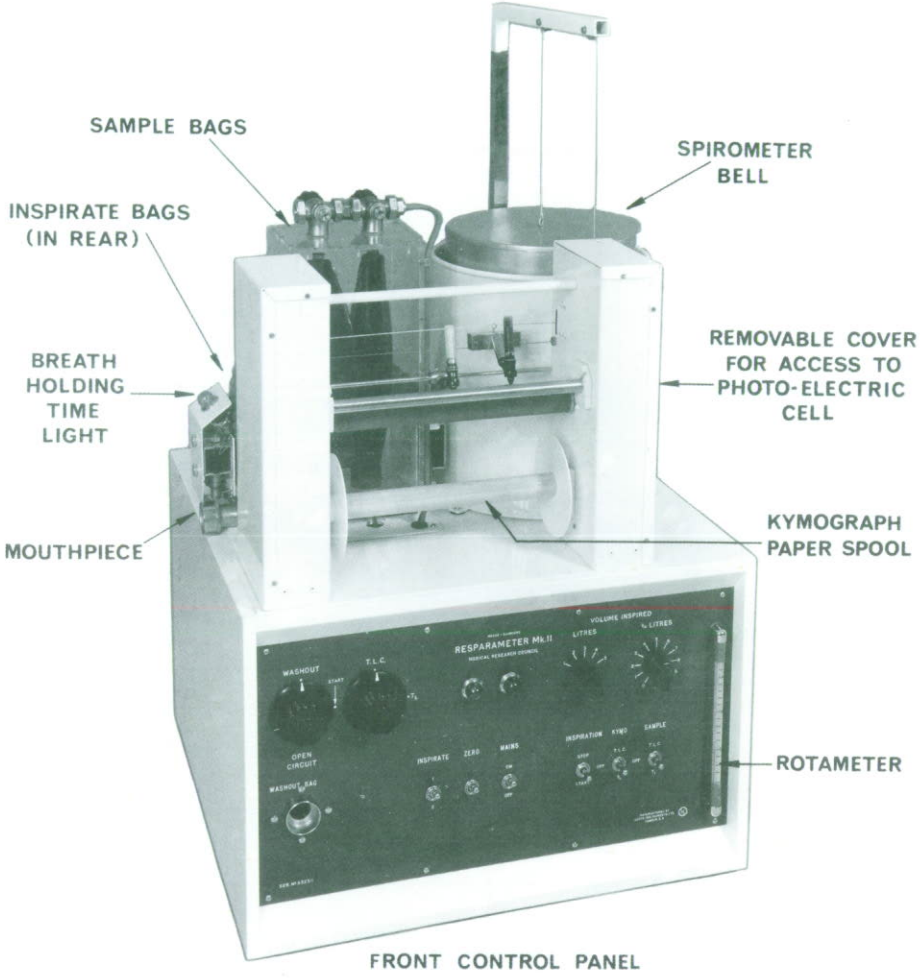
SPIROMETRY

This was carried out using a water seal spirometer which had a string attached to the top of the inverted bell passing over two pulleys to a counterweight at the other end of the string. A calibrated disc attached to one of the pulleys enables FVC to be read off. A pointer, held in place by a relay for 1 second enabled FEV_1 to be determined. A drain cock fitted to the bottom of the water reservoir allowed the water to be drained off for routine maintenance/cleaning. The whole thing was made out of tin so any chip in the protective paintwork quickly led to the formation of a rust patch. Eventually the parts exposed to water were treated with epoxy resin which was just appearing on the market. Three adjusting screws on the bottom of the spirometer enabled it to be accurately levelled. The water level needed to be checked at the start of each day and a one-way valve had to be inserted in the side arm of the tube which the patient blew down as a guard against the patient inadvertently breathing in rather than out, sucking water into the tube and risking inadvertent drowning of the patient!

LUNG VOLUMES

This equipment was built on a 'Handy Angle' framework and stood about 5 feet high by 2 feet deep by 4 feet long (not exactly portable). Again it used a water seal spirometer which now had a home-made ink pen attached to the counterweight and this wrote on an electrically operated Kymograph of about 9 inches diameter which rotated at 1cm per 10 seconds, a paper chart about 10 inches by 30 inches being fixed to the Kymograph at the start of each test. The pen consisted of a small open ink reservoir with a short length of narrow bore tube soldered into the side. As supplied the ink tended to dry up in the narrow tube overnight so to prevent this a drop or two of glycerine was added to the ink. Care was needed here since too much glycerine meant the ink never dried on the paper trace resulting in an awful mess when the trace came to be measured. The equipment, as today, was a closed circuit

containing about 10% helium into which the patient breathed. Oxygen was added manually from an external cylinder and carbon dioxide removed via a 'Calsoda' scrubber contained in the centre of the spirometer. To circulate the gas around the circuit some sort of fan was necessary. As the tiny 'in-line' fans used today weren't available we developed a home-made centrifugal fan made out of brass sheet driven by an external electric motor. The problem was in maintaining a gas tight seal between the motor and the fan as commercial seals were not available either. This was solved by the drive between the two units passing through an oil bath filled with car engine oil of the correct thickness. One of my jobs, at the start of each day, was to top up the oil level since there always seemed to be a slight leak in the oil bath itself. A small tray containing sawdust on the floor beneath the unit caught any drops of oil otherwise the cleaners (and there were far more of them in those days!) would complain loudly.



FRONT CONTROL PANEL

The helium analyser was manufactured by 'Cambridge Instrument Company' but, because stabilised power supplies were only just being introduced, our first analyser was run off a car battery and again it was my job to put a battery on charge each night.

We had three batteries in use, one on the analyser, one on charge and the other "settling" since they were not very stable when first taken off charge. A small rotary pump took a sample of gas from the main circuit and passed it through the helium analyser. Very little equipment was available commercially and it was necessary to make most of the equipment in-house and for that reason research institutes usually had extensive workshop facilities.

The early oxygen analysers had a Perspex screen marked from 0-100% and a light beam was focussed on this to indicate oxygen concentration. Unfortunately the light beam was so faint that it was necessary to have a black cloth over the analyser and operator to take a reading. Fortunately 'Servomex' at about that time brought out an analyser with a 10 turn potentiometer calibrated from 0-100% mounted on the front so now it was only necessary to turn the knob to move a light beam over a mark on a small screen on the front panel and read off the concentration. Again the instrument was operated by batteries until stabilised power supplies were available.

The helium analysers, as now, were sensitive to oxygen but, whereas the correction factor is built in to todays machines, 40 years ago it was necessary to calibrate for the effect of oxygen and apply a correction factor if the oxygen concentration was anything other than 21%. Remembering that computers and calculators were not available, such correction factors and all results were calculated using slide rules and Log tables, making calculation of results a real bind. The department did obtain a 'Facit' mechanical calculator shortly after I started work but most of the senior members of staff had first call on this and, as the most junior member, I was way down the packing order and consequently became very good at using a slide rule!

Because the spirometer was the water seal type it was most important to set the spirometer level at the correct point before starting measurement of lung volumes. Setting the spirometer too high in the water risked a patient with a good expiratory volume blowing the bell out of the water, setting the spirometer too low in the water gave rise to the risk of a patient with a good inspiratory capacity causing the bell to "bottom" with water being sucked over into the carbon dioxide absorber and possibly into the patient.

TRANSFER FACTOR (called Diffusing Capacity in those days)

This equipment was 3ft x 2ft x 4ft, again not particularly portable. Up until the late 1950s the operator had to manually turn some sort of large bore multi-way, home-made tap system to connect the patient to the various ports for expiration, inspiration, breath holding, washout, sampling and washout and this required considerable skill

both on the part of the operator and the patient. Results obtained were not at all repeatable and some way had to be found to control all the parameters involved. Just as I started work at the Unit and electrically operated valve box and crude volume detection system was just being developed and this project was given to me to develop further. Again a water seal spirometer was used, again with a pen added to the counterweight, but now, to achieve the greater accuracy required, the Kymograph was about 18 inches in diameter and rotated at a speed of 1cm/sec. The method of setting the various volumes consisted of a series of fixed and moveable contacts attached to a large disc driven by the movement of the string fixed to the spirometer. It was an extremely clever but simple system with the whole thing powered at 50 volts DC. One drawback for the operator was that if the power was not turned off before volume adjustments were made then the operator received a painful reminder of the fact by having a 50 volt electric shock. The patient breathed through a Perspex valve box made in the workshop with each of the 4 ports controlled by 50 volt solenoids. These made a satisfying 'clunk' each time they operated and technicians working in other laboratories could tell when measurement of diffusing capacity was being made.

Early carbon monoxide analysers were made by the 'Infra Red Development Corporation' and these had a rubber belt drive between the beam chopper and the synchronous drive motor. These belts were for ever breaking and my boss decided we could make our own belts out of some strong cotton. It was important that the knot in the cotton was to the outside of the belt otherwise, as the belt passed over a pulley, it would slightly slow the speed of rotation causing the analogue indicator to give a little 'kick'. I spent much time learning how to tie knots in cotton which would lie on the outside of the belt. The early IRDC analysers had a case made out of thin steel and were fairly sensitive to changes in ambient temperature and we soon turned to analysers made by 'Grubb Parsons'. These stood about 3 feet tall and were so heavy that it needed two people to lift them but, because they were so massive, they had tremendous thermal stability although the weight caused many problems when we subsequently took them on surveys in this and other countries.

The 600 ml sample of gas collected during expiration was collected in a 1 litre rubber bag and for some reason the sample was being transferred to another bag before being passed through the gas analysers, which were incorporated into the lung volume apparatus. This transfer was accomplished by having the actual sample bag contained within an empty 1 gallon oil can (remember we used engine oil in the pump seal on the lung volume apparatus) and at the end of the test compressed air at a known flow rate was applied to the can forcing the gas sample into the external sample bag. By having a small spirit level attached to the top of the can the movement of the bubble indicated by how much the can was being distorted as pressure was applied so that the compressed air could be turned off before the whole thing exploded! To prevent the tin being blown up by excess pressure a safety blow off device was introduced in the compressed air line.

The volume detection system was improved by having a disc with holes drilled in it corresponding to 100 ml increments of volume. A light shining through the disc with a photocell on the other side allowed volume increments to be counted enabling much better control of volume. Eventually these two pieces of equipment were combined and made much smaller, the prototype was then given to a commercial firm for manufacture and thus was born the 'Meade/Saunders Resparameter'. The water seal spirometer still persisted for some years until the rolling seal spirometer used today was introduced.

EXERCISE

Exercise was performed on a home-made treadmill, the belt being supplied and fitted by engineers from the National Coal Board. The motor was thought to have come second hand from a ship.

Expired gas was collected in large Douglas bags of 40-100 litre capacity the contents of which were squeezed through a gas meter, manufactured by Parkinson Cowan, to obtain ventilation. These were very similar to the gas meter in many homes although it had a slightly lower resistance. During an exercise run it was necessary to switch several of these bags into the expired line one at a time. Gas samples were collected using Brodie bottles where the flow of mercury from an upper chamber to a lower chamber caused a sample to be taken. Huntly tubes, again relying on the flow of mercury, were also used for gas sampling although here the mercury flowed into an open container and only years later was this thought to be dangerous due to the build up of mercury vapour in the laboratory.

The analysis of the gas samples obtained during exercise was performed using the Lloyd-Haldane apparatus where the carbon dioxide and then oxygen were absorbed in turn by freshly prepared chemicals, the change in volume after each absorption giving the amount of each gas present. This analysis required great skill and much practice, each sample taking many minutes.

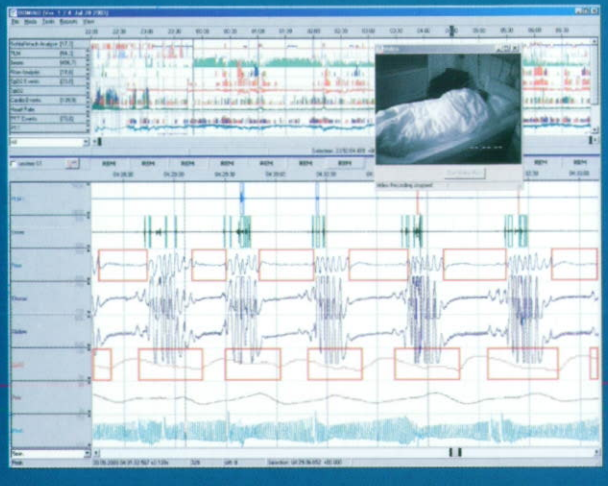
Most exercise tests, in those far off days, seemed also to involve the taking of arterial blood which also needed analysis. Reliable blood gas analysers were not available and again chemical analysis was necessary using the Riley bubble method where even greater skill was needed. Analysis of each sample took about 25 minutes. Generally it was only possible to perform one exercise test per day and if, for any reason, the time of starting was delayed, it was not unusual to work well into the evening analysing the samples. Because of the time taken to clean, sterilise and prepare the laboratory only 2 or 3 full exercise tests with arterial bloods were performed each week.

To measure oxygen saturation, use was made of a spectrophotometer and took about 30 minutes for each sample (nothing was done quickly in those days). The method involved passing light at two different frequencies through a 10 ml sample of arterial blood to obtain the changes in optical density and then performing a complicated calculation. The theory behind the method is exactly the same as that used today using pulse oximeters, but they of course give instant results.

Medical Devices for Sleep Diagnostics and Therapy

SOMNOmedics

SOMNOscreen



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"ON THE BLOWER"

By Nigel Clayton, Alan Moore and Brendan Cooper

Comment regarding filter efficiency

Following the last edition of Inspire, we received this letter from Ian Cliffe who works at the City General Hospital, Stoke-on-Trent.

Dear Jackie

I am writing in response to the comment made in Inspire Vol.2 No2 Sept 2003 by Alan Moore with regards to the SMED filter.

In the Article Alan states that the "filter specification is equally impressive as competitors". Looking at the literature regarding filters I find it difficult to understand how Alan has come to this conclusion.

Firstly there is no independent test data from the Centre for Applied Microbiology and Research, Porton Down and secondary, although the filter was tested using 1% Sodium chloride, as specified in BS4400, the laboratory used was situated in Pretoria, South Africa.

The test data from the laboratory claims, 99.84% efficiency on rising flow rate (RFR) and 99.99% efficiency on falling flow rate (FFR). The flow rate used in obtaining this data was less than 5 litres/min.

When you look at the data supplied by Air Safety, they claim that their filter is 99.9999% efficient when tested at a flow rate of 30 litres/min. If you compare this with the SMED filter at a similar flow rate the efficiency goes down to 96.69(RFR) and 97.99 (FFR) which makes it over 10,000times less efficient.

I think if comments are to be made in Inspire, it is important that they are correct and not misleading.

Yours sincerely

Ian Cliffe

Alan's comment was a general comment regarding many of the filters available today and not a comparison with one particular manufacturer. I agree that the figures from Air Safety do look impressive, however if we are going to assess filtration efficiency for use in a respiratory laboratory, it is important that all filters are tested at a typical respiratory flow rate of at least 10 litres per second (600 litres/min). From our point of view this would give the true efficiency of the filter.

I understand that Porton Down are due to run an independent test on the S-Med filter. If we get access to the data, hopefully we will be able to publish it in the next edition of Inspire .

NC

Dear Ian,

I had no idea that you had a specialist interest in this subject. My words in the article were *"Filter specification is equally impressive as competitors"* – not competitor and, as Nigel has pointed out in his remarks, this was a referring to the market in general. There are, after all a number of filters sold in the UK – some of them using the 3M filter material like that in the SMED device.

I note the figures you quote – impressive looking. However, as Nigel has pointed out, just because a filter performs well in Porton Down testing at very low flow rates, this does not necessarily mean that at flows observed in clinical practice any one filter is any better than any other.

Perhaps you could use your knowledge and influence to encourage manufacturers of filters to publish data from tests which have clinical relevance – we'd all be grateful for that. May I suggest an article on the subject for the next issue of Inspire as a good starting point?

Regarding your comments about where the SMED filter testing was performed, are you insinuating that the testing in South Africa was any less robust than that which occurs at Porton Down ? If you are, then surely you would want to make the same comments about the SensorMedics filter as their testing was also not conducted at Porton Down or indeed any other filter not tested at that establishment ? I can hear the Viasys and other company lawyers winding up now !

At the end of the day, what matters is the clinical significance of the data you quote – I think the jury is still out on that one.

My market intelligence tells me that one company who have until recently had more than significant market share in the filter field are starting to experience some serious competition. Coincidence is a funny thing isn't it ?

Regards,

Alan Moore

AM

Manufacturer and product news

Ferraris Cardio Respiratory

Scottish regional representative.

Ferraris are pleased to announce the addition of a new regional based area representative for Scotland. Faith Goodson has joined the team and will be responsible for the Morgan Medical, Delmar Reynolds and Ferraris Medical product ranges.

Alternative service support for Morgan manufactured products

Morgan Medical are not happy that another company is also offering service support for their products. A spokesman for Morgan Medical has made the following statement:

Sometimes in life we can be fooled into purchasing an inferior product, the outside looks the same, the package is the same size, it looks the same but it is not the genuine item. Morgan Medical is committed to delivering effective, efficient, prompt and price sensitive service on all our products, so beware that when you buy your maintenance agreement, or look for service support, you are buying the genuine article. There are those who would supposedly offer an alternative solution, but they are not approved distributors and do not have access to authorised new spare parts manufactured by Morgan.

We strongly advise that you stay with what you know is genuine, the real article which comes from an approved and CE registered source and which has an appropriate warranty.

NC

Viasys

Improved service?

Other manufacturers please take note. At last we seem to have a company which is responding to our demands for improved service. Four additional experienced service technicians have recently been appointed by Viasys, one of which is Tim Allan, a familiar name from Cranlea. Lets hope we now see the first class U.K. service backup which Viasys are claiming.

The national sales team has also been increased by five, making the sales department nine in total.

Talking about service, Jaeger and Sensor Medics now offer 24/7 on call support at their main headquarters in the USA and Germany. I'm not sure if this will be of use to us in the UK, although you may contact their UK service department should you require more information.

Clinical Support specialist

Also new to the Viasys team is Dr Simon Donoghue. Simon has joined as a clinical support specialist having worked as a Clinical Physiologist at Aintree Hospital, Liverpool.

Clinical workshops 2004

Several clinical workshops are planned for 2004. As key sponsors, Viasys will be supplying appropriate equipment for these events. Dates and course contents will be sent to all Respiratory units across the country in due course.

Special offer

If you plan to purchase a new Jaeger Master Screen PFT system you may be interested to hear that Viasys will also supply the Impulse Oscillatory Spirometry, off-line input and net-link, free of charge. This offer is valid from 15 November 2003 to 31 March 2004.

NC

Radiometer

New 700 series software

For those of you using the Radiometer 700 series blood gas analysers, a new version of software has just been released. This has many new features, the most notable being a new trouble shooting menu (this does away with the need to go searching through the manual) and a display bar showing the status of each electrode at a glance. This should be made available to all 700 users within the next few weeks .

TCMTM4 transcutaneous monitor

Radiometer has just launched the new TCMTM4 transcutaneous oxygen and carbon dioxide tension monitor.

The TCM4 is the first transcutaneous monitor to use Windows® CE and touch-screen technology, making it very intuitive to use. On the large colour display it is easy to follow trend curves, enabling an overview of patient progress over time.

Since the calibration unit now forms an integrated part of the monitor, calibration takes place automatically.

Two specific features of the TCM4 are firstly the optional SmartHeat™ feature which quickly stabilizes transcutaneous values by increasing electrode temperature by one degree during the initial five minutes - without compromising patient comfort. Secondly, the SmartTrend™ feature uses a unique algorithm to improve the stability of measurements, so they reflect actual physiological changes in patient status.

A website about transcutaneous monitoring, www.tc-monitoring.com, will also be launched simultaneously with the TCM4. On the website you can access a short demonstration of the new monitor and learn more about continuous monitoring of oxygen and carbon dioxide in neonates and infants.

NC

Fisher and Paykel Healthcare UK

In November 2003 Fisher & Paykel Healthcare launched a standard CPAP machine with optional upgrade to heated humidification.

The HC211 provides all the features of the newly enhanced HC221LE including:-

* Ambient Tracking ™
* Proportional Ramp
* Compliance Software

Also released in November is the second mask in the FlexiFit™ series - the HC405 - a nasal mask with "glider" and swivel tube attachment.

Further additions to the range of Fisher & Paykel CPAP units and interfaces are planned in the near future.

NC

Vitalograph

Vitalograph have recently upgraded the Alpha spirometer. Now called the Alpha III, it is faster, quieter, lighter and now features lung age, based on spirometry values. As an incentive to stop our patients smoking, lung age only appears on the report if the patient is a smoker and the results are outside the normal range.

Vitalograph has also been receiving complaints from customers regarding the unreliability of third party service providers. It has been reported that these companies usually offer a full service but only deliver a calibration check. These are commercial companies and should not be confused with hospital EBME departments. Incidentally, Vitalograph offer service training courses for EBME departments should you wish to service your own equipment.

Just like buying a new car, Vitalograph now offer a free 5-year warranty on all new equipment. However, to maintain the warranty, the equipment must be serviced annually by a recognised and authorised service provider.

Pulmolink

New ComPAS "SQL" software

What a strange world we work in. Third parties providing equipment contracts and now third parties providing equipment software.

In January we reported that Pulmolink supply their own

ComPAS software for Morgan systems. The Windows™ based ComPAS software has now progressed into an SQL data structure providing increased speed and performance together with network capabilities and full hospital mainframe interfacing.

This latest release of ComPAS completes the project to enable it to function with all the following instruments: Morgan Benchmark (TT-501), Morgan Transflow (TF-544), Morgan Autolink Body Plethysmograph. It is also capable of operating new hardware in the Medisoft range of systems, such as the Body Plethysmograph and the Hyp'Air PFT systems, providing a possible alternative to Medisoft's Exp'air software.

Other New Products & Improvements

Responding to a Pulmolink questionnaire that some UK labs completed last summer, instrument manufacturers Medisoft have addressed the requirement that many laboratories still favour the traditional rolling seal spirometer for lung volume measurements. Medisoft now produce Spiro'Air, which is claimed to be the first totally digital volume displacement spirometer with a frictionless interface and a resolving power down to 8 ml. It is constructed from two stainless steel drums sealed with a silicon rubber membrane and features automatic positioning and flushing at each test.

Recent additions to the Pulmolink range of products include the new low-cost ST-75 spirometer from Fukuda Sangyo Europe.

Pulmolink's pulse oximeter range now includes the Digit™ fingertip oximeter - ideal for simple, spotchecks in clinic or "cable-free" shuttle tests!

Following feedback from several Pulmolink customers, Markos Mefar now offer improved numbering of the Dosimeter cups used with their MB3 unit, to assist easy identification.

NC

Alan Moore's 2003 Customer Service Award

It comes as a very pleasant surprise when a company identifies a batch problem with a product component and then, without any prompting from ARTP or any one else, does all the right things in the pursuit of excellence in Customer Care.

It gives me great pleasure to give for my personal 2003 award for excellence in Customer Care to Devilbiss. The problem they identified related to a batch of power supplies installed in their 9000 series CPAP machines. At this point, some of the more unscrupulous companies keep quiet and say nowt – the logic being tell everybody that theirs is an isolated case and nobody will know any better. Honestly, this does go on even amongst the big medical corporates.

Not so with Devilbiss however. They arranged to see every customer personally, at the same time asking if the hospital medical engineering folks could be present. They explained what the problem was and explained that they would arrange for each suspect device to be collected from the patient by courier, modified and returned the same day. On top of this, Devilbiss offered to pay any administrative costs that might be incurred. This, in my opinion represents the very best practice in customer care and my award goes to Nicola McGregor, UK Sales Manager and Tim Newby, European Supremo.

Alan Moore's "couldn't organise a booze up in a brewery award - 2003."

Likely candidates for this award continue to come to our attention via Watchdog and personal contact. There are two companies who, in partnership, are jointly winning the race for this award by a mile. If issues which I have raised with them are not resolved by the time of the next issue, naming and shaming will occur.

Another Newcomer

Kath Johnson who many of you know from her previous existence with Vital Signs/Breas Medical has now established a new company – Carina VT Ltd. Initially, Carina have been appointed as exclusive UK agents for the Pulmonetics range of products. However, Kath is in the process of establishing other product lines and she advises me that if she can be of any help personally to those who may need some advice with Breas sleep products, then she'd be happy to help as she has always done in the past. I'm sure many of us will be grateful for that help given the dearth of knowledge at Vital signs on this part of the Breas product range. Contact Details are :-

Carina VT Ltd
Wellington House
Westcott Venture Park
Aylesbury
HP18 0XB

Tel: 08454900231

Kath's email address is kjohnson@carinavt.com

AM

If you have any problems regarding equipment malfunction, quality control/ calibration, service response times, software issues etc. please feel free to voice your opinions off the forum so that we don't get sued.

Please contact the Manufacturer's Liaison Committee direct at Watchdog@artp.org.uk. We will then be able to collate this information including verification of accuracy before commencing on an appropriate course of action.

Minolta found a problem in the firmware of their 3i, 3iA, 3Si oximeters manufactured between August 2002 and September 2003. Minolta decided to replace all the oximeters, worldwide with new ones. It affects about 300-400 oximeters in the UK and Sunrise and ourselves are notifying the users and are arranging the swap-out. This includes all those provided by Sunrise and Stowood Scientific Instruments. I think that they are acting very responsibility, at the cost of a massive replacement (the returned oximeters are probably just going to a tip).

BC

THE GIFT OF THE BLARNEY

1st Inaugural Meeting of ARTI and ARTP, Dublin, Ireland September 5th & 6th 2003

by Dr Brendan Cooper, Chairman, ARTP

Well, there have been many Anglo-Irish disagreements over the years, but it can safely be said that this gathering of healthcare scientists in respiratory physiology was a true bringing together of like and amicable minds. Not that this was an Anglo-Irish affair, people gathered from Wales, Scotland and Manchester too. For years, I have been trying to persuade ARTI that this would be a great idea. Unfortunately, this is not the first time the Brits have invited themselves to Ireland – but ARTP were a lot more welcome!

The meeting was superbly put together by Geraldine Lawless, Michele Agnew and Jackie Hutchinson at the fabulous and prestigious venue of Trinity College, Dublin, which is the Oxford/Cambridge of Ireland with a lot less of the snotty snobbishness the English counterpart can exhibit. Ireland's top university is in the centre of its capital, next to the shops, the banks and nearby to pubs. (On reflection, everywhere is nearby to a pub in Dublin!!)

Delegates and exhibitors made there way by car, train plane and boat. Indeed, rumour has it Kevin Hogben made it by car, train plane and boat – the Garda tried everything to keep him out! In fact, I thought I had seen Kevin on our flight from Birmingham. There was a large bloke in and orange white and green leprechaun suit with an orange wig and a can of beer serenading the back end of the plane. (Oh Easy Jet has a lot to answer for turning most of the capitals of Europe in to Stag/Hen party venues!!!)

Our own arrival was smooth and uneventful, with the airport coach dropping us off at the new and impressive "Spoik" in O'Connell Street (200ft brushed steel spike). Having dumped our bags at the hotel, we made our way to Trinity and soon found the registration desk and the exhibition in the Conference Centre. Trinity College on any day is heaving with students, tourists and the odd beggar. (The skill is in differentiating between the students and the beggars, the latter being by far the better dressed!)

The lecture theatre was humming ready for action, and there was an audience of between 50-60 people. After a warm welcome from Geraldine, the meeting kicked off with a spirometry session, but not before the little leprechauns in the audio-visual system decided to close down the system, and go for a scoop or two of Guinness. With the skill of Keith Butterfield (who I'm sure banged the PC with a mallet at one stage!), we eventually got the system running, avoiding my talk being a mixture of "chalk and talk" with some charades thrown in! (It reminded me of a massive conference in Lisbon many years ago when in the main session of a huge auditorium the power completely failed. Out of the utter darkness a quiet, squeaky voice in broken English continued to give the presentation he had learned by rote. He got to the end of the talk and left the stage to rapturous applause just as the lights came back on only to reveal an empty stage and no sign of the "ghostly" presenter!)

Spirometers and spirometry were covered without a hitch by myself and Michele Agnew (Dublin). The comparison was made that spirometers are like Guinness and Murphy's stout, one is good but the other is better, depending upon your taste. The final speaker of this session, Dr Brian Connell (Dublin), spoke on asthma. He had kindly stood in at the last minute and had brought his own slides with him. Unfortunately, the projector itself either (i) had an asthma attack, or (ii) decided it had always wanted to be a Russell Hobbs toaster and began launching slides up to the ceiling with the accuracy of an Iraqi missile launcher – and in a lot less than 45 minutes!! In an example of utter professionalism, Dr Connell proceeded to describe his slides, and, when the projector came back on, the pictures weren't quite as good as he had lead us to believe. His solution to a patient with brittle asthma who was strongly allergic to their cat was simple – shoot the cat! A fabulous performance. I don't think he ever found all his slides before he left.

The second session on lung volumes had excellent presentations from Nigel Clayton and Richard Hawksworth (Dublin), before Dr Tim McDonnell presented a talk on lung volumes for the clinician. This was an excellent insight from a self-confessed "non-physiological" chest physician who basically relies on and trusts the lab to produce accurate and reliable results. A concept we can all agree with. He also mentioned that the Irish were trying to introduce a ban on smoking in pubs and a tax on fat! (Good luck to you!)

A tea break followed. (I had wanted a Guinness break, but the brewery declined our request on the grounds that they had only just caught up production after our last ARTP conference!) This gave us a chance to view the equipment and services available in Ireland. Interestingly, CPAP, nebulisers and oxygen are provided by companies directly to patients (like oxygen in the UK), so departments do not issue CPAP directly. However, it appears that the lung function department plays a central role in recommending which type of device the patient should have.

The final session of the day proved to be extremely interesting for all. Keith Butterfield (by now in a white boiler suit, with a screwdriver and clipboard) updated us on the likely format of what an accredited laboratory would require.

It appears that Ireland has a fledgling accreditation system for hospitals which is yet to include detailed criteria for lung function labs. The geography of the country, the size of departments, the number of staff, the complexity of tests and the population size, were all factors that would need a range of different accreditations in Ireland. In fact the picture is similar for the UK mainland as well, but on a larger scale.

Geraldine Lawless delivered a superb talk on the need for and essentials of, a quality assurance programme in lung function. There was much discussion about how we can implement such programmes in our departments.

The final talk of the day was perhaps the most interesting. Trefor Watts had collected information on staff, qualifications

and training in the UK and Ireland and presented a comparison. The Chair of ARTP made a total arse of himself suggesting that the population of Ireland was 7 million, when in fact it is 3.7 million. (Contraception has had more of an impact on Ireland than I was led to believe!). Trefor then showed that the population served per technician was 14.2 and 14.9 million for England and Ireland, respectively. Quite a stunning similarity! Ireland has 55 staff in 31 labs and England has 833 staff in 200 labs (probably?). This meant that ARTI had about a 75% turnout and ARTP 4% of our respective workforces. (More fool the 96% of UK staff who didn't make it!) It was this excellent presentation that made us realise we have more in common than we ever differ by.

Now it was at this stage that the meeting took off in a way I kind of expected with a traditional warm Irish welcome – a drinks reception around the exhibition, kindly sponsored by Ferraris Medical. Well, you see, many of us had travelled since early morning, missed lunch and were now knocking back the white wine and Guinness at a rate of knots. The conversation flowed like the booze. I was chatting famously with a chap about the ins and outs of sleep breathing disorders, only to find out he was a day-tripper from Kerry who had come to see the Book of Kells at Trinity College Museum. I think it was getting on for 7.00pm before we all filed out onto Grafton Street before meeting up at yet another bar (Messr's MacGuire) by 8.00 p.m.

We all had a fantastic evening, enjoying "the craic", and we were even entertained by what I thought was traditional Irish dancing, only to realise Hogben hadn't eaten either and was "mid Hogben-shuffle" in the main bar. If Dublin was a painting, enjoying yourself is the canvas against which the paint of living is applied! We left the pub after much talking and socialising not long after 11.00pm. It was an early night!

It must have been one of those sausages I ate, but I awoke to find what felt like the "Spoik" being pushed through the centre of my head. Two Hedex and a bottle of water later, soon saw the chance to get a good lining of a full Irish breakfast on my stomach.

The first session consisted of an excellent exposition of transfer factor by Adrian Kendrick. (The audience all changed seats five times during his talk and he never even noticed!) Adrian disclosed that the Ogilvie paper was published as the same year he was born, 1957. It crossed my mind, was Adrian born or did he just diffuse?

Dr Seamus Donnelly delivered a thorough update on interstitial pulmonary fibrosis, which kills many more people than a lot of well known cancers but attracts relatively small amounts of money for research or palliative care.

After coffee, which included views of digital pictures taken at our socialising the night before (– not a pretty sight in the cold light of day!) we went back to the Screening for Sleep Breathing Disorders session. Julie Lloyd gave a thorough and clear update on basic screening systems, before Maria Boyle (Dublin, but from Cork originally) explained that Murphy's was actually better than Guinness, because like the Murphy's she was from Cork too! Her update on Polysomnography was very succinct and informative. The final talk in this session was from Dr John Kiely (Drogheda) on some fascinating case studies in sleep-breathing disorders. His insight into these cases stimulated much discussion. However, over lunch there was slightly more discussion over the outcome of the Ireland-Russia game at Lansdowne Road later in the day, for which he had a ticket.

Lunch was served in the Trinity Dining Hall in some considerable grandeur, and gave further opportunity for conversation and interaction between delegates. The peas scattered all over the table and in peoples' hair afterwards supported this observation!

The final session of the day was a series of updates on lung disease from three eminent Dublin consultants. The first, Professor Walter Mc Nicholas, was a quality update on sleep breathing disorders and echoed themes of the previous session. Unfortunately, one of his younger children had had access to his Powerpoint presentation and had turned on some of the fancy effects available. Humour grew to annoyance each time a bullet point came in with a revving engine and the screech of tyres from slide 3 until seven! One little McNicholas wouldn't be getting ice cream for tea tonight!

A consultant physician, Dr Stephen Lane (Dublin) updated us on COPD and showed that the use of GOLD guidelines meant that treatment and diagnosis was little different across the Irish Sea. A fascinating final talk from Mr Vincent Young, consultant surgeon, (Dublin) updated us on thoracic surgery and why pre-operative spirometry and assessment was so useful. All these clinical sessions gave us a different perspective on the tests that we perform and where they fit in the patient pathway. The session slightly over-ran, but you can put that down to the "gift of the Blarney".

The meeting was drawn to a close and Geraldine and Michelle were thanked and presented with flowers for all their hard work. They then presented ARTP with a commemorative Dublin Crystal plaque marking the 1st inaugural meeting of our two organisations. This will be on display at our Annual Conference.

As the last light to the lecture theatre was turned off and the door pulled slowly closed, I'm sure I heard the sound of a slide drop flutter down from the ceiling and bounce onto one of the chairs!

So what have we learned from the fabulously enjoyable conference? Well, we have a lot more in common than we perhaps first thought. We also have a lot to learn from each other and together. I think we feel that ARTI and ARTP should work more closely together in the future and that further joint meetings could take place possibly each year. We will let you know what is decided.

On Saturday night, I sank some of the most exquisite Murphy's at Gallagher's Boxty (a traditional Irish restaurant – well worth a visit) that I have ever drunk – yep, Guinness may be good, but Murphy's is better!! We visited a large hotel where we were entertained with traditional Irish dancing and folk music, to which the audience, mainly Irish, roared with appreciation. It was so refreshing to visit a country where people have a pride in their culture (which looks better than Morris-dancing!); a capital city were an international football match takes place without loutish behaviour on the streets afterwards; where conversation is as essential as breathing itself and where everyone feels like they've arrived home, even if it is their first visit.

Thank you to Geraldine, Michele and all of ARTI. You made us feel so very welcome, and I feel we have established a greater friendship which will continue to grow in the years ahead. Thanks must go to all the delegates who contributed to the meeting and also to the manufacturers who supported such an important event.

RECRUITMENT REPORT
June 2002 - June 2003

by Jackie Hutchinson, ARTP Administrator

A telephone survey was undertaken in July 2003 to evaluate the effectiveness of advertising through the **ARTP Mailshot Service**.

A total of 52 posts were advertised across a range of NHS grades; posts in the private sector have been excluded for the purposes of this report.

Posts Filled	Remaining Vacant	No response
38	5	9

Of the 5 remaining vacancies 3 have been recently advertised and recruitment processes may still be ongoing. The 2 remaining vacancies are for basic grade physiologists at Doncaster Royal Infirmary and an MTO3 at Harefield Hospital.

Of the 38 posts filled the following response was received:

Resulting from ARTP Advert	Not resulting from ARTP Advert	Unsure
27	7	4

Of the 7 posts where appointments did not result from the ARTP Advert, 3 were for MTO4's and 4 for MTO2's. All of these Trusts said that the overall response had been 'low'.

The advertising response was described as follows:

High Response	Low Response	Advert not monitored
5	19	12

Although descriptions of 'high' and 'low' responses is subjective, this is indicative of the continuing problem of attracting an adequate field of applicants. It is also surprising that 12 Trusts do not monitor their response in recruiting to scarce professions.

Comparative Analysis

The following table compares an advertising survey conducted in the period June 2000 – Feb 2001, with the above results. To ensure a meaningful comparison only those posts with recorded outcomes and specifically graded MTO2 – 4 were included.

	Advertised		Filled		%	
	2000-01	2002-03	2000-01	2002-03	2000-01	2002-03
MTO2	7	12	5	11	71%	91%
MTO2/3	4	-	1	-	25%	-
MTO3	21	9	5	4	24%	44%
MTO4	4	12	4	12	100%	100%
TOTAL	36	33	15	27	42%	82%

The immediate conclusion to be drawn from this comparison is that ARTP direct advertising has been considerably more effective in the later period; indeed, 82% of the posts advertised have been filled compared to 42% in the earlier survey.

Part of the explanation for the significantly higher success rate is to be found in the number of MTO4 posts advertised during both survey periods, all of which were filled. This may be the result of regrading MTO3 posts to MTO4 in view of the difficulty in recruiting to the lower grade. It is significant that most Trusts are still reporting a low response to advertising. If recruitment remains difficult it is likely that grades will gradually drift upwards, possibly assisted by the new NHS pay system, Agenda for Change.

Joint Statement from the Association for Respiratory Technology & Physiology (ARTP), the British Thoracic Society (BTS) and the British Lung Foundation (BLF) for World COPD Day.

World COPD Day 19th November 2003 is an opportunity to reflect on the burden that this debilitating disease makes on our nation's health. Both national and international guidelines recommend the use of spirometry to help screen susceptible patients with a view to determining the severity of COPD.

The ARTP, BTS and BLF want to emphasise the importance of appropriately trained staff making accurate, reliable and safe measurements in spirometry. The failure to use appropriately trained staff could lead to misleading results and possibly incorrect diagnosis.

The organisations jointly recommend the attainment of the ARTP/BTS National Certificate of Competence in Spirometry as the "gold standard" by which all practitioners of spirometry are assessed for competence both in Primary and Secondary Care arenas. It is very important for individuals or centres carrying out spirometry to diagnose COPD have undergone suitable training by the appropriate trained staff as recommended above.

Furthermore, we want to work towards the mandatory implementation of the certificate of competence for all NHS personnel performing spirometry within five years. We therefore appeal to local health trusts (primary and secondary care) to financially support programmes in spirometry training to ARTP/BTS standards throughout the UK.

Patients with all lung diseases deserve these improvements in their healthcare service, so that we can diagnose and detect lung diseases early and intervene to alleviate or halt the disease processes.

Dr Brendan Cooper, Honorary Chairman, ARTP
Prof Stephen Spiro, President-Elect, BTS
Dr Mark Britton, Chairman, BLF

Thoughts from the Annual Congress of the European Respiratory Society

Vienna, Austria

27th September to 1st October 2003

Article by Georgina Martin, Head ofRespiratory Services,
St James's University Teaching Hospital, Leeds Teaching Hospital Trust,
Leeds LS9 7TF

Austria has long been a pioneer in the struggle to combat pulmonary tuberculosis, a disease known since the turn of the twentieth century as "Vienna Sickness". It was at this time that pneumological departments were first established in some of the major hospitals of this country in order to enable physicians to develop therapies for this terrible disease. Vienna is one of the great European capitals. The old town is surrounded by monumental buildings including the Hofburg and many world-class museums. Other attractions include the Belvedere and Schonbrunn palaces.

Vienna has a strong cultural tradition with its famous Viennese coffee houses and wine taverns.

As I sit with my coffee in one of these esteemed establishments pleasantly passing a beautiful Autumnal afternoon (no, sorry, rewind that thought) scrutinising my congress journal and postgraduate study packs, I began to think.

I had been determined to make this trip despite the difficulties and frustrations of funding and support. I was also realistic enough to realise that without help of company sponsorship supplied by Resmed, DeVilbiss and Boehringer Ingelheim it would have been impossible. I would like to thank them for their generosity, foresight and support.

I then carried on thinking .....

Respiratory physiologists are health care professionals. We have the expert knowledge required to perform respiratory investigations and plan treatment strategies in order to provide a comprehensive service.

Nearly all respiratory investigations are performed without medical supervision, placing the patient's total safety in the hands of the physiologist performing the test.

Reporting on the diagnostic findings of respiratory investigations is usually performed by the physiologist, as is the appropriate selection of treatment strategies.

The support of the physiologist is sought many times for research projects and the use of specialist equipment in diagnosis is almost the sole responsibility of technical staff, once again with no medical input.

Subsequently consultants and physicians have come to rely heavily on this support and, as new and developing technologies emerge, support and guidance is once again in demand from the technical staff

These demands placed upon us means we have to continually develop. The complexities of the new technology in areas of respiratory treatment will require expert technical staff dedicated to each speciality. This will be necessary to provide teaching and support to medical staff, student and junior staff and other health care professionals.

On top of all these demands we are being urged (and with State Registration pending) towards Independent Practitioner Status and assuming many roles previously undertaken by medical staff.

As I sat sipping coffee in near isolation from my colleagues I pondered on how many from our professional body were here at this most splendid 13th Annual ERS Congress.

Since 1990 the number of delegates attending has risen year on year from 4,000 in its inception to a staggering 13,000 this year. Does this increased attendance reflect the increase in clinical physiologists? I think not.

Due to the financial position of most NHS trusts there are a lot of heads of department out there that are involved in "budget shuffling". This in turn detrimentally affects recruitment, training, equipment etc. This inevitably leads to a budget shortfall. It would be interesting to carry out a survey to see how many departments had adequate or fair training/educational budgets for attendance at even the basic courses or conference meetings.

As I ordered another coffee at the Cafe Central, legendary meeting point for members of the literary world at the turn of the century, I began to muse about the famous Martin Luther King speech (the only reason for this must have been a massive caffeine overdose as I am not usually prone to prophetic rambling of this nature or the place I was sat). "I have a dream" well, maybe a daydream. What if we start speaking up, the powers that be may start to listen.

Adapting presumptuously that most famous speech to our

needs:

The NHS has given us a bad cheque; a cheque that has come back marked "insufficient funds". But we refuse to believe that the bank of justice is bankrupt. We refuse to believe that there are insufficient funds in the great vaults of opportunity in this our NHS.

So, it is time to cash this cheque, a cheque that will train and develop our professionals sufficiently. We need to remind our trusts of the fierce urgency of now. This is no time to engage in the luxury of cooling off or to take the tranquillising drug of gradualism. Now is the time to rise from our isolated little labs and let the equality of our profession match others within the NHS. Now is the time to open the doors of opportunity for all physiologists, with State Registration just round the corner, Agenda for Change and National Occupational Standards. Now is the time to lift our profession from the obscurity within the NHS to the solid rock of partnership with other professions.

It would be fatal for our trusts to overlook the urgency of the moment and to underestimate the determination of many in our profession. Those who hope (managers and consultants) that we need to blow off steam and will be content will have a rude awakening. There will be neither rest nor tranquillity in our profession until the physiologist is granted citizenship into the NHS. We will continue to shake the foundation of our trusts until the bright day of justice emerges.

We must forever conduct our struggle on the high plane of dignity and discipline. Again and again we must rise to the majestic heights of meeting business managers with lead clinicians. We must not distrust all NHS managers, for many of our managerial brothers have come to realise that their destiny is tied up with our destiny and their promotion is inextricably bound to our profession. We cannot walk alone.

There are those who are asking the devotees of our trust "When will they be satisfied?" We can never be satisfied as long as our professional bodies are not listened to. We cannot be satisfied as long as we have no or insufficient training budgets. We cannot be satisfied as long as we do not have sufficient equipment funds. We cannot be satisfied as long as staffing levels are minimised. We cannot be satisfied as long as departments are not integrated into new building structure adequately. NO, NO we are not satisfied.

Now with the help of a liqueur coffee (double whisky) I say to all my professional colleagues that in spite of the difficulties and frustrations of our NHS. I still have a dream.

I have a dream that one day there will be a Congress swarming with Clinical Physiologist of all grades.

I have a dream that one day the Clinical Physiologists, Clinical Scientists, Medics, Nurses and all Health Care Professionals will sit around the table together.

I have a dream that one day every college, university, and educational establishment will be banging on our door with over-subscribed applications for our professional training. I had a dream today.

Our nettlesome task is to discover how to organise our strength into compelling power.

OBITUARY
Gail Slade

One could not fail to wonder, when meeting Gail Slade, who recently passed away following a short illness, at the contrast between the diminutive figure and the bubbly character that one faced. Effervescent, full of life, gentle and, above all, cheerful, this character served her well in dealing with patients throughout her career.

Gail began her Clinical Physiologist role in the Lung Function Laboratory at the London Chest Hospital, in 1982, then moved to the Royal London Hospital, Whitechapel, where she remained until joining the Respiratory Laboratory at Great Ormond Street Hospital for Children, London, in 1989, as a Senior Technician (she obtained her HTEC in Medical Physics and Physiological Measurement at Paddington College in 1986).

Gail's happy nature, coupled with her in-depth knowledge of children's fiction and, particularly, Star Trek, made her an instant hit with the young patients at the hospital who, it must be said, also appreciated her short stature. Indeed, a rite of passage for many regular patients during Gail's career at GOS was standing next to her to prove they had finally exceeded her in height! Gail's nature was such as to revel in this fun while conducting the patients through their lung function tests in a professional manner. Parents were reassured by Gail's knowledge of current issues in respiratory function and, indeed, in healthcare in general.

Gail was into her second year studying for a degree in Health Care Science with the Open University and was a keen student, often to be found reading subjects as diverse as Dickens and Egyptology in her spare time. Rugby Union was a great passion (Gail was a one time member of the Saracens rugby club) and the irony is that Gail did not live to see England's recent triumph, which she had confidently predicted at the start of the year. Gail was 'Little Miss Sunshine' to so many people and her family, colleagues and friends will fondly miss her.

Aidan Laverty

Gail Slade, born 8th April 1964; died 18th July 2003

AGENDA FOR CHANGE

What is happening for Physiological Measurement Scientists?

Physiological Measurement Scientists (PMSs) may be understandably concerned about the progress of the Agenda for Change pay talks. This is because we are no clearer on how much most of you will be paid under that new pay system than we were at the start of this year.

Amicus in liaison with other organisations has been working to solve the issues for NHS staff on Medical Technical Officer (MTO) scales. The attempt to evaluate MTOs and apply the outcomes to all forty or more MTO disciplines was always going to be difficult. It produced evaluations of the lowest common denominator and greatly undervalued your contribution to delivering healthcare. The evaluations had also not kept pace with clinical and professional developments that effect you all. The Department of Health now realise fully that MTO is a grade not an occupation.

As a result of highlighting difficulties Amicus and the professional bodies have been encouraged to carry out this work in a more reasoned and rational basis. Because of the diversity of roles across Physiological Measurement it will be impractical to evaluate each discipline at each level of practice. Instead, professional bodies, the Registration Council for Clinical Physiology (RCCP) and Amicus will identify post-holders from across the disciplines which may act as benchmark jobs for each level of practice under the new pay system. We hope that one 'family' of profiles will cover the vast majority of Physiological Measurement Scientists regardless of your discipline.

Once evaluations take place work will be undertaken with the same group to verify the outcomes and make comments on any job profiles to improve them and in order that they reflect the work that you are doing. Amicus particularly welcomes the involvement of the RCCP and your professional body in this work. Change of this kind cannot take place unless the profiles are understood and work for you. Of course any developments will be reported to you via the professional bodies.

The Working Group for Agenda for Change (Professional bodies, RCCP, IPS and Amicus)

ARTP PLAYLIST

Compiled by Keith Butterfield

Some suggestions for music requests to play at all your Christmas functions

'Every Breath You Take' - Police
'The Air That I Breathe' - The Hollies
'Exhale' - Prodigy
'Oxygene' - Jean Michel Jarre
'Puff the Magic Dragon' – Peter, Paul & Mary
'My Iron Lung' - Radiohead
'Black Lung' - Rancid
'Breath of Life' - Magnum
'Breathe' - Midge Ure / Pink Floyd / Faith Hill
'Inhale/Exhale' - Nasum
'The Cough That Came With A Prize' - Bloodhound Gang
'Take My Breath Away' - Berlin
'FEV1ER' - Peggy Lee
'Aqualung' - Jethro Tull
'Love Is Like Oxygen' - Sweet
'I'm For Ever Blowing Bubbles' - Trad
'Air on a G string' - J S Bach.
'Blowing In The Wind' – Bob Dylan
'Inspiration' - Chicago.
'Morgan a Woman' - Bee Gees
'Love is in the Air' - John Paul Young
'Londonderry Air' - Trad
'The Warmth of Your Breath' - Fishbone
'Spit' - Kiss (near enough sputum anyway)
'(Hans) Rudolph the Rednosed Reindeer' - Trad.
'Things can only get better!' - D-ream

Anything by…
Mick Jaeger (and the Rolling Seals)
Puff Daddy
REM