# Annals 2015 & 2016

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Editorial

How things change?

Due to some unforeseen circumstances the editorial lead was ‘delegated’ to a certain jobbing anaesthetist out in the sticks of district general land. We have tried to incorporate the vast majority of the information from 2014 into this edition so that both calendar years are represented. As editor I apologise now for any omissions.

2015 has certainly been a year of change within the SSA; new council – trialling for the first time of having the individuals spread across different points of the compass. This has taken some time to get up and running but we’d hope the next three years of service improves.

We underwent a ‘corporate rebranding’. Upgrading our emblem to something more ‘modern’ and easier to reproduce while maintaining an instant recognition and appeal. We certainly went through some robust discussion about dropping the traditional flowers but hope you all agree that the new emblem is a perfect and upgraded symbol of who we are and what we stand for.

The format of the annual spring meeting changed in 2014 from the family orientated Crieff/Peebles model to a more scientific approach with the trainees running the Thursday and the council organising the Friday. Dunkeld seems to be a very acceptable centrally located and indeed, beautiful location.

The website has undergone a revolution under the fantastic directorship of Dr Matt Freer and now has good user interface and an ever-expanding library of facts and abstracts. You can now join and sign up for any of our meetings all online with instant acknowledgement and invoicing. We have also spread the umbrella of support for all of our sub-speciality societies with a communal events calendar which will freely advertise any Scottish or local meeting. Please spread the word amongst the anaesthetic community around the country.

We have already been able to advertise meetings from SSAPS, WOSOA and SPAN.

We received the sad news of the deaths of past presidents Drs Douglas McLaren, John May & Professor Alistair Spence. They were all
stalwarts of the society and their influence persists in the many of us practicing individuals who gained immeasurably from their teaching and professional example they set. Obituaries for each of them and Dr Maggie Stockwell (who died at the end of 2013) are included in this edition.

With the ongoing financial crisis we are all feeling the pressure to do even more for even less – I wonder if we will reach an equilibrium or continue to lurch from near disaster to crisis point in the near to medium term future?

Where to from here? As THE national society we hope to spread the influence of the SSA to increase our membership numbers and attendance at our meetings. We are hoping to collaborate with the AAGBI for alternating winter meetings in a similar way to the work we do with the RCoA. We are constantly looking for ways to ‘spend’ our money wisely and encourage all to apply for an educational / travel grant to further individuals learning – please see the website for details of how to apply. The society has also continued in our support for the AAGBI / Lifebox charity aiming to provide pulse oximeters to those theatres where they are not yet in routine use. Last year we donated £5000 and this year we will support the ‘Lifeboxes for Rio’ campaign and donate a further £1000.

Who are we?

The SSA is the oldest national anaesthetic society in the world celebrating our centenary in 2014.

We stand to represent all anaesthetists in the country, promote anaesthesia and provide education, research and networking (both social and professional)
2015 President’s Message

Dr Alistair Michie

I write this as a semi-retired Consultant Anaesthetist, reflecting on the (still) enormous honour of becoming President of this wonderful and famous Society.

The Society is in a bit of transition at present, with Council deciding to change the format of the Spring meeting in particular, in response to the wishes, views and changing lifestyles of the membership.

We had a successful spring meeting at Dunkeld House Hotel in May 2015, with a very high quality two day programme over the Thursday and Friday, incorporating a Black Tie Dinner on the Thursday Night, and a superb Trainee Scientific programme on the Friday, of interest to all.

This is being repeated again this year, and I hope to see many of you there. Please look out for booking forms and visit the website now.

In November we had a very successful two day conference (WSM) at Airth Castle, organised mainly by Matt Freer with help from his colleagues in Forth Valley. Once again a fantastic programme and very positive feedback.

The Winter Scientific Meeting of the Scottish Society of Anaesthetists in November this year is in Aberdeen, with the RCoA again. It only seems like yesterday that myself and Fergus Millar in Dundee took the step of joining the two organisations study days together, as they were both scheduled for Dundee, but a month apart in the same year. The joint event is now a huge Biennial fixture in Scottish Anaesthesia.

We continue to work in sometimes difficult, financially constrained circumstances, and in what seems at times to be a war of attrition re contracts, pensions and workforce changes. We need to make sure that Anaesthesia is fully represented where political decisions are being made.

The Society still has a role in fostering debate on current issues, represents all areas of practice across Scotland, and has robust links with the AAGBI and the RCoA.

On a sad note I must mention the recent deaths of Three Past Presidents, Professor Alastair Spence, Dr John May and Dr Douglas McLaren.

All were great servants to Anaesthesia and to this Society over many years. They will be very sadly missed.

On a lighter note, I must thank the outgoing executive of Gordon Byers, Andrea Harvey and Brian Stickle for their fine stewardship of the Society through a difficult time. In addition I need to thank the trainee representatives who contribute so much to the Society, and continue to organise great programmes for the trainee day/meetings.

The other group requiring huge thanks are the other members of Scottish Society Council. They play an important role in organising our meetings, but also in fostering debate and
bringing new ideas to the table, whilst mapping out the SSA’s future.

I wish the “new boys”, the new executive, Bernhard Heidemann, John Donnelly and Ewan Jack every success in steering the Society forwards.

Please do take time to visit our new website which is slowly evolving, and allows on-line booking of our meetings and much improved functionality.

We look for comments, feedback and ideas from the membership and contacts information is also there on the website.

The Society remains in good health and in May 2014 we held another successful Trainees’ Meeting in Crieff linked to the Annual Meeting the following day. The future of the Society is totally dependant on the enthusiasm and participation of trainees so it was encouraging to see such a good turnout and I am particularly grateful to John Allan, Moira Hendrie and Sabah Munshi for putting together such an interesting programme. I also congratulate the Trainee prize winners, Liane Tait who was awarded the Sir Donald Campbell Quaich for the best oral presentation and Alyson Primrose, winner of the James McG. Imray Memorial Salver for the best poster presentation. The Annual Meeting followed its normal format with a varied scientific programme for the clinicians run in parallel with the social programme for the accompanying partners and families but, to many, the coup of the year was to attract James Robson, doctor to the SRU and British and Irish Lions, to deliver the guest lecture. James gave an absolutely fascinating talk on the modern game of rugby, illustrating in vivid, slow motion, associations between tactics and varying severities of injuries and also let us into some of the secrets of the professional conflict between medical and coaching staff. As is customary, the meeting finished with the Annual Dinner and Ceilidh and although numbers were relatively low it is testament to the social tradition of the Society that a great time was had by all into the “wee sma’ oors”.

2014 President’s Message

Dr Ian Johnston

I believe that I can write, without fear of contradiction, that the last 12 months have truly been momentous ones for both the Society and Scotland in general. It was an enormous privilege for me to be elected President (of the Society - not Scotland!) in the year of our centenary and I would like to take this opportunity to thank Council and the members of the Society for allowing me the opportunity to serve in that role. I do believe, however, that I was fortunate in that most of the hard work surrounding the Centenary celebrations had already been done and I, again, congratulate my predecessor Neil Mackenzie for an extremely successful year and for his tireless work in leading us seamlessly through the festivities. On, possibly, a grander scale, the country eventually went to the polls in September to decide our political and national future. Despite the final vote it was a close run thing and kept the whole of the United Kingdom on tenterhooks until the eleventh hour, but regardless of the outcome it is likely that there will be repercussions which will have a significant effect on the Society.
Nevertheless, times move on and it is apparent that the modern day clinician now prefers to attend “stand alone”, midweek scientific meetings rather than weekend functions involving families. Council has been discussing the future of the Spring Meeting for some years and has now agreed that we should try a new format for this year then seek feedback from the members. The 2015 Annual Scientific Meeting will therefore be held in Dunkeld on Thursday 30th April followed by the Presidential Address and Dinner. The Trainees’ Meeting will continue on the Friday and, although designed specifically for trainees, this meeting will include much content appropriate for CPD and annual appraisals, and consultants and specialists are encouraged to attend both days.

To the diehards of the Spring Meeting this may appear to be a sad occasion as many will have fond memories of the great socialising in Aviemore, Peebles, and Crieff and the excitement of their children as the annual “get together” approached. However, although it has always been a social Society, it is unlikely that Drs McCallum, Boyd et al. would have foreseen how it was to develop when they planted the seeds in 1914 and so we too must accept the changes and embrace progress.

The recent format of the Winter Meeting remains unchanged and 2014 saw our biennial joint meeting with the Royal College of Anaesthetists. This meeting normally attracts a large number of delegates but, thanks to the excellent programme put together principally by Susan Smith and Jane Morrison we believe that we had a record attendance and received extremely positive feedback. Willie Frame, a long time supporter of the Society, delivered the Gillies Lecture in his inimitable and informative way and kept the audience entertained to the end. An interesting feature of this meeting was the number of delegates from England and that they had become aware of it through College rather than our own publications. We had concerns that communication between the Society and its members was not as effective as it could be so we are in the process of taking steps to improve matters. Despite the best efforts of the Editor the website was beginning to look rather dated and important information was becoming less easy to find. Thanks to Matt Freer, who has taken the lead on this, we will shortly have a brand new, user friendly website which will have all important information to hand and allow on-line registration and booking for events, and to keep up with the times the Society is now on “Twitter” and “Facebook”. There should now be no excuses for not knowing about a meeting or event!

Always a popular event, the annual golf meeting soared to even greater heights to celebrate the centenary and our thanks are to Charlie Allison (who seems to be even more active since his retirement) for organising. We were blessed with one of the finest days of the year at St. Andrews and had two thoroughly enjoyable rounds of golf at the Eden, and Strathclyrum Courses. However, the highlight was, perhaps, the superb dinner, courtesy of the R&A and held at Forgan House, overlooking the 18th green of the Old Course and the two very entertaining after dinner talks on the history of St. Andrews golf given by our guests, John Mills and Arthur Morris, both R&A members and retired consultants from Ninewells.

I was delighted to be invited to represent the Society at a meeting and dinner commemorating our Centenary, organised by
Crawford Reid and hosted by the Royal Society of Medicine: Anaesthetic Section. Many of the “Great and Good” of Scottish anaesthesia over the last 40 years were speaking and I regretted that I had not had access to these mines of information when I was sitting across the exam table! Many thanks to Crawford for his efforts and for keeping our southerly colleagues informed of the advances and innovations from north of the border!

It was with great sadness that we learned of the death of Dr Archie Milne in December of last year. Archie was consultant in Edinburgh until 1983 and President of this Society in 1981. Our thoughts are with his family and his widow, Noel

I remarked upon last year’s Independence Referendum at the start of this message. By chance, as I was coming to the end of my first term as regional rep. on Council in the late 90’s all the talk was about devolution and the widespread rumour that the Scottish Executive were unwilling to liaise or negotiate with any specialty that wasn’t represented by a Scottish College ie. Anaesthesia was to be represented by either our medical or surgical colleagues. I don’t know if this threat ever came to fruition but it is certainly what inspired my unlikely interest in medical politics. Seventeen years later and devolution had metamorphosed into independence. I happened to be at the AAGBI Congress in Harrogate on polling day when much of the discussion revolved around the likely outcome and, in the event of a “Yes” vote, the future of training and governance in Anaesthesia as a specialty in Scotland. It would appear that, despite all the hype and campaigning in the two years leading up to the referendum, neither the AAGBI, nor the Royal College had been approached to discuss these issues! Whether or not the prospect of independence remains on the horizon, there is no doubt that the devolution of power to Scotland is progressing and it may be that, despite all our debates and discussions those seventeen years ago, the Society may be required to take on a more political role than before, with a greater involvement in governance issues. What is essential is that we no longer be left out in the cold with regard to health or specialty matters, and adequate representation and dialogue with our political masters (or elected employees!) is ensured.

The last year has been a great honour for me, and one which I have thoroughly enjoyed but I now look forward to this new era and handing over the reins to our incoming President, Alistair Michie and his Vice-President, Liz McGrady. They will be a superb team for the challenges that await them and I wish them all the best. They will also be joined by a new Executive from Edinburgh, Forth Valley and Fife, the Aberdeen team having completed their term of office. The majority of the work of the Society is carried out behind the scenes by the Executive, who get little of the credit, so on behalf of my three presidential predecessors and myself I would like to thank Gordon, Andrea and Brian for their support over the last four years and wish them a well earned rest!
Grants

Travel

The Society is keen to encourage both trainees and career grade staff to travel for the purposes of working in or teaching in developing or disadvantaged countries. Grants will not normally exceed £1000. Travel grants may also be awarded to those wishing to another centre to learn a new technique or acquire experience in a particular specialty.

In 2014 we awarded two maximal grants and are keen to give out more.

Research

The Society is also willing to consider applications from members for similar sums to support research in any area of anaesthesia, patient safety, pain management or critical care.

Again, in 2014 we handed out one maximum award and would like to maintain our constitutional record of distributing more.

To apply for either a travel or research grant please write an application, outlining your position with details of the activity (travel or research) which you propose to undertake and the sum sought.

Please explain how the grant will be used to support your proposed activity.

Further details can be found on the website (www.ssa.scot)

Please send your application to the Honorary Secretary of the Society: Dr Bernhard Heidemann, Department of anaesthesia, Edinburgh Royal Infirmary b.heidemann@nhs.net

Website

You will have noticed that the Society has a brand new all singing and dad dancing website

The address is a no brainer of www.ssa.scot

The huge amount of work that this has taken has largely been due to Dr Matt Freer from Forth Valley.

Functions:

Online membership payment
Online payment for meetings

Immediate invoicing

Immediate attendance records for meeting

Free advertising for all ‘umbrella’ society meetings

We have agreed to provide free advertising of any meeting organised by Scottish members and/or by Scottish based societies. These are all collated onto a communal calendar allowing everyone to see how much CPD activity is happening locally/nationally. It has already been used by

Scottish Paediatric Anaesthetic Network (SPAN)

West of Scotland Obstetric Anaesthesia association (WOSOA)

Scottish Intensive Care Society (SICS)

Scottish Society of Acute Pain Services (SSAPS)

Any other organisations wishing to take advantage of this need simply email the editor of the annals or via the website to the site master (Matt Freer)
Presidential Address
Dr Ian Johnston May 2014

“A Play on S-Words!”

It’s a great honour to be invited to be President of such a venerable society particularly in this, it’s Centenary Year, and also such a pivotal year for the country. Those of you who attended the Centenary Meeting will remember the excellent presentation which Alistair Mackenzie gave on the history of the Society. What was slightly disconcerting was, that in the early years of the Society all the Presidential Addresses appeared to focus on academic subjects. Fortunately attitudes have changed and recent addresses have taken a more light hearted approach to the occasion, often including a brief personal history along with a favourite sport or hobby. The choice was therefore easy! Although no longer fit to play I’m an avid follower of rugby and I also like to play an occasional round or two so was it to be golf or rugby? Unfortunately two of my predecessors of recent years beat me to it!

As this is a historical year for the Society I thought I might delve into the archives, on the way mentioning a few people who I admired or who have had a great influence on my life. Some of these links are pretty obvious but
others may appear somewhat tenuous. I then came to realise what a small and close-knit specialty anaesthesia is in Scotland. What also surprised me was how many of the topics that I was considering talking about began with the letter “S” so that my planned title had to be abbreviated to “A Play on S-words”.

My first two S’s are historical figures, both pioneers although neither of them anaesthetists, but we should recognise their contributions in this year. James Young Simpson, has been lauded for the last 170 years for his introduction of chloroform into clinical practice firstly by experimenting on himself and his friends in what must have seemed like a 19th century “e-party” but then he had the courage to go and practice it on his patients.

Dr William Scott

Similarly, but less well recognised, we should not forget the contribution made by William Scott in Dumfries a year earlier. It’s quite incredible to believe in these days of Health and Safety that he took the word of a lowly ship’s surgeon who had just sailed into Liverpool with some cock-and-bull story that a dentist across the Atlantic had rendered a patient unconscious with a commonly used solvent and within two days had tried it out on one of his own patients. Although the implications to medicine of Simpson’s discovery were probably far greater than those of Scott, both men, and indeed their guinea-pig patients, have to be admired for their courage. I was delighted to see on a recent visit to London that the plaque in Gower Street, reads “The first anaesthetic in England etc...” not “In Britain, Europe or the old world “ as was once claimed.

On reading the history of the Society I noticed that one of the founder members was a Dr Johnston from Aberdeen. This intrigued me as his name was spelled the correct way and that the Johnston side of my family hailed from...
Aberdeen. John Johnston was indeed one of the 11 founder members of this Society who attended the first meeting in February 1914. Surprisingly, he was appointed President in 1920, 1922 and 1936, the only person to serve three separate terms, and also gave two Presidential Addresses. I can only pray, for all of our sakes, that history does not repeat itself.

Seeing John Johnston’s name in the Society’s Annals got me to start thinking about my own family and my roots. In fact the Johnstons were one of the most ancient and powerful of the border clans known as the “Rough-footed” and with the winged spur as their emblem. Originally settling in Annandale, they did keep watch against the English but admittedly spent most of their time feuding with their great rivals the Maxwells and the Crichtons.

The chief seat in those days was Lochwood Castle set in the middle of a quagmire just a couple of miles south of Beattock.

However, in 1585, Lord Maxwell took revenge on the Laird of Johnstone by setting fire to Lochwood, remarking with glee that he would give Lady Johnstone “licht enough by which to set her hood”. Unfortunately besides the castle and furnishings, Johnstone’s chest containing all the papers and jewels of the family were also lost.

\[\text{The Johnston crest and remains of Lochwood Castle}\]

A watercolour of the remains of the tower is depicted with the clan crest and motto which reads “\text{Numquam Non Paratus}”. Now there are two literal translations of this. The first, which I prefer is “\text{Never Unprepared}”. The other, simpler translation “\text{Aye Ready}” seems more in keeping with a penniless 3rd division clan aimlessly struggling to regain the status of its Premiership peers.
Lochwood, however, was not the only stronghold used by the Johnstones to store their ill-gotten gains. Just north of Moffat is a hollow in the hills which bore the name of the Marquis’s Beef Stand, now known as the Devil’s Beef Tub, because the Annandale reivers used to hide their stolen cattle in it. There were several cattle thieving families around at the time but the Johnstones were obviously a more selective breed as they “sought the beeves that made their broth” only in Cumberland and Northumberland thereby avoiding upsetting their immediate neighbours.

After centuries of fighting the English, the clan sided with the Stuart Kings and after the restitution of the Monarchy in England, the Chief of the Clan, James was created Viscount of Annan, Lord Johnstone of Lochwood, Lochmaben, Moffatdale and Evandale, and Earl of Annandale and Hartfell. The Earl of Annandale was one of the oldest and most honourable titles in Scotland, Robert Bruce himself having been the 7th Earl.

The family did indeed split in the 14th century, the chief moving to Aberdeenshire but sadly the current chief, Sir Thomas A Johnston IV, lives in Mobile, Alabama.

So there we have it: a bunch of hot headed, royalty crawling, title collecting, cattle thieves.

My parents moved south of the border in search of employment shortly before I was born, I attended the local primary school, where, by all accounts I did fairly well - probably the only time in my life.

However, my father had always been determined that I was going to be educated in Scotland and had plans for me to return up north. As a boy he had played both rugby and cricket against George Watson’s and had decided that it was the place for me.

Watsons and I had a love/hate relationship. I loved the sport and hated just about everything else. In my first year in history class I was asked who was the greater of the two Scots heroes – Wallace or Bruce? Now my knowledge of Scots history was minimal to say the least but although he had a monument named after him, Wallace had been captured and disembowelled whereas Bruce was the man who had hammered Edward II at Bannockburn. It was, apparently, not the right answer. I was totally unaware that Wallace was the local patriot whereas Bruce was reputedly a French invader, a plutocrat, only interested in his own well being.

With mediocre academic achievements I finally left Watsons and the time had come to decide upon a future career. Despite my modest higher results I decided that medicine might be a possibility, at which point Dad, never to do things by the conventional route, announced that the best way to get into university is to turn up on the doorstep and present yourself.

So donning my best bib and tucker the two of us hopped into the car and drove north again. The first stop was Edinburgh which turned out to be an interesting experience involving climbing over planks on the roof of Edinburgh Royal and knocking on the Prof. of Surgery’s window. Despite being welcomed through the window Pat Forrest could obviously recognise my academic potential and we were on our way again.

Next stop north, Dundee and a totally different experience. The unforgettable Judy
Greig, secretary to the Undergraduate Dean, who appeared to run the whole Medical School singlehandedly welcomed us into her office and despite my mediocre qualifications and without consultation, immediately offered me an unconditional place. So I was to spend my next six, very happy years in Dundee.

In 4th year in Dundee we had to carry out a research project which would count towards our final results. Thinking if I could choose something related to anaesthesia I would be able to spend a couple of weeks of the summer in my local hospital and get it out of the way. However, the plan backfired somewhat when I was put in touch with the Head of the Anaesthetic Department at Ninewells, Ian Lawson who then passed me on to the Head of ITU, Iain Gray, to organise something for me in Intensive Care. I still remain amazed at the enthusiasm which Iain showed in supervising the project for the next two years (not the two weeks that I had planned), his tolerance as I slowly destroyed the department’s supply of co-oximeter cuvettes and his assistance as I attempted to write my first paper. It was then that I realised that I really wanted to do anaesthetics so it’s Iain Gray whom I must thank for being my inspiration and for me standing here now.

Dr Iain Gray

Having decided on my future career I again spoke to Ian Lawson who arranged an SHO post for me in Dundee. All now being sorted I decided to temporarily escape from the teaching hospital circuit and disappeared up to Shetland for my surgical job at the Gilbert Bain. It never crossed my mind that I would come back with a wife!

On agreeing to my anaesthetic job, Ian Lawson had asked me to write back to him a few months in advance to confirm that I still wanted it so it came as quite a shock when he announced that he had no knowledge of me and there was certainly no job for me in Dundee. Hurriedly I opened an atlas of the UK,
stuck pins in various places and wrote to each
department. First reply came from Aberdeen
who were holding their interviews in a couple
of weeks so I flew down and was very
fortunate to be appointed.

Aberdeen then had a very close and friendly
department including stalwarts like Greg
Imray and Ian Smith and I still believe gave us
an absolutely wonderful grounding in
anaesthesia.

My first blunder in anaesthesia occurred on
my very first list with Lawson Davidson, who, I
didn’t appreciate at the time, was then
President of this Society. I had been told that
nearly all lists started at 9 o’clock so I duly
turned up in good time to find Lawson half
way through the first case. His was one of the
few that started at 08.30 and it was soon
round the bush telegraph that this new-start
had started late! I eventually decided it was
time to move on so was delighted when Mike
Telfer phoned me to offer me a job in
Glasgow Royal. Mike was to be another
inspiration and a great support during my
training

I was now preparing for the final exams. The
format of the Irish exam suited me better
than London so I travelled over to Dublin.

Of course Robert the Bruce or Robert de Brus
or Bruys, wasn’t really French at all. He was
born at Turnberry Castle in Ayrshire in 1274
(or was it at Lochmaben Castle?) and as
mentioned earlier was son of the 6th Lord of
Annandale. Although from Norman nobility he
was descended from both King David 1st and
also Henry I of England and thus was one of
the claimants to the Scottish throne.

As we all know Bruce was defeated by Edward
1st, his brother killed and his wife captured. He
went into hiding in a cave near Kirkpatrick
Fleming, or was it in Balquhidder Glen or
Drumadoon on Arran? It is actually most likely
to have been a cave on Rathlin Island off the
north coast of Ireland. Now we all know the
story:

“Looking upwards to the roof of the cave he
was attracted by a spider trying to swing from
one part of the roof to another. Six times it
tried and six times it failed. Bruce realised that
he had just fought six battles against the
English and was in a similar situation to the
spider. He decided to be guided by the spider’s
luck and on seeing the spider succeed at his
seventh attempt gained inspiration and
returned to battle culminating in Bannockburn.”

I too was struggling with exams but took
inspiration from Bruce. But it was then that I realised that it was not
my childhood hero that I had something in
common with - just a small arachnoid!

Of course it is all fiction. Bruce never gained
any inspiration from a spider. The true story
involved his ally “Black Douglas” but was
taken 500 years after the event by Sir Walter
Scott and attributed to Bruce in “Tales of a
Grandfather”.

A clear out was happening in Glasgow Royal
so it was time to fall on my Sword and move
on. Tempted by the Queen’s shilling I joined
the Army. Despite the disruptions, Army life
was great. My first posting was to Munster in
Germany then back to HQ, the Cambridge Military Hospital in Aldershot.

To complete my higher training I was sent to Frenchay Hospital in Bristol which had the most brilliant collection of anaesthetic characters – too many to mention but two that will forever stand out were the great buddies Baskett and Zorab.

Drs Baskett and Zorab

They were completely different characters but almost joined at the hip. Peter Baskett was one of the most inspirational and supportive characters I have ever met and John Zorab probably the most respected.

My first consultant job was to be with 22 Field Hospital based in Aldershot but before starting it I was allowed a sabbatical, working with Teik Oh at the Chinese University of Hong Kong – this proved to be a brilliant time for the whole family. Life was just about perfect but somebody had to go and spoil it!

While we were in Hong Kong the unexpected happened, Saddam invaded Kuwait and we were heading for war. My unit back home was the first to be deployed, and I was convinced that I would be called back to join them. However, much to my frustration the obvious is rarely part of the Army’s plans and I was sent off to my “alternative” posting in the Falklands, about as far away from the Gulf as you could get at the King Edward VII Memorial Hospital.
A somewhat younger looking Dr Johnston second from the left with the Falklands Field Surgical Team

The same fate did not befall my surgeon who **had** been sent to the Gulf, and there being no budget to employ a civilian locum, the MOD in their wisdom hurriedly commissioned a retired urologist into the Army to join our Field Surgical Team - probably the oldest commission of the century! The first problem was finding a uniform to fit our “Freddy Boswell”, as he was known by the squaddies.

Looking back, the Argie’s would have been wetting themselves if they could have seen what we had sent to defend our sovereign territories! Despite eventually being recalled to the UK in time for the Gulf Land battle, it was over and done with so quickly my services weren’t required, again much to my frustration and Kay’s relief.

At last it was time to hang up my sword and settle down and it was just by chance that we were holidaying near Inverness when a job was advertised so I went in for a look.
I shared an office for about 10 years with Howard Spenceley who I was later informed was the very first Highland rep. on the Council of this Society. Howard was at the time President of the Inverness Wine Society and was fairly knowledgeable about wine. It is amazing after gossipping to each other for 10 years, how much information will diffuse into the grey matter!

I was fascinated to read that during the 18th century more wine was drunk in Edinburgh than water, the theory being that the water was largely contaminated. Wine has been called the “Blood stream of the Auld Alliance” and none more so than the “fresh, fragrant clairettis” or claret, the wine of the Bordeaux region. The history of this link was mainly influenced in the 14th and 15th centuries by England’s determination to hold on to its colony in South-West France and also to create a new one in Scotland.

The first formal treaty between the Scots and French, however, dates back to 1295 with Philippe le Bel and John Balliol but the semi mythical origins go back to 777 when Charlemagne, whilst fighting the Germanic hordes in France heard of King Accaius of the Scots’ victory over the Saxons at Athelstaneford and suggested a military alliance between the two Celtic nations. That victory over the Saxons reputedly gave us our 2 national flags of today – as the Scots were preparing for battle the white cross of St Andrews appeared as a cloud formation in the sky. The scene is depicted in Matthew Scotland’s book “The Story of the Saltire”. And in celebration of the alliance, it was agreed to adorn the Lion Rampant with Charlemagne’s “Fleur de lys”.
Foreign trade in wine was well advanced by the 13th century and Bordeaux was in an ideal situation to export its wines. For centuries every town had developed vineyards to cater for local demand and the best growths came from the upper reaches of the Garonne and Dordogne, easily accessible to the port.

England did boast some if its own vineyards at the time but the French claimed that these wines could “Only be drunk with closed eyes and clenched teeth” and there was therefore a ready market for Gascony wines.

The fame of the wine reached the Scots via their merchant communities in the English ports and soon ships were sailing from Dundee, Dumbarton and Leith to the Gironde to stock up. Maritime laws were less sophisticated in those days and bad debts from the Scots a common problem and both the Justiciar of the Lothians and King Alexander himself had their ships seized at Kings Lynn in Norfolk as security for outstanding debts in Bordeaux.

Alexander III was a great oenophile. In one year alone, 1253, he pledged all the duties from Berwick port as security for the repayment of the sum of £2197 which he owed a Bordeaux merchant - a sum which was described as representing a wine lake deeper than Lithlithgow Loch. However, Alexander and Scotland were to later pay for developing this nose for claret.

The opening lines of Barrow’s book on “Robert the Bruce” read:

“On the afternoon of March 18th 1286, the King sat in Edinburgh Castle dining late with his Lords and drinking some of the blood red wine of Gascony …………! Pulling himself away from the ensnarement of claret, the King set out for Fife, perhaps in a hope of yet producing the heir the country desperately needed. He crossed the Forth in a storm only to fall from his horse over the cliffs at Kinghorn, only a short distance from his Palace of Dunfermline and the arms of Yolande his young French wife”

Alexander had no immediate heir, all three children from his previous marriage having died and his granddaughter Margaret
perishing on the journey to inherit the throne, so Edward Ist was asked to arbitrate between - the new claimants to the throne

Robert Bruce and John Balliol.

Balliol had already sworn allegiance to Edward and was the favoured choice but, on claiming the throne, and with Bruce still straining at the leash, was immediately summoned to London to explain why he hadn’t paid Alexander’s wine bills. This was a test of submission for Balliol. The Scots nobility bade him to reject Edward’s authority, sign the Alliance with Philippe le Bel and strike out for independence - all very topical in 2014! In response, Edward sent his army north, committed terrible atrocities at Berwick and garrisoned the country. Conveniently, Balliol made his escape to the papal Chateau of Gevrey Chambertin, never to return and passed his time away drinking the finest of burgundies!

In 1372, and on friendlier terms, the wine fleet from the British Isles comprising 200 ships sailed to Bordeaux to collect 3 million gallons of claret – approximately 6 bottles for every man, women and child in England, Scotland and Wales.

By 1445 the volume of wine traffic was exceeding 13,000 tons.

The wine supplied to Scotland was absolutely pure and several laws were passed by Parliament in the 15th century to both safeguard its quality and also control its price. It was illegal to buy claret from Flemish merchant ships in Leith as they were suspected of adulterating the wine and any native trader convicted of “cutting” the wine could be given the death penalty. By the end of the 16th century even the common folk were drinking a good deal of wine despite a price rise of 800% in 40 years.

Wine was normally shipped after the Vendange, the initial fermentation, and drunk as soon as possible before it turned sour.
What little was left by the end of the year had sugar added but this only disguised the taste rather than improve it, but all was to change by the end of the 17th century. The rapid transformation in claret was dependant on a simple invention – the cork. Before this none of the stoppers used was very effective and air would leak past the bungs in the hogsheads oxidizing the wine. Hogsheads, wooden barrels holding 46 gallons, were particularly unsatisfactory from this point of view unless the wine could be consumed at one sitting! The invention of the cork meant that wine could now be kept and was soon differentiated into new and older vintages and the wine merchants started to recommend that it not be drunk too soon. This paved the way for several innovations in wine production leading to the greatest misnomer in the business.

“Clairette” the Gascon word from which claret is derived means a “freshness and lightness of colour”, resulting from the practice of mixing red and white grapes - a sharp contrast to today’s full bodied reds.

By the 1700’s claret carts rumbled freely through the streets of Edinburgh although much of the wine was obtained illegally due to the high taxes to which it was now subject. Records suggest that the Scots had developed a taste for Spanish wine but in fact over 90% of the wine assumed to be from Spain was from Bordeaux and had been imported via Spain or Portugal to escape the high duty.

Transporting the wine by sea was relatively cheap resulting in claret being sold more cheaply in Scotland than in Paris, with ships now setting out from ports round the whole of the Scottish coast.

Chateau bottling was exceptional before the 1800s, most wine being shipped in wooden hogsheads and bottled just before consumption with local dealers having their own waxing stamps for the cork. Wine was now the staple drink throughout the whole of Scotland including the Western Isles and the Highlands (and even Peterhead), supplying bars, taverns and gentlemen’s clubs.

The Tappit Hen, from the French word topynett, which held a quart, was the standard measure so it’s not really surprising that rowdy scenes were common. Clerihugh’s Tavern in Edinburgh’s Old Town was a favourite haunt of the lawyers and it was common for them, particularly the senior partners, to do business with their clients whilst enjoying the wine and revelry.

More and more ports were doing business with Bordeaux and setting up French colonies at home – prime examples being Little France and Burdiehouse (reputedly a corruption of Bordeaux) in Edinburgh. Dumbarton got one over on Glasgow by establishing a colony of French merchants in the burgh thereby allowing wine to be landed there in preference to its rival up the Clyde.

Official figures in 1740 recorded 4000 tuns being exported to Ireland, 2,500 to Scotland and 1,000 to England - amazing figures considering the population differences, but it was reckoned that at least 3 times that quantity was actually being drunk.

Coincidentally the foremost trading company in Bordeaux in the 1700’s was owned by a William Johnston, whose family hailed from Moffat. They were the principal exporters of Chateau d’Yquem and Chateau Latour and for
a period of 10 years bought the entire
production of Chateau Margaux. Today, the
Johnstons remain the sole modern testimony
to the once substantial Scottish involvement
in the Bordeaux wine trade.

Sadly, the early 19th century saw a change in
the fortunes of the Wine Alliance as high taxes
drove the Scots away from the grape to cheap
whisky which established itself as our national
drink but there has been a remarkable
resurgence in the consumption of wine in the
last few decades.

Here we are celebrating the centenary of the
oldest society in the specialty yet we are now
one of many specialist societies mostly relying
on the income from their scientific meetings
for survival.

During my time at the AAGBI one of my
responsibilities was to liaise with these
societies. There are currently 37 registered
with the AAGBI, and I’m sure there are many
more not registered and this does not include
the Colleges or most of the regional societies.
We hear that many of our regional societies
are currently folding due to lack of support
and whilst the development of subspecialties
must be encouraged there are concerns over
the viability of this number within the
restrictions of our study leave. There is no
easy solution but I suspect that for many to
survive they may have to forego some of their
autonomy and shelter under the wings of the
larger organizations.

The future of the profession lies with the
trainees and there is no doubt that the role
and expectations of trainees is changing.
Richard Marks’ talk at the WSM this year
entitled “Generation Y” highlighted the
trainees expectations of training - an
expectation that it will be delivered by the
trainers ie. us, rather than self-achieved and
with an absence of criticism.

There is always room for improvement in
training. Huge emphasis is quite rightly put on
advanced airway training in anaesthesia and it
is a ready source of income for the specialist
societies. Advances in airway equipment,
techniques and new guidelines are essential
for patient safety. I have, however, personal
concerns over a deterioration in basic airway
management and poor laryngoscopy

I was astonished to find at a recent GAT
meeting that only 1 trainee in an audience of
over 250 had given more than 5 bag- and-
mask general anaesthetics in the previous 12
months and I believe that this change in
practice is reflected in current airway
difficulties in the anaesthetic room. As a
trainee I saw a gum elastic bougie being used
perhaps 2 or 3 times a year. This year, in my
own hospital, we are using approximately 1
bougie for every 3 intubations. Very few of
these involve consultants but the trainees
have all been signed off as competent at
intubation.

Whilst we strive to improve training perhaps
our methods of assessment may be at fault.
DOPS and A-CEX etc. enable us to qualitatively
assess our trainees’ technical skills but our
natural reaction is to use this as a quantitative
exercise. We are asking the question “Did you
attempt this and did you succeed” rather than,
“Whether or not you were successful, how
could you have done this better?” and this has
led to a box ticking / number counting
philosophy. What comes out at the end of a
training programme is dependent on us, the
trainers, and we should not be too hasty in our criticism.

We have a responsibility to promote safe anaesthesia through demonstration and education. Guidelines reflect current best practice but I remain cautious about protocol driven anaesthesia as although useful in the acute emergency situation, protocols restrict our ability to think, to weigh up the individual situation, to use and develop our clinical judgement and may promote DEFENSIVE rather than SAFE anaesthesia – not necessarily synonymous! Without this ability to use our clinical judgement we regress to technician status and in the past would never have benefitted from the developments of Simpson and Scott.

Following the devolution vote in 1997 the then President of the Society, Ian Davidson expressed his concerns about future lines of communication between the Scottish Office, the Scottish Executive and Anaesthesia, a concern again raised by Iain Gray in his Presidential Address two years later. These ultimately led to the establishment of the Board in Scotland and to the Scottish Standing Committee. We are truly at another crossroads in Scottish history not knowing what will be the outcome or the effect of the referendum on September 18th. Whatever it be, the pressures and constraints of healthcare delivery will be the same.

The Health and Social Care Act 2012 and Clinical Commissioning Board would appear to be putting a greater emphasis on the independent sector for health care delivery south of the border with a greater strain on the acute services. The case for the Act states that “Simply doing the same things in the same way will no longer be affordable in future” and this undoubtedly will also apply to Scotland. For much of my lifetime we have been fortunate in Scotland in providing high quality health care albeit with relatively better funding and staffing than our neighbours. Current funding, however, with the emphasis on targets and waiting times is unlikely to be representative of what we can expect after September.

Worryingly, the recent report from the Competition and Market Authority on their investigation into the private health care market did not criticise the disparity between consultant surgeons and other consultant groups’ fees in the private sector. While this probably came as no surprise the implications of it are far reaching with the emphasis in England and Wales on subcontracting NHS work to the independent sector and the uncertainty over our future direction in Scotland. The fundamental principles of pay parity for all consultants in the NHS has never been under greater threat.

It is gratifying that despite the removal of distinction awards, the threat to discretionary points, 9:1 contracts and Generation Y we still have an active College Board and AAGBI Standing Committee in Scotland including three elected members to the parent bodies and all should be congratulated for their continuing enthusiasm.

It is essential that we as clinicians, and our political representatives strive to maintain not only our highest clinical standards despite the ongoing pressure on resources but also the status of our specialty within the profession for without that all the efforts and vision of our predecessors such as Featherstone and Gillies will be wasted.

It has been a privilege for me to work in my chosen specialty but what has been an even greater privilege, and something which I don’t think we fully appreciate in our training years, is the trust and faith which our patients put in us.
Ladies and gentlemen, friends and colleagues, it is with great pleasure that I stand here today delivering this address to you. I have been connected to and attending meetings of this ancient Society since my earliest days as a trainee, some years ago.


I must thank my long term friend and past trainee colleague from registrar days in Aberdeen, Dr Ian Johnston. Our paths crossed in Aberdeen as fellow registrars before moving in different directions to pursue our careers. Ian has had an excellent year as President and I thank him for his skillful stewardship of the Society over the last year, and his contributions to the Society over many years. Ian has also been a stalwart of the AAGBI as first an elected Council member and latterly as an office bearer on the executive.

I must also thank the Council of the Scottish Society of Anaesthetists (SSA) for nominating me as Vice President and subsequent President of the Society.

It remains a huge honour to become President of this ancient and famous Society. I look back in awe at the names of past Presidents from the last Century or so.

So please bear with me as I ramble on about my back ground and family in the North East
of Scotland and my education and training. I will mention a couple of my personal heroes and reflect on the changes or not in 36 years of practice so far! This really is the story of a journeyman Anaesthetist and his travels and travails through the specialty of Anaesthesia in the UK. It is also as story of opportunity and success through education. My parents were both from north east farming stock and grew up a few miles apart on the Ellon road north of the city. My mother’s home was Aitkenshill Farm, a hop skip and a jump from Donald Trump’s new golf course at Menie estate. My father’s home was Craigieford Farm nearer Ellon. We often spent time in later years as a family on Menie beach, unknown and unspoilt in those days, playing on the massive sand dunes, now incorporated into the golf course contours.

My Father went to war as a raw 19 year old, and returned a decorated veteran of fighting in France and Germany. He was twice wounded in action and was awarded the Military Medal for gallantry in Goch Germany, near the Dutch border. Had war not intervened my father would have become a farmer, although he harboured an ambition to be a teacher like his school headmistress mother. I once asked my father about the war and he just said “Alistair, I killed lots of German soldiers and I didn’t enjoy it, and I prefer not to talk about it”.

My parents got married and lived in the City of Aberdeen where my father was a policeman for 25 years. My mother had been a children’s governess in England as a young girl until she was old enough to enroll as a trainee nurse at Royal Aberdeen Children’s Hospital. After having four children, my elder brother, the twins a brother and sister, then me, she returned to work at RACH. Unfortunately, by this time she had marked Rheumatoid Arthritis, still active today, and was unable to continue working, to her eternal disappointment.

So I was, in local parlance “a loon fae the toun’. Unlike my parents I wasn’t brought up in the Buchan Doric, but in the local city patois-fit like an a that!

I was born at Aberdeen Maternity Hospital on 1st July 1955-a baby boomer.

I lived in a council house within a large council estate in Kincorth at the southern edge of Aberdeen. Our house overlooked the old bridge of Dee, and the nearby banks of the river and its environs provided a wonderful if sometimes dangerous playground. My first school was Inverdee Infants, a feeder school with Primary 1 and 2 only. I vaguely remember my early days there, remembering more vividly Miss Gordon, the elderly headmistress. One day she asked me what I wanted to be in later life. I emphatically replied “I am going to be a Doctor!” I recall her bemused expression and muted laugh. The die was cast! In primary three I moved to the nearby Abbottswell Primary School, for the next 5 years. The wee loon fae the council hoose did nae bad efter a’! I passed my “eleven plus” and was enrolled at Robert Gordon’s College in the city centre on a fee free bursary, paid by a local endowment fund.

A year later we moved to the Midstocket area of Aberdeen, close to Aberdeen Royal Infirmary and Foresterhill Medical School Campus. I stayed there till I left home after my marriage in 1977, 15 months before my graduation.
Who was Robert Gordon?

Robert Gordon (from Wikipedia)

A man possibly indirectly responsible for my opportunity - a good start in life.

Robert Gordon was a local man from Aberdeenshire, born into an established well to do family in 1668. He belonged to the Pitlurg branch of the Gordon family, descended from John Gordon of Auchleuchries, 3rd son of John Gordon of Scurdargue. He was first cousin to Elizabeth, the Gordon heiress, who married Sir Alexander Seton, founding the line of the Earls and Marquesses of Huntly, later Dukes of Gordon. Some of you will recall Dr John MacKenzie’s splendid account of their history in a previous address to this society.

Robert Gordon’s great grandfather was knighted by James 6th and married Lady Forbes, a clan to whom my family name Michie is connected. He died young leaving 2 sons and a daughter. The youngest of these was Robert Gordon of Straloch, who became a Cartographer mapping much of Scotland, and a map of Edinburgh which prevailed for almost a century. He was reportedly the first Master of Arts Graduate from Marischal College, studying Humanities, Mathematics and Philosophy.

He later studied in Paris, returning home on his father’s death.

He amassed 17 children, of whom the 5th was another famed cartographer.

The 9th a lawyer, graduated from King’s College Aberdeen. To the Kirk’s displeasure he married Isobel Menzies – a Catholic. He died young in 1680, leaving four children, the eldest of whom was Robert Gordon himself, born in 1668. Robert was left 20000 Merks (or 1100 pounds) by his father at the tender age of 12. At the age of 15 he became a Burgess of the City of Aberdeen, allowing him to trade as a Merchant within the Burgh. In 1689 he graduated from Marischal College alongside his manservant, both with Arts degrees.

He soon left Aberdeen to travel Northern Europe, before settling in Danzig(Gdansk).
He quickly established himself as a trader and merchant, becoming successful and wealthy. He lent funds to Marischal College in 1692 and by 1699 was providing low interest loans to Aberdeenshire landowners looking for working capital.

At that time Danzig’s geographical position in the Baltic, made it one of Europe’s premier trading ports, trading in grain and many other goods. As many as 40 thousand scots lived between Poland and Lithuania in the 17th century. The combined population of these two counties then would be about 7-8 million. So a sizeable influx of Scots, mostly pedlars, but a smaller proportion of wealthy merchants like Robert Gordon. Along with Dutch merchants they controlled much of the banking and commerce within the region for many years. Within a few years Robert Gordon built up a modest fortune here.

In 1720 he returned home to Aberdeen, having missed the worst of the famines, French wars and the disastrous Darien Project which ultimately precipitated the Act of Union in 1703. By his return, commerce was again improving, and the Act of Union had “bedded in”, politically and fiscally.

He remained unmarried with no obvious heirs, and decided that his fortune should be put to good use and not go straight to the taxman. As a youth he had read the works of Baillie Skene, extolling the virtues of Education and Welfare of poor boys in Hospitals (another name for boarding houses for boys).

In Edinburgh both Heriots and George Watson’s formed the template for his own institution. His philosophy was for the maintenance, aliment, entertainment and education of young boys from the city, whose parents were poor and destitute, and he wrote this into his “Deed of Mortification” as it was known. Work on the building started in 1730 on land previously owned by the Dominican Blackfriars. He sadly died a year later, before the School’s completion, mostly from overeating it was said.

The original house remains the centrepiece of the School premises today. It was designed by William Adam, father of the better known Robert Adam of Culzean Castle fame near my home in Ayrshire, amongst many other projects and designs, including Edinburgh’s Charlotte Square.

William Adam was never considered a great creator or possessed of imagination by his peers, but he did however become a pre-eminent architect of his day building Hopetoun House, Haddo House, Duff House and Mavis bank, all fine buildings still standing today.

The Hospital was eventually completed in 1732, a year after Robert Gordon’s death, but lay empty until 1745 when funds for furnishings and interiors were finally found. Almost immediately, disaster struck. In 1746 The Duke of Cumberland (Butcher Cumberland) and his Hanoverian troops arrived in Aberdeen en route to routing the Jacobites at Culloden. He commandeered the hospital, renamed it Fort Cumberland, built a moat, and installed his garrison of troops there.

It was 1750 before the hospital was ready, after successfully sueing the Government for reparation funds to repair the damage caused by the Hanoverians.

The original Hospital then opened in 1750. At this point all pupils at the school were boarders, but in 1881, the Hospital became a day school known as Robert Gordon’s College. In 1903, the vocational education component of the college was designated a Central
Institution (which was renamed as Robert Gordon's Institute of Technology in 1965 and became the Robert Gordon University in 1992). Boarding did not return until 1937 with the establishment of Sillerton House. In 1989 RGC became a co-educational school.

Still today, Robert Gordon’s admits significant numbers of pupils on bursaries, from fundraising via former pupils, and a permanent team of fundraisers.

University beckoned for me at the tender age of 17.

I had “skipped” fifth year at school on the prompting/advice of the careers master.

I hardly realized that almost everyone else in my year had covered most of the syllabus in A levels or SYS. I had only done Highers, and I was just about the youngest in my year. Early pre-clinical years were spent between Old Aberdeen and Marischal College in the city centre, then we moved to the wards and real patients at Foresterhill. Somehow I managed to muddle through the last few years of the final 6 year course in Scotland.

King's College was the first university in Aberdeen, the third in Scotland and the fifth in the British Isles. In 1495, William Elphinstone, the relatively newly appointed Bishop of Aberdeen, petitioned Pope Alexander VI on behalf of King James IV to create the facility, to cure the ignorance he had witnessed within his parish and in the north generally.

King’s was known as Aberdeen University after gaining its Royal Charter. St Andrew University dates from the 12th century, Glasgow was founded just before Aberdeen in the 15th century, and Edinburgh university was founded in 1582.

The earliest ENGLISH speaking chair of Medicine was established at King’s in 1497, with a position of Mediciner. Medical teaching however was not continuous throughout the next few centuries and was fully revived at Marischal College in the 19th century, becoming one of the most professional schools in the UK.

The original King’s College still exists today, though much extended on a bigger campus. In 1593, Marischal College was founded in the city centre as a separate and Protestant alternative University.

The original Marischal buildings were demolished in favour of the current building which was built in stages from 1835 - 1906. It is the second largest Granite building in the world, built in a semi gothic style of grey Aberdeen Granite. El Escorial Palace in Madrid is the world’s largest.

The University vacated Marischal many years ago and since 2011, after renovation internally and cleaning externally, it has become Aberdeen City Council HQ.

I graduated from Aberdeen University Medical School in 1978, having married my lovely wife Eileen at King’s College chapel in April 1977, and began work in Aberdeen Royal infirmary as a Surgical House Officer.

The original ARI opened at Woolmanhill in the City centre in 1742, just a few years after Robert Gordon had died. It received its royal charter in 1773.

The Medical School and Infirmary moved to a new joint campus in 1938, to its current Foresterhill site, then surrounded by farmland, but now as a huge Medical site with Adult,
Maternity and Paediatrics. Sounds familiar, perhaps a bit like another new set of buildings in the South side of Glasgow?

The next stop on my medical travels was Yeovil District Hospital for six months as a Medical PRHO. It was a very new, modern hospital, but tiny in comparison to ARI.

There were just two Medical House Officers and I had sole responsibility for almost all the chemotherapy patients for the district. They would arrive for treatment 6 days a week and I administered most of the treatments. I was supervised at a distance by the Oncologist in Taunton, who also held clinics locally, but I could enlist my Registrar’s help if needed now and again.

I was soon taught to do all the marrow biopsies, venesections etc, and even plate out and fix the marrows for microscopy by the pathologists. I learnt to cannulate and draw blood very quickly. That helped in my next post as a brand new SHO in Anaesthesia at Princess Margaret Hospital in Swindon.

The job, hospital and staff were great and I learnt so much from the six Consultant Anaesthetists. I was on call after 4 weeks and doing e.g. Paediatric ENT lists on my own after a few months. A bit scary looking back now!

Without wishing to denigrate Swindon, it was a great town to get out of, in easy reach of Bath, Bristol, Oxford, Cheltenham and numerous picturesque villages.

After 12 months I was offered a Registrar post in Aberdeen after a successful interview.

My return to Aberdeen was very fruitful, with all subspecialties on one site apart from Ophthalmology and Plastics and Burns at Woodend General Hospital.

I worked at ARI, Woodend and The Children’s Hospital, covering all three on call, and spent two week blocks in Maternity and ITU on a regular basis too.

My two eldest daughters were both born at Aberdeen Maternity Hospital, during that time. I was impressed by, and learnt much from many of my Seniors in Aberdeen, but two in particular hold a special place in my memory.

The first of these was the “Great man” Dr Michael Tunstall who influenced my love of Obstetric Anaesthesia. Sadly no longer with us, but the words of Felicity Reynolds, written before his death, encapsulate his qualities perfectly:

“Mike is in my view, by far the most important contributor to Obstetric Anaesthesia that the UK has ever produced”

He was a true original thinker and made no fewer than three ground breaking advances. Who else could claim such an achievement?

1. **Entonox.** While we were taught that nitrous oxide and oxygen, stored as a liquid and gas respectively, could only be given from four cumbersome cylinders (two plus two spares), he set about showing that they could be safely mixed, and so created Entonox, to this day the most widely used form of labour analgesia in this country.

2. **Isolated forearm technique.** Concerned about awareness when light anaesthesia came into fashion, he invented the isolated forearm technique, allowing strength to be preserved in one arm after giving suxamethonium,
to make it possible to detect awareness and even, as he pointed out, amnesic wakefulness.

3. **Failed Intubation drill.** An obsession with the need to intubate Obstetric patients led to terrifying failure to intubate/failure to ventilate situations, panic and sometimes maternal death. Mike Tunstall said in essence “Don’t panic - plan.” and developed the first failed intubation drill

Unfortunately for Mike Tunstall, BOC kept the patent for ENTONOX and he never made any money from his genius.

Another hero from those days was Dr James McGregor Imray, better known locally and affectionately as “Greg”. He was a man of many parts; farmer, surgeon, golfer and visionary. Greg was very sharp, like the scalpels he once wielded before Anaesthesia became his career. He was a major force in developing Neuroanaesthesia, modern Intensive Care and Cardiac surgery in Aberdeen. He played a huge part in the building of a purpose built ITU and getting Cardiac Surgery funded as a regional centre, along with his Anaesthetic and Surgical colleagues.

He was sometimes a bit irascible on the golf course but always fun to be with and a great teacher. Much missed and revered too.

The time came to leave Aberdeen as Senior Registrar posts were limited, and the road to Glasgow opened up for me. I spent three very happy and successful years at the Victoria Infirmary. Once again I learnt much from many people, and much about the political side of medicine from Robin Marshall and Alan MacDonald. I was on the Consultant Rota from my first day there and was really a “Consultant in Training”.

In 1987, there were precious few Consultant posts advertised in Glasgow, although I had been encouraged to apply to the Western Infirmary or the Victoria where I had worked, if any posts were advertised. I took a gamble and applied for a Consultant Job in Ayrshire, without any real idea about the place. A pre-interview visit dispelled any doubts and the rest is history. We moved to Alloway, birthplace of Rabbie Burns and I have enjoyed a wonderful family and professional life there ever since.

I worked in all the small hospitals in Ayr and its environs and had a sortie into the North every Thursday to work in Ayrshire Central Hospital -the maternity unit, on its own in Irvine. Central it was NOT! In 1991, the new Ayr Hospital opened, making my previous itinerant working week much simpler. In 1993, politics, as usual, got in the way, and we were forced into a split by two competing trusts. I then found myself working only in Crosshouse Hospital in Kilmarnock and the “Mat” in Irvine, 9 miles apart. We eventually managed to get a new, safer, better Obstetric Unit on site at Crosshouse in 2006.

A lot has changed since I started out as a trainee in 1979. I have chosen some aspects to reflect upon, and cherry picked some of my own areas of practice.

**Then and now**

When I started Anaesthesia in 1979, there was very little monitoring and mostly a basic ECG, mechanical Oscillotonometer for BP and yourself, looking at visual cues of colour, vasoconstriction and feeling for a palpable pulse. Anaesthesia machines were pretty
basic Boyle’s machines and most ventilators were fairly rudimentary like the Blease Manley. Our new Anaesthesia workstations are merely a further development of this, still providing a regulated source of gases and controlled inspired concentration of volatile agents. Additional safety features and sophistication of ventilation and ease of use has been added but the principle function remains.

One major difference today is the dramatic reduction in Mortality and Morbidity related to Anaesthesia and Surgery. It is very difficult to compare historically but as a rough guide:

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Even in the 80s Medical mishaps and fatalities related to Anaesthesia were worryingly high, and more often caused by human error than equipment malfunction. Problems were picked up late and hypoxia and / or death was a consequence. Circuit disconnections were commonly featured in lawsuits in the USA. The Harvard Guidelines and the parallel AAGBI Minimal monitoring Guidelines here in the UK, were introduced in the mid eighties and acted as a stimulus to the proliferation of new monitors to monitor Pulse Oximetry, Capnography, Continuous ECG, FIO2 in circuit, disconnection alarms, contemporaneous charting of BP and HR and the presence of a trained Anaesthetist at all times! We take all this for granted today, and more. In addition, training research and overall knowledge has improved as Anaesthesia has become more of a Scientific discipline, and less of an art.

Obstetric Anaesthesia

When I began work in the Maternity in 1980, as a very junior SHO, the prevailing rate of LUSCS was only about 12%-15%.

General Anaesthesia was commonplace for Emergency and Elective caesarean sections. Post dural puncture headaches were problematic and Epidurals for Elective LUSCS were time consuming and unreliable. Anaesthetic related Maternal Mortality was also still a recurring feature of the Triennial Maternal Mortality reports.

As a “died in the wool” Obstetric Anaesthetist, I have since then witnessed the major improvements in care generally for pregnant women, including better ante-natal care and staffing in Maternity Units.

Undoubtedly the revolutionary change in Obstetric Anaesthesia was the Sprotte and then Whitacre needles, being introduced into practice. Post dural puncture headaches dropped from 10-20% incidence to less than 1% in elective LUSCS under Spinal Anaesthesia. Maternal Mortality related to Anaesthesia has fallen drastically to. Directly related deaths have been around 3-4 per annum more recently, but were around 20-50 cases per annum in the 60s and 70s.

Recognition and early treatment of SEPSIS is one of the current priorities in the labour ward and antenatal clinic.

There are however, some major challenges that remain in Obstetric Anaesthesia:

- Ageing mothers
- Obesity
- Multiple /repeat LUSCS
- Rising LUSCS rates.

These will not disappear!

Orthopaedics and trauma

I have been involved in this area of Anaesthesia for all my career, and in essence the Surgery has become more complex, and often slower, in ever more complex patients with multiple co-morbidities. Patients that we
would shy away from in the past are now a regular feature in our everyday lists.

Spinal Anaesthesia has played a massive part in recent “Rapid Recovery Programmes” for major lower limb surgery. It is the preferred option for elective Hip and Knee replacements almost everywhere in the UK.

Preoperative assessment and education of patients, standardisation of pathway, avoidance of PCA, multimodal Anaesthesia and Analgesia, Minimum time in bed and early mobilisation and discharge. These are some of the basic tenets of rapid recovery.

New drugs

In the late 70s and early 80s there was a plethora of Intravenous Induction agents, namely Thiopentone, Methohexitone, Althesin and Propanidid, and then along came Propofol, an alkyl phenol, chemically unrelated to any previous sedative or anaesthetic.

Thiopentone remains for increasingly rare indications, even in Obstetric Anaesthesia. The others are long gone due to major side effects or hypersensitivity.

Along with many of my peers at the time I lamented the disappearance of Althesin which had many wonderful properties. Alas no more!

Despite its lack of water solubility and complex formulation, Propofol remains king and is uniquely versatile as a sedative in Anaesthesia and Dentistry, and used in ITU and Total Intravenous Anaesthesia.

Muscle relaxants were often unpredictable, particularly in the Emergency patient, and brought secondary cardiac effects with them. Sometimes these were useful as with D - Tubocurare, for broad brush hypotension in certain situations, but more often there were unwanted bradycardias or tachcardias, not to mention a significant incidence of Anaphylaxis. Recurarisation occurring late on after reversal was a recognised problem of some of these drugs.

In the early 80s both Atracurium and Vecuronium arrived simultaneously, with little or no unwanted cardiac effects. They were “clean” relaxants with predictable reversal in most situations. The later Rocuronium has its likes and dislikes among anaesthetists.

The unique Sugammadex also originated in Scotland at what was Organon Pharmaceuticals development laboratories at Newhouse, by the M8.

It has found a place in European Anaesthesia but still awaits clearance in the USA.

Paradoxically the drug was originally priced for the USA market after Organon was bought over.

Volatile

Methoxyflurane, Trichloroethylene and Halothane have all disappeared from Human Anaesthetic practice, and even Isoflurane is little used now in the UK.

Sevoflurane is No1, and Desflurane has its exponents on a smaller scale.

The introduction of new volatiles was Evolutionary, rather than Revolutionary, but today we have drugs that are not metabolised appreciably and are not irritant to the myocardium. In essence safer all round, with more rapid onset and offset.

It is extremely unlikely that any Pharmaceutical company will spend the required multi millions to find any new volatiles in the near future.
Analgesics

We still seek the holy grail, as many false hopes have come and gone. Morphine based drugs and analogues are still here in regular uses, and Fentanyl, Alfentanil and even Remifentanil are old stagers now. Pregablin and Gabapentin have prevailed in management of Chronic pain and used sometimes in major orthopaedics.

Side effects still plague the use of opiates, but who knows-some day?

New techniques and Equipment

The Laryngeal Mask Airway (LMA) represents the biggest change in airway management in my career, adopted worldwide in everyday practice.

Thankfully for Dr Archie Brain its inventor, and the company who introduced them, Propofol had also arrived at that time. A marriage made in heaven! If Thiopentone had still been the mainstay of IV induction of Anaesthesia then, it might have been a different story.

Ultrasound is ever present now for line access and both limb and plexus blocks.

Local anaesthetic blocks for upper limb especially, have seen a huge resurgence in popularity with the advent of ultrasound. I cannot claim to be “ultrasound trained” as my practice in recent years has not included on call or upper limb surgery, where line access or limb blocks are almost mandatory. It is slowly finding its way into Obstetric Anaesthesia, but images are often difficult to see clearly in the obese patients where its use is of most need!

With the challenges ahead, every little helps.

Future Challenges

In general terms the challenges for us in Anaesthesia and Healthcare generally Include the following:

- Age and frailty
- Obesity and its sequelae
- Cost constraints
- Supply vs demand

I am constantly impressed with the skills and knowledge of my younger colleagues, and I am confident that the current and future generations of Anaesthetists will continue to seek perfection and improvements for their patients.

Finally, I must touch on some personal details.

I acquired my first love at a relatively early age-no not my lovely wife Eileen, but Aberdeen Football Club. I spent many a Saturday afternoon watching often poor fare, until the glory days in the eighties when I relished in the success in both domestic and European football. Since the end of the eighties it has been back to an often masochistic pastime watching Aberdeen on occasion.

More recently though I have enjoyed occasional visits to watch Aberdeen play away games in the central belt, with modest success too, with my son-in-law and another daughter’s partner-both Aberdeen fans to.

However, my only real love is here today, my devoted and wonderful wife Eileen, mother to my three equally wonderful daughters.

Thanks for listening to the ramblings of an ageing journeyman, who I think, made the most of his opportunities.
Regional Reports

In our traditional round up of what has been happening around the country we ask for a representative from every hospital to provide a report of what they have been up and what personnel changes have occurred. From the windswept beauty of Gilbert Bain to the (about to be) new splendour of Dumfries & Galloway Royal there are anaesthetists up and down pushing the boundaries of physical endeavour and ability.

This edition contains some reports filed initially for the ‘forgotten’ Spring 2015 publication hence the reason that some hospitals have two.

We are exploring the possibility of some inter hospital ‘challenge’. There is so much talent and ability amongst us all that this should be celebrated.

Ninewells are probably providing an impossible benchmark for the rest of us as they organised the first ever ‘Archies’ Challenge. The logistics let alone the physicality of this feat are to be congratulated and leave most of us more than impressed.

2014 Dr Gray’s

The last year has seen further changes in the consultant anaesthetic staff at Dr Gray’s. Jenny Walker has retired and Judith Kendell has gone overseas to return to VSO work in the Central African Republic. Jenny has been a consultant in Elgin and also in Oban. We wish them both well.

In their place we have appointed Dr Andrej Andrasovsky who joins us from Wexham Park Hospital in Slough and is due to start in May 2015. We are recruiting to the remaining post as I write.

Alastair Ross has been with us now for 7 months and brings his experience of working with EMRS to the department. He has updated our transfer equipment, personal protective equipment and introduced transfer drug bags as well as useful checklists. We continue to transfer out to Aberdeen, Inverness and beyond and if January and February (15 transfers) are anything to go by we may be heading for a record 90 transfers this year. Our patients continue to get larger and larger. We have added a box to the transfer checklist indicating if a bariatric ICU bed is required at the other end.

We are finally getting brand new ultrasound machines after making do with a second hand radiology machine for the last 2 years. Our S-nerves have now been bought and will arrive in the department in the next few days.

2015 sees us try, once again, to do enhanced recovery for arthroplasty. We have had a positive start to the year and may get some extra physio input to help us along the way. Iain Macdonald has been to Blackpool and Guernsey to pick up some tips on Enhanced Recovery. We continue to struggle for beds, with medical patients permanently boarded in our orthopaedic ward throughout the year and have had 2 outbreaks of D&V hampering elective surgery.

Rob George is our Lead Clinician and Chris Taylor becomes the Educational Supervisor for the 12 FY1 doctors who rotate through anaesthetics as part of their critical care module. I have been trying to avoid further altercations with broken toilets after a hand injury and wound dehiscence left me out of action for a month last summer. Doug McKendrick has been taking to the slopes both at the Lecht and abroad and is now an expert skier.
And last but not least, Bernd Zaunseder is engaged to be married to Anna.

Chris Smith

2014 Institute of Neurological Sciences (INS)

The past year has seen the appointments of Dr Rahul Karve, Dr Chris Hawthorne & Dr Ryan Campbell. Two of these posts were as a result of our ever expanding neurosurgery and maxillofacial surgery services and the other post was a replacement post for Dr Robbie Thorpe who has relocated to Northern Ireland. We wish Robbie all the best with his career there. Chris brings with him an impressive research pedigree which will be a great contribution to us. Rahul along with Dr Kathryn Simpson now provide Consultant input to the new Acute Pain Service. Ryan has stepped up from Neuroanaesthesia Fellow in to his Consultant role and has brought with him considerable IT expertise. Dr Donna Fraser has been appointed this year too as our very first Specialty Doctor and has been a valuable addition to the department.

Dr Ratnasabapathy, our clinical lead, has achieved several milestones over the year. These include fulfilling the FICM guidelines to have all critical care beds covered by a dedicated intensivist 24/7 by increasing the cohort of consultants in the department who provide regular critical care. An Acute Pain Service has been provided for the first time at the INS with one consultant session per week supported by a Clinical Nurse Specialist. Trainee gaps have been addressed by the introduction of a rolling non training number Clinical Fellow post and a Specialty Doctor post to cope with staffing of the resident on call Rota. We are looking forward to our first service Clinical Fellow who is due to commence in May this year.

We continue to have overwhelming interest in both the year-long National Training Numbered Neuroanaesthesia Clinical Fellow post and the Airway Fellow training blocks. We are delighted that rotating trainees consistently give positive feedback from their time with us. Neurosurgical trainees are now spending a period of four months in Neurointensive care which appears to be mutually beneficial and an innovative move for surgical trainees who will spend the next seven years with us.

The year has also seen Linda Reynolds, one of our experienced critical care nurses, stepping in to the role of Patient Flow Co-ordinator. She has gone a long way towards improving the problems we have had with moving patients efficiently from destination to destination throughout their journey within the INS from admission right up to discharge to base hospitals.

From the INS, we have had a great view of the South Glasgow University Hospital (SGUH) taking shape over the past few years although there may be a weakness in a thermal exhaust port which goes straight to the main reactor. We are currently awaiting an NSD decision for a national Deep Brain Stimulation service bid. Regional Services is also about to see a major reorganisation with the relocation of ENT surgery, an expansion to eight theatres, and a new 7T MRI scan. We wait with interest to see the impact of the new recommendations of management of Stroke in the next few years.

Our challenges continue to be the national trainee shortfall, continuing improvements to the Interventional Neuroradiology service, finding hot water, a toilet that works and a parking space.
2014 Royal Alexandra Hospital

Greater Glasgow and Clyde’s major restructuring is slowly rumbling into life – the South Glasgow University Hospital (aka The Death Star) has been handed over to the board, and staff and patients will be moving in within weeks. While good at strategic, big picture, pronouncements, GG&C has often been lacking in the nitty gritty detail of how things will work, and I think this is fair comment at present. Those who are transferring to the new hospital for the most part don’t have the information about their working week, how they will travel to work, where they will put their stuff, and crucially for anaesthetists, which surgeon they will be working with. Details, details....

Meanwhile, five miles away in Paisley, we watch with interest. A small number of surgical lists are transferring, but overall, we are not anticipating any major changes to the way we work – apart from getting busier, if the doom-mongers’ predictions of insufficient capacity at the Death Star prove correct. Our paediatric ward is under threat, and with it the straightforward paediatric cases we do – tonsils, manipulations etc. At present it is safe (our local MP says so, so that’ll be true, then) but that could change again.

GG&C is having a management restructure related to all of this, and having been managed in directorates for several years, we are going geographical again – in June we will become the South Clyde sector. We have a new director and “Chief of Medicine” (I think somebody has watched too many episodes of “House” before coming up with that one), and I am hopeful that a bit more local management will be good for us – Clyde has always felt like the poor cousin who fell on hard times and had to be bailed out. As an anaesthetist working as part of the pan GG&C Surgery and Anaesthetics Directorate, I felt an awful long way from any decision making that affected me.

We were joined last summer by new consultant Shashi Timalapur, who was a Glasgow trainee, and have recently welcomed Staff Grade Claire Burnett back from maternity leave, after the birth of baby Roddy, so we are currently at full complement – a slightly unusual situation over the last few years. However, this won’t last long as Tom Goudie is retiring in September, and no doubt there will be the usual “vacancy management” gap. Tom started a year after the opening of the RAH, so remembers what it is like to work in a new shiny hospital. He will be missed for many things, but particularly for his entertaining rants when theatre lists have the pointless delays which seem to be part and parcel of the way we work now (or is that just us?).

We have managed to give quite a lot of anaesthetics, while training our trainees, keeping up with the pension changes (of increasing interest to this author as the years pass), and trying not to be too grumpy when another pointless rule nobody has asked us about is instituted.

Hilary Aitken

April 2015
2014 Forth Valley Royal Hospital

FVRH has recently appointed two new chronic pain consultants, Gordon Stewart and Dan Govenden earlier this year. Paddy McKendry and Thomas Kelgiorgis were appointed into the general anaesthetic department. Once Kathy McIntosh returns from her maternity leave we will be a happy cohort of 30 consultants and three SAS colleagues.

Congratulations to our past SSA representative Judith Wilson, who recently had a baby boy, Angus. I believe she is currently enjoying her multiple coffee mornings while on maternity leave.

FVRH is one of four Scottish pilot sites for a joint venture between The Scottish Government and The Institute of Healthcare Optimization based in Boston, USA. The project is intended to assess and then improve the flow of patients through Scottish hospitals. Having completed this initial assessment FV is concentrating on the flow of emergency medical patients through our assessment units and downstream medical wards. This prestigious project is being led by our own Chris Cairns. Future phases will repeat the same process in ageing and health, surgery and intensive care.

Other initiatives currently ongoing include the trial of a ‘procedure room’ which will initially centre on regional anaesthesia blocks to improve theatre efficiency. This will also allow greater exposure and improve training for all 17 of our anaesthetic trainees. Eventually we aim to expand this area to pre-optimise patients, insertion of invasive lines and improved care for trauma patient’s pre-op. Both Andy Longmate and Paddy McKendry will lead this initiative.

In June this year we are undertaking a prospective trial comparing rectus sheath catheters with the use of a bolus pump delivery system to epidural anaesthesia for all major abdominal surgery. Current audit data has been very encouraging in the benefits of this technique.

On the economic front the profits for Starbucks are on a continuous upward trend which is in no small part due to the hard work and dedication from the anaesthetic department. There remains a conflict with our alternative caffeine providers Costa, WRVS and Serco. The tribulations of having so much choice are hard to bear for us all.

Finally, preparations for the forthcoming Annual Scientific meeting to be held at Airth Castle are progressing nicely with a stellar cast of presenters promised.

Dr Matt Freer April 2015

2014 Royal Infirmary of Edinburgh

Life at RIE continues to be busy and changing. Once more we have become a construction site as work has now commenced on the old car park for the new Sick Children’s Hospital and Department of Clinical Neurosciences. So car parking remains a hot topic (as it always has been) and numerous discussions are going on regarding the integration and impact of the expansion.
We have welcomed the arrival of Drs Mort Kelleher (Hepatobiliary and Transplant), Abigail Walsh (cardiac interest), David Coad (Orthopaedic interest) and Amanda Bull (General) to our department over the past year and sadly said goodbye to Dr Ashish Satapathy who left for the warmer climes of Singapore. Drs Mike Logan, Dermot McKeown and Duncan Weir have now retired although continue to provide some clinical sessions as despite the expansion in our consultant numbers, we always seem to be short! This is probably due to the increasing demand for theatre sessions across all specialties and the involvement of anaesthesia in interventional radiology and the expanding area of pre-operative assessment. Kate Farquharson, our Unit Co-ordinator continues to work her magic by attempting to ensure that despite all this anaesthetic cover is provided. This has been aided by the implementation of our e-Rota which has now run for a full year and brings into question how we ever coped with paper and a ring binder. Abigail Walsh will shortly be going on maternity leave whilst Dr Charlotte Scott will be welcomed back to the department in the next couple of months following almost back to back maternity leave.

Dr Bernhard Heidemann remains at the helm of our department but there have been a number of changes with Dr Kallirroi Kefala taking on the role of clinical director of Intensive Care in RIE and Dr Stuart McLellan has taken over the role of clinical director for Critical Care for Lothian. This vacancy has come about due to Dr Mike Gillies taking on the role of Associate Medical Director for Theatres, Anaesthetics and Critical Care for Lothian whilst Brian Cook has become the Medical Director for Acute Services. So there has been quite a shuffle in the management team and in offices. And office space has become a hot topic in the department as we now know how much area per person is available in each of the offices in the anaesthetic corridor so those with more room are being encouraged to share.

Dr Sarah Thompson continues in her role as College Tutor for ST3+ trainees and Dr Adam Paul has taken over the mantle as College Tutor for the CT1 and 2 trainees from Dr Ishrat De Beaux. Both are providing excellent support for our trainees resulting in good morale for those attached to our department.

Trainee numbers continue to be challenged and with the increase in less than full time training and the numbers on maternity leave we find ourselves increasingly working alone. This is proving challenging as often our surgical colleagues fail to appreciate that we do not get a break during our 10 hour day. As a further effect of the reduction in trainee numbers, and the desire to have a consultant delivered service, we now have resident consultant cover on all weekday night shifts and weekend day shifts. It is anticipated that with the move of DCN and RHSC that we will be providing twenty four seven cover 7 days a week within the next couple of years. Whether this will adversely impact on training experience is yet to be seen.

David Ray March 2015

2014 Western/Gartnavel, Glasgow

Tears stream down my face as I write. By the time you read this the Western Infirmary/Gartnavel department will be no more. Most of its members will be split between the South Glasgow University Hospital and
Gartnavel General, the latter having assumed its new role as an “ACH+”.

Consultant in-and-outs have been as follows:- Robert Docking is our only in, having been appointed with an ICU interest. Our outs have been more substantial. Tony Vassalos, Chris Hawthorne, Ben Shelley, Carol Gray, Sabah Munshi and Kathryn Bennett have taken up consultant appointments in NWTC, the INS, GJ again, Dundee, Lancaster and Monklands. Som Gangiah resigned. Our retirees include Pauline Stone and Louie Plenderleith (already left) plus Joyce Reid and Tom Algie (imminent). Their departures mark the passing of a gentler age. More prosaically, a great wealth of experience and commitment has moved on.

It is only natural that those of us scarred by the traumatic centralisation of cardiothoracic services in GJNH are a little apprehensive about the changes ahead in south-west Glasgow. No doubt the first few years will not be problem-free but the new department will be loaded with youthful talent. Hopefully the positive spirit and humour that has characterised the Western Dept will be preserved to some degree in both GGH and SGUH. Words cannot accurately convey how good it has been to work here these last 20 years.

Colin Runcie

2015 Aberdeen Royal Infirmary

The year 2015 brought further changes to the Anaesthetic Department. People came and people went and the Department also returned back to its original location after a period of refurbishment.

During 2015 the Department welcomed several Consultant Anaesthetists. Dr Julie McDonald, Dr Jill Austin, Dr Navanit Nagdeve, Dr Joanna Szygula, Dr Naveen Kirodian and Dr Satish Narasimhula all took up posts with mixed General, Orthopaedic and Obstetric interests. The Department was further supplemented by the appointment of several Consultants to hybrid posts created between Anaesthesia, ITU and Medical HDU with the appointments of Dr Douglas Coventry and Dr Ian Scott. The Department also lost a few Anaesthetists. Dr Chris Trotter left for the happy grounds of retirement whilst Dr Lewis Walker left for Carlisle and Dr Manish Chhablani for Lincolnshire.

Despite these appointments the Department continues to be somewhat stretched on a day-to-day basis reflecting the situation across the country. The opening of two new Main suite theatres, one with the Da Vinci robotic system, and two new orthopaedic theatres at Woodend Hospital have created new posts and new work in equal measure. As with elsewhere the out of hours service continues to metamorphose and is currently being reviewed with a view to the roll out of a new pattern of levels of on-call, on the General on-call rota at least although changes may also arise on the other rotas including; Maternity, Cardiac, Paediatrics and ITU. At the top Dr Alistair McDiarmid remains as RA/TPD, Dr Brian Stickle as UCD and Dr John Read as Chairman of GAASSC. Whilst all appear happy one probably shouldn’t comment on the amount or colour of the heads of hair.

In summary 2015 has produced another year of change for the Anaesthetists at Aberdeen Royal Infirmary. We have settled back into our old offices and some of the old routines. As we move into 2016 we look forward to some IT advances with an electronic Departmental rota and hosting the joint two day Winter meeting of the Society and The College of...
Anaesthetists in Aberdeen in November 2016. See you in November if not in May!

Paul Bourke Jan 2016

2015 Queen Elizabeth University Hospital

Well we moved in...

They say moving is one of the most stressful events in life, however, moving out of your old department, keeping it running and starting in a new department simultaneously just added an extra layer of challenge. And always multitasking we did it for three hospitals at the same time.

We bid farewell to the former departments of Anaesthesia of the Southern General Hospital, The Victoria Infirmary and The Western Infirmary, Glasgow- this is the order in which they closed! The day surgery unit of the Victoria Infirmary remains open and Gartnavel General Hospital has reinvented itself as a day hospital so as a department we continue to work across several sites in GGC.

We now reside as an enormous department of 92 consultants, 102 trainees, 3 SAS, 2PAs and 3 admin staff. Now that makes for one hell of a Christmas party, not to mention rota nightmare. Fortunately the gigantic brain of Alan Hope writes software allowing our rota runners one great big screen shot to herd the flock. We have colleagues from Inverclyde and the Institute of Neurological Sciences who do missionary work with us and as a department we do a fair bit of outreach at the Beatson Oncology Centre.

We have 20 main theatres in the new hospital with an additional 4 in our obstetrics and gynaecology annex. We are lucky enough to have a great advantage over our surgical colleagues – a suite of offices adjacent to theatres – the hub of which is our ‘goldfish bowl’ – a meeting point for whining about (the lack of) parking permits coffee, lunch, chit chat and more whining about (the lack of) parking permits.

It is a truly amazing building, we have posh food outlets, a skyscraper helipad, interactive toys to be played with in the kid’s hospital waiting area when you need some down time or distracted from car parking permit chat. The only real negative would be the lack of car parking permits. This is a double edged sword as there are so many more MAMILs strutting around the department in their cycling gear.

We would like to welcome the following consultants who have been appointed in the past 12 months – Angela Jenkins, Finn O’Sullivan, Euan Black, Bob Docking, Sue Wilkinson, Neil Logan, Mani Chandran, Anurag Singh, Christ Wright and Russell Allen.

And a farewell and thanks for dedicated years of service to those who have retired – Louie Plenderleith, Tom Algie, Joyce Reid, Lynn Newman and Jane Purdie. Some colleagues are missed now they have gone to work further afield – Claire Barker to Northern Ireland, John McDonald to Lewis, Andy Woods to the Golden Jubilee, Ramesh Sai to Canada and Stephen Noble to the north of river – thank you for all your hard work – you are missed but not forgotten.

It’s been an interesting and challenging transition but it is fair to say after the storming and norming we are starting the performing in our theatres.

Theresa McGrattan Feb 2016

2015 Institute of Neurological Sciences (INS)
For the first time in a few years there have been no changes to our consultant body with no retirements and no new appointments.

With the completion and opening of the Queen Elizabeth University Hospital together with a link bridge to the Institute we hope that time critical transfers of patients with brain injury can be expedited which should help improve patient care. The other obvious benefit is that we now have access to two much better coffee shops!

Construction of the Glasgow University Imaging Centre of Excellence (ICE) Building which is attached to the INS has also now commenced. The 1st floor of this building will provide 4 new theatres which are to be used for neurosurgery and maxillofacial surgery. The longer term plan is that following completion of the ICE Building there will be a renovation of our existing theatre complex.

Both the Glasgow Airway Skills Lab (GASLab) and Brain Injury Transfer (BRIC) courses are still running at the Institute and are continuing to be well subscribed. Also the 12 month advanced neuroanaesthesia post and 3 month advanced airway posts continue to prove popular with trainees.

Dr Kevin Fitzpatrick Feb 2016

2015 Ninewells

Life in the department is generally good and we’ve many reasons to be upbeat. Pamela Johnston has assumed the role of clinical lead and has done a great job of doing stuff without upsetting people. We have three new consultant appointments. Ben Shippey has travelled from across the water (Fife that is) to be appointed Director of the highly acclaimed Clinical Skills Unit of the Dundee Medical School. He stills gases on a part time basis, and does some anaesthesia too. Gillian Campbell has returned home from the North West of England, and Carol Gray has managed to sneak out of Glasgow under cover of darkness and a bit of rain. Both were lured into the maternity unit several months ago and haven’t been seen since.

We have a number of fellowship posts that have attracted trainees from outside the region. Ruth Neary (Regional Anaesthesia), Katrina Dick (Pain) and Olly Robinson (ICU) have recently completed fellowships and Ayman Mustafa (Regional Anaesthesia) continues to be a welcome addition to the department. On the outgoing trainee front, Alison Kearsley has been exported to Australia and Neal Willis has headed via Edinburgh to the Glasgow Royal Yorkhill Hospital for Southern Children (or whatever it’s called) and seems to be doing good things there. We have acquired a new tranche of trainees who seem to be a good bunch, and we must be doing something right because many of them have actually chosen to come here. The trainees excelled at our last CEHD before Christmas. This featured some lively debates, a presentation of 24 hrs in the anaesthetic department, and an award ceremony including the coveted ‘Silver Spur’ award for cowboy anaesthesia and the Coffee Room Champion. The latter has been made necessary because of the retiral of Grant Hutchison, whose sage advice, wit and repartee helped make the coffee room a great place to be. He will be sorely missed, as will Neil Mackenzie who has also retired after 28 years as a Consultant in Tayside. Amongst other responsibilities, Neil has been Clinical Lead and President of the Scottish Society of Anaesthesia, and he has contributed greatly to our department and the specialty as whole. Sadly, by this time this goes to print we will also have lost Justine Nanson who after 15 or more years as a consultant here has finally
bitten the bullet and followed her husband (who is Director of the Glasgow School of Art) to the west of Scotland. We all wish them all the very best.

By the time this goes to print, after a fairly spectacular period of ill health, we should have welcomed back our clinical services manager Ally Adams into the sacred walls of our department. Ally is a highly respected and well liked clinical manager which is perhaps a rare breed. Our initial scepticism of having a manager with an office in the department has proved unfounded. We wish him good health and a seamless transition back to working life. Hopefully by the time you read this Ben Ulyatt will be also be back to work after fracturing his clavicle cycling down a cliff on his own in the dark. Earlier in the year Paul Fettes suffered a ‘minor’ head injury coming off his bike. He is now back to normal – well normal for him at least.

Dundee is undergoing a lot of very positive changes at the moment with the Waterfront project. Work is well underway to reconfigure the centre and connect it more with the River Tay. As part of this, work on a new iconic V&A museum (the only one of its kind outside London) has started. Dundee is also currently World City of Design (honest!) and only recently lost out in UK city of culture to that other centre for all things cultural – Hull. Hmmm. To mirror the redevelopment of the city, we are undertaking our own (albeit slightly less ambitious) transformation of Labour Suite theatre facilities and, for the first time, elective work is taking place in the main theatre suite area. Despite hope that efficiency would improve dramatically, Parkinson’s law has been successfully applied and we can now complete a half days work comfortably within a full working day. We are also busily preparing ourselves for our metamorphosis into one of the 4 national trauma centres. Great news for patients – they can expect to join a bigger trauma list.

Finally our departmental input to teaching and research is worth mentioning. Dundee is currently ranked as one as of the best medical schools in the country and students are reputedly coming here out of choice rather than because they cannot get in elsewhere. The anaesthetic department certainly does its bit to promote this and the students seem to appreciate it. Postgraduate anaesthetic training is also going well, and the department seems to be collecting green flags and a ‘best kept secret’ reputation as a great place to live and work. The FRCA pass rate has been pretty good and was 100% at the last sitting. The fertility of the department seems to be pretty good too, with an impressive birth rate and too many new additions to mention (well I cannot remember them all anyway). The department also continues to be active in research both in the lab (led by Professor Tim Hales) where one of our trainees Fiona Bull should be congratulated on her recent PhD, and clinically led by Graeme McLeod recently made Professor.

Paul Fettes Dec 2015

2015 Perth Royal Infirmary

Departures, arrivals, and goings-on in Perth in the last year? May Mok left us for Singapore, after five busy clinical and educational years with us. Her energy, cheery demeanour and expensive handbags are much missed. And Peter Coe has retired. During 27 years in Perth he saw the “new” Infirmary open, the Bridge of Earn Hospital close its doors, and the department more than double in size. He played a central role in the life of the department, including as Head of Department. He had many areas of interest and expertise, but was perhaps most proud of his career long
interest and expertise in the difficult airway. We wish Peter a happy retirement.

But the department has continued to attract talent from around the world. We have appointed new Consultants Simon Scothern and Rob Vaessen, from New Zealand and Holland (albeit via Glasgow). Tim Smith has rejoined us, from Australia, as a long term locum. Their fresh faces and ideas are welcome and stimulating. We also lost Wendy, our secretary, to Auckland, but were lucky to replace her with Lesley who fitted in fantastically. Our new Consultants’ arrival was been rapidly followed by an (unrelated?) outbreak of pregnancy. It was great to celebrate the arrival of Stephanie Sim’s Angus, Judith Nieman’s Finn and Lesley’s Lucy, especially after what had been a few fairly fallow years in Perth.

At work, inertia remains the moving force in NHS Tayside. The Geriatricians have done such a great job that the hospital is overwhelmed by our ageing local population, and we lose huge amounts of elective operating through lack of beds. We hope that part of the solution lies with a new combined ITU/surgical HDU, and a same day admission ward. We are not sure that the patient safety week of wearing t shirts and aprons will solve too much, but it was a bit of a laugh. And a couple of our colleagues managed to get off the on call rota- a first for PRI. We continue with our varied elective and emergency workload, with the same frustrations and challenges as anaesthetists across the country. And our office air-conditioning still doesn’t work. Cheerful trainees continue to support and stimulate us all, and it was pleasing that a Deanery visit proved highly complementary of the excellent training and education delivered in Perth. In May Mok’s absence, Arthur Ratcliff has taken over the Tayside Primary tutorial teaching programme. The medical students seem ever younger, born after the start of my anaesthetic career and oblivious to the attractions of ABBA. Ewan Ritchie, our Clinical Leader, and Duncan Forbes, the rotameister, continue their roles with such enthusiasm and good humour that we all know they are keen to continue indefinitely. Great effort guys!

Outside work, in 2014 in close succession we survived the referendum, and loved the Ryder Cup. Perth and Perthshire remain beautiful, best experienced in lycra or walking boots. We still sing, sail, cycle, run, golf, walk dogs, and enjoy going for a curry. There is a concerning volume of “which university?” and pension-related conversation, albeit balanced by “which primary school?” and “at least you have a pension!” chat. We held an inaugural interdepartmental Geriatric-Anaesthetic Society (GAS) “wine tasting and lots of eating” get together. In spite of a slightly harsh negative marking system, Jo Doughty did us proud, coming (nearly) first with her extensive knowledge of a range of wines.

So, in spite of the departures, arrivals and goings-on, not too much has changed. Indeed, other than the recent death from old age of “Edgar,” the departmental fish probably look healthier and better looked after than for many years, in spite of Rob Vaessen’s valiant attempt to catch them all before cleaning the tank. Perth Royal Infirmary remains a great place to work, and Perthshire a fantastic place to live.
2015 Royal Alexandra Hospital, Paisley

The big news from Greater Glasgow and Clyde is of course the opening of the Big Shiny Hospital of Ever-Changing Name (BShoECN), this week known as The Queen Elizabeth University Hospital Trust - but that may have changed again by the time you read this. I’m sure other reporters will have more to say about it, but we in Paisley seem to be the back stop for the things everybody else forgot about. Apparently we’re the only place on the patch that covers all the bases for breast surgery patients with other medical conditions possibly requiring level 3 care postoperatively; ditto if you require eye surgery and need a bed for the night – all those managers, all that planning...

As reported last year, we are back to being Clyde sector for most specialties which seems to be more sensible for those of us on the edges of the empire. It is great for the members of the Medical Staff Association to sit in a room and hear what the plans and problems are from someone who is our manager, on our site, whom we know by name. We might even get some much needed infrastructure spending soon now that the BShoECN is complete – the floor and ceiling of our ITU have been scheduled for propping up/generally fixing for a few years now, and we’re hoping this gets done before the ITU actually ends up in A&E (literally, not figuratively).

Tom Goudie retired at the end of 2015. His presence around the department is missed, but we discovered Malcolm Smith can do a great impersonation of the famous Goudie Rants - as demonstrated at Tom’s leaving do - so if we need a fix, perhaps Malcolm will oblige. Tom has been replaced by Paul McConnell, who joins our ITU team from Ayrshire. He was a Paisley trainee in the past, so is a weel-kent face round here. The number of consultant colleagues that your correspondent remembers as wet-behind-the-ears trainees is increasing – hopefully they will return the favour and make sure I’m doing things properly as I slide down the other side of the competence parabola!

Our only new baby this year is Zach Almaki, a little boy for Ahmed after three daughters – he’s still outnumbered at home, but not as badly as previously. We have at least two other babies under production, but more of that in next year’s report...

Hilary Aitken Jan 2016

2015 Raigmore Hospital

It’s been a ‘calm before the storm’ year in Raigmore as 2016 is the year in which a 3 year rebuild of main theatres starts. Expect a run on ear defenders and emergency generators in the local industrial merchants, as the plan is that the build runs adjacent to clinical work. As you might predict the finer details like Where/When To Do Displaced Work haven’t actually been clarified yet, so if any of you have a spare broom cupboard with piped gases let us know.

The paediatric facilities are in the middle of a full rebuild too and the new place will be finished in the spring. We have been working with colleagues up North of North in Wick to support Caithness General Hospital over a rough patch, and Highland as a whole is trying to work out a sustainable solution. Some of the department are also involved in setting up a new networked Pre-Hospital response
through BASICS to fill a geographical gap in Scotland’s cover.

There has been a wee bit of staffing turnover. Lisa Handcock has defected to the relative peace of Bangor. In the last year or so we have welcomed 2 new colleagues, Marian Mackinnon from Monklands and Mike Leggate from Aberdeen, and we managed to convince Morag Sutherland to stay on and stop migrating ever northwards. A current recruitment round means we will end up with 21 consultants and finally have a separate ITU rota. This will shock some incumbents as the debate about The Split Rota has taken 2 decades and taken on a mythological status. Here’s hoping the eventual birth of the unicorn after that long gestation won’t be too messy or painful.

Next door a shiny new campus university has just opened, the River Ness Flood Defences were finished just in time (phew) and the repertoire of sporting challenges has increased further this year with the World Orienteering Championships and the new Etape Loch Ness event. If the health board allows anaesthetists out of the hospital at weekends, it looks like there will be even more lycra/goretex on display in our (admittedly casually dressed) department.

Hopefully the positive karma in the city at the moment will sustain us through a challenging time ahead at work.

Dan Baraclough. Dec 2015

2015 Hairmyres

Lanarkshire continues to struggle on amidst ever increasing number of patients attending Hairmyres instead of falling into the tractor beams of the Death Star!!!

Despite this, at least in the anaesthetic department, morale remains high!! We continue with our ongoing feminisation of the department with the appointment Dr Nina Tatarowska in the last year & 2 further babies with another one on the way. Early in 2016 we will also welcome Dr Austin Rattray to our ranks & have bid a fond farewell to Dr Karen Reynolds. At the last count we have now expanded to 16 consultants (with another job pending) & dropped to one middle grade with the retirements of Dr Gladys Mekoa & Dr Tadeus Wiekewitz. In recent times, we have also expanded our physician assistants in anaesthesia to 3 with the arrival of Fiona Robertson.

As well as trying to work out how to deal with the ongoing demands of our increased workload we also need a strategy of covering on call as the whole department grows old. None of us wish to be still carrying this burden into our 60s but as yet a solution eludes us. Should anyone have any suggestions, please forward to ............... Oh well, at least we’re not independent & staying in Europe!!!!! (Ed – are you sure?? Better check up on Boris Johnston’s latest plans....)

Grant Haldane February 2016

2015 Royal Infirmary of Edinburgh

Changes are afoot at RIE! The views from theatre are slowly but surely being obscured by the building of the new Sick Children’s and
the Department of Clinical Neurosciences which appears to be making good progress towards it’s anticipated completion in 2017. Within RIE there have been a series of building works. Changes are being made to the second floor to accommodate the relocation of renal and transplant high dependency units, whilst on the first floor work has been going on to facilitate the expansion of critical care to a 42 bed unit come 2017. On the ground floor changes to the endoscopy suite have meant anaesthetists must negotiate a more circuitous route from CT to the angio suite and our mall area is currently undergoing changes which will see us have a Marks and Spencer Simply Food. Many of us envisage an expansion in our waist lines and a reduction in our bank balances as a result.

In RIE we are making progress towards a twenty four seven consultant delivered service. At present we have resident consultants from 8am on a Monday until 8:30 pm on a Friday and then resident consultants on weekend long days. With the appointment of new consultants, we are now slowly making progress towards covering weekend nights as well. Joining the resident consultant group in the last couple of months are Drs Jennie Irvine and Grace McClune. Dr Alistair Simpson has joined the obstetric on call group, Drs Phil Docherty and Helen Usher have joined the Transplant group and Dr Robbie Lendrum has joined the cardiac group. Critical Care has also had new appointments in the shape of Drs Kenny Baillie, Alistair Gibson and Gregor McNeill. As a result our staffing levels are considerably better although with an increasingly young department school holidays are proving a challenging time!

The department has suffered a big loss this year with the retirement of two obstetric anaesthetic consultants who together had more than 40 years of experience in this area. Although in bodily form Drs Vicki Clark and Anne McCrae were petite, they were huge personalities. Tickets for their leaving party were in such demand that despite the venue managing to take 180 people a waiting list had to be commenced. The department is now quieter and their humour and advice is sorely missed.

2015 Royal Hospital for Sick Children (Edinburgh)

There’s a temptation to think that a department keeps trundling on with the ‘same old, same old’ until the day someone asks you to come up with a review of the year! Unlike our lucky Glaswegian counterparts, we carry on in our Victorian surroundings in Scenines, but the new Children’s and Neuroscience hospital is rising up from the mud of car park B next to the NRIE at Little France, a little higher every day. Everything is set fair for a move across in late 2017. Exciting times!

Suzanne Boyle is now permanently on the consultant staff and we also welcomed Kevin McCarthy, Andras Husz, Neal Willis and Gil Gavel. Gil and Neal got caught in our revolving door and have moved on to pastures new, we wish them well. David Rowney is now the paediatric lead for SCOTSTAR, and Emma Dickson our college tutor. Some of our retired colleagues are also still spotted from time to time, Louise Aldridge for the occasional locum, Dave Simpson at the occasional meeting and Ian Hudson still walking the dog nearby.

Congratulations too from all of us to Karen McGrath on the birth of baby Poppy, to Pamela Winton for James and to Omair Malik for baby boy, Zakir.

Phil Neal Dec 2015
2015 Stracathro Hospital

It has now been two years since the last report from Stracathro and although not much has changed we continue to be busy and the future for Stracathro appears to be secure and bright!

We no longer have waiting list initiative operating sessions on Saturdays and Sundays as the Scottish Government discontinued funding for this at the end of March 2015. This has meant that the surgical ward now closes on Saturday lunchtime and because of this most joint replacement surgery is done at the start of the week.

We welcomed Morag Gray as Charge Nurse in recovery in June 2014 and we have a very dedicated and efficient band of fourteen anaesthetic/recovery nurses who occasionally get the chance to work in Ninewells – seeing some of the more challenging aspects of surgery and at the same time keeping up their professional development.

The opposite traffic on the A90 has brought us some new surgeons and although we still have the same core anaesthetic input from Ninewells we are delighted to be getting more trainees coming to Stracathro. Our patient catchment area now extends from Grampian – general surgery and orthopaedics- to Fife- plastics, orthopaedics and vasectomies!

Now that we have the Susan Carnegie Clinic (Psychiatric Unit ) on site we are able to do the ECT sessions in theatre. This offers a first class service for these patients and indeed we had an excellent report from the SEAN committee after their recent inspection.

The three NESSA meetings are still held at Stracathro. It really is nice to see so many retired members of staff at these meetings but I would like to encourage a few more, younger members to attend these events.

Our congratulations to Neil Mackenzie for his year as President of SSA in 2014 and although he has retired we are delighted he is doing some of his locum sessions in Stracathro.

Jan Beveridge. Dec 2015

2015 New Children’s Hospital (Yorkhill)

Greetings to everyone from sunny (not very) and fragrant (very) Govan. It has been an eventful year for all of us, firmly punctuated in mid June by our move to our new home in the New Children’s Hospital on the South Glasgow University Hospital campus.

The first half of the year saw everyone working extremely hard in an effort to make the move go as seamlessly as possible, however this was through a heavy atmosphere of fear and trepidation. Optimism was nowhere to be seen and morale appeared to be at rock bottom. However the summer came and went and by mid-July we found ourselves in a big (not nearly big enough) shiny new hospital on a big shiny new campus working away quite happily. Alas gone is the legendary Yorkhill Friday fish, chips and peas. Many mourned this until the discovery of M&S Simply Food. The distances we now have to cover and the extra necessary calories required to facilitate this have meant most of us are spending a little bit more on lunches than before but our diets have certainly changed for the better. Those in the department with five or more discretionary points however are rarely seen in M&S as they prefer to purloin lunch from the Campden Food Co.

It is fair to say that the theatre suite is not quite what we envisaged but we are getting
used to it. However with our current set up we are nowhere near as slick a service as we were prior to the move. This is due to a number of factors. Firstly our day surgery unit is ridiculously small and always congested, and married to a clunky and almost unworkable EPR system, assessment of a list of day surgery patients takes twice as long and often results in theatre delays. Similarly our new ward design now means the majority of our patients are in single rooms configured on a semi-circular floor with no line of sight for the nursing staff. Nursing pressures and stress levels have therefore been extremely high and there has been an associated attrition of staff compounding the situation. I have heard however that there is a drive to recruit around 80 new staff to address this issue.

Following our move we are now receiving patients up to the age of 16. What has become increasingly clear since the move though is that with our current footprint we do not have the capacity to accommodate all of the services we are being asked to provide. We knew this would be the case of course when we all saw the plans for our new hospital but our concerns fell on deaf ears. So I fear that before long we will be looking at split site working! What goes around comes around obviously.

This year saw us say a fond farewell to Dr Pauline Cullen who retired in September. Her sharp wit and sense of humour will be missed by all. We wish her a long and happy retirement.

The department welcomes Dr Arti Shah onto our cardiac consultant rota, and Drs Shane Campbell and Neal Willis were appointed to the general rota.

Until next year,

Ross Fairgrieve Dec 2015

2015 Golden Jubilee National Hospital

So here’s the 2014/2015 update from the hospital down the river with the cute green roof.

Whilst there has been an air of anxiety/hope/despair/excitement lurking in the skies over the Southside of Glasgow, here in Clydebank life has finally become.... well....normal! And it only took seven years folks!

Obviously that doesn’t mean that there hasn’t been change - frankly there have been more comings and goings than the Rangers management team or the cast of Hollyoaks!

The lovely Neela Desai and Rhona Siegmeth returned back to glam up the department - Neela from maternity leave and Rhona from a brief sojourn working for the MDU. Paddy Christie and Geejo Rappai joined the department in 2014 as new consultants, and on a par with Van Persie leaving Arsenal for Man U, one of Glasgow’s most memorable anaesthetists moved from the cardiothoracic to the general rota. Derek Paul was responsible for training anaesthetists in the vagaries of thoracic anaesthesia for three decades and we will miss his many, many words of wisdom. Mind you I never did truly understand that bloody ECG Mexican wave thing and a girl can only fake it for so long...On the Cardiothoracic side, Karim Elkasrawy returned after a year in Liverpool learning how to steal hub-caps and rapidly replaced Alan "lucky" Millar as "most cursed on-call Consultant" The laconic Colin Runcie finally concluded that everything was just getting a little too settled here and decided to throw himself full time into the mayhem of the New Southern General/ South Glasgow University Hospital/ Queen Elizabeth University Hospital/ large hospital near Krispy Kreme drive thru.... However his leaving undeniably marked the passing of a gentler age and we still miss his
ability to utter profanities with such aplomb. Thank goodness we still have David Reid to murmur the odd curse word! Another departure in 2014 was the uber quirky Dominic Ray who will always be famous (infamous!!) for being the bloke that bought our magnificent, much talked about coffee machine. Sure the cost of it equated to the GDP of a small nation but it makes a load of people happy... and more importantly, functional in the morning! We wish Colin and Dominic all the best in the future. 2015 saw the appointment of Dr Giuseppe Bozzetti (28 points in scrabble even without any bonuses) poached from the Heart & Lung Centre at Wolverhampton. So far the author has not detected any cliched Italian volatility in his personality but secretly wants to be around on the day when his placid nature is pushed to the limit - provided that I'm not that reason!

Ben Shelley will take up his consultant post in February 2016, a decision not made by competitive interview but rather squatters’ rights, since we appear to have been working for him since the place opened in 2008. We continue to see trillions of bushy tailed and bright eyed trainees rotating through the department every year from Tayside and the West of Scotland. Like nomadic tribes they wander from place to place putting down transient roots in various anaesthetic departments. Despite this, they maintain a great work ethic and zest for life fuelled in part by a large amount of caffeine and the wonders of the Friday lunchtime macaroni cheese special.

So let’s get down to the nitty gritty - currently we are currently the most productive healthcare facility in the country** The vast increase in ophthalmic and orthopaedic work has led to busloads of blind, limping patients turning up and making us look like an overflow car park for Lourdes. Cardiology and Cardiothoracic surgery continue to bring in increasingly complex work which tests your own cardiovascular response to stress. Heart rate monitors are now a standard of monitoring for cardiothoracic anaesthetists and ideally should be below 200 bpm. Anything higher and you need to cut down on the espressos!! But slowly and surely we’re building a cohesive department that’s fun to work in! Well, fun in the same way that some folk like leaping off bridges on bungee ropes... or putting their heads in lion’s mouths. Never boring! Never the same! Always good for chat or gossip! So if you’re looking for a job working with interesting people, in difficult environments, doing a variety of jobs, using skills such as negotiation with hostile forces or assessment of tense situations then join the Royal Navy!
But if you don't like boats consider us....

** Not based on any actual evidence

Isma Quasim Jan 2016
Reports of meetings

Drs Jim Dougal and John May making a song and dance about the last annual meeting at Crieff Hydro

The Society traditionally met twice a year.

- An annual meeting in the Spring – a social event with an emphasis on the family and networking
- A scientific meeting in the Autumn/winter – more academic and incorporating the annual Gillies Lecture.

A trainees meeting was also held over one day with a good mix of networking, academia and presentation of trainee works.

Some years ago we combined the spring meeting with the trainees and increased the academic component to help meet the CPD requirements of many of us. This format continues to this day with the council organising one day and the trainees the other.

The scientific meeting grew and we arranged a joint meeting with the Royal College over two days which has been very successful.
We have now entered into negotiations with the AAGBI and plan to organise similar two day events with them to increase the reach of the meetings, foster good relationships around the whole of the UK and improve the CPD availability for all.

2015 saw two excellent meetings at Dunkeld and Airth Castle.

Annual Spring meeting – Dunkeld April 2015

Report from the Winter Scientific Meeting Glasgow Nov 13-14th 2014

Continuing our relationship with the Royal College Dr Susan Smith and Jane Morrison organised a splendid meeting with our highest attendance ever. Over several sessions we were educated on anaphylaxis and anaesthesia showing that we can expect an on table mortality of 3-9% which is similar to that reported for mortality following lightning strikes. NDMR remain by the far most common agent responsible at ~ 60% of cases but latex (at 18%) is rising fast. Next up was some impact of anaesthesia on laryngeal surgery

The Friday had significant choices for all. An excellent summary of the ‘Good, Bad and Ugly of research and publication’ with recent anaesthetists bringing our specialism into disrespect it is important for us all to appreciate the limitations and pressure to publish. A session was dedicated to perioperative lung injury and the part we can all play in minimising this complication of surgery.

Report of the Annual general meeting

Dunkeld Hilton - Thursday Apr 30th 2015

For the first time the Society changed the format following last year’s consultation process and the ‘main’ meeting was held on the Thursday prior to the trainee meetings.

Some traditions remain though and an early AGM reported the recent progress with our attempt at widening the appeal and remit of the society as representing ALL anaesthetists in this great wee country of ours. We also kept the lunchtime forum involving John Colvin and David Ray from the RCoA and AAGBI respectively. There remain many challenges facing us all but we have strong representation to support us – especially in the AAGBI whose council appears to be over a quarter Scottish!

We remain in excellent financial health following the highly successful centenary year and our joint RCoA meeting held in Glasgow at the end of 2014. This rude financial situation, in contrast to some of our better known national institutions is despite a significant increase in our support to trainees for grants etc and a considerable contribution to ‘Lifebox’ run by the AAGBI

The scientific component of the meeting then took us for a cross country run through a myriad of conditions and situations from the change in obstetric mortality reporting by Liz McGrady, hypothermia from Ian Scott and the impact of coronary stenting by Steve Leslie.

The afternoon involved Mike Basler at his disagreeable best – the take home message would seem to be to continuously question
the worth of new drugs and take everything with a pinch of salt. Less controversial perhaps was Justine Royle – a urologist from Aberdeen who would seem to be destined to be Scotland first robotic surgeon. There are well advanced plans for the country to have three of these space filling machines within the next two years so progress does come to those that wait.

Back to matters that affect all of us and unlikely to be ‘cured’ in the near future we had an update on the changes to the pensions which certainly got many of us talking over coffee.

A penultimate session from Iain Wilson on the huge undertaking of the recent Lancet Commission proving that surgery is being seen as a public health issue and then Jo Craig who tried to educate us about the novel oral anticoagulants with unpronounceable names which will have implications on our practice.

The finale was, as is tradition, the presidential address by our new ‘boss’ Alistair Michie. His words can be found elsewhere in these annals – my only disappointment is that despite most of his working life being in Ayrshire he still seems to support the Dons rather than the far superior Killie!

Ewan Jack

Trainee Meeting

Dunkeld Hilton - Friday 1st May 2015

It has been said that change is as good as a cure and this year’s meeting certainly had its fair share of changes. We switched from the Crieff Hydro to the new venue at the Dunkeld Hilton. The conference format also saw some alterations with the Annual Spring meeting being held on the Thursday followed on by Trainee meeting on the Friday. We saw a change in our leadership as Dr Ian Johnston handed over the presidential reigns to Dr Alistair Michie and we wish him well in his new role.

There was also a change to the trainee committee with myself, Sarah Stobbs and Callum Kaye joining veteran rep John Allen and we hope to live up to the fantastic job carried out by our predecessors.

The Friday meeting proved popular as usual with many anaesthetic trainees and medical students in attendance. The advantage to the new format was the increased turnout of trainees at both days and a boost in the consultant presence at the Friday meeting, which is fantastic to see. However it was not surprising at the level of interest considering the variety of speakers on offer.

The trainee element commenced on the Thursday as Dr Mathew Day, Dr Fiona Breckenridge and Dr Marie Davidson delivered captivating oral presentations on Botulism, Preoperative fluid management and Preoperative temperature control. All talks were extremely interesting and well received with Dr Day managing to pip his fellow speakers to the post winning the top Oral presentation prize.

The morning session began with an engaging talk from Dr Malcolm Watson who spoke eloquently on the topic of regional anaesthesia. With a PhD under his belt in this subject, he delivered a fantastically informative presentation which left us wanting to get out our old anatomy books and see which nerves we could block! Following on, Dr Adam Paul spoke on the expanding topic of Obesity in obstetrics. His case based presentation was not only informative but also very entertaining.

Next we welcomed our own in house speaker Dr David Ray who is currently a council member of the Scottish society of
Anaesthetists and Chair of the AAGBI Scottish Standing Committee. Dr Ray delivered an interesting and informative talk on Hip Fractures which invited us to question the use of cement in our older more frail patients.

Lunch was followed on by Dr Willie Tullett who covered the topic of Medico legal matters. His direct approach, in depth experience and interesting collection of cases meant that caffeine was not required was required to fend off any postprandial somnolence. The afternoon welcomed Dr Iain Wilson who travelled up from Devon to talk to us on the future of the speciality. Headhunted by our own trainee rep Dr Callum Kaye at his daughter’s wedding, Dr Wilson had no choice but to attend. His talk very much reaffirmed why we entered the anaesthetic speciality, whilst giving some excellent advice to those about to apply for consultant posts.

Our final speaker of the day was the well regarded Professor John Kinsella who spoke on the topic of the initial management of burns. His wealth of knowledge meant it appealed to both pre and post FRCA trainees and concluded the excellent round of speakers.

The standard of poster presentations at this year’s meeting was extremely high and selecting the top twenty-five to be displayed was no easy task. We would like to thank all our guest speakers who helped to judge the posters and the worthy winner was Dr Alexandra Nelson. Her poster on Anaphylaxis under anaesthesia in NHS Lothian was well written, interesting and educational.

Finally we would like to say our fond goodbyes to Dr John Allen who is leaving his role as trainee representative to join the consultant world taking up a post at Crosshouse Hospital, Kilmarnock. John has been the backbone of the Scottish Society of Anaesthetists trainee committee and we would like to thank him for all the hard work he has put in over the years. John has left us with very big shoes to fill (size 13s I do believe) and we hope to carry on delivering his high standards in the future.

We would also like to thank the SSA committee for all their support over the year and helping us in the organisation of the trainee meeting. They have all put in a tremendous amount of time and effort to ensure the Scottish Society of Anaesthetists spring meeting remains a quality and popular event in the yearly anaesthetic calendar.

We look forward to welcoming some old and new faces to next year’s meeting, which will once again be held at the Dunkeld Hilton and we hope to build upon the previous year’s successes.


Report from WSM

Airth Castle Nov 5th 6th 2015

With the change in the council and several other meetings happening at the same time of the year the organisers of the annual winter scientific meeting had some blood pressure rises and calories burnt to make sure that this meeting went ahead as planned.

In the event they shouldn’t have wasted any energy at all as the result was one of the best scientific meeting ever attended.

Dr Matt Freer had pulled a lot of strings and brought a selection of nationally recognised names to educate and even entertain the almost 100 strong crew of anaesthetists. With a clever advertising push we managed to encourage colleagues from English and Northern Irish hospitals to join us in our plush surroundings.

With the central location and the high standard of the hotel we were well looked after – even if the pie count was a wee bit
high on the Thursday – luckily the well-equipped gym was close by.

The dinner proved successful with some not needing any ‘top up snacks’ until they reached the close by 24 hour garage at about 03:00.

We enjoyed the splendour of the actual castle for a drinks reception and were even piped down to dinner with the atmospheric backdrop of a misty evening reverberating to the sound of local fireworks.

The speakers were fantastic and scored very highly on the delegate feedback.

We are constantly trying to keep up to speed with the time and this was the first ‘twitter’ compatible meeting the SSA has organised. The enthusiasm of Drs Calum Kaye (trainee rep) and Deidre Conway in setting this up and running it throughout the two days has been deemed a great success with 99 retweets and 9,500 impressions across the platform (No – I don’t quite understand either but it seems very impressive indeed!) We hope this becomes an integral part of our future meetings until someone develops an even more integrated method of communicating 😊

The actual educational content was fantastic

Dr Robbie Lendrum informed us of novel ways of dealing with those tragic pre hospital cases of aortic disruption with experience from Australia and London. Then Mr Craig McIlhenny a local urologist and director of the Faculty of Surgical trainers at the Royal College of Surgeons (Ed) educated us on the rise of the checklist and how it is the associated culture that really makes surgery as safe as it is today but why we still make mistakes. Dr Stephen Hearns showed us some very interesting photos and scenarios that make up his work with the ERMS our national retrieval service.

One of the highlights was the debate between Drs Kerry Litchfield (our local hero) and Will Harrop-Griffiths (a true UK national hero). Dr H-G started by regaling us with reminders of some of his previous successes however his pride came before the fall of a rare loss to Dr Litchfield on the motion that ‘This house believes obstetric anaesthesia is more a state of mind than a sub speciality’ – apparently the truth has been confirmed and Obstetrics is a sub speciality 😊

There was a session on dealing with emergency laparotomies with some updates from the English (Welsh and NI) NELA project via Dr Mike Grocott and some local examples of reporting and QI activity from Dr Srikanth Lakshminarayan at Forth Valley.

Dr Andy Longmate gave a very well received and thought provoking Gillies lecture – it was certainly appropriate that we had the Scottish National lead for patient safety giving the lecture which has always been centred on safety issues. His lecture is published elsewhere.

Friday had a lot to live up to and didn’t fail to impress with two of the highest scoring talks from our own David Rowney on paediatrics and Edinburgh based Dr Peter Henriksen giving us all advice on cardiology patients – what to look out for and what cardiologists can assist with.

Following the recent legal changes (Duty of Candour and Montgomery case from Lanarkshire) it was appreciated that Mr Robbie Wightman the senior solicitor from the Central Legal Office offered us all some background and evidence of what we need to be aware of and how to avoid coming across his desk in the future.

Dr Denny Levett impressed us with her extensive work at extreme altitude increasing the world’s knowledge of hypoxia to the nth
degree. Even the pictures and results of hypoxic, yet conscious volunteers blew some of the audience away.

Dr Michael Moneypenny, the director of the Scottish Simulation centre reminded us why simulation training is vital in our high risk profession. Finally an update on what poisons may present to ED or critical care and the way to deal with them from Dr Aravind Veiraiah of the Scottish Poisons bureau was appreciated by all.

All in all the educational content was superb and the catering improved after a couple of choice words were used by the chief organiser.
Dr Srikanth Lakshminarayan getting excited about his QI work on laparotomies

Who’s there?

Dr Denny Levett – She’s been to Everest don’t you know.

Dr Longmate (Gillies Lecture) being thanked by President Dr Alistair Michie
2015 Gillies Lecture – Dr Andy Longmate. National lead for quality and safety

Dr Andy Longmate in full flow

Quality, Safety and Improvement in Healthcare

It is sometimes interesting to pause and reflect on our journeys. Twenty-five years ago, in 1990, Tim Berners-Lee was developing the World Wide Web. In the same year I was working as a Medical Junior House Officer in Edinburgh’s Eastern General Hospital. We worked around 80-90 hours a week and were paid in “UMTs”- units of medical time - reimbursed at around one third of normal rates for nights and weekends. I wrote letters; used paper and telephones. One of my key duties was retrieving case notes from storage whenever patients were admitted out of normal working hours. In six months only one patient was referred to Intensive Care from our acute medical receiving unit.

Safety was less about systems and more a matter of personal vigilance, coupled with a culture of professional excellence and responsibility in, at times, challenging situations. An ability to quote, understand and interpret scientific studies was rightly valued amongst peers; professional standing and status were often associated with an ability to demonstrate such knowledge.

Around the turn of the century The Institute of Medicine published two seminal works describing a chasm or gap between the care we could have and the care that was being delivered\textsuperscript{1,2}. One source estimated that it took 17 years to translate evidence into
Practice^3^ Consequences of wasted resources were identified. Harm associated with and caused by medical care was acknowledged. Quality was defined as comprising six distinct elements or pillars and safety was identified as one. The best quality care should be safe, timely, effective, efficient, equitable, and person centered. No other industry has the potential to free up resources from non-value added and inefficient production practices than healthcare; no other industry has more potential to use its resources to save lives and reduce human suffering^4^.

Anaesthesia has a strong track record for safety – this Lecture has had an emphasis on safety and quality since its inception.

During my early training I learned how concern for patient safety had underpinned many aspects of our practice, from the development of the Boyle’s machine and safe medical gas supplies to the emphasis on non-technical skills and systems approaches. Anaesthesia also stood out as a specialty in the 1990s because of the emphasis on staff well-being – we recognised the importance of appropriate training, support and rest; and emphasised the importance of the individual’s contributions which were acknowledged and valued. Creating the conditions for the healthcare workforce to find joy and meaning in their work is essential if we are to successfully address our quality gaps^4^.

Learning from episodes of patient harm was of paramount importance during my training; usually with a focus on developing safer systems and processes to prevent or reduce likelihood of repetition. The devastating consequences of apparently routine anaesthesia for Albert Woolley and Cecil Roe^5^ and more recently the tragic permanent disability suffered by Grace Wang following epidural chlorhexidine administration shows us that we have more to do as a profession to further improve safety in the evolving and complex contexts in which we operate.

In 2008, and in that context of a quality chasm and global concerns about safety, the Scottish Patient Safety Programme (SPSP) was launched as an attempt to reduce avoidable harm and mortality and improve patient safety across Scotland. The underlying principles were based on the application of improvement science to specific issues and areas of harm in intensive care units, operating theatres and general ward settings in acute hospitals. The Programme used a breakthrough series collaborative implementation model^6^, which was conceived by Paul Batalden, and is an approach to accelerating the spread of evidence-based care. Key components include leadership support, multi-disciplinary approaches, a requirement for a commitment to participate by teams and the use of improvement experts alongside content experts. Teams are invited to “show and tell” with progress reports at learning sessions that intersperse action periods during which teams are encouraged to make changes that will improve care. The breakthrough series is by no means the only answer^7^ but it is one systematic approach that can be employed in an attempt to accelerate reliable implementation.

The SPSP involved and engaged frontline staff in leading changes and improvements to processes that they could control, and taught the model for improvement^8^ as a simple framework to help design, plan and execute improvement activities. The PDSA (Plan-Do-
approach was taught as a way to drive specific improvements. It provides a structured experimental learning approach to testing changes and allows new learning to be built into the experimental process. At its core is the idea of translating our ideas and intentions into action, shifting us from deduction and guessing what will happen (which can include our assumptions and biases) to a state where we test and study what actually happens and then base our next steps on what we have seen and learnt. It sounds easy but this is not always the case. The PDSA cycle should be used as part of a suite of improvement methods and is not in itself the answer to all challenges; the apparent simplicity belies a sophisticated and powerful tool that needs to be applied correctly if it is to be used successfully in the complex social systems in which we work.

Some of what we learnt during the first phases of the Scottish Patient Safety Programme was not new. The Consultants who trained me were experts in process reliability. They had honed and refined their understanding of process by multiple sequential tests and iterative learning week after week on regular lists with the same surgeons and operating theatre teams. The Scottish Patient Safety Programme built on this and brought encouragement for teams to explicitly work together towards shared goals, with an emphasis on collaborative testing, learning and step-by-step changes.

We were encouraged to see the gap between randomized controlled trial (RCTs) and pragmatic improvement efforts in our own units and theatres. In RCTs much real life variation and complexity are controlled out as part of the design. We were challenged to understand and improve processes, outcomes and application of best evidence in our own units, settings and contexts. Contextual factors are powerful influencers of Quality Improvement (QI) success.

We started using time series data on run and control charts (these were first used by Walter Shewhart in the 1920’s and used at the Hawthorne factory) to understand variation in our systems. We saw that statistical power and clinical significance can be derived from frequency of observations as well as the number of patients.

The anaesthetic chart is a good example of a time series run chart. We track key parameters and describe our theories, predictions, interventions and countermeasures during the course of an anaesthetic. We annotate these charts so that it is easier to see and understand what has happened.

We were challenged to see that the science of discovering new knowledge needs to be complemented by the science of reliable implementation and quality improvement – drawing on psychology, social sciences, systems thinking, measurement and statistical variation and building on the foundations laid down by Joseph Juran, William Edwards Deming and Avedis Donabedian.

The Scottish Patient Safety Programme is active now in other contexts; in primary care, mental healthcare and maternal and children’s healthcare.
In acute care, work continues on more complex multifactorial challenges such as the early recognition and treatment of sepsis and anticipation, recognition and response to deteriorating patients.

We are testing new ways to better monitor and measure safety. In 2013 Charles Vincent and colleagues published The Measurement and Monitoring of Safety framework. Safety can be assessed by a process of enquiry around five loci; past harm, reliability, sensitivity to operations, anticipation and preparedness and anticipation and learning. It is informative to ask five safety questions about one’s own department and system:

- Is care safe today?
- Has care been safe in the past?
- Are our clinical processes and systems reliable?
- Will care be safe in the future?
- Are we responding and improving?

The framework has shifted the emphasis from measuring and reducing past harms to looking for the presence of safety as a tangible attribute across our systems. The framework is being tested in Scotland. You tube video clips give an accessible insight into the work.

Improvement in healthcare has occurred since the inception of the NHS. Our challenge as medical professionals is to ask whether we are able to accelerate further improvements. If we can then we need to better consider the question of “by what method?”

Improvement is now recognized as a key competency for anaesthesia, critical care and pain medicine training by the Royal College of Anaesthetists. The Royal College of Physicians are leading the way with the excellent “Learning to Make a Difference” programme. The Academy of Medical Royal Colleges has stated the desire to ensure that all doctors learn and develop skills in quality improvement (QI) and to develop approaches that empower doctors to put QI skills into practice for better patient care. Stephen Powis, Medical Director at the Royal Free London sums things up when he states that “In order to practice medicine in the 21st century, a core understanding of QI is as important as our understanding of anatomy, physiology and biochemistry”.

Experiencing healthcare at first hand or by proxy with loved ones can bring mixed reviews. Kate Granger, a doctor with an incurable illness held us to account with the “#hello my name is…” campaign. How many of us introduce ourselves by our first name and explain who we are?
Finding ways to place people at the centre of their care, to listen to them, their families and carers, and act with purpose of what we hear will be the big challenge in coming years.

Understanding useful ways to hear the voice of the patient and respond and ways to give and receive feedback from one another will be crucial. Kate Granger helped us recognise and gain more understanding of the importance of social movement and social media in effecting large scale change.

There are many ways to interpret and improve person centredness, but Don Berwick nicely captures the essence in an extract from “My Right Knee” 19.

References

14. https://www.youtube.com/playlist?list=PLzuTYNEZWHB4YTUJD1_96IRDxJbd4FjD
Obituaries

It is with sad news that we must inform you of the deaths of four of our past presidents and Dr Bryan Kennedy.

**Dr John May (1949 –2015) SSA President 2009**

John Robertson May sadly passed away on September 14th, 2015, aged 66, after a long illness. Most will remember John as President of this Society in 2009-10 but it is possible that he may be better recognised as our longstanding piper at Society functions.

Hailing from North-East Aberdeenshire, John was actually born in Edinburgh but was forced to leave Scotland at an early age when his parents took over a general practice in Derbyshire. His heart remained in the north, however, and he returned to Aberdeen graduating with a BSc. in Zoology. Whilst in temporary employment, working in a blood transfusion laboratory in London, he was inspired to pursue a career in medicine and, on enquiring, was immediately accepted for training at the Royal Free Hospital. His intention at the time was to follow his parents into general practice and so he embarked on his own training programme culminating in an anaesthetic SHO post in Sheffield. This was to change the rest of his life. It was during this programme that he was to meet his beloved future wife, Jan, and his enjoyment of anaesthesia and the friendship of anaesthetists persuaded him that anaesthesia was the way forward. It proved to be an inspired decision – following career moves to Edinburgh and Nottingham he completed his anaesthetic training in 5 years! John frequently joked about this rapid progression stating that “he made sure that he never stayed in one place long enough for them to find out about him!”

He was appointed to his first consultant post in Lincoln in 1984 but the “call of the north” once again drew him away, and the family subsequently moved to Inverness in 1993, leaving many close friends behind.

John was probably the most self-deprecating individual I have ever met, frequently putting himself and his clinical abilities down, but always with that characteristic wry smile on his face. Nothing could actually have been further from the truth. He was a superb clinical anaesthetist and, possibly even more importantly, a super doctor in the broadest sense. Surgeons were always delighted when John was working with them as he was always prepared to anaesthetise the least healthy of patients and they knew they would get a “safe and sensible” anaesthetic with no unnecessary wastage of time. John was not averse to investigations or monitoring but just had the knack of knowing which were necessary and which not. He was often heard referring to excessive invasive monitoring as
“needless meddling” and he was usually correct. Similarly, although always ready to embrace new techniques, he never lost sight of the benefits of some of the older ones that he had learned during his training. In particular, he was passionate about basic airway management and determined not to let these skills be lost with the development of modern airway equipment. He proved to be a brilliant and sympathetic teacher and numerous past trainees returned to express their gratitude for the experience and knowledge which they gained from him.

To John, it was a privilege to be able to work as a doctor and it continued to astonish him that his patients would put their total trust in him. He was devastated when forced into retirement by ill health. He viewed work from all perspectives and considered a cancelled case a personal disaster for the patient. On taking over as Convenor of the Department during its most severe staffing crisis, one of his duties was to decide which lists should be cancelled. This he hated but it soon became obvious that he was using his own time to come in and cover some of the unstaffed lists. His explanation of this was that no one would be able to complain if he needed some time off in the future but there is no record of him ever putting this theory to the test!

He always put patients first and they loved the fact that someone was taking an interest in them rather than their clinical condition. He spoke to everyone and made them feel involved whether they be hospital cleaner or senior manager. On appointment as Clinical Director for Surgery he had the canny knack of analysing a potential problem and humbly explaining it to those involved, thereby enabling them to understand and appreciate the opposing views and he would invariably find a solution. Clinicians had huge respect for John, the nurses and theatre staff loved him and the managers were envious of his interpersonal skills. But most of all, the patients loved him.

He was passionate about Scotland and the Scottish Society of Anaesthetists and was truly shocked when informed that he had been elected as Council’s nomination for President. He genuinely didn’t believe that he was worthy of the position and took some determined persuading to accept. Once installed, however, he could not have taken the role more seriously nor worked harder for the Society.

His greatest love next only to his family, however, were his pipes. A piper of some repute and considerable skill, having played with several pipe bands including London Scottish and Dornoch, John’s pipes went (almost) everywhere with him including orthopaedic theatres, to entertain the patients, and Indian curry houses on department nights out. He would pipe at any opportunity and the AAGBI were particularly grateful to him when although “short of puff” he agreed to pipe at the Congress Dinner in Edinburgh and I was personally moved when in 2014, and in poor health, he came out of piping retirement to briefly reform his, now legendary, partnership with Jim Dougall for my Presidential Installation in Crieff.

John was indeed a character and is sorely missed by many friends, colleagues and Society members on both sides of the border and beyond. He is survived by Jan and their three children, all of whom were staunch supporters of the Society, and their two grandchildren.
Ian Johnston

Prof Alastair A Spence CBE (18/09/1936 – 30/11/2015) SSA President 1996

Anaesthetists throughout Scotland, and indeed many members of their families, will have been saddened to learn of the death, after a debilitating illness, of Alastair Spence, a strong supporter of our Society and its President for 1996-7.

Alastair was born in Prestwick, educated at Ayr Academy and studied medicine in Glasgow, graduating in 1960. After pre-registration house posts at Ballochmyle Hospital, Ayrshire and Glasgow Royal Infirmary he started his anaesthetic training at The Western Infirmary in Glasgow where he was greatly influenced by another past President, Dr Tony Pinkerton. Having obtained the Fellowship in 1964 he started his academic career as an MRC fellow in the hyperbaric medicine programme in the University Department of Surgery at the Western. In 1966 he moved to Leeds for three crucial years working with John Nunn as a Steinberg Research Fellow with Senior Registrar status to complete his clinical and academic training. He returned to the Western in 1969 as Senior Lecturer and head of a new academic unit, his success being shown by his progressive promotion to Reader (1976) and a Personal Chair (1980). His final career move was to the definitive Chair in Edinburgh (1984).

The range of his research work, and the resulting body of published work, was wide, especially that involving younger colleagues, but his major interests related to two subject areas: first, the possible adverse effects of general anaesthetic agents on both patients and, in trace concentrations, on operating theatre staff; second, and stemming from his time with John Nunn, the respiratory after effects of surgery and anaesthesia on respiratory function. From the latter evolved recognition of the role of pain and the need for its better management as expressed through two major reports produced by groups he led. The first was a collaboration between the Royal Colleges of Anaesthetists and Surgeons (of England), the second came from the Clinical Standards Advisory Board, and their impact on the management of post-operative pain has been considerable.

Not surprisingly, during his career he was recruited or elected to serve just about every organization relevant to our specialty imaginable at local, national and international level, too many to mention here. Dental anaesthesia, postgraduate training and medical staffing were major activities at various times, but the organisations he led were almost certainly the ones which were
most important to him. These were the Anaesthetic Research Society (Chairman 1987-91), the British Journal of Anaesthesia (Editor 1973-83; Board Chairman (1983-92) and the Royal College of Anaesthetists (President 1991-4), as well as this Society. Under his guidance the Journal grew in academic standing, and achieved a level of financial success enabling it to be a major contributor in the establishment of an independent Royal College of Anaesthetists so it was entirely appropriate that he was its first President.

At the time of his move to Edinburgh clinical academic medicine was struggling because of the importance of research in the evaluation of activity, and he missed no opportunity to emphasise to others the need to deal with this. However, the other aspects of clinical academic medicine (contributions to undergraduate teaching, postgraduate training and standards of patient care) were all recognized as important, and supported fully. Perhaps the most important marker of the success of his academic career is that no less than six younger colleagues subsequently occupied UK Chairs. He was an excellent lecturer himself, much in demand at home and abroad, gave many eponymous lectures (including our own ‘Gillies’), and received invitations to meetings throughout the World. Having seen our College through to independence he might have been entitled to relax a little, but the establishment of the Scottish Clinical Simulation Centre, now at Forth Valley Royal Hospital, was the result of his work from this later time.

Not surprisingly he received many honours: CBE from the Crown; and Awards & Eponymous lectures from Anaesthetic (Clover, Gillies, Robertson, Rollason), other Medical (Hunterian) & Dental (Fish) groups, and several Fellowships, either honorary or by election: FRCS (Ed & Eng), FRCP (Glas & Ed), FDSRCSEng (Hon) and FFAEM (Hon).

In spite of the significant time spent in London, not forgetting the considerable travel involved, Alastair always maintained his cheerful, welcoming, outgoing approach to everyone he met. He always had time, in spite of his many commitments, to discuss mutual interests (not necessarily anaesthesia!), ideally with a cup or glass in hand, and he and his wife, Maureen, were generous hosts. They married in 1963 and she, with their sons Andrew and Stuart, survive him after supporting him through his final illness.

Tony Wildsmith

Dr Margaret Stockwell (1944 – 2013) SSA President 2006

Dr Margaret Stockwell, Maggie, to all who were privileged to know her, was born and brought up in Paisley. She was educated at the John Neilson Institution in Paisley and the
University of Glasgow, graduating MB ChB in 1969.

On completion of two pre-registration house officer posts at the Royal Alexandra Hospital, Paisley she moved south to a senior house officer post in Obstetrics and gynaecology at Chase Farm Hospital, Enfield, Middlesex. During the course of that post she acquired the DObsRCOG. In 1971 she was persuaded to explore the option of pursuing a career in anaesthesia and was appointed senior house officer at Hillingdon Hospital, Uxbridge. During that post and the registrar post which followed she gained the D.A (Eng) and passed the FFARCS. In 1974 she returned to her homeland taking a registrar post at the Royal Infirmary, Glasgow. The following year she qualified FFARCS and was soon appointed senior registrar. Having completed her training, three years later she left the department at the Royal to become consultant at the Southern General Hospital in Glasgow.

In 1983, however, seeking what she perceived as a somewhat greater challenge and one which she had particularly enjoyed as a senior registrar, she returned to Glasgow Royal to take up a consultant appointment with a major clinical commitment in cardiothoracic anaesthesia, the post in which she was to remain until her retirement in 2006.

Throughout her consultant career she served on a number of committees at local and national level, including the National Panel of Specialist and the Scottish Standing Committee. She was elected President of the Glasgow and West of Scotland Society of Anaesthetist in 1997 and President of the Scottish Society of Anaesthetists in 2006. In 1998 she was elected to Council of the Association of Anaesthetists of Great Britain and Ireland. Notable amongst her many contributions as a member of council was her skilled and dedicated chairmanship of the International Relations Committee. In recognition of her invaluable work on this important Association committee she was awarded a Pask Certificate of Honour for services to the specialty.

From her early school days Maggie developed a keen interest in music and was soon recognised as having a very considerable talent as a singer. She was encouraged to join Paisley Abbey Choir and was granted a scholarship to receive singing lessons at the Royals Scottish Academy of Music and Drama. Later, when working in the Home Counties as a Senior House Officer in Obs and Gynae she seriously considered giving up medicine to follow a full time career as a soprano. However, her singing teacher, whilst recognising that she had all the necessary voice skills, persuaded her that a career in medicine would be more likely to ensure job security and yet allow her to continue her enjoyment of singing. When she returned to Glasgow, despite her heavy commitment to the ever increasing demands of the cardiothoracic service at the Royal Infirmary she continued her great passion for singing as a member of many prestigious choirs including the BBC Scottish Philharmonic Singers, the Royal Scottish National Orchestra Chorus and the Scottish Chamber Orchestra Chorus.

Her patients, her colleagues in anaesthesia and the surgeons with whom she worked will remain grateful that she followed the advice of her singing teacher and elected to pursue a career in anaesthesia. At the same time, her many friends in the world of music and all those who had the opportunity to enjoy her singing, were not deprived of a wonderful talent.

Maggie was a highly popular member of the hospital staff. Her enthusiasm and dedication
to her clinical practice was an inspiration to all her colleagues, both young and not so young. Her impromptu renderings of small excerpts from her extensive repertoire at departmental parties and other social occasions (even sometimes when waiting for the next patient coming to theatre!) will be remembered with great affection for many years to come.

She leaves a husband, Ian Gray, whom she met as a fellow member of the Hyndland Parish Church Choir, two step sons and a younger brother.

W. Leslie Baird

Dr Douglas McLaren (died 11/11/2015) SSA President 2005

Douglas attended Bellahouston academy before matriculating in Medicine at Glasgow University in 1964. He was a popular and accomplished member of that year until graduating MB.ChB in 1970.

Being a true south sider of Glasgow he elected to complete both his house jobs in medicine and surgery at the Victoria Infirmary. Indeed, it was during his medical residency there that he met a young staff nurse Harriet Buchanan who later became his wife.

Subsequent to this he spent 6 months in Obstetrics at the Royal Maternity Hospital (Rottenrow) under the guidance of Professor C. McNaughton. It was around this period he began to consider a career in anaesthesia.

He joined the anaesthetic department at the Royal Infirmary Glasgow in 1972 and quickly obtained his fellowship in 1975.

Cardiac surgery was a developing specialty at this time and Douglas acquired a particular interest in the newer techniques of cardiac anaesthesia.

He further enhanced these skills with a spell at the Brompton in London.

He was appointed consultant anaesthetist at the Victoria Infirmary in 1979, and thereafter to the Western Infirmary.

Undoubtedly Douglas was one of the most skilled and knowledgeable Cardiac anaesthetists at that time and a great many juniors benefited from his expertise and calm logical approach to difficult cases.

In 2005 he was elected president of the SSA and proved to be a very popular appointment having already served as honorary treasurer between 1987-91.

Latterly his health began to fail and despite cardiac surgical interventions on a number of occasions there was very little improvement.

Douglas died suddenly at home on the morning of Remembrance Sunday 2015.

He is survived by his loving wife Harriet and children Douglas, Stuart, and Jane. He will be sadly missed by all of us who knew him.

Bob McDevitt

Dr Bryan Ross Kennedy (died 22/01/2016 from complications of Addison’s disease)

Consultant anaesthetist (b 1935: q Aberdeen 1960; FFARCS)
Bryan Ross Kennedy (BRK) from Fraserburgh Academy won a scholarship (Bursary Competition) to study Medicine at the University of Aberdeen. He achieved distinctions in pharmacology and Maetia Medica. After house jobs with Sydney Davidson and Tommy organ as chiefs, he embarked on a career in anaesthesia in Aberdeen. He passed the FFA when still an SHO and published clinical research in peer reviewed journals which marked him as an outstanding anaesthetist in training. Years later as an expert witness he was called to give evidence at a Californian medical litigation citing his published abstract in the JAMA on intravenous regional anaesthesia. The redoubtable Professor Bill Mushin recruited him as lecturer in Cardiff but in 1968 Bryan chose to return to Aberdeen as a consultant where he developed expertise and popularity as a chairside dental anaesthetist throughout Aberdeenshire. Also, where appropriate and with dextrous expertise he made blind nasotracheal intubation look easy. A most clubbable man his 25 years service in the TA was recognised by the Territorial decoration and Bar. His wide circle of friends in the Royal Northern and University Club and previously the Aberdeen Conservative club will remember his unrivalled generosity and bon homie especially at his home in Upper Balblair, Midmar. His was an extraordinary memory with a prodigious vocabulary which could solve the Daily Telegraph crossword with little delay. BRK had three marriages; he leaves three sons and a daughter from the first, a daughter from the second and Margot his wife of 29 years years who was a tower of strength as disability gradually set in – yet fearlessly they both travelled regularly in style to the world’s exotic destinations.

BRK was exceptionally well read and his favourite quote from the classics was “Atque in perpetuum, frater, ave atque vale” (Now and forever, brother, Hail and farewell). As a host he used this to greet his friends – yet it was the hospitality in between which was legendary.

Iain Levack
Trainee Abstracts

For many years now the society has supported our trainees to present their findings at our annual meeting. There are now two separate prizes to be won – for best oral presentation (Sir Donald Campbell Quaich) and best poster (Prof Greg Imray Salver). The trainee committee ranks all submissions and notifies those for oral presentation. These projects are then marked and graded by an invited panel of senior experts before a consensus decision is made.

From 2015 the top placed abstracts are available via the website (www.ssa.scot)

We hope to be able to host all submissions there in time.

Abstracts presented at ASM May 2014

An audit of Intrauterine Fetal Resuscitation measures at the Ayrshire Maternity Unit.

AJ Primrose

Crosshouse Hospital, Kilmarnock, Scotland.

Intrauterine resuscitation involves the application of specific measures to a mother in active labour, with the intention of improving oxygen delivery to the compromised fetus.[1]. These measures include; full left lateral tilt, high flow oxygen, 1000ml crystalloid fluid bolus, discontinuation of syntocinon, tocolysis and the use of Vasopressors if maternal hypotension is evident. The goals of intrauterine resuscitation are to optimize fetal condition so labour may continue safely, buy time so a regional technique maybe utilised for Caesarean Section or to improve fetal wellbeing prior to operative delivery.

Methods

All Caesarean Sections performed under General Anaesthetic between January and November 2013 were retrospectively analysed. Those Caesarean Sections undertaken due to fetal compromise (Category 1) were reviewed and evidence of intrauterine resuscitation documented. Time from decision for Caesarean Section to knife to skin was also investigated.

Results

Thirty-two Category 1 Caesarean Sections under General Anaesthetic were performed for fetal compromise.
<table>
<thead>
<tr>
<th>Intrauterine Resuscitation measure</th>
<th>Percentage of mothers receiving resuscitation measure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full left lateral tilt</td>
<td>18.75</td>
</tr>
<tr>
<td>High flow oxygen 10-15l via Hudson mask</td>
<td>9.38</td>
</tr>
<tr>
<td>1000ml crystalloid fluid bolus</td>
<td>6.67</td>
</tr>
<tr>
<td>Syntocinon Discontinued</td>
<td>30.00</td>
</tr>
<tr>
<td>Tocolysis (Terbutaline 0.25mg S/C or 2puffs GTN)</td>
<td>10.71</td>
</tr>
</tbody>
</table>

Mean Knife to skin time for those receiving no Intrauterine Resuscitation measures was 19.2 minutes (8.79) and for those receiving one or more Intrauterine Resuscitation measures was 14.5 minutes (7.54).

**Discussion**

There are no current guidelines on the use of intrauterine resuscitation for fetal compromise at the Ayrshire Maternity Unit. As a result, these manoeuvres are not routinely practiced. Evidence suggests these simple measures can improve fetal oxygen saturations[2] and do not appear to delay knife to skin times for Category 1 Caesarean Sections. As a result of this audit, a new guideline outlining how to perform intrauterine resuscitation has been produced for the Ayrshire Maternity Unit and the implementation of these manoeuvres will be prospectively audited.

**References**


**Trainee assessment of consultant delivered training**

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Multi source feedback (MSF) has been used in the assessment of trainees in a variety of specialities from 2007 with the introduction of Modernising Medical Careers (MMC)[1]. It is a reliable method of assessment, and studies have shown it to be acceptable by the majority of doctors with a
subsequent improvement in performance[2]. We hypothesised that by using MSF we could assess and improve the quality of training provided by consultants.

Methods

For the last two training years (2011-2012, 2012-2013) trainees have been asked to anonymously assess the anaesthetic consultants on 7 categories of teaching, training and out of hours support. Each question was given a score from 1-5. The results were collated for each question and a departmental profile was produced.

Results

In total 12 out of 27 (44%) trainees participated in the survey. There were 222 responses over the two years reflecting the assessment of 25 consultants.

The following table summarises the results.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>1 Poor (%)</th>
<th>2 Average (%)</th>
<th>3 Good (%)</th>
<th>4 Very Good (%)</th>
<th>5 Excellent (%)</th>
<th>Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace Teaching</td>
<td>0</td>
<td>5</td>
<td>27</td>
<td>47</td>
<td>18</td>
<td>4(3-4)</td>
</tr>
<tr>
<td>Opportunities for procedures</td>
<td>0</td>
<td>5</td>
<td>34</td>
<td>38</td>
<td>23</td>
<td>4(3-4)</td>
</tr>
<tr>
<td>Out of hrs support</td>
<td>0</td>
<td>7</td>
<td>28</td>
<td>40</td>
<td>23</td>
<td>4(3-4)</td>
</tr>
<tr>
<td>Assistance with Portfolio</td>
<td>0</td>
<td>9</td>
<td>39</td>
<td>35</td>
<td>16</td>
<td>4(3-4)</td>
</tr>
<tr>
<td>Formal teaching</td>
<td>0</td>
<td>9</td>
<td>43</td>
<td>34</td>
<td>13</td>
<td>3(3-4)</td>
</tr>
<tr>
<td>Assistance with Audit/Research</td>
<td>0</td>
<td>17</td>
<td>49</td>
<td>24</td>
<td>9</td>
<td>3(3-4)</td>
</tr>
<tr>
<td>Assistance with exam preparation</td>
<td>0</td>
<td>16</td>
<td>45</td>
<td>29</td>
<td>9</td>
<td>3(3-4)</td>
</tr>
</tbody>
</table>

Discussion

By involving trainees in assessing the quality of training allows departments to identify areas for improvement. In our department we have initiated a variety of improvements, some of which have been led by the trainee’s. To improve the response with this quality improvement project we have considered linking trainee participation with their educational supervisors structured report.
Redesigning an anaesthetic chart improves documentation.

L. Gallacher¹, J. Nieman², P. Milligan³, K. Livingstone⁴, G.M. Cowan¹

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The anaesthetic chart is an important medico-legal document. The Royal College of Anaesthetists has published a dataset for charts [1] and Quality Improvement Scotland issued recommendations for documentation as part of their Clinical Standards in Anaesthesia in 2003 [2].

A previous audit at Monklands hospital [3] revealed deficiencies in the completion of charts, including the recording of ventilator settings in patients who were undergoing positive pressure ventilation. These results were presented to the department and the subsequent discussion hypothesised that a possible cause was the lack of a specific prompt for recording this data. An opportunity was taken to redesign the chart to include specific prompts for this data and reaudit.

Methods

The audit was registered with the local clinical quality department and no further ethical approval was necessary. Three investigators collected data anonymously during each audit cycle. Charts were inspected after the patient had left the immediate care of the anaesthetist, i.e. in the recovery area or ward. No announcement was made of either audit cycle and more than a year passed between the presentation of the first cycle and the reaudit. A two tailed fisher’s exact test performed using prism 6 software.
Results

The first cycle audited 173 charts. Ninety-eight patients were ventilated and 49 (50%) of these had the settings documented. The second cycle after the chart change audited 205 charts of which 118 were for ventilated patients. Ninety-one (77%) of these ventilated patients had the settings documented. This was found to be a significant increase (p<0.0001).

Discussion

Our findings show an improvement in the documentation of ventilator settings after the charts were changed. It is unlikely that the brief presentation of data a year previously had changed practice, and we think the improvement is due to the prompts on the charts.

References

2. NHS QIS. Clinical standards. Anaesthesia - Care before, during and after, 2003, NHS QIS, Edinburgh, UK

A prospective audit of “group and save” compliance in patients listed for emergency surgery.

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Emergency procedures carry significant risk of perioperative haemorrhage. Trauma, co-morbidities, sepsis and coagulopathy all contribute to this risk. It is essential that patients presenting for emergency surgery have appropriate pre-operative investigations, particularly a valid “group and save”(G+S).

In this audit we aim to establish our compliance with this standard.
Methods:

Upon arrival to theatre, patient case-notes were checked for documented evidence of G+S status. If this was absent G+S status was confirmed by consultation with blood transfusion. Minor procedures which did not require G+S were excluded from analysis.

Results:

Initial Audit:

23/32 (72%) patients had a valid G+S/cross-match.

There was printed evidence of this in 11/32 (34%) cases.

The following changes were applied to address this:

1. Education sessions were delivered to FY1 doctors to improve awareness of the importance of G+S/cross-match in emergency surgery.
2. Introduction of MSBOS – a local protocol detailing the transfusion requirements for common emergency and elective procedures.
3. Haematology department to ensure that all medical staff can access the blood transfusion online portal.

Repeat Audit

26/30 (87%) patients had a valid G+S/cross-match.

There was printed evidence of this in 14/30 (46%) cases.

Discussion:

We have demonstrated a deficiency in the pre-operative work-up for emergency surgery. After liaising with surgical consultants and our transfusion department we helped introduce procedural changes and led an educational drive. This has led to a significant improvement in compliance with G+S completion pre-operatively, however documentation remains poor. To address this we have constructed a theatre-checklist that junior medical staff should complete when preparing their patients for theatre.

This is currently being reviewed by the Transfusion Committee and our Surgical Directorate prior to being formally introduced. Improved compliance and documentation of pre-operative theatre work-up will enhance patient safety in our hospital.

References

The effect of shellac nail polish on measurement of oxygen saturation by pulse oximetry

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Shellac manicures have become increasingly popular since their introduction in 2010. They are expensive, usually last two weeks and require removal with acetone. In current practice women must remove polish prior to surgery because of possible interference with oxygen saturation monitoring. Studies to date have failed to find a significant effect on oximeter readings with either acrylic nails [1] or coloured polish [2, 3]. Our study aims to investigate whether Shellac affects the accurate measurement of oxygen saturation by pulse oximetry.

**Methods**

Data were collected over a two day period in March 2013 from twenty adult female volunteers attending a nail salon in Glasgow. A baseline saturation reading was obtained on each subject’s natural, unpolished right index fingernail using a Guardian Pro Line portable pulse oximeter. A licensed nail technician applied Shellac to the same finger and the measurement was repeated. Analysis was performed using a paired student t-test. p<0.05 was considered significant.

**Results**

The mean pulse oximetry reading at baseline was 98.1% and after Shellac application, 98.15%. The values were not significantly different (p=0.8).

**Discussion**

This study demonstrates that Shellac polish does not affect pulse oximetry measurement of oxygen saturation and may not need to be removed prior to surgery.

**References**


Improving trauma efficiency

L. Tait and E. Jack

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Emergency theatres can be chaotic including to late start times and changing patient order. This leads to mistakes and poor morale. We proposed a system to improve the start time in our trauma theatre. Secondary aim was better communication for complicated patients receiving early anaesthetic input prior to surgery.

Methods

Start times 1st January-28th February 2013 were reviewed from “time into anaesthetic room” on our theatre system, Sapphire. Our new system involved the trauma consultant identifying 1-2 patients to be first on the list for the following day, who would be seen by the anaesthetist that day. Patient details would be recorded in theatre to allow staff to know who/what was being done the following day. This patient would be in reception by 08:30 aiming to start anaesthesia before 09:15 (NTIG target). Data collection forms were completed and corroborated from Sapphire for April and re-audited in July. The results were presented to both departments.

Results

100% of start times in January and 78% in February were after 09:15. This reduced to 29% in April and 35% in July, a clear improvement as illustrated in figure 1. There was an average improvement in start time by 16 minutes. There was also a significant increase in the team discussion documented.

Figure 1: Results of late starts (%)
Ward staff reported being happier with this arrangement as they found it easier to prepare for theatre.

Discussion

The implementation of our system has improved efficiency by improving start times and morale. We have shown sustainability through re-audit. This has been taken on at a local level as a new policy in trauma.

Trauma patients are often elderly with many co-morbidities and are often frail, requiring a degree of optimization prior to receiving an anaesthetic. The implementation of this simple system means that these patients have earlier anaesthetic input, optimization and reduced chances of postponement.

A prospective, observational study of emergency laparotomies at Royal Alexandra Hospital, Paisley.


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The UK Emergency Laparotomy Network collected data from UK hospitals, and found that emergency laparotomy carries a high mortality risk, that the variability of care was high and that standards of care should be reached [1]. No Scottish hospitals were included. Our study aimed to collect data on all patients undergoing an emergency laparotomy in our hospital, and was the first assessment of its kind in a Scottish hospital combining anaesthetic and surgical data.

Methods

Data was collected on all patients undergoing an emergency laparotomy over a two month period. Those patients who had gynaecological surgery, an appendicectomy or hernia repair without bowel resection and those attending for re-laparotomy were excluded. Data was collected on patient demographics, surgical factors, ASA grade, timing of laparotomy, grade of most senior anaesthetist
and surgeon present in theatre, use of goal-directed therapy and level of post-operative care requested and achieved. P-possum scoring was used to predict patient mortality.

Results

Thirty-six patients underwent an emergency laparotomy in the 2 month period, with a male to female ratio of 17:19. The mean age was 60 years; range 13-89. The mean predicted mortality risk was 15.7%, calculated by P-possum scoring, using physiological and operative parameters. Consultant anaesthetists were present in theatre in 28 cases (77.8%) and consultant surgeons were present in all cases. Goal-directed fluid therapy was used in only three cases (8.33%). The level of post-operative care requested was available in 97% cases. Overall 30-day mortality was 19%.

Discussion

This prospective observational study of emergency laparotomies was the first reported from a Scottish hospital. Consultant anaesthetist presence in theatre was high. Use of goal-directed fluid therapy was only used in three cases. The mean mortality risk predicted was slightly less than the actual 30 day mortality of 19%.

References


Survey of Medical Student Views on Anaesthesia

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With the introduction of Modernising Medical Careers¹ into postgraduate medical training in 2005, further pressure has been put on both junior doctors and medical students to decide upon their chosen specialty at a much earlier stage.
Methods

We surveyed fifth year medical students across Scotland about their views on anaesthesia as a potential career. A ten-question survey was devised and sent out to the Scottish medical schools.

Results

We received 168 replies; 43% were male and 57% female. Students were asked how long they had spent on an anaesthesia rotation; this ranged from no days to greater than one month. 24% of responders had completed an anaesthetic student-selected component (SSC), 53% stated this is something they wanted to do. Responders were asked whether they would prefer a separate anaesthetic attachment, rather than one as part of a surgical rotation. 73% said a stand-alone anaesthetic attachment would be preferable.

We asked students if they would consider anaesthesia as a career and results are shown in figure 1. We asked what factors influenced this decision, the commonest answers being: challenging nature of the job, varied practical procedures, application of the basic sciences and team-working. Students were asked what factors would dissuade them from choosing a career in anaesthesia. The most popular answers were: non-continuity of patient care, perceived busy on-calls and reduced patient contact.

Fig. 1

Students commented that they had self-proposed SSCs in order to increase anaesthetic exposure, and felt they benefited from basic science teaching and practical skill sessions that were included in anaesthesia attachments. Others stated they wanted anaesthetics as a formal part of the curriculum.

Discussion

We feel we have highlighted an important issue in undergraduate curricula in Scotland. Medical students want more formal anaesthetic teaching during their training and the vast majority of our responders feel it should be a stand-alone attachment.

References

1. Modernising Medical Careers: Third Report of Session 2007-08, volume I. Published by House of Commons Health Committee, 08/05/08.
We report our response to a severely compromised airway, following bleeding into a patient’s neck after facial surgery and radical neck dissection.

**Case Report**

Institutional approval and written patient consent granted. An elderly patient had excision of a 7cm squamous carcinoma of the cheek, including total parotidectomy and radical neck dissection. Laryngoscopic grade (MAC 4) was 2b and a tracheal introducer was used. The next day, after food, the patient had a coughing episode and developed rapid neck swelling. He became hoarse, manually displacing his deviated trachea to swallow. He was given 300µg glycopyrrolate, 150µg clonidine and commenced on 4ng.ml⁻¹ remifentanil Target Controlled Infusion. Location and depth of the cricothyroid membrane was assessed using ultrasound (Sonosite S nerve, Bothell, WA), indicating marked tracheal deviation (Fig.1). Airway management plan was: Plan A - awake retrograde tracheal intubation; Plan B - “awake look” videolaryngoscopy with transoral intubation; Plan C - awake surgical tracheostomy. The patient gargled 200mg lidocaine and Plan A was performed successfully. After surgery for haematoma evacuation, awake tracheal extubation was chosen. The catheter was cut from the tip of the tube and kept in place, secured to the skin at the oral and cervical ends. The patient recovered in the High Dependency Unit.

**Fig 1: Probe aligned to deviated trachea**
Discussion

Postoperative bleeding into the neck resulted in critical airway compromise in an unfasted patient. This influenced our decision to secure his airway awake. We did not choose fibreoptic intubation due to accumulation of secretions and potential to block his airway during instrumentation. Ultrasound-guided retrograde tracheal intubation has been reported in a patient with difficult upper airway but normal neck anatomy[1]. We believe this is a first report of ultrasound-guided retrograde tracheal intubation in a patient with critical airway compromise and added problems of full stomach and swallowing difficulties.

References


Local Anaesthetic Systemic Toxicity, A Review of Safety

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Local anaesthetics (LA) are widely used throughout medical practice. Although adverse events and complications are rare, they do occur. These range from mild symptoms to major CNS and/or cardiac toxicity that can result in disability or death. It is the responsibility of clinicians using LA to understand their potential for toxicity and be prepared to respond when these events occur.[1]

Methods

We performed a 2-stage review of the recognition and management of local anaesthetic systemic toxicity (LAST.) The first stage was an audit of the availability of guidelines and intralipid in the areas where LAST was possible. Part two was a survey of knowledge of LAST. A web based survey was sent to anaesthetists and non-anaesthetists. Formal ethical opinion was sought but was deemed unnecessary.

Results

Our audit revealed 4/5 (80%) theatres had the AAGBI guideline [2] for management of LAST available, 5/5 (100%) theatres had direct access to intralipid. None of the non-theatres areas had the guideline or the right volume of intralipid immediately available. The survey had 45 respondents, 15 (33%) anaesthetists, 17 (57%) surgeons and 13 (43%) other medical/dental staff. Fifteen (100%) of
anaesthetists were aware of the safe dose of levo-bupivacaine with only 10 (33%) of non-anaesthetists knowing the safe dose. Ten (77%) anaesthetists knew the correct dosing of intralipid in contrast to non-anaesthetists where only 5 (17%) were aware intralipid was used in management of LAST.

Fig 1. Responses from non-anaesthetists about "what may be important in the management of local anaesthetic toxicity?" n=30

Discussion

Our audit revealed that areas away from theatre are not well prepared for LAST. For anaesthetists our survey results are encouraging, the majority of respondents had good knowledge of both identifying and managing LAST. Performance amongst other groups who administer LA was not so good. Knowledge of dosing was poor with over a third of respondents either under or over-dosing their patients. The ability of this group to recognise and manage LAST was poor. This was surprising with surgical training syllabuses highlighting the need for knowledge of local anaesthetics and their safe use.[3]

References

2 Safety Guideline, Management of Severe Local Anaesthetic Toxicity, AAGBI 2010  
 http://www.aagbi.org/sites/default/files/la_toxicity_2010_0.pdf
3 Core Surgical Training Syllabus, ISCP 2010  
 https://www.iscp.ac.uk/documents/syllabus_CORE_2010.pdf

Paracetamol and metabolic acidosis

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Metabolic acidosis is common in patients admitted to critical care. We present a case with an unusual potential diagnosis.

A 60 year old female admitted to the Intensive Care Unit (ICU) hypotensive and oliguric with a profound metabolic acidosis. She had an extensive past medical history including multiple prolonged preceding hospital admissions and was an inpatient for 2 months prior to her referral.

She required fluid resuscitation, inotropic support and renal replacement therapy following ICU admission. Her acidosis failed to improve over the next 24 hours. After discussion with Clinical Biochemistry, a potential diagnosis of Pyroglutamic Acidaemia was investigated via urinary organic acids.

Pyroglutamic acidaemia results from excess pyroglutamic acid resulting from glutathione depletion, via the gamma-glutamyl cycle. Several administered medications can result in this including paracetamol. The resultant acidosis differs from that resulting from acute paracetamol toxicity and is more commonly seen in patients with chronic paracetamol ingestion [1][2].

Inborn errors of metabolism within the gamma-glutamyl cycle are rare, but well described in children. Recently, there have been several reports of apparent acquired pyroglutamic aciduria and high anion gap metabolic acidosis in adults in association with paracetamol use. [3]

The resultant acidosis is more common in females who are malnourished as this patient was. Our patients’ urine organic acid screen revealed a normal level of pyroglutamic acid; whether this was indeed a true result or an effect of a delay in testing and prior cessation of paracetamol is unclear.

Paracetamol, malnourishment or cachexia are not uncommon within our adult critical care population. The management of this particular acidosis is supportive and should quickly resolve although it does raise the question about the use of N-acetyl cysteine use as a prophylactic measure in our undernourished patient population and this case highlights a need for increased awareness with paracetamol use.

Fractured neck of femur patients – the feeding problems continues!

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Malnutrition is a predictor of poor clinical outcome in the elderly.[1] Up to 60% of hip fracture patients are clinically malnourished on admission.[2] This study assessed the perioperative nutritional state of patients admitted with a proximal femoral fracture and examined if adequate nutritional support was achieved.

Methods

Prospective, observational audit of 30 patients, admitted with a proximal femoral fracture, over a one month period. We recorded: patient demographics; surgical delay; nutritional state on admission; documentation of Malnutrition Universal Screening Tool (MUST) score; dietician input and daily calorie intake through food charts. Nutritional state was re-assessed weekly and at discharge. Outcome was measured by length of hospital stay and thirty day mortality.

Results

Mean age 87, M: F 1:2 and all patients were ASA three or four. Five patients (17%) had a prolonged (>24 hours) fasting period. All patients had a MUST score completed on admission, 27% were underweight and 30% were high risk for malnutrition. Twenty six patients (87%) were appropriately assessed for dietician referral. Thirteen patients had food charts; on average, hospital meals provided 1500kcal daily. No patient achieved >75% of the provided calories with 69% of patients achieving 50% or less. Only three patients were started on nutritional supplements. Twenty-three patients (77%) lost weight, averaging 6% weight loss during admission. Mean length of stay (LOS) was 23 days and 30 day mortality 9%. Four patients (13%) gained weight, their mean LOS was 17 days and 30 day mortality 0%.
Discussion

Malnutrition in the elderly originates in the community. Following major trauma it’s difficult to reverse nutritional deficits in hospitals. It’s therefore concerning that no high risk patient achieved their recommended calorie intake. Perioperative optimisation needs to include early nutritional intervention, early anaesthetic review and adjusted anaesthetic techniques to support feeding.

References


Emergency caesarean section under general anaesthesia; who, why and when?

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Regional anaesthesia (RA) is known to be safer than general anaesthesia for caesarean section (CS) [1]. National surveys have shown that 10% of maternity units can achieve more than 88% of emergency (category 1-3) caesarean sections under RA [2]. We carried out an audit to identify which patients were receiving a general anaesthetic (GA) for emergency CS, and the reasons for this, in an effort to identify and address barriers to appropriate RA.

Methods

We reviewed case notes retrospectively for all emergency CS carried out under GA over a 1-year period. Data collected included indication for GA and presence of pre-existing regional technique.

Results

There were 808 were emergency CS during the audit period. Sixty-one (7.6%) of these were carried out under GA (category 1: 35, category 2: 26, category 3: 0). For category 1 CS, the most common obstetric indication was fetal bradycardia (12, 34%) and the most common anaesthetic indication was urgency (25, 71%). Six (17%) had a pre-existing labour epidural, and four (11%) had a spinal attempted or carried out. For category 2 CS, the most common obstetric indication was failure to progress (7, 27%) and the most common anaesthetic indication was inadequate regional technique (11, 42%). Ten (38%) had a pre-existing labour epidural, and eight (31%) had a spinal anaesthetic. Overall, there were three instances where block level before skin incision was not documented following RA, and one where top-up dose was not recorded.
**Discussion**

Our unit has a low rate of emergency CS under GA compared to previous findings. In many cases the anaesthetist and obstetrician documented different categories of urgency, suggesting suboptimal communication between specialties. Poor documentation was also noted. We recommend reassessing the category of urgency when the mother arrives in the operating theatre and the use of formal drills to facilitate improved communication.

**References**


**A Survey of Antiemetic Use At Royal Alexandra Hospital, Paisley**

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Postoperative nausea and vomiting (PONV) affects ~ 30% of patients undergoing surgery and is regularly rated as the outcome that patients most want to avoid [1]. However, every drug we administer has potential side-effects, and there are cost implications of unnecessary drug administration. The annual expenditure on selected antiemetics in our department is £40,022.25.

**Methods**

We surveyed the incidence of PONV in recovery and antiemetic usage, in order to identify any need for change in practise. Multifactorial PONV predictive scores are significantly more accurate than single risk factors [2]. The Apfel score is based on between 0 and 4 risk factors for PONV. We carried out a one-day snapshot survey looking at: surgical specialty, Apfel score, intraoperative antiemetics, primary mode of anaesthesia, N&V in recovery, rescue antiemetics in recovery.
Results

Total number of patients=27; male=11; female=16

Gynaecology=8; ENT=7; ortho=7; general=3; trauma=1; urology=1

Apfel score and intraoperative antiemetic use

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Two patients experienced PONV in recovery. One of these patients required three rescue antiemetics in recovery in addition to the two they received intraoperatively. The other patient received one rescue antiemetic in addition to one received intraoperatively.

Monthly recovery room nausea rates in our hospital are around ~7%.

Discussion

If the Apfel risk scoring were to be applied in our department, antiemetic usage would increase. However, the overall incidence of PONV in our recovery is much lower than that quoted nationally: 7.4% vs ~30%. The reason for this is unclear and may be multifactorial. Regardless, it is questionable whether a higher rate of antiemetic usage is appropriate, with the potential increase in side-effects and increased costs.

References


Audit of pain following paediatric day case surgery, and of parents’ interest in web based information on analgesia

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Paediatric day case surgery is commonplace and parents need support to treat their child’s pain on discharge. Following the creation of a website to help parents manage their child’s pain [1] a local audit was designed to assess how useful they found it.

Methods

Following a pilot audit of 22 patients, a larger audit was carried out over four months once the website address was added to the child’s appointment letter. Parents gave permission to be telephoned at home and discharge information and analgesia given as usual. Questions asked were about information given, pain at home, management undertaken, whether advice was sought and from where and time until the child was back to normal.

Results

Of the 96 parents that responded, 94 received analgesia information. 54 said their child was in pain at home though all gave paracetamol and/or ibuprofen, but 43 were not back to normal by day three. 18 parents sought advice, pharmacist being most common. Children having adenotonsillectomy, circumcision and maxillofacial surgery had most problems with pain. Only 29 parents noticed the website and 15 looked at it, all gave positive feedback.

Discussion

The department failed to meet the standards as set by the RCoA, as many children were in pain and not at baseline by day three [2]. There are many reasons why we might fail to meet audit criteria, for example, recent restrictions on codeine in children in 2013 [3], limiting options for discharge analgesia. Of the parents who used the website 100% gave positive feedback suggesting it may be useful. Most parents did not notice the information in the letter suggesting it needs highlighted. We plan to re-audit once oral morphine can be provided in an acceptable form and with the website information provided on discharge.

References

1. www.mychildisinpain.org.uk: Well Child, Edge Hill University, University of Central Lancashire, University of San Francisco School of Nursing, Royal College of Nursing, ocbmedia.
2. Royal College of Anaesthetists Raising the Standard: a compendium of audit recipies 3rd Edition 2012 Section 9.9 Pain at home after day case surgery in children. Dr G Bell
3. MHRA Press release June 2013
Trainee Prize Winners

Sir Donald Campbell Quaich (Oral presentation)
2014 Liane Tait – Improving Trauma Theatre efficiency
2015 Mathew Day – Botulism

James McG Imray Salver (Poster presentation)
2014 Alyson Primrose – Audit of intrauterine fetal resuscitation
2015 Alexandra Nelson – Anaphylaxis under anaesthesia
Honorary memberships

It is not often that these esteemed honours are bestowed on individuals but over the recent past two very worthy people have been recognised by the Society for their impact to the workings of anaesthetists throughout the country and indeed the wider world.

Dr Iain Glen gaining his honorary membership from President Dr Ian Johnston

Dr Iain B Glen

It was with great pleasure that at the AGM of 2014 the members present unanimously accepted Council’s nomination of Iain Glen for Honorary Membership of the Society in recognition of his enormous contribution to intravenous anaesthesia worldwide.

Iain was brought up on a small farm in Arran and qualified in veterinary medicine at Glasgow University in 1963. After a short spell in Kenya, he returned to Glasgow as a lecturer in the Vet School with an interest in anaesthesia. This whetted his interest in the clinical pharmacology of new anaesthetic and sedative agents appearing at the time and in 1972 he moved to a research post with I.C.I. Pharmaceuticals in Cheshire. He joined the Anaesthetics project team looking for novel I.V. and inhalation agents. A year later he selected 2,6 di-isopropyl phenol (propofol) for its promising profile of activity and subjected it to more extensive pharmacological investigation.

The rest, as they say, is history and propofol has become the most widely used intravenous anaesthetic throughout the world. Iain transferred to the Medical Affairs Department
within I.C.I., playing a major role in the clinical trials programme leading to the drug’s launch in 1986. Iain was responsible for many of the Phase4 studies supporting propofol’s extended use in maintenance and sedation. This led to computer controlled administration techniques for drug delivery and he was instrumental in persuading I.C.I. (Or Astra Zeneca as it had now become) to develop a commercial target controlled infusion system (TCI) to facilitate Diprivan’s delivery and the Diprifusor was born, using a pharmacokinetic model devised by Gavin Kenny in Glasgow.

Iain retired from Astra Zeneca in 2000, but has retained his paternal interest in propofol and continued to work on anaesthetic drug development and delivery as an independent pharmaceutical consultant until 2012.

Throughout his long and distinguished career, Iain has worked closely with anaesthetic colleagues, many from Scotland, and I know he has found this collaboration both productive and enjoyable. He has many friends within the Specialty and was pleased to participate in the recent Centenary Meeting of the Society. I can think of no worthier candidate for Honorary Membership of the Scottish Society of Anaesthetists than Iain Glen.

Dr Iain Wilson gaining his honorary membership from President Neil MacKenzie

Dr Iain H. Wilson

Iain Wilson will be known to many members of the Society, he having been a long time supporter of the Society and frequently spoken at our meetings. Born in Glasgow and graduating from Glasgow University, Iain was to spend time training in anaesthesia in the RAF and the South-West of England before being appointed Lecturer in Anaesthesia at
the University of Zambia, a job which was to greatly increase his awareness of the value of accessible healthcare and effective training and education and have a huge influence on his future career. On completion of his own training he was appointed to a consultant post in Exeter, rapidly progressing to Director of Medical Education then Medical Director and was invited by the AAGBI to sit on its International Relations Committee, remaining an active and inspirational member for 21 years. Election to Council of the AAGBI soon followed, culminating in its Presidency, and in 2013 Iain was awarded the “Sir Ivan Magill Gold Medal”, only the 6th recipient of the highest award in anaesthesia. He was appointed Chair of the Publications Committee of the WFSA, organising the donation of over 18,000 books to anaesthetists in developing countries, he started the journal, “Update in Anaesthesia” now the official journal of the WFSA, and is the friend of many a trainee having set up the online “Tutorial of the Week” facility, initially intended for overseas learning but now used by many an FRCA candidate. However, he is perhaps better known for his pocket sized “Oxford Handbook of Anaesthesia” probably the most popular and frequently used textbook for anaesthetists.

Always a champion of safety, Iain was invited to join Atul Gawande in the WHO “Safe Surgery Saves Lives” initiative, which led to the widespread implementation of the Surgical Safety Checklist, and then persuaded the WHO to include pulse oximetry as a standard of care for all anaesthetics worldwide. This culminated in Iain becoming a founding Trustee of “Lifebox”, a charity formed to provide robust and affordable pulse oximeters, thereby ensuring safe monitoring for anaesthetists and their patients and to which the Scottish Society of Anaesthetists was delighted to make a significant donation. Iain Wilson is one of the most likeable and generous people, with a passion for helping others less fortunate than himself and it is a personal delight that the Scottish Society of Anaesthetists awarded him a much deserved Honorary Membership of the Society.
Social

ARCHIE challenge

How fit are we as a speciality? This has been questioned recently in some well researched BMJ papers. However, most hospitals will acknowledge that their anaesthetic departments have more than their fair share of lycra clad individuals.

Who watches TV? Who’s been on TV? I don’t mean the ‘that’s my face in the crowd during the rugby match’ – I mean – interviewed and followed on an epic adventure type of TV………

Step forward Paul Fettes and Barry McGuire on behalf of Ninewells Anaesthetic department

There is an exciting plan to provide a new state-of-the-art paediatric twin theatre suite with much of the funding coming from charity. The ARCHIE foundation was launched last year in Tayside and has embarked on a major fundraising exercise to fund the first of what we hope will be a number of projects in an ongoing relationship with NHS Tayside. Grant Rodney head of paediatric anaesthesia can take much of the credit for this development. Our department has literally run with this, having taken a pivotal role in the ARCHIE mountain challenge in the summer of 2015. The challenge took the form of a continuous relay by foot and bike over all 130 mountains in Scotland over 1000m with a drop of 100m on all sides (which we are calling the ARCHIEs). This massive challenge was completed in 15 days and 9 hours despite wintry conditions and it featured on The Adventure Show on BBC 2. A gala dinner in September complimented the challenge which raised over £30,000. The challenge has been set for any other team to try and better this inaugural ARCHIE relay but Ninewells can claim to be the first and best TV coverage team ever.

Golf outing

The Society maintains a healthy appreciation of its social function. The traditional golf outings are one important aspect of that.

All individuals are encouraged to join in – trust us – there is no skill required.

2015 saw a rag tag bunch of individuals heading for the Buchanan Castle course for lovely food…….err I mean some competitive and skilful golf. The eventual winner was deemed to be Dr Alex McLeod which was seen by some as revenge for ‘allowing’ Dr Guy Fletcher who champions the mighty St Andrews back in 2014. The ever young Charlie Alison was second and David Ure coming in a commendable third.

The 2016 outing will be held at Dunfermline Golf Club on June 17th – please contact John Donnelly at john.donnelly@nhs.net for a place and further information.

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The motley crew competing to be 2015 golf champion (well done Alex McLeod – front, blue sweater)

Golf outing 2014 with Guy Fletcher receiving his trophy from President Iain Johnston
Next Meetings

Annual Spring Meeting
Includes annual trainees meeting and Annual General Meeting
Dunkeld Hilton Hotel
May 5th & 6th 2016
www.ssa.scot for details and booking

Golf Outing
Dunfermline Golf Club
17th June 2016
John.donnelly@nhs.net for details and booking

Annual Scientific Meeting
Joint with Royal College of Anaesthetists
Chester Hotel
Aberdeen
November 3rd & 4th 2016
www.ssa.scot for details and booking