ANOTHER STRING TO THEIR BOW

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PETER WALLACE
PRESIDENT OF THE SCOTTISH SOCIETY

SIR GRAEME CATTO
PRESIDENT OF THE G.M.C.

SSA PRESIDENTS AT PEEBLES
IAIN GRAY, MIKE TELFER, IAIN DAVIDSON, ALASTAIR SPENCE,
JOHN THORBURN, DOUGLAS ARTHUR, FARQUHAR HAMILTON, WILLIE MACRAE
ISOBEL KIRKWOOD, PETER WALLACE AND JIMMY WILSON
Welcome back to the Annals, a comprehensive archive of Scottish anaesthesia. Donnie Ross’ classically-posed cover sets the scene for a feature on some interesting sidelines of our more resourceful colleagues. Donnie tells me he started the picture in Florence and finished it in Aberdeen - I just wonder who it depicts in that department? Well, it’s certainly not John Mackenzie!

I am delighted that GMC President Sir Graeme Catto agreed to give us some encouraging words on revalidation & standards. From Peebles, again reviewed by Neil Mackenzie, Peter Wallace addresses progress in intensive care & anaesthesia in his most engaging fashion; Liz McGrady contributes a history of obstetric anaesthesia in Glasgow; Mike Harmer shares his vision of the future and Colin Moore inserts a great regional paper in the trainee prize event.

I was happy that Ian Smith agreed to put his perhaps-unrivalled experience in children’s dental anaesthesia down in print for all time. I am also grateful to two retired members, Duncan Ferguson and Sandy Forrest for sending in interesting historical features. Ian Calder skilfully optimises his observations of airway management in a most authoritative Gillies Lecture; Alan Thomson tells us about the Trainees’ Meeting and David Marsh lobs a great golf report. Comic relief comes from the cartoonist Bud Neill, Grant Hutchison’s Lachlan and further adventures of The Vital Spark, now Tignabruaich’s floating ADC.

THE SOCIETY AND THE ANNALS

Much has been settled for our Society and its Annals during the last four years. In fostering Scottish sections of our College & Association, rather than seek a political dimension in the devolved Scotland, we decided to concentrate on our academic & social roles. Changes made at annual meetings expanded the educational base but our congeniality remains paramount. The challenge for the Society now is to engage more members in partaking of these delights, particularly trainees & young consultants. As the Peebles Saturday is free for trainees & the whole weekend geared to family activities, your Council hopes further progress will be made in years to come. The Annals meanwhile has evolved into a magazine, while remaining the organ of record for our activities. Hopefully you may have found some of it entertaining. I look forward to Steven Lawrie taking it forward further next year - maybe even onto the web?

I suppose I can be indulged for a moment’s crystal ball gazing to an era of nurse anaesthetists & robot surgeons, advocated by some. All I will say about nurses giving anaesthetics is I hope it’s not in my time - you know, stewardesses will be driving the planes next! Better help for us would be a preferable way to go. But I do like the sound of robot surgeons - especially for varicose veins!

And what about the new contract? SCHMS & the Minister may be revealing their moves about now. Maybe the 1000 Scots docs voting ‘No’ did us all a favour in providing a lever for change? And perhaps the merit award system, so scandalously under-recognising our speciality, will get the chop too?

Thanks to our patrons Roche & Abbott; to Mark, Paul, Bill & the gang at Fairprint and Bruce at Forfar Photocentre for their considerable professional help. I salute all of you who contributed unstintingly over the past 4 years to make my time here so enjoyable. I can now look forward to going to Scottish Society meetings, having relinquished my role as ‘the prat with the Pentax’.

Charlie Allison
view from the top

Sir Graeme Catto

President of the General Medical Council

For A' That  

The man of independent mind,

He looks and laughs at a' that.  

Robert Burns (1759-1796)

Within five minutes, the young lad was surrounded by two professors (one physician, one surgeon) and his G.P. The local view, however, was that only the paramedic who had arrived first on the scene really knew what to do to ensure that all went well. That’s how it is in Glenbuchat. You don’t have to wait the five hours in A & E enjoyed by Londoners, but the folk are pretty shrewd. They make up their own minds on matters of the day and rapidly form judgements on quality. I doubt if they would be impressed if they knew how much of my time is spent addressing such issues as appraisal, revalidation, registration and licensing, rather than treating patients and teaching.

And yet, the bureaucracy associated with farming is now at least as formidable as that required in medicine. The need to demonstrate greater accountability permeates all sections of our society reflecting, I suspect, a desire for something more tangible than the somewhat tarnished concept of “trust”. And so, we expend considerable effort to devise procedures that will retain or regain public confidence in our enterprise. After a turbulent few years, it may be that we have been at least partly successful in achieving that aim in medicine. Confidence in doctors remains remarkably high; more than 90% of people trust their doctor if the opinion polls are to be believed.
The recent public consultation on the GMC’s proposals for reform has been supportive and we are cooperating closely with the Medical Royal Colleges. For the present, the medical profession appears, perhaps uncharacteristically, united. Although the GMC is part of the powers reserved for the Westminster Parliament, we must link effectively with the Scottish Parliament’s vision for health and healthcare. Revalidation, the need for all doctors to show regularly that they are up to date and fit to practise, is part of that process.

Anaesthetists, perhaps because of the nature of the specialty with the ever-present possibility of the unexpected, have been at the forefront in developing performance procedures and specifying the requirements for continuing medical education. The advances in the specialty in recent years have been impressive. The local opinion of doctors would have been quite different if only there had been an anaesthetist present in Glenbuchat that autumn afternoon. Graeme Catto

I’m not sure if her licking technique will get that cow revalidated but the doctor on the bike has definitely failed.
The Standing Committee is bedding in now, but the times continue to be “a changin” (Dylan, R., circa 1965). The new proposed contract has been at the forefront of minds over the last year. We can take confidence from the involvement of Veronica Reid in the ongoing discussions on terms & conditions of service. Hopefully Veronica will provide a further conduit for the views and particular concerns of anaesthetists in these discussions.

Neil Mackenzie continues to represent us ably on SCHMS. In the face of proposed changes to their constitution they have been persuaded of the value of our continuing contribution. A good number of anaesthetists from all around Scotland sit in this forum - a situation to be encouraged.

We accepted an invitation to take part in meetings of the NHS Scotland Forum which is an exercise in consultation prior to the publication of a white paper by the SEHD on the future direction of the NHS in Scotland. Catriona Connolly & Peter Alston have provided our input. It seems useful to make use of these small portals of communication with the health department. Hopefully the annual meeting with the CMO Mac Armstrong will prove mutually illuminating and we were pleased to have him come and speak at the open meeting in February.

Harry MacFarlane and Ian Johnston have come to the end of their first term and I thank them for their considerable efforts. Congratulations to Ian on his election to Association Council. It is of course useful to have the Presidential resource, in the form of Peter Wallace, virtually on tap.

The Standing committee is yours and there to be used. I hope to see you at our next Meeting.

I apologised to the Editor for the ancient reference at the beginning. There is more than the old world that “is rapidly ageing”. Still, it is a classic – even in Angus.

Jim Dargall
The activities of the Society continue effectively and quietly, but around us major challenges are occurring which will affect us all. The contract shambles has exposed how significantly political devolution may affect the way we practise; although appraisal has commenced for many, revalidation, a potentially more threatening process is still undefined; finally the European Time Directive and other workload pressures will result in the most acute difficulties for the service within the next two years and demand major changes.

Hopefully the BMA will get its act in order and on a specialty basis the Association & College must protect our interests while maintaining clinical standards. It is pleasing the elected Scottish influence on our UK bodies continues North of the Border - the restructuring of the RCA Scottish Board and the establishment of the AACBI Standing Committee now seem particularly wise. Although the Scottish Society has decided to take a less prominent political role, it is represented on these committees. The Council of the Scottish Society has a different dimension to the other bodies, as its members are elected on a regional basis. It often attracts capable & articulate colleagues who do not wish to stand for more overtly political commitments. Your Council thus has a unique voice and I am sure it will be heard in appropriate places.

In the past year, the Society meetings have been well organised and supported. The changes to the Peebles format have seen an increase in members attending the AGM, accompanied by a resurgence in support from the Trade. The one-day trainee meeting appears to suit current working commitments better and this years meeting at Stirling was a great success. Our Inverness colleagues bravely took the Scientific Meeting out of its traditional areas of support and triumphed! A high quality scientific programme, culminating with a fascinating Gillies Lecture from Ian Calder, was completed by a well-supported and well-refreshed ceilidh.

Presidential duties are totally reliant on an efficient and effective Executive. I have been fortunate to have been supported by a highly experienced trio in their last year of office. I thank Doctors Mackenzie, Bannister and Allison most sincerely for all their efforts. I'm sure their successors will find the Society in a healthy & enthusiastic condition.

Peter Wallace
presidential address

"CONFESSIONS OF AN UNJUSTIFIED SINNER"

Peter Wallace  Western Infirmary, Glasgow

M y title is an inaccurate plagiarism of James Hogg’s "The Private Memoirs and Confessions of a Justified Sinner". The 'unjustified' bit fits my persona better and a public confessional at this stage in my career must surely be good for the soul. More pragmatically it allows me to dip into various aspects of my experiences without excessive preparation & a rigid structure. The first confession I must make is that although James Hogg's masterpiece is lauded as one of the classics of Scottish literature and I've tried to read it, I have never got past the second page. I also offer an apology to friends from the West who've heard much of what follows during a recent presentation to the Glasgow & West of Scotland Society of Anaesthetists. I suppose Professors have one lecture they tout around the world, so why not a jobbing anaesthetist like me?

Heritage
I might as well get over the personal failings at the beginning and must be reasonably accurate, as my wife is in the audience. My title is an inaccurate plagiarism of James Hogg's "The Private Memoirs and Confessions of a Justified Sinner". The 'unjustified' bit fits my persona better and a public confessional at this stage in my career must surely be good for the soul. More pragmatically it allows me to dip into various aspects of my experiences without excessive preparation & a rigid structure. The first confession I must make is that although James Hogg's masterpiece is lauded as one of the classics of Scottish literature and I've tried to read it, I have never got past the second page. I also offer an apology to friends from the West who've heard much of what follows during a recent presentation to the Glasgow & West of Scotland Society of Anaesthetists. I suppose Professors have one lecture they tout around the world, so why not a jobbing anaesthetist like me?

Heritage
I might as well get over the personal failings at the beginning and must be reasonably accurate, as my wife is in the audience. I clearly eat too much, drink too much, do not take enough exercise, do not walk the dog, watch too much television, will not/cannot play Scrabble and when I was Clinical Director was affectionately but accurately called The Fat Controller. It is not all my fault, as you can see from a photograph of my parents with the obvious physical similarities! I not only share my father's physical attributes but many of his personality traits. He was a bright man with a bit of spark & imagination about him, but had the most remarkable lazy streak and an amazing ability to procrastinate. He had a weakness for alcohol which was his eventual downfall, particularly as his ambitions led him into the licensing trade in Troon. I must say that, while sharing many of his failings, I also learned from him in marrying a sensible, stable, hardworking & attractive wife who has so far kept me on a slightly less destructive path than my father. Despite criticising him, ten years before this photo he was playing golf off scratch, a level of performance that I've never managed to achieve in any field and of which I am truly jealous.

My folks ran a small hotel in Troon, and in retrospect it was an ideal upbringing for working in the NHS. Money was always short, equipment & carpets required replacement, rooms needed redecorated, customers were queuing up at opening time and staff were always difficult to come by. My folks worked hard to aspire to two AA stars and my mother's proudest moment was to feature in Egon Ronay's Good Food Guide - shades of hospital league tables! Whatever the background difficulties, what mattered most was that the customers got the service they wanted and had the perception of a professional outfit. I now realise that I learned more in how to deal confidently & courteously with patients in my time as a barman rather than as a medical student.

George Santayana, the philosopher stated that "those who cannot remember the past are condemned to repeat it". It may be self-indulgence but I feel that my medical career has not only benefited from what I learned from my parents but there are also echoes from previous generations which affect my attitudes.

I was educated at Marr College in Troon and it was only years after I left that I learned that it had been built on the site of Wallacesfield Farm, which members of my family had worked for two centuries. Indeed, I can trace back to a great, great, great something grandfather Thomas Wallace, born there in 1802. I have a sense of identity & belonging, reflected in the fact that my predecessors must have had an extremely hard & difficult life on the very site where I received a comfortable education.

Perhaps my Ayrshire peasant genes have imbued within me a realisation life is not fair (physicians have more merit awards than anaesthetists!), bad things happen for no obvious reason (whether it's a crop failure or an unexpected cardiac arrest in theatre) but morning & Spring always come & there is continuity & progression. Change occurs continually with the seasons (which we cannot control) but also by initiative & hard work.

My grandfather seemed a clever man and spoke similarly of his grandfather in turn. It strikes me Thomas Wallace, back in 1802, was probably of the same intelligence & ability as me, but never had my opportunities. I hope that thought restrains some of my egotistical failings. I also reflect on the fact that whereas my sister & I were the first Wallaces ever to go to University, I'm also the first male Wallace never to work with & be familiar with horses. My father and elder brother were into horses but I missed out. The echoes in anaesthetic practice are there - I was taught blind nasal intubation with Ether & CO₂ which is now history; more recently I remember Archie Brain telling me his laryngeal mask made airway skills (which I was bemoaning our junior colleagues had lost) similarly redundant. Things move on...

Anyway, as I self-indulgently confess my sense of continuity with my predecessors, I think of those stocky little peasant farmers turning into obese professionals. Perhaps what they passed on is not all bad for my chosen career, as suggested by W. H. Auden:

Give me a doctor, partridge plump,
Short in the leg and broad in the rump,
An endomorph with gentle hands,
Who'll never make absurd demands,
That I abandon all my vices,
Nor pull a long face in a crisis,
But with a twinkle in his eye,
Will tell me that I have to die.

University
I confess I drifted into medicine without any particular ambition. The Rector pointed out there was always a need for doctors, they were paid well and as someone who was quite good at Science it might suit me. Off I went to Edinburgh, aged 16, for an interview on a very wet day - the only thing I can remember is being rejected and the purple dye from my Marr College blazer running down my fingers. Glasgow came to the rescue and I spent a reasonably contented 6 years there as a medical student.
FARQUHAR HAMILTON HANDS OVER THE REINS OF OFFICE TO PETER WALLACE AT PEEBLES

THE WALLACES AT THEIR TROON HOTEL

PETER'S ALTER EGO
I gravitated towards a flat with a group of colleagues as lazy as I was, and it is a source of amazement that any of us qualified. Attendance at one clinic a week was not unusual but we did try to make sure that at least one of us turned up to tell the others what was going on. Not being one of the swotty boys who arranged residences with the Professor many years in advance, I ended up sending an memo around at the last moment with 6 months in the Southern General and 6 months surgery at Kilmarnock which was the making of me. I genuinely believe that I learned my trade in those months and mostly from the senior sisters.

Nightingale wards left much to be desired but I now realise that they worked very well as a medical community. Although not defined as such, the first two beds on the right provided hospice care and the first bed on the left was ‘intensive care’ where I was shown my first CVP line in 1968. The next couple of beds were high dependency as we would know them now. At the far end of the ward there was an ambulatory area whose inmates assisted the permanent staff in their duties. There was even a winter escalation policy with ‘red beds’ at the middle of the floor!

I was introduced to anaesthesia in the theatres at Kilmarnock by Graham McNab; and after a subsequent spell in obstetrics, he was kind enough to arrange an introduction & an interview at the Royal Infirmary for an S.H.O. post in anaesthesia. It is therefore all his fault but I am very grateful to him.

### Into Anaesthesia & Intensive Care

I started as an SHO in the Royal in February 1970 and fairly rapidly came to the conclusion that I liked the work and it appeared to suit me. Although I have fond memories of all the consultants there at that time, the individual who made the most impression on me was Walter Norris. Walter unfortunately died aged 47 following surgery for an acoustic neuroma, but his influence has affected me for life. It was only after he was gone that I was aware of the strong personal bond that I had developed for him. His main research interest was in sedation and I was rapidly involved in a number of studies with him. It seems surprising that Mandrax was the benchmark to judge other sedatives at the time, but he gave me a firm grounding in research techniques; I am ashamed to say that I’ve never fulfilled his aspirations.

If ‘Uncle Walter’ had not died when he did my life might well have taken a different course.

In retrospect, I am surprised that at that stage in my career I did not have any particular interest in intensive care but again there are echoes from the past in my subsequent development. I had polio as a 6 year old child and spent three months in Irvine Central Hospital and, indeed, did not wish to be discharged home on Christmas Eve because Santa was visiting the next day!

Later, as a student, I was taught by Dr. Peter McKenzie in the Infectious Diseases Department of Belvedere Hospital. As Farquhar Hamilton indicated in his Presidential Address last year, the development of intensive care has been closely related to the management of polio. McKenzie and his colleagues had been to Denmark in the 50’s and, with Professor Ferrester & Donald Campbell, developed an interest in respiratory support. Donald built on this to develop intensive care at the Royal where he was years ahead of his peers. With hard work, initiative and deft handling of influential surgeons & physicians, the hospital had in Ward 25, an ICU, a decade before the Western Infirmary, where I was eventually appointed Consultant. The 1976 history of the Western states “the policy decision to establish an Intensive Care Unit was not taken without misgivings. The general dinicians feared they would lose control of patients for whose survival they had been struggling.”

The down years you can feel the negative influence of the established medical tribes. Hopefully, things have changed?

I was all set for a consultant job in Ayrshire where I had my roots & had spent a happy 2 month rotation as SR in Paediatrics. I was the only applicant for that job, but it was suggested to me that to keep my nose clean with the establishment I should show willingness & apply for a post at the Western, based round cardiac surgery & intensive care. I was totally astounded when I was appointed to the Glasgow post and still remember my embarrassment at having to phone my mentor Graham McNab and inform him that I wouldn’t be coming to Ayrshire.

### Western Infirmary

I arrived at the Western on 1st January 1976. Cardiac surgery didn’t start for some years, but I joined as the fifth Intensive Care Consultant in the new unit. We’ve done a 1:2 on-call since then and although the work has felt of high intensity throughout, when I look back the pattern has changed considerably. Twenty years ago we admitted a patient every couple of days and now it’s more than one a day. Interestingly, occupancy has remained much the same, but clearly it was a more leisurely activity then, with an enormous length of stay.

In 1981 there was a kick-up in the mortality rate & it reached 40% in 1982. This was before the days of APACHE scoring and I was convinced it was just a matter of a more severe case-mix. Richard Marsh, an S.R. with us at the time, suggested the only thing that had changed was our pattern of sedation when Etomidate was introduced. I confess I thought this absurd but Ian Ledingham, a surgical colleague, picked it up and ran with it. Ian was shrewd enough to hone down on trauma patients, where there was a reasonable comparison of severity of illness. By concentrating on patients whose injury severity score did not change over the years, he showed mortality had varied enormously and there was a significant difference between those sedated with Etomidate and the previously standard Morphine. With the withdrawal of Etomidate from ICU, our mortality fell within one year to what it had been before.

It was fascinating that another colleague, Winifred Finlay, had been looking at what she thought was a totally separate phenomenon of low cortisol associated with higher mortality. It was only in retrospect that two apparently disparate findings came together, when it became clear that the manufacturers had evidence showing Etomidate had a significant effect on adrenal function affecting survival. It was a shattering event at the time, many patients dying unnecessarily from our lack of knowledge.

Ian Ledingham’s persistence was admirable. It certainly knocked the complacency out of me about my attitudes to ICU and from then on I realised whatever you do there is always a downside. The upside was that our unit became involved in sedation and, with my previous experience from Walter Norris, I again became involved in this field. Walter taught me sedation is derived from the Latin verb ‘sedare’ and I was stationed around for a year or two quoting this & the work of others who had undertaken one of the first ICU trials of Propofol in the Western unit.

### Shock Team

Ian Ledingham left another inheritance of immense value to me, and to the Western, in the Shock Team. I am sorry that I unjustifiably squabbled with Ian over the years, but he developed an internationally renowned research group from which we all benefited. The Shock Team grew out of Ian’s ‘Clinical Shock Study Group’ who started investigating the effects of transfer on critically ill patients following the opening of Gartnavel General Hospital. When Ian left in 1988, the service was provided by three registrars, but had been adopted as a regional facility transferring patients across the West of Scotland from Stranraer to Stornoway. The number of patients transferred has risen dramatically and the service is respected as a model for retrieval teams across the UK, which are sadly lacking.

When Ian left in 1988, I was Department Chairman & took over responsibility. I must thank Ian for inadvertently turning me into a national expert on transporting the critically ill. He gave me the opportunity to tour the UK & other places talking about this and I’m now embarrassed to admit that my expertise was based on the magnificent total of one actual transfer between hospitals. In conjunction with the ICS, we’ve produced national guidelines and provided a safe service in the West of Scotland where 5,000 patients have been transferred, with only one death in transit.
This indicates high quality care, but also saves the referring hospitals on-call staff. The service has been breaking over the past years with only four full time staff, but I hope that good news of new funding will emerge soon to allow a fully-resourced service involving doctors & nurses to continue into the future.

Intensive Care Provision
Despite the move to independent Trust status, the critical care transfer service has allowed the West to use its intensive care beds as a pool for best effect. The great increase in transfers has been for 'bed space' reasons, because of bed shortages in initial hospitals. Opening even a few beds reduces the number of these transfers but overall we are clearly short of critical care beds in the West of Scotland as a whole. The Scottish Intensive Care Society audit is a valuable tool in gaining evidence of service shortages. Although our mindset is established that 'things are not improving', it is salutary to note there's been a 21% rise in Scottish ICU beds in the past year with an overall occupancy of approx. 50%. In Glasgow we increased from 22 to 29 beds.

The problem now emerges here that we have reached the full capacity of our existing buildings. Further expansion requires a major capital build, not only long-term but compromised by political necessities obvious within Glasgow, with the maintenance of five acute receiving sites. Most of us involved in intensive care look at the grim side of life and don't recognise other improvements that have been made. It's clear from the Scottish audit that our intensive care is performing well, if somewhat over-stretched. Examining SMRs with international comparators shows we have outcomes that match the best.

We should be proud of this. It will be for the next generation to continue activities to identify good & bad practice and provide guidelines/assistance to further improve standards.

Ethical Dilemmas in Intensive Care
One of the main priorities over coming years will be to identify more clearly the patients who benefit most from intensive care. The mortality rate remains high amongst our patients and with increasing age is even more significant. The question of withholding or withdrawing treatment for patients in intensive care will become a most difficult matter. In many units more than 50% of deaths now follow withdrawal of active therapy. The ability to prolong death is not something that we should be undertaking and recognition of futile treatment is a duty of every intensive care doctor. This principle is recognised even by Archbishop Cormac in his discontinuing medical procedures that are burdenome, dangerous, extraordinary or disproportionate to the accepted outcome can be legitimate. It is the refusal of overzealous treatment.

Although the ethos suggests that withholding & withdrawing are similar in principle, I have always felt it was wiser & kinder to recognise when withholding is justified rather than getting into problems of an unpleasant, undignified death in intensive care. The problem is that an awful lot of it is subjective opinion; and, although scoring systems assist us with mortality rates in groups of patients, individual judgement is difficult. There are increasing pressures from society's expectations to treat all ill & I would hate to get to the stage where 'a good death' is assumed to be equivalent to 'a medical death' and require all possible interventions even if expected to be of no avail.

As I reach the end of my public confession, I believe that these softer, greyer problems will be the most difficult to deal with. The ethos of intensive care will require more consideration than has been afforded in the past and will also require a change in attitude from a number of my younger colleagues who are looking for high-tech magic bullets. While Activated Protein-C in sepsis may offer promise and fancy things such as Swan-Ganz catheterisation remain popular, there is growing evidence that basic simple therapies such as the use of insulin, low-dose steroids and adequate feeding are equally important. The next generation may need an Etomidate experience to learn of the harm they can do and prevent the complacency and self-righteousness that can infect all doctors.

The Future for Anaesthesia?
In future years I worry about the fragmentation of anaesthesia into its sub-specialties. Although I have had the privilege of serving as President of the Scottish & UK Intensive Care Societies, I've always viewed myself as anaesthetist 'doing' intensive care rather than an intensivist. As Intensive Care Medicine develops and units in the UK become larger, there will naturally be more full-time intensivists; but I fear that my generation has clouded the water rather than giving the lead required.

While the Intercollegiate Board for Intensive Care Medicine (on which I also served) has done to much to establish competencies required in intensive care & an appropriate training programme, the obsession with developing a CCST by the evangelical dilettante wing evincing a multi-disciplinary mantra has confused & discouraged trainees. I have always worked as a consultant in a multi-disciplinary unit and welcome input from other specialties into intensive care but I believe the contribution of anaesthesia to the status quo has been marginalised. We should have been building up support within anaesthesia for sub-specialisation to satisfy current NHS needs, while in parallel encouraging input from other specialties. Intensive care will achieve its separate identity, as will pain medicine, but I believe it is important they remain related to the overall family of anaesthesia, as the common threads are more important than the differences. Together our group has a huge influence.

This enormous clinical spectrum of anaesthetic responsibilities strains our workforce. It is clear that we will shortly have a major crisis when the European Time Directive bites. Our Royal College census has already identified a significant shortfall of Consultants over the next 10 years. I have always been against the concept of nurse anaesthetists; but if the semantics were to be different and additional high quality staff introduced to the anaesthesia team, under our direction & supervision, is it time to be flexible in modernising our attitudes?

Finally, for all specialties within the practice of medicine, it is fundamental that we maintain the trust of society & our patients. I do not need to rehearse the catastrophes that have dented our credibility in the public's eyes, nor speculate on how appraisal & revalidation will eventually emerge. Change is inevitable and we must accommodate it constructively. Some will be difficult & unpleasant, but overall I believe there is progression and we should concentrate on positive aspects rather than the negative. Although the profession feels attacked, it is worthwhile remembering a recent MORI poll indicated that 90% of the general public trusted nurses & doctors to tell the truth and considered that they were doing a good job. Unsurprisingly, at the other end of the league table were journalists & politicians!

And remember, when you are feeling hard done to, that even Jesus had difficult times...
SPECIAL FEATURE

another string to their bows

National Anaesthesia Days have attempted to shine a light on our dark arts. Perhaps this selection of articles will show Scottish anaesthetists are interesting folk who quite often possess another string to their bows. Many thanks to all these brave souls!

FARMING

William Easy is a consultant at the Vale of Leven Hospital and has a 300 acre farm on which he runs sheep & beef cattle.

Lady Bracknell in "The Importance of being Earnest" says "To lose one parent, Mr Worthing, may be regarded as a misfortune; to lose both looks like carelessness." I am not sure whether I was careless or perhaps just doubly unfortunate when I chose my career. Medicine in the NHS is 'undergoing a period of great change' which I take to be a euphemism for going down the tubes, as that is what appears to be happening. Agriculture in the United Kingdom is being systematically wiped out by a combination of sequential misfortunes and the policies of a government which cannot see beyond the M25 ring.

Medicine, from the viewpoint of a 1962 school-leaver, seemed to promise a rosy future, and didn't look too different when I qualified. Hospitals seemed to be run by the medical consultants and a medical superintendent. Wards were run by severe middle-aged spinsters whose word was law and whose advice one was well advised to take if one wanted to survive one's house jobs. Of course, a houseman's lot was onerous, but you could look forward to those balmy days in the distant future when you only had to ask (or even hint) and things would happen. Actually, it hasn't quite turned out that way.

When I moved back to Scotland in 1989, I had no intention of farming, but did want somewhere to live with a bit of space about me. I also wanted to take sufficient exercise to ensure that I didn't die of the consequences of obesity & hyperlipidaemia. Consequently, when one of my colleagues drew my attention to a farm for sale just four miles from the hospital, it seemed foolish not to at least have a look at it. It turned out to be far too big, needed miles of new fencing & the farmhouse was literally a ruin. So when my offer to buy was accepted, I drew a deep breath and went to look for a residential caravan, in which I spent the next 18 months while the house was resurrected.

Anaesthetics & intensive care is a stressful occupation. Burn-out & suicide are not infrequent consequences of choosing such a career, so there's a need for something completely different to take one's mind off the stresses of work. Apart from those dashes down the corridor to emergencies, a medical career is also pretty sedentary. Farming is in some senses the perfect antidote. It forces me to take exercise (although the addition of a quad-bike to the stable diminished that a bit) and it certainly takes my mind off work while I'm at home. It's difficult to think about problems you left behind in ITU when you are trying to dodge the wrath of twelve hundredweight of cow whose feet you are trimming! And it forces me out in the fresh air - too fresh sometimes.

Those cold, dark February mornings when I heave out of bed at 6am and go out into the sleet to feed cattle - well, my bed seems very attractive then. But it has to be done. Animals have to be fed and all the routine things like checking the sheep on the hill become more important in inclement weather - so out I go!

It had occurred to me that I might get a less-than-cheery welcome from my farming neighbours, as I don't come from a farming background (well, not Scottish hill farming, anyway) and, worse than that, despite having spent half my life in Scotland, I'm still an Englishman. However they displayed to me the goodwill & friendliness innate to rural Scottish communities. They regarded me as a bit of a curiosity, I'll admit. Why would a doctor want to struggle away trying to earn a crust at farming, when he had a perfectly good occupation already, which didn't require him to get cold, wet and dirty? Why does he have so many questions when he must (surely) be well educated? Why, when we answer his questions, does he often appear not to understand the answer?

Some of these questions I have already answered for you, and the answers to the rest are probably obvious when you think about it. One asks not just because he doesn't know; one asks because one needs to know. When a calf is born and doesn't want to suckle you need to know why it is not suckling and you need to know how to get it to suckle (without getting kicked by an irritated mother). And you need to know these things fast, because a calf that doesn't get colostrum in the first six hours may die, and will certainly be prone to numerous potentially fatal infections.

I didn't understand because they spoke a different language. It wasn't just the very broad rural Scots accent; it was truly a different language. I mean is that woolly animal a young sheep, an old lamb, a hogg, a gimmer, a sookit-gimmer, or a shearling? It wasn't just the very broad rural Scots accent; it was truly a different language. I mean is that woolly animal a young sheep, an old lamb, a hogg, a gimmer, a sookit-gimmer, or a shearling? And what I am I meant to understand when told in answer to my question about the lack of a pregnancy in a cow that I've nurtured since she was born - "Well, she is probably a Jenny Willox" (I subsequently discovered Jenny Willox was one that wasn't sure which line to stand in when sexual equipment was doled out & consequently received a mixed, non-functional set!)?

Neighbours regarded me with amused tolerance, and obviously decided to educate me properly. My vet appeared astonished by my lack of knowledge of comparative anatomy, but we soon decided this was a mutual learning opportunity. When I asked him how to treat something in a sheep or a cow, he would ask how I would manage it in a human. I was able to return some of my neighbours' kindness by giving them a better understanding of things like infection and antibiotics. All in all it's been a symbiotic relationship, though I'm sure I've been the net gainer.

When a calf is born and doesn't want to suckle
There is also a symbiosis between the two parallel careers. It is not just that the physical activity of the one complements the sedentary life-style of the other. It is not just that the fresh air of one complements the welcoming, warm indoor environment of the other during the cold winter months. Caring for animals somehow helps in the caring for people — and helps to keep life in perspective. As one of my neighbours is wont to say when we are glumly standing round a dead calf lost perhaps at the calving or perhaps with pneumonia “Could be worse Doctor Bill, could be you or me lying there!” And I have learned more than once when watching poor non-thriving, miserable lambs, which I know will not survive, that death is not always the worst option. That’s a valuable lesson to take back to the ITU.

One career may be a financial disaster, the other an organisational disaster, but I get a lot out of both of them, and wouldn’t wish to be without either.

**BEES**

Robin Allison

Robin, a Dundee consultant, is keen to tell us all about the buzz of bee-keeping.

**IMAGINE A STILL SUMMER DAY**

*When nothing is moving, least of all me.*

*I lay on my back in the hay.*

**The warm summer soothings, that made me feel good...**

Bee keeping for me always evokes the feel-good effects of summer, as described by Cliff Richard in song. In my mind I hear the concentrated hum of bees. My nostrils are assailed by the wonderfully sweet smell of nectar & honey as I lift off the heavy honey supers. Removing the queen excluder, I am ready to examine the frames in the brood box. Bees continue to alight at the hive entrance, some with stomachs bloated with nectar and others with pollen baskets loaded yellow/orange with the protein required to feed the larvae to maturity.

The smoke I have already used to subdue the colony has caused the bees to cling to the honeycomb at the edges of the brood nest. They are instinctively swallowing honey, ready to transport it to a new home, their interpretation of the smoke being that evacuation of the current home is imminent. In this honey-bloated state, stinging with consequent loss of the bee’s life also results in the loss to the colony of a valuable quantity of honey. The inadvisability of this course of action makes stinging likely in only the most extreme circumstances.

The brood nest contains bees in all stages of maturation from eggs to larvae to sealed worker brood, where metamorphosis from larva to worker bees is occurring. Small areas of recognisably larger sealed cells represent drone brood. My inspection does not dissuade a foraging worker from performing a bee dance, wiggling her abdomen as she traces a pattern to direct her fellow foragers to areas of rich nectar source. The queen is easy to find as I have previously marked her thorax with a bright paint spot. One of her wings has been clipped. A retinue of half a dozen or more worker bees, all facing her and attendance to her every need, surrounds her. She concentrates on one thing only — egg laying.

I am glad to find no queen cells. These large, pendulous, waxy protrusions from the comb surface are formed when the worker bees judge that the brood box is becoming congested. Then selected larvae are fed royal jelly for longer than the normal worker larvae, with a view to raising queen bees. This is a natural means of colony propagation and leads to swarming. Swarming however represents a risk of losing bees, which is not conducive to increasing honey production.

So everything in the garden is rosy. I have a healthy, young, energetic queen that has been bred from a strain that has an antipathy towards swarming. She produces bees that are energetic nectar gatherers, acclimatised to the sometimes cool Scottish weather so that they still fly on cloudy days. The bees are contented & docile on inspection, disease resistant and in winter form a small cluster that consequently use up stores only slowly, thereby increasing their chance of survival until Spring.

This is of course beekeeper heaven.

It is almost inevitable that the bees will make preparations to swarm at some time in the active season — May, June or July. This compels the beekeeper to exercise his skills in swarm control.

At that very stage where queen larvae have been fed the royal quota and the cells have been sealed to allow metamorphosis to progress, the trigger to swarming has been released. To avoid swarming occurring, it is imperative to anticipate the intention to swarm before the first queen cell is sealed. For this reason, during the active season, inspections require to be carried out every eight days or so.

Detection of swarming intent allows one of several recommended manoeuvres to be carried out, in advance of swarming, to separate the established queen and flying bees from the remaining bees and one retained queen cell. However, where the queen has been clipped & unable to fly, if swarming occurs the queen is merely ‘lost overboard’ and the other swarming bees, in her absence, merely return to the hive to await the emergence of the first virgin queen, who will then lead the swarm. Where the queen is clipped, fourteen day inspections will safely anticipate definitive swarming.

When the virgin queen emerges, it has been shown that she instinctively flies, perhaps on more than one occasion, to very specific areas where she will mate with a number of drones. Only the strongest drones in this coupling but they pay for the privilege with their lives as the queen retains their gonads for the rest of her life and never mates beyond the first few days or weeks of her life. Of course, just as is so often the case in the human situation, some drones may be less than ideal partners and the genes they contribute may result in the queen producing bees that fall short of the desired qualities. She may then be removed by the beekeeper to allow the workers to raise queens from eggs taken from a desirable colony in the hope that the next queen raised will establish more judicious drone contact.

Beekeeping can be a twelve-month a year activity. Spare hives are repaired in winter. Spring is the time for feeding light syrup to build colony strength for the forthcoming season. Migratory beekeeping is favoured by some & involves moving hives late at night or early in the morning to bee pastures of oil seed rape, raspberry blossom, clover or heather. At harvest time, the keeper collects his bounty and replaces it with the relatively insipid concentrated solution of Tate & Lyle, which the bees take down into the hive to see them through winter. The beekeeper gets his comeuppance when he extracts the honey from the comb. Hands & everything he touches always seem to get incredibly sticky. It’s far easier to eat the honey as the bees left it - in the comb.

But it is summer with the sound, smell & sight of industrious bees that represents, for me, the essence of beekeeping. It is then that I marvel at the efficiency and organisation of the bees. It is then that I realise my shortcomings when the bees unexpectedly swarm; but I gain much satisfaction when I retrieve the situation by successfully hiving the cluster. It is indeed the memory of working with the bees on that still summer day that distracts me from the reality of the grey November skies.

**JOURNALISM**

Leyla Sarai

Leyla retired as a Consultant at Western Infirmary, Glasgow through ill health in 1997. Sarai contributed widely to the medical & national press. This is adapted from her recent BMJ profile — see them here for their permission to reproduce it.

I didn’t want to be a doctor while I was at school in London. I longed to be a journalist. I was euphoric when I landed a job as a freelancer for the *New Musical Express* when I was 17. I had to keep it quiet because my dad equated pop music with mainlining hard drugs and shook his head in despair whenever he happened upon either of my siblings or me listening to a punky record. Because of this, there was a delicious forbidden thrill about slopping off to the NME offices after school and encountering a feast of illicit temptations free gig tickets, free LPs, and free film preview tickets.
BILL EASY, AT WORK (IN BOTH PICTURES!)

ROBIN ALLISON
GETS HIS COMB OUT

LEYLA SANAI
A MOST ACCOMPLISHED JOURNALIST
A WHOLE PAGE OF THE ART & CRAFT OF OUR MAESTRO DONNIE ROSS
I still applied to medical school, partly due to parental pressure and partly rising to a challenge. My headmistress predicted I'd never get the grades, so it was with a certain smugness that I managed to do so. I also liked the idea of working with people, & the whole communication with/listening to/empathising with patients aspect really appealed to me. I found the psychological aspects far more interesting than dry science. I was usually the pupil at school who ended up inadvertently creating toxic chemicals over my Bunsen burner owing to boredom.

Edinburgh medical school is an exemplary institution, but while I was there, the divide between preclinical and clinical was rigid. I found myself spending time in the wet labs and forgetting about the dry bits of anatomy, and the process of memorising thousands of anatomical facts with no correlation with clinical actions was anathema to me. The only subject I shone in was psychiatry. I kept up my journalistic interest by continuing to freelance for the NME and contributing occasional articles to the Scotsman, Guardian and the Observer.

I spent my elective working in a busy hospital in Manhattan, New York, and it was here that I discovered that clinical medicine did inspire me. The hospital was flanked by the contrasting areas of Chinatown, with its non-English speaking population who largely avoided Western medicine, the deprived slums of the Bowery, characterised by malnutrition and drug misuse, and the affluence of Wall Street, presenting casualties of the exhaustive stress, speed, and glared fatigue of real life. When I returned to Edinburgh, I was filled with enthusiasm, now finding clinical medicine exciting and rewarding, I became one of the keen swots I'd always derided.

I enjoyed my preregistration house jobs greatly. The feeling of being an essential cog at the bottom of the complex wheel was uplifting. In 1990, after the junior house officer year, I was accepted onto a medical rotation at Edinburgh's Western General Hospital and obtained my membership to the Royal College of Physicians in the first 18 months of my rotation. This left me free to pursue some research. I devised and carried out a couple of studies, one on antarrhythmics and the other a foray into the world of endothelin, which I became interested in when I read about the vasoconstriction seen in multiple organ failure. I managed to get a couple of publications and a few presentations abroad out of this work. To someone who had never been to a conference in a more exotic location than Oxford, there was something deeply satisfying about basking in the sunshine in Barcelona's Rambles in the name of science.

My enthusiasm for intensive care led to a decision to enter anaesthetics. During my training, I carried on scribbling, sometimes under the guise of a pompous title (News Editor of the British Journal of Intensive Care), and other times writing accessible articles for the general public in the broadsheets. I started contributing to the Herald in 1995, and was ecstatic when I was given my own column in the Herald magazine in 1998. Publications are ever evolving, and so after a few years on each, I would move on. TV and mediocropical columns in the BMA News Review followed, as well as articles for the Sunday Herald, Scotland on Sunday, the studentBMJ, and BMJ Career Focus. I also acted as medical adviser for Cardiac Arrest & several other medical programmes, and was asked onto various radio programmes.

I became a consultant at the start of 1999 and I love my job. Anaesthetics is so varied that one day you can be looking after a frail 90 year old and the next, reassuring a teenager before a minor operation.

I have recently invented and patented a device to stop patients from choking down on their laryngeal mask/endotracheal tube on awakening. Sometimes this can be like trying to prise a carrot from Red Rum's gnashers, and the patient may become an unpleasant shade of navy. My invention made it into the final round of the Medical Futures Innovations Awards 2002.

It may sound as if I've glided through life on a gilded lily. Far from it. Like everyone, I've had rough times. There are compromises to be made along the way. I may have got all my exams first time but I was a slogger rather than a natural genius, so inevitably the social life crawled through some phases so barren as to make the Sahara look lush by comparison.

These last few years I've been dogged by ill-health from scleroderma. I've had over 30 hospital admissions and more than 20 procedures, including several bowel resections; bilateral thoracic, lumbar & digital sympathectomies; countless admissions for insertion of peripheral or central lines for infusion of courses of vasodilators, antibiotics, blood transfusions; or for investigations- angiography, M.R.I., C.T., echocardiography, ultrasound, lung function tests and X rays. After the first eleven examination procedures, I managed to get back to work in August 2001, using my annual leave as a day off each week, but since then my fingers have become severely ulcerated & necrotic, with a relentless progression through almost all fingers in turn. I managed to keep working until a necrotic bowel led to yet another laparotomy in February 2002.

The future is now uncertain. I love anaesthetics, but my hands are curled into contractures and most of my fingers are now ulcerated, gangrenous, swollen, missing bits, cellular, infarcted and/or stuck in fixed flexion. At the moment, with the unbearable pain & continual treatment, I'm just taking each day as it comes and have no energy to look into the future. When I force myself to face reality, a return to anaesthetics looks impossible, which is heartbreaking after all these years of investment in my career. At the moment, the present is enough of a challenge. I'll try to get through the present and consider the future if and when I get there.

My advice to other doctors wanting a varied life is to go for your goals. You've got nothing to lose except your pride, which is a good thing to get rid of anyway. As the German writer and philosopher Johann Wolfgang von Goethe said: "Whatever you can do or dream you can do, begin it. Boldness has genius, power and magic in it. Begin it now."

1 Sanai L. How to be a media doctor. BMJ 2002,2/34
ministrations have eliminated the latter's conscious participation, also between anaesthetist-and-patient, surgeon and theatre staff. Unquestionably one of the functions of the anaesthetist is to ensure that the wellbeing of the patient is the ultimate destination of that sometimes testosterone-fuelled vehicle.

Here again is a potential cross-over point - both anaesthesia and art demand emotional intelligence, the ability to understand the feelings of other people as well as one's own, and, where possible, to utilise that understanding to improve the outcome. Considering the benefits of emotional intelligence combined with a facility for mental modelling, it's perhaps not so surprising that many anaesthetists become successful medical managers, with at least some degree of understanding of the dynamics both of individuals & of groups. Here again, integration of skills derived from very different environments is a useful path to follow.

MAGISTRATE in Grove-white

I heard in the Sheriff Court three weeks later. In the meantime, I banned him from Arbroath - he gave a Dundee pending the disposal of another matter (assault, I suspected) as he had quite warmed to him.

In one marital breach I heard in Arbroath, I deferred sentence as I had expected an appeal, but against my ruling. I thought that the fine was very lenient, fiscal's rebuttal, I ruled the court was competent. He pleaded himself fortunate that they never complained, at least not to me.

Came the Scottish Parliament & with it Britain's first taste of the European Human Rights Act. Suddenly, elected councillors were no longer eligible and were removed from the bench forthwith, lest they try to buy votes by making 'popular' judgements. The rota for the court came down to 1:2, which even for a monthly court meant I was beginning to impose on my colleagues. I count myself fortunate that they never complained, at least not to me.

I sit as 'Solitary Justice'. In some Commissions they sit as teams of three. I don't wear a gown, as I prefer the distinction between the lay-justice, a man of the people, and the lawyers sitting around the table in front of me. The cases I hear from ton-up drivers on the Forfar by-pass, to dog-fouling of footpaths.

The latter, though infrequent, are usually intense, laden with neighbourhood blood, & supported by amateur video evidence.

I've once been accused, along with the Fiscal & two Clerks of Court, with conspiring to pervert the course of justice. The head of legal services had to forward the accusation to the High Court of Justiciary - fortunately it was thrown out at the first calling.

On another occasion I was faced with a fairly colourful Pictish Nationalist who challenged the competence of my court to try him for speeding. After hearing his arguments, followed by the Fiscal's rebuttal, I ruled the court was competent. He pleaded guilty but appealed against my fine. I had expected an appeal, but against my ruling. I thought that the fine was very lenient, as I had quite warned him.

I usually sit at Brechin, occasionally Forfar, less often Arbroath. Brechin & Forfar present all the problems you might expect in rural burghs, even if skewed by the A90 & its speed cameras. Arbroath however manages to imitate many of the problems more associated with inner-city communities. The fine totals are much smaller: the amounts which can be extracted following breach of the peace, assault and petty theft seem paltry compared with speeding fines. For a while, the TV detector van appeared to be targeting single mothers on the benefit list. Provided they show they've set up a TV licence instalment scheme for the future, I usually leave it at that. In vandalism, the first priority is usually compensation for the victim.

In one marital breach I heard in Arbroath, I deferred sentence pending the disposal of another matter (assault, I suspected) being heard in the Sheriff Court three weeks later. In the meantime, I banned him from Arbroath - he gave a Dundee address - and from contacting his wife. Ten days later I was called in to Stracathro on a Sunday morning, to find he had sustained bilateral ankle fractures jumping out of his wife's flat while the police were coming up the stairs. The story doesn't end there - years later I was watching a TV documentary about a drugs bust, when I saw our hero limping in, looking for supplies at the back door of a flat which was being searched at the time.

Another regular task is the Means Court. Here, unpaid fines are formally reviewed & the punters are invited to explain. Some are rescheduled at a rate agreed under pain of imprisonment for further failure. If circumstances allow, they may be converted to a programme of supervised attendance designed to help avoid future offending. Those who fail to attend the Means Court are likely to find the police at their door with an arrest warrant. This disturbed me at first, but my mentors assured me that the matter is always resolved by the immediate payment of the outstanding sum. The lack of audit worried me.

Since I retired from full-time work, I have made myself available for unscheduled 'Custody' cases. When someone is arrested on a JP's warrant, the case must be heard in the District Court as soon as practicable, even though no court is sitting that day. In the dozen or so cases I have heard, nearly all have been instances of refusal to respond to repeated summonses. A few have been failure to attend trial hearings, when witnesses have been called and then have had to be sent away. None has been for inability to pay a fine under warrant. It really does appear that funds are suddenly available to address what was hitherto an intolerable burden of debt.

I am advised the retiring age from the lay justices' bench is 70 - youths can go on to 75. I have to keep my nose clean though. Between 1988 & 1992 I received two parking tickets for exceeding the time allowed - one on Justices training business; the other while anaesthetising dental cases at Arbrough Health Centre. When I recently earned a third, this time on my own account, the Secretary of Commissions in Scotland detected a pattern and wrote to warn me. Chastened, I struggle on.

BOOKS

Great Hitchens

Gran is a Ninewells consultant, who writes for the medical & non-medical press.

I started writing when I was a medical student. My first success came when I won second prize in the Punch 'Student Humour' competition in 1977 - the required theme was 'The Year 2001'. You can imagine what bizarre reading that makes now. There really wasn't a second success - the business of being a trainee doctor halted almost all writing activity (except for the occasional essay question & endlessly rewritten research papers).

Then, a couple of years into my consultant job, I was driving home from Inverness with my wife one day. We're both keen hillwalkers, and as we passed Kingsussie I mused aloud about an oddity in the names of the local Munros - there are four mountains over 3000 feet called Geal Charn, and all are within spitting distance of Dalwhinnie. What's that about? Why so many white peaks in close proximity? And then, free-associating dreamily, I remarked: "But it would be useful if you wanted to climb all the Munros in alphabetical order, wouldn't it?" And all the way home the thought nagged: Well, why not? Continuous rounds of the Munros had become something of a minority sport. Wasn't a walking tour of all the Munros just a logical extension of this? Admittedly, it would involve walking something like 16,000 miles back & forth across Scotland, but didn't that just add to the fun? By the time we got home, I had received two parking tickets for exceeding the time allowed - one on Justices training business; the other while anaesthetising dental cases at Arbrough Health Centre. When I recently earned a third, this time on my own account, the Secretary of Commissions in Scotland detected a pattern and wrote to warn me. Chastened, I struggle on.

That was the birth of Lachlan, the idiot hero of most of my hill-walking stories - a man who can take a mildly eccentric idea and push it firmly towards lunacy. His adventures first appeared in The Angus Courier (a hillwalking magazine with a surreal bent matching the tone of the stories); then in a slim volume - Munro's Fables. A much-delayed sequel, Other Fables of Lesser Heights, should reach the book shops soon.
Encouraged by this mild success, I found myself branching off into non-fiction – something I’d never imagined myself doing while I was hammering away optimistically on my old manual typewriter. But if you’re not writing novels, there are few outlets for fiction these days.

So, without really planning to, I have managed to get all sorts of odd interests out of my system and on to paper: occasional pieces about words & their origins for the BMJ; articles for various astronomy magazines; a column explaining the physics of natural phenomena for the Outdoors section of the Scotsman.

More recently, I won a commission to visit Chile for the travel magazine Wanderlust, and that has led to several other articles and now a regular column. These short pieces suit the episodic opportunities I have for writing – there’s too much else going on in life for me to spend days on end at a keyboard. Everyone’s supposed to have a novel in them, but I’m not sure how mine’s going to get out.

So my publications are many & strangely various, but few of them are the sort of thing casual acquaintances pick up on: “Oh, you’re the guy who wrote so entertainingly about solar eclipses in the Scotsman!” I’ve never heard that. Not once. But there’s one word I seem able to mention at almost any gathering of anaesthetists and get an immediate response: Biggies. You know … that thing about how giving an anaesthetic isn’t like flying a plane. Today’s Anaesthetist. That was me.

Really, there’s all sorts of good stuff out there with my name on it, but all anyone ever remembers is Biggies.

The Book & the Walk, Lachlan’s first adventure.

It’s your round,” I remarked, since the rain showed no sign of abating.

“Oh God, oh God, oh God!” cried Lachlan, clutching his chest with one hand and his brow with the other.

“Very well,” I said. “I’ll get them in. But it’s definitely you next time.”

“No, no,” gasped Lachlan weakly. “I’ll buy you a drink. In fact …” (Some sixth sense had made me hang across the table in an effort to muffle his next word, but I was too slow) “… I’ll buy everyone in the bar a drink!” he cried, in triumphantly.

For an instant, silence descended throughout the room, broken only by the clatter of dominoes tumbling from someone’s nerveless fingers.

And then a raucous hubbub of voices arose, in which the words “double” and “Macallan” were easily discerned and oft repeated.

I confess that I may have whispered a little at this point. “Oh, Lachie, Lachie,” I moaned, “What have you done?”

“Fear not,” declared Lachlan, “for I have this minute formulated a plan so brilliant as to guarantee me fame, and fortune far beyond your petty dreams of avarice.”

And he strode boldly towards the bar and the waiting, predatory barkeep.

Halfway there his steps faltered, however, and he sidled back to our table as inconspicuously as is possible for one who is the centre of avid, thirsty attention. (Which is to say, not very inconspicuously.)

“You couldn’t lend me twenty quid until then, could you?” he whispered.
The reward is great, however. Nearly 2500 people, largely kids aged eight to eighty, regard it as an integral part of the festive season. Failure is not an option.

There’s great satisfaction to be had in turning ordinary people into stars for a day, or six days to be more accurate. The pantomime is our most successful outreach time and finances our other activities. Some of the ‘stars’ actually get tempted into trying their hands at something more challenging, such as the Scottish Communities Drama Association Festivals in the Spring.

Looking back over the years there is a paternalistic delight to be found in the number of personal relationships that have blossomed under our Cupid’s gaze, some of their offspring now completing the loop by treading the boards themselves.

The heathen feast of Christmas is still anathema to a significant proportion of our population. A music therapist friend, aware of this and eager to avoid treading on corns, enquired what would be appropriate for festivities at Ardbelach, the Social Care Home. She was given carte blanche to do what she liked, as long as she kept religion out of it. Incidentally, she’s an adherent of the Baha’i faith.

I never cease to be amazed at the religious diversity which thrives alongside endemic religious intolerance, where children are forbidden the sacredness of swing parks on the Sabbath or Harry Potter. The Playhouse cinema survived A Clockwork Orange but showing Jesus Christ Superstar was its downfall.

To indulge in amateur dramatics at all requires a well-developed sense of humour. As stage manager I frequently take small parts (please avoid the obvious), usually the ones no-one else wants. This year I am typecast as King Neptune. It is impossible after heaving on ropes and climbing on chairs & ladders in the wings dressed in nothing but a muslin toga and a fluorescent crown to take oneself, or be taken, seriously ever again.

To appreciate ‘Am Dram’ at the best of times requires an ability to suspend disbelief in favour of keeping entertainment live. I believe the late Douglas Adams declared that he preferred the radio version of the Hitchhiker’s Guide to the Galaxy over the T.V. version because the colour was better. Modern recorded media with their near-perfect performances & staggeringly realistic special effects have become the norm and no longer amaze. Audiences become lazier & less willing to use their imaginations.

Against this backdrop, we presented a production of Alan Ayckbourn’s Table Manners. As Thespian Societies go, we are a very small group & our coat has to be cut according to our cloth. Thus Norman was a bluff Yorkshireman (O.K., just) but the triplet sisters were played by a Lewis Primary teacher, a well-bred Edinburgh secretary and best of all, a strongly accented German girl. The imagination has to run overtime to explain these discrepancies, but it’s a tribute to the skills & devotion of the actors & directors that we get away with trying their hands at something more challenging, such as the Scottish Communities Drama Association Festivals in the Spring.

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To indulge in amateur dramatics at all requires a well-developed sense of humour. As stage manager I frequently take small parts (please avoid the obvious), usually the ones no-one else wants. This year I am typecast as King Neptune. It is impossible after heaving on ropes and climbing on chairs & ladders in the wings dressed in nothing but a muslin toga and a fluorescent crown to take oneself, or be taken, seriously ever again.

To appreciate ‘Am Dram’ at the best of times requires an ability to suspend disbelief in favour of keeping entertainment live. I believe the late Douglas Adams declared that he preferred the radio version of the Hitchhiker’s Guide to the Galaxy over the T.V. version because the colour was better. Modern recorded media with their near-perfect performances & staggeringly realistic special effects have become the norm and no longer amaze. Audiences become lazier & less willing to use their imaginations.

Against this backdrop, we presented a production of Alan Ayckbourn’s Table Manners. As Thespian Societies go, we are a very small group & our coat has to be cut according to our cloth. Thus Norman was a bluff Yorkshireman (O.K., just) but the triplet sisters were played by a Lewis Primary teacher, a well-bred Edinburgh secretary and best of all, a strongly accented German girl. The imagination has to run overtime to explain these discrepancies, but it’s a tribute to the skills & devotion of the actors & directors that we get away with trying their hands at something more challenging, such as the Scottish Communities Drama Association Festivals in the Spring.

Looking back over the years there is a paternalistic delight to be found in the number of personal relationships that have blossomed under our Cupid’s gaze, some of their offspring now completing the loop by treading the boards themselves.

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ION GROVE-WHITE
READY FOR
ANOTHER MORNING
AT THE BENCH

GRANT HUTCHISON
DREAMING OF THE HILLS
AND LOOKING
FOR INSPIRATION

ANDREW
HOTHERSALL
DIRECTS HIS
MERRY TROUP
OF PLAYERS

FIONA CAMERON (MILLAR)
WITH HER THREE DAUGHTERS
MORVEN, MHAIRI & AILSA
IAN SMITH
IN RETIRAL MODE
AND IN HIS HEY-DAY
IN THE DENTAL SURGERY
IAN SMITH describes his work

a million extractions
(well maybe half a million)

I'm glad I have retired. I now don't have to struggle to understand how a new anaesthetic machine works, with its "dynamic compensation for the breathing system compliance, easy hardware upgradability & open platform communication". Some even have no flowmeters, reminding me of demand-flow machines I used in dental anaesthesia.

It was a different kind of struggle that today's young anaesthetist will never see - trying to anaesthetise a fit 16 stone rugby player for a full dental clearance in a dental surgery. Thirty years ago there was no Venflon, no endotracheal tube, no monitoring, just an old McKesson demand flow machine with a Goldman Inhaler (Maximum 2% Halothane) a Ferguson Gag, Gamgee packs and a Braun nasal mask - in the sitting position. Demand-flow only worked with a gas-tight nosepiece and no mouth breathing.

No wonder dental anaesthesia has been described as the "last art form" or "blood sport" in anaesthesia, depending on your point of view.

Early Days

Lack of electronic monitoring wasn't a problem as there was no electronic monitoring in hospital either. Anyway, lack of monitoring had effectively, if unintentionally, already weeded out those without a stomach for anaesthesia; and the concept of "isolated location" hadn't been invented, as most theatres were attached to the parent ward and therefore isolated from each other. In those days, SHOs & registrars were also expected to help out by doing single-handed locums in Elgin & the Islands.

Such was the common scenario & standard of the times when Bryan Kennedy & I embarked into this field of so-called private practice (really NHS practice, forfeiting 20% of our hospital salary before the days of full salary plus 10%). We were following in the footsteps of Tommy Macdonald & Iain Levack's father Bill, joining, or competing with, two SSA Past Presidents Alfie Raifan (who celebrated his 90th. Birthday recently) and Lawson Davidson. Ronnie Milne did a little but John Latham had a large dental practice which he handed over to me for 2 weeks 3 times a year, when he went to Devon.

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Working relationships

The relationship between anaesthetist & dentist is very different from the anaesthetist-surgeon one. We enabled dentists to treat their most difficult patients and earn a living - they have to be businessmen because they are paid only for work done.

Sometimes the dentist and I engaged in role reversal - he gave the anaesthetic and I pulled the teeth - all perfectly legal, you know!

The GA session was often a highlight of the week for clinic staff - it was "the day the doctor comes." In fact the lady in the bakery where I bought my 'car lunch' (a pie & a can of the less-sticky Diet Coke) knew me as "the mannie wi' the twa big bags."

My car was also described as the only one in the North East with three squash racquets, three oxygen cylinders and a case of Grouse (in which I kept not whisky, but spare drugs etc.)
Travel
Going round the practices, community clinics and some of the peripheral hospitals, where minor surgical, gynaec & other lists were still done regularly, became a way of life. The frequency varied from weekly or fortnightly to two-monthly. In my hey-day I provided a peripatetic service to over 50 locations in Grampian & beyond, covering 30,000 miles a year and anaesthetising about 6,000 children a year - at that time the Royal Aberdeen Children's Hospital did about 4,500 a year.

I regularly stayed overnight to save travelling, having had a game of squash & a curry with some of the dentists. I have played squash in every squash club between Dingwall and Forfar or Edzell - where I often arranged matches between the Aberdeen & Dundee Departments before NESSA meetings.

I used to say my ideal evening was a game of squash, a shower, a sauna, a pint, a curry and sex, all in one night - well five out of six wasn't bad, if I had to miss out the sauna.

Travelling round the North East, I soon got to know the best places to eat or stay, and the best places to buy local delicacies - like fresh or smoked fish. The Buckie dentist once told me that "the best place to buy an ice-cream in Buckie was Cullen!"

I found there were wide differences between practices, due to geographical location & social class. Some were single-handed doing one or two cases a month, bringing in the local nurse to oversee recovery. Others used one surgery for GA & the other for recovery. Others used three or four surgeries, each acting as its own recovery with the dentist, a DSA & a nurse, while I, the machine & oximeter moved to the next surgery after the patient woke up. In my early days, some practices had 3 or 4 sessions of 10-20 patients a week, using two or three anaesthetists.

At one practice a queue always formed up the garden path awaiting my arrival, and the practice to open at 1.30pm. As I struggled past to get to the door to give my coded knock, there were mutterings of "Hey min, get tae the back o' the queue". However a wiser and probably regular patient told him to "Shut up! That's the Mannie!"

Lingo
I had to learn a new language too - stories to tell the children as they went of to sleep, with "Happy Gas" or "Fairy Wind".

I normally offered all school-age children a choice, with 90-95% opting for inhalational induction. Not all paediatric anaesthetists agreed with this approach, with one from Glasgow informing me that "no snotty six year old is going to tell him what to do".

The difficulty arose when the child wanted gas, but the parent insisted on an IV induction. Having two 'goes' getting into a vein in a struggling six year old produced one of the only two complaints I've had, (the other was more trivial). Patients were generally very appreciative of the service they received.

The new language required a nodding acquaintance with dens in dente, germinated odontomes & cusps of Caribelli, and an appreciation that 4 x 3's is not the same as 3 x 4's.

A new set of abbreviations also had to be learned:

N/20 - the GA session (nitrous oxide)
DTC - not cure, but dental treatment completed
ANK - appointment not kept, so MPNT - must pay next time.
PTTA - patient is terribly anxious, really means pain in the arse
TFFO - told to *** off
R Sith - Pencillin, paracetamol and p*** off
DNWMMMA - Doesn't want Mr. Murphy again (didn't speak to patients)
FLK - Funny looking kid
NLKNP - Nice looking kid, funny looking parents
GA Tidy - Give a GA and tidy up the mouth

On one occasion a treatment card had to be completely rewritten by the nurse, after an exasperated young school dentist wrote:

"P***ing little madam, like her mother, Doesn't like men.
I bet she does when she gets older!"

Kids In the Surgery
Preoperative parental psychological support is important, but usually lacking when Mother sends the child in with Auntie, or worse Father, with the words:

"Ye widna catch me going in there" "I min fit it wis like"
"Better her than me - she's a fae heart, ye ken"
"She diana ken fits gonna happen"
"He's only gonna look at you teeth" "He's nae gonna hurt ye"

and, like before, she wakes up, sore & spitting blood, deceived by the only person in the world she thought she could trust.

Or you'll hear a different approach, more matter of fact
"Get in there and get your teeth out. I took a day off my work for this"

Granny was always great - she'd been through it all before, and went away wiggling her hips, if accidentally (or intentionally!) you called her "Mummy".

Post-operative psychological support is also helpful.

"I'm nae takin' her back to yer butcher" (the dentist down the road was always a butcher)
"Look fit ye've done tae ma bairn" - age 4 - third visit for extractions, no teeth left, a 2 litre bottle of Coke a day because "she doesn't like water"
Father: "What did the nasty man do to you, then?"
Me (interjecting): "He fed you sweeties for 4 years"

Reluctant
Children have their own evasion techniques, such as saying at the last minute that they've eaten, or wanting to go to the toilet (again) or locking themselves in the loo & trying to escape through the window. Some simply ran away, to be pursued by the parents and occasionally the police. One 14 year old didn't turn up, so we phoned the school and were able to tell his astonished mother that he hadn't been at school for a week!

A 13 yr old Irish gypsy quine was taken round four practices before we could persuade her to have treatment. Then we couldn't get the surgery door open afterwards, as her Mum was kneeling behind it in prayer!

Many of these terrified children have multiple abscesses in their mouths for weeks or months. In the case of the younger children, one must blame the parents, but bad teeth with abscesses seem to be socially acceptable in some sections of society. If the child had abscesses in the groin, it would have been taken into care because of 'neglect'. A common attitude was "My Mum says I don't need to go to the dentist because I don't have sore teeth".

I always insisted that the parent get the child into the chair, within reach of the anaesthetic machine. One mother wasn't happy with me because I wouldn't "do it" on the stairs. The only exceptions were the handicapped - I once induced a child standing on a window-sill looking out over the rooftops, then caught him & carried him to the chair. But that was OK as it was long before the days of routine preinduction monitoring.

I mustn't get carried away with memories of the handicapped patients, but I particularly remember the aggressive enuretic microphobic who was given amphetamine at night for enuresis and barbiturate during the day for aggression. His mother took the same drugs at the opposite times to help her to sleep at night and cope with the child during the day!

Once, when I had a particularly negative rapport with a mother, I got a sly kick from the dentist, who whispered in my ear "I wouldn't argue with her - she's already killed her man"

I also provided a service on request to Her Majesty's Prison; and, in the same week, I looked after a High Court Sherriff and a Procurator Fiscal. What variety there is in anaesthesia!

Clinical problems were surprisingly rare, the commonest being laryngospasm or choking, which never required intubation. Does anyone want a virgin laryngoscope? A tooth was "lost" about once every 8 years - in the stomach. Fainting was more common among relatives or new staff than patients.
Teenage Girls
Teenage girls could be difficult, requesting an inhalational induction because they “canna tak a needle”, in spite of cuts on their hands from fish-filletting knives, tattoos & earrings everywhere I could see (and probably in places I couldn’t!)

In older times, girls used to have a complete dental clearance and dentures fitted before marriage, so that dental treatment would not be a financial burden on their future husband. I recall a clearance and fitting of an immediate denture for a 16 year old lass who was getting married the next day. She wanted to be able to smile in the photos, even though she wouldn’t manage to eat the meal.

You weren’t supposed to anaesthetise girls who were pregnant - but these were different days. I remember in the 50s, at Gynae Out-Patients, Professor (later Sir) Dugald Baird gave as his reason for ‘helping’ a girl: “Bad teeth!” We laughed, but that said it all. She was socially, financially & intellectually deprived and could not even look after herself, far less a baby - and that was ten years before David Steel’s Act made abortion legal.

Young Men
There were unique recovery problems in young adult males. One chased me round the surgery calling me names. Another took an hour to recover as, unknown to me, he had been standing all night on a train from London.

I once asked a 21 year old man if the lady waiting for him was his sister, wife or girlfriend.

“No. Hinnna get a blonde”

“Dona believe in girlfriends. They jist ging & get themselves pregnant”

The nurse said his brother had just landed in that predicament so his mother had told him “to bide awa the quines”

The same nurse, an experienced lady, called me back with some unusual urgency in her voice to an 18 year old boy. She wasn’t sure how to cope, as he was about to do what he really should do only in private. I simply instructed him to “Put it away, please.”

Changing Times
It must be remembered that the scenarios I’ve described in dental practice took place in completely different times, medically, socially & legally. There will be some readers who can go back a further two or three decades. Would they like to do an article?

What was routine & accepted practice in one decade, may become unacceptable in the next. 40 years ago, more GAs were given outside hospital than within. The 60s were reckoned to be the safest time to have a dental GA, in spite of the huge numbers given by CPs & dentists, using a technique that had hardly changed in 100 years - pure nitrous oxide, as halothane had just come in but was too expensive.

The late Mike Coplans calculated the UK mortality to be one in a million which, if my memory serves me well, must have been much better than any surgical specialty at that time. Although the numbers of GAs went down over the years, the number of deaths remained the same - about two a year in hospital and a similar number outside. This compares to 10 a year killed by ambulances & fire engines and 15-20 killed by police cars.

A significant number of children die from riding ponies and many men die on the golf course. Is golf a stressful game?

A Look Back on my Career
Forty years ago, as a GP in Yorkshire, I gave my first GA (gas oxygen & ether by mask) for a retained placenta in a small maternity home. I had no previous postgraduate experience, no suction, laryngoscope, scoline, or endotracheal tubes - and I couldn’t have used them anyway. I think this was the beginning of my interest in anaesthesia.

I can’t imagine doing the same thing a decade later after the changes in the 60s, such as the introduction of external cardiac massage, anaesthetists helping resuscitate patients in the wards, the introduction of respiratory units (without electronic monitoring) and a surge of interest in teaching anaesthesia. Even then the ECG, like the capnograph, was regarded as a research instrument, not for routine monitoring. “No you can’t have the ECG. Dr. Rollason’s doing his research”

It was another couple of decades before electronic monitoring became routine. About the same time (1990), the Fowrillo Report recommended that general anaesthetists continue to be available outside hospital, but thought sedation was a safer alternative. It is interesting that in the last 15 years there have been four ambulance calls to sedation patients in the area I covered.

But the writing was on the wall and a clinic was set up in the mid 90s at the local psychiatric hospital. It was not ideal - one inhabitant looked at the nice kids waiting anxiously and exclaimed “Fit a lo’ o’ ugly buggers - they’ve got faces like pig’s ears” At least that adult patient was in the right place.

Fees were low and set as part of the dentist’s remuneration from the dental pool. The dentist was superannuated on them but we were not. Few anaesthetists were tempted and about 8 years ago this area was unsuccessful in attracting an anaeasthetist to do a Saturday morning dental list for £90 with no expenses. At the same time, clinics run by a South African doctor had difficulty in recruitment offering 50% of the GA fee - the organiser admitting to me that fewer than half of his “anaesthetists” were accredited.

The final straw for the dental profession came in the early 90’s when everyone else was getting rises of 8%, their remuneration (including anaesthetic fees) was cut by 8% across the board - a reduction of 16% at a time when more & more conditions had to be fulfilled. Subsequent increases were worth even less each year. Today it’s impossible to get an NHS dentist in the N. East. The Government now wants to employ a ‘salaried’ dentist! Patients will arrive at reception to be told “Yes, you have got the right date & the right time - but you are a year early”

A few years ago, I hung up my dental gag for the last time and rode off into the sunset. I’ve no regrets at pursuing this particular career path. It was hard work, but I didn’t find it particularly stressful & the money was useful. In fact I enjoyed it, especially my social contacts with the dentists, many becoming personal friends. My wife & I attended their weddings, went out for meals and were invited as honoured guests to Dinner Dances, where I had to sing for my supper by saying the dental grace:

“Doon the heidie, clasp the paws
Thank the Lord for gi’ing us jaws”

I enjoyed the professional independence, being able to organise my life & work to suit myself. I liked being out & about and away from the Anaesthetic Department, getting to know the area. I also appreciated that unique dentist-anaesthetist relationship.

Similarly, I had no regrets about stopping, though the night after I gave my last dental anaesthetic was a bit like a Celebration of Life (as a funeral is now called) - “weeping shall endure for a night but joy cometh in the morning”.

This article formed part of the Norman Rollason Memorial Lecture given by the author to the North East of Scotland Society of Anaesthetists on the 40th Anniversary of its founding in April 2000 (which seemed to titillate your Editor)
THE PUFFER
STILL OPEN FOR BUSINESS AS THE TIGHNABRUACH CENTRE FOR AMBULATORY SURGERY

EPISODE 10: CME & APPRAISAL

Further digests from Captain Para Handy & his Crew have reached us from the Kyles of Bute.
Because rural day surgery is so topical, we reproduce this interview for the interest of Members

CHARACTERS

Para Handy: Skipper/Surgeon & Chief Executive
Dougie: The Mate and Chief of Anaesthesia
MacPhail: Engineer; Whisky, Isoflurane & Cardioplegia Distiller
Sunny Jim: Ship's boy, Charge Nurse
Leo Strunin & Tony Wildsmith - Distinguished R.C.A. Visitors (who ask the questions)

Have you anything new to tell us about this year, Captain?
We've never stood still on the puffer and it's the same now that she's a wee hospital. One day MacPhail's pot still nearly boiled dry and left him with some 150° proof Whisky at the bottom. It was literally a heart stopper - the paramedics had to defibrillate Willie the Alkie who had purloined a hipflask-full for 50p. Gavin Kenny's cardiac surgeon pal Mr Abu-Dabbi heard about it and then researched the stuff as cardioplegia - it worked brilliantly. We were going to market it big-time - in London, the U.S.A. and world-wide. We even had the bags printed wi' a snappy name I had devised - "PARA-PLEGIA" - funny that it never caught on.

Captain, have you all been keeping up your CME?
Aye, since your man Neil Mackenzie, three sheets to the wind at Peebles, suggested I go on Council as rep for the Kyles of Bute, I've sent the lads to support all the Scottish Society meetings.

Dougie and I went back to Peebles. We tried to enter the fishing but clearly they wanted their man Donald to win (as he does every year). You know they wouldn't allow us to take our usual twa sticks o' dynamite on the boat, so that was the end of that.

Awbudy was up on the golf course - jeez it was steep, like yon golf course in Peebles where Julie Andrews comes over the brow bawling like a banshee. The Peebles hills were alive wi' the sounds of gowfies winging their way into neighbouring fields an' the sight of all those duffing doctors shinning o'er the fences to retrieve them. Mair 'in the woods' than Tiger Woods!

Dinner was a grand affair - first we blagged our way into the President's cocktail party and got out on the balcony wi' a' the big knobs. Man Dougie, do you recall what a crust it was, but such an honour being there wi' aw those kilts & merit awards! Now I see that annoying wee bugger Allison wi' his camera has airbrushed us out of the photographs, but we were there!

Macphail went to Inverness, where he learned a great deal about this'n'that. Before the meeting, he & Ian Johnston disappeared for a couple of days doing the rounds of local pubs with good malts. The Macphuish man Ian Calder evidently talked a lot of sense about difficult airways: he should come & try to gas some of our chinless wonders wi' yon fibreoptic cable we purloined from that BT engineer. The ceilidh was a bit of a blur - Macphail being a bit vague about some fiddling he did wi' a lassie from Aiberdeen. Don't get the wrong idea - the lady was on the piano at the time!

Sunny Jim attended the 'Trainees' do', where he & Alan Thomson were so engrossed in their lunch-time pints they almost missed the afternoon. Jim had a wee session on the simulator, but said it wasn't nearly as realistic as that Sally the Sailor's Friend he was recently exported from Hong Kong, with whom he had spent many a happy night toasting & turning in the Minches.

So how are you getting on with appraisal?
The GMC will be no problem at all. Sir Graeme Catto was over on a yacht from Mull - they had to take shelter here and spent four days sampling all the local produce. He suggested that it's always best to be appraised by one of your own - but there aren't too many fisherman-surgeons or anaesthetists to do it. We sent him away happy back to London wi' a bottle of whisky and a couple of boxes of Loch Fyne kippers.

Which anaesthetists & surgeons have been working here this year?
Tighnabruach's still a great place for locums, especially with all those waiting list initiatives we've been doing. Jim Dougall & Roddy McNicol were down - a pair of important intellectuals from Glasgow (if you can believe that!) They had a good glug of Chablis am' gobbled down two dozen oysters each. Gosh, I hope their wives were suitably impressed back on their boat.

Then we were visited by yon Mike Harmer from the Association: he was up in the Borders & heard about our scallops. Being ca'd 'Harmer' we thought he was going to be a real gangland heavy. Well - the lad looked mair like Bemie Winters than Vinnie Jones! Turned out Mike was Editor of some sleepy magazine - I canna mind if he said it was a 'top-notch' or a 'top-shelf' publication.

Greg Imray brought his pals Farquhar Hamilton & Iain Gray down for the golf. They are all retired now, so you'd expect them to have improved, but they still hit it all over the place. Their language was also choice about our undulating greens. Greg thought we had buried an elephant under that mound on the front of the 4th. Naturally I laughed it off, but didna tell him we had hidden six coos there wi' suspected foot & mouth!

Willie Macrae & Alastair Spence, two fine old friends, came on a fact-finding mission for Greater Glasgow Health Board. To keep them off the scent, we got them to play 9 holes with Dougie while we sorted things out on the boat that we didn't want them to see. They had both been retired a while and felt anaesthetics wasn't as much fun after their Schimmelbusch masks got metal fatigue.
Big Peter Wallace was back too. He said he was down here for some quiet meditation prior to his coronation in London. He'd brought this fantastic ornamental chain with him and tried it on for size about 15 times every day. It looked very old but I noticed it had Shanks of Barrhead engraved on all the links. I think Peter must be the next Lord Mayor of London or something - he's certainly got a fine torso to hang the chain on! He also told us that he wanted peace & quiet, as he had to spend the week writing out an important address. Heavens, he must be a very slow writer - I just hope he remembered the post-code!

John Mackenzie & Alastair Chambers, a couple of real cheeky chappies from the Granite City, brought us down a nice bag of butteries and, like all North-East country folk, showed a real keen interest in the woolly livestock grazing on the golf course. John told stories about shunts he'd done on the Aberdeen bypass (it's called Anderson Drive isn't it?). Alastair said he had set up a domiciliary-PCA service - I went right away that he meant home-delivery pizzas - a profitable sideline for him, I would say.

Iain Levack & his family came here on holiday in their caravan. One night I found him wandering, but then he had been taking the local waters. However we had an unfortunate incident the next morning when the farmer thought they were tinks and tried to shoo them off his land. I told him that Dr. Levack, by his own admission, was one of Scotland's best-kent doctor-gypsies, but he was never, by any stretch of the imagination, a tink, even if he did sell matches & clothes-pegs around Morningside when he worked in Edinburgh.

Gavin Kenny was back again - he's a Professor now. He asked if we got good I.T. in Tignabruaich? I told him he'd get a very tasty high tea at the Royal Hotel - wi' scones & home-made jams but then he said something about megabytes & chips? I thought he might be better going back up to McDonald's in Tarbert.

Have you had any politicians down here again?
Not so many of them this year. You know Lothian Health Board thought it might be a good idea to have a new Edinburgh ADC on the Royal Yacht Britannia, but that didn't find favour then with Susan Deacon - she kent it was much more important to the Leith economy as a tourist attraction.

The Health Minister Malcolm Chisholm came down for a day with Brian Wilson. He asked about our "deferred waiting list" but no-one waits here for anything if they pay a little sweetener to Doogie's wife, who keeps a special account for us. Confusion reigned when big Malky told us he was having terrible trouble wi' an arsehole in the Cabinet. Naturally, we offered to do the poor man's haemorrhoids there & then, but evidently he was just referring to some other member of his Government, a Lord no less, who had been making a real wee nuisance of himself with the proposed hospital changes in Glasgow.

I hear the Royal Family were here again, Captain?
Aye, the Queen & Duke came here for the Jubilee - they took the Royal train to Gourock then had a wee sail 'down the watter' on the Waverley. They came specially to open our Unit—the puffer looked smashing wi' a lick of fresh paint & the Royal Standard up the mast. We had lots of dignitaries & big nobs on the pier, but Her Majesty & Philip greeted Doogie & me like old friends & insisted on coming to the galley for a cup of MacPhail's brew, just like old times, when they'd sail in on the Royal Yacht and stay blearthing for hours. We sent tea up in paper cups for the Lord Lieutenant & the Provost, not to mention Jack McConnell, but we used Maisie's best china down here for the Royals.

Have you treated any interesting Patients recently, Captain?
Ye know of course that there's a lot of mad people around here. There was yon simple lad Alec Macleod who set his jacket on fire because he wanted a blazer. He got 20% third degree burns but we put the fire out & sent him to Canniesburn. Then there was old Jack Macdonald who fell in a cement mixer & is a wa' now. I'm joking - he'd a superficial abdominal injury and was sent to Gartnavel for a new navel. Then there was that guy who fell in the harbour wi' a life jacket on - Bob they ca'd him - we fished him out and got him going with some CPR (coffee, pie & rum).

What anaesthetic techniques are you using then?
We use a lot of the TIVA, as we still get that Propofol cheap. Doogie's boy, who's a right wee nerd most of the time but a real computer wizzkid, converted the chip off an old Nintendo to act as controller for our infuser, which we made out of a glue-gun. We got a loan of a Desflurane thingy but no-one used it, so we stripped it down and used the heater to keep our cocoa warm. Our mainstay is MacPhail's own-brand Isoflurane, though some patients think they've got meningitis afterwards.

What relaxants do you like to use?
Personally I don't think you can beat Laphroaig or Springbank. Macphail's Talisker is an acceptable substitute & the price is right.

No Captain - muscle relaxants?
Our masseuse Shona finds a quick application of Deep Heat is good for any strains from the shinty. In fact MacPhail's Talisker is not a bad rub either, and it's a good paint-stripper too!

Atracurium? Suxamethonium?
Never ony need for them. The locals get paralytic easily enough without them. But we might try it one day for the fishing . . .

Finally, Captain, what do you think about the future?
Well I see continued success for the puffer as an ADC, unless we have a major ballup. As this is the last time you'll be reporting from here, we wish the readers "all the best" from Tignabruaich we would love to see them down here for a visit anytime.
Members, guests & families enjoyed what, for many, is the highlight of the Scottish Anaesthetic year, the traditional Society Spring weekend in the Borders. Council's radical changes to the format the year before have borne fruit with a pleasing increase in attendance & particularly welcome upsurge of interest from the Trade, represented by a record 26 companies. "The best annual meeting in recent years" was a commonly expressed view.

Fine Spring weather led to excellent scoring in Friday's golf competition. Fortunately for the Society's reputation, our guest lecturer from Cardiff was unable to emulate his Welsh compatriot's success of two years before and Bob "the Bandit" McDevitt walked off with the main prize. On the angling front, Donald Miller retained the Grouse & Claret trophy with the sole catch of the day (a 3½ pound trout), despite Iain Davidson's genuine hard luck story.

Saturday's full educational programme necessitated an uncivilised early start. Nevertheless, Liz McGrady attracted a large, if somewhat subdued, audience for her keynote address on obstetric anaesthesia. She gave us fascinating glimpses into the evolution of the specialty, particularly in Glasgow, before reviewing current practice & potential future developments. This was followed by the trainees' prize competition where we had five excellent presentations from a' the airts covering basic laboratory research, applied clinical research & audit. After much deliberation, first prize was awarded to Colin Moore from Edinburgh and second to Phil Neal, also from Edinburgh. (As a totally impartial Secretary, I might add that both pieces of work were actually carried out in Dundee!)

Farquhar Hamilton chaired the shortened AGM in his customary precise & professional manner. Brief oral reports from the Chairman & Convenor of the RCA Scottish Board & AAGBI Scottish Standing Committee replaced the politically-dominated debates of past AGMs, reflecting the Society's changing role in Scottish Anaesthesia.

After lunch, the newly installed President, Peter Wallace, delivered a reflective and revealing Presidential Address. He drew on his roots in rural Ayrshire which had imbued in him a deep sense of fairness & service - qualities which have pervaded his whole professional life. He gave us interesting insights into the development of anaesthesia & particularly intensive care in the West of Scotland, with some predictions as to future developments.

The afternoon was rounded off in the usual fashion with the Guest Lecture. This year Professor Mike Harmer gave us a comprehensive if somewhat daunting review of the problems facing anaesthesia at present. He indicated potential pathways for the future, raising many more questions than answers and leaving us with much to ponder.

A full accompanying guests' programme ran throughout the day including a well-received barbecue cookery demonstration (indoors!), an archery competition and a wide range of activities for the 60 - 80 children present. The evening finished as always with the Annual Dinner & Ceilidh where members, guests & colleagues from the Trade ate, drank, sang & danced well into the small hours. Particular mention goes to Maggie Stockwell & Iain Gray for their superb musical accompaniment at Dinner and to John May for his customary expertise on the pipes.

Sunday morning's departees seemed even more dishevelled than normal - a sure sign of a highly enjoyable weekend. More members & trade delegates bear testament to the continuing good health of the Society and Council hopes to build on this in future years. Book early for next year to avoid disappointment! (25th to 27th April 2003)
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IS THAT BAKED ALASKA,
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THE PRESIDENT REWARDS JOHN MAY WITH A DRAM THEN WELCOMES MEMBERS TO THE GALA DINNER

SPORTS AND COOKERY SECTION
It is surprising how many invitations arrive on one's desk inviting one to some meeting or other - how do you decide which to accept? When an invitation came from the Scottish Society of Anaesthetists it didn't take too long. To be guest speaker at the legendary Peebles meeting is indeed a great honour. Added to that was the prospect of a game of golf and the opportunity to console fellow Celts over the state of our respective rugby teams. Rather than use one of the 'regular' lectures, I offered the Honorary Secretary a choice of four topics of current interest. He and your President chose this title!

Time To Change Course
We often think of anaesthesia as a young specialty but surely the time has come to realise that we are no longer the infants in medical practice and hold a vital position in so many aspects of medical care. Over the years we have diversified enormously moving from the role of 'gas-passer' to become involved in aspects of peri-operative care and pain management.

This ever-increasing diversification has led to an unimaginable increase in consultant anaesthetist numbers. But are we now approaching a time when we need to consider whether we are growing too fast for our own good? The next decade will almost certainly continue to see further expansion of consultant anaesthetist numbers but will also raise a number of critical issues, mainly related to manpower. We will all have views on how this might affect our specialty in the future — these are mine!

The concept of the specialty being at a crossroads is far too simplistic for our current situation. A crossroads implies that there are likely to be a maximum of three options: straight ahead (as we are), left or right. Staying as we are is not an option and the thought of two options is again too simple. Far from being at the crossroads, our specialty is in the middle of Spaghetti Junction. There are certainly a lot of decisions to be made and we will certainly eventually emerge on a track but it may take some time to get there.

I intend to look at the current situation with regards to manpower & training in general; the sub-specialties of pain, obstetric anaesthesia & intensive care; management; and the roles of our professional bodies, the Association of Anaesthetists & the Royal College of Anaesthetists.

Manpower
Traditionally, anaesthesia controlled its numbers well and has seldom been in the situation of extreme glut or paucity of trainees to fill consultant posts. However, we are likely to see major problems in the future. The first will be in the next few years as a consequence of an acute shortage of trainees due to the change from four to five years SpR training. By the end of the decade, if expansion of consultant ranks continues at the current rate (or maybe even greater, according to Government announcements) there will be a serious shortfall in trained staff to fill consultant posts. The current growth in posts is likely to be further enhanced by the need to comply with the Working Time Directive and the much-heralded, long-promised new consultant contract.

Even though we are able to predict that we're heading for problems in the next decade, how can we hope to rectify this, as any increase in manpower takes an enormous amount of time, even assuming it to be possible. One has to increase the number of students but are we rapidly reaching saturation point, as in the past year more than one medical school had great difficulty in filling all its places? In the current anti-doctor climate is it any great surprise that intelligent young people might choose to ignore medicine as a career? Current medical schools are full to overflowing and, if a further expansion is needed, there must be widespread establishment of new ones. Even if implemented immediately, such would be hard pressed to produce their first doctors before 2010! Even if universities could produce many more doctors, how could we attract them into anaesthesia? As a subject, anaesthesia certainly doesn't carry a high profile within most medical school curricula.

Perhaps the best option is the establishment of more PRHO posts in anaesthesia & peri-operative care. Over-arching our concerns is the knowledge that the predicted massive shortage of general practitioners, particularly in deprived areas, could absorb all the additional doctors, and still need more! If we are to weather the predicted manpower shortages, we may have to look at our specialty and decide whether our training is right or even consider radical solutions such as reversal of our diversification or the 'unthinkable' of non-medical anaesthetists.
Training in Anaesthesia

Training has seen so many changes over the past decade, most designed to limit excessive trainee working hours but at the same time providing a better structure. The adequacy of training is supposedly assured by regular appraisal & assessment. The final result, compared to an equivalent trainee of 10 years ago, is less time spent at the 'coalface' & thus less practical experience - a situation which concerns consultants & trainees alike. The problems are not unique to anaesthesia though.

The latest proposals are to reduce training to attain CCST after 3 years as an SpR. The argument is that this brings the UK in line with many European countries, but will it be the start of a specialist, yet sub-consultant grade? The Government could see many advantages in this! Of course, the overnight change from five to three years will give a temporary increase in 'specialists' but within 3 years that would disappear, as the numbers leaving any system must always balance those entering. If such a change occurs, we must be ready for it have programmes available to allow such '3-year specialists' to undergo further sub-specialty training. Will it provide a greater number of 'specialists' overnight, as NCCG's with 3 years in a training programme at some time may be able to seek equivalence & CCST? The possibility of this increase in specialists, with no actual change in overall staff numbers, has a certain political appeal!

If training continues to be reduced in duration & content, how can we hope to ensure competence? In particular, how will we turn a generalist into a sub-specialist? Do we need an extended CCST training period? Or do we take a lead from civil aviation and use simulators both to train & ensure competence? Their use certainly allows safe introduction of new techniques & lessons to be learnt from errors. Perhaps, just as importantly, they make it possible for a large number of scenarios or critical incidents to be practised in a short timescale - effectively they can put a lifetime's exposure to serious critical incidents into one day! However, simulators are seen by some as a test & hence a threat.

Interestingly, this is not the view of commercial airline pilots who view them as a vital quality assurance indicator. Others feel they aren't life-like enough and so will not take the exercise seriously (clearly they haven't been to a simulator session)! Finally, of course, they are expensive, but put in the context of the cost of medicolegal claims against the NHS, if they reduce the number of operator errors, they are potential cost savers.

Obstetric Anaesthesia

It has to be recognised that obstetric anaesthesia takes up a disproportionate amount of on-call time for the actual clinical commitment. There is no way to modify the need for anaesthetic cover in this field as it has been the case with other emergencies (the introduction of 'NCEPOD' theatre sessions). Virtually every hospital has to cover an obstetric unit and, with impending manpower shortages, this area of practice has to be examined carefully. Whilst we clearly need medical presence for operative delivery, is that the case for anaesthetic techniques?

The situation for the current trainee is one of good experience of regional techniques but very limited experience of general anaesthesia. Many trainees will receive their CCST having done less than 10 GAs in obstetrics. For many, a general anaesthetic is a hair-raising experience. With something like 90% of operative deliveries being performed under local anaesthesia and thus a very small number of general anaesthetics, we must view with great concern the recent cluster of deaths in pregnant women associated with airway management. Should we be reconsidering our strategy of "pushing" for regional anaesthesia?

If we need to reduce anaesthetic manpower on our obstetric units, should we consider an alternative such as non-medical epiduralists? Anyone could be trained to do epidurals but will it solve our problems or just add another person to the list needed to run the obstetric unit. Current proposals for a pilot study in Nottingham will be closely scrutinized. Surely the point about anaesthetic cover is that we have too many small obstetric units.

If all units delivered a minimum of 5000 mothers per year, we could more than halve the demands. Widespread closure of small obstetric units is a politician's nightmare but their retention is becoming our nightmare. If politicians do not help healthcare providers overcome this problem, it may be forced on them by manpower issues - then, I suppose, politicians could blame us!

Intensive Care

Equally draining of staff is intensive care. The argument for non-anaesthetic cover for ICU is strong on large units, as long as one member of staff has appropriate airway skills, the remainder could come from any background. Certainly the role of the ICU nurse practitioner is one worthy of consideration.

There's a trend towards providing a high(ish) level of training in ICU, such that many, if not most, SpRs attain an intermediate level of ICU training. Again, this poses manpower issues if all trainees have to spend so much time on intensive care units. Perhaps we need to remember that we are primarily training anaesthetists and, if someone wants to pursue an intensive care career, that specialist training should come after the CCST - it probably will have to if the proposed 3-year CCST is introduced!

Just as with obstetrics, though, do we need to consider why we have so many intensive care units? Is there really any evidence that given good stabilization care, patients are jeopardised by being transferred from smaller DGHs into large central ICUs? Big is not necessarily beautiful but has advantages in respect of manpower & the range of treatment modalities available. Again, proposals to disinvest from DGHs will be met with local fury & political pressure. If we don't do something, worse will follow.

Pain: Chronic & Acute

Our involvement in chronic pain dates from the days of destructive blocks. Modern management is a 'different kettle of fish' and perhaps we have to explore our role. Certainly the importance of pain management programmes is gathering momentum, but much more effort must be put in at the grass roots to limit the development of chronic pain. The Pain Service Framework Group in Wales will propose a much more radical approach of a limited number of chronic pain centres but expanded nurse roles in the community & in general practice. Again, is the place for specific pain experience after CCST?

Most UK hospitals have some sort of an acute pain service. For many this is nurse-based, with little need for actual 'hands-on' input from anaesthetists. Thus we may need to question our continuing involvement in anything but a supervisory role. We need to look at the direction acute pain is going as the options are closer links with other areas of pain management, or the development of peri-operative care teams, which will take over fluid balance & general symptom control in the peri-op. period. Is this really the route we want to take? Are we at risk of de-skilling ward/surgical staff & in the process become glorified house officers? At a time of impending manpower problems, do we really want to take on even more roles outside theatre? This whole area needs to be watched very carefully!

Major Sub-Specialty Training

I think we have to ask ourselves what we are trying to achieve in our training programmes. Should we be trying to train SpRs to be proficient in every aspect of care (perhaps as was the case 20 years ago) or have developments in sub-specialties been such that we must limit what is taught so as to produce 'generalists' who then undertake specific training in a number of fields that may be appropriate to their future career aspirations.

The Impending Staff Shortfall

If we are not going to have enough staff in the future, what are our options? We could restrict our services, both by limiting the supply for surgery and by withdrawing from specialist areas such as ICU, obstetrics, pain and go back to 'gassing'. We could decide to recruit anyone, irrespective of standard of training or we could look at the unthinkable - non-physician anaesthetists.
Nurse anaesthetists are used throughout the world in different work patterns and their role varies from assistant to the anaesthetist through to total independent practice. In the USA, the nurse anaesthetist has filled a valuable role over the years in 'less popular' areas where medical anaesthetists have not been prepared to work. They are also popular in centres where they work alongside a medically-qualified anaesthesiologist who is able to generate their own work. However, the nurse anaesthetists' political lobby has become very strong and there appears to be a war developing between the two factions.

The problem for us if we chose such a route, even if we went for a more controllable system such as used in parts of Europe, is where do we get the nurses? We have not yet enough nurses to provide adequate care on our wards and intensive care units are always short-staffed. Although it might solve our problem, it may not solve the overall problem as although we could cover surgical workload, it would be unlikely to exist if there are insufficient nurses to care for patients! The alternative U.S. system is the Anaesthesia Assistant - a science graduate working alongside the anaesthetist. This looks relatively attractive and there may be suitable people out there but given the increasing difficulty in filling medical school places, wouldn't efforts be better channelled to attract such people into medicine as a whole rather than become technical assistants.

So the unthinkable of non-medical anaesthetist probably remains an unlikely solution to our problems. It is not a simple, cheap or quick solution. If we go down this line, it will need a complete change of mind set by all healthcare staff, not just anaesthetists.

Academic Anaesthesia
So far, things have been doom & gloom but, on the surface, academic anaesthesia is not looking too bad; at present there are only two unfilled chairs. The problem though is that virtually all the chairs filled in the last five years have been NHS-funded with clear disinvestment by Universities. The reason is simple and relates to the Research Assessment Exercise (RAE). We cannot easily compete in this exercise where clinical research has little or no standing. Certainly departments that concentrate on basic scientific research are viewed favourably by universities and their funding councils, but how are they viewed by the anaesthetic fraternity? Our problems are further compounded in that even those departments producing good research may not always get 'returned' in the RAE because their particular work does not fit into the overall University 'research field'.

If research remains a problem in ensuring the survival of academic anaesthesia, we have much more chance in the field of teaching. Widely spread changes in medical school curricula mean that if a department wants to invest a deal of time & effort on teaching, they are invariably pushing on an 'open door'. As teachers, anaesthetists have a dual to offer and are recognised as enthusiastic & motivated. Academic anaesthesia needs both limbs of University life to be represented but at a time of increasing problems in higher education funding, we cannot be complacent.

Healthcare Reforms & Management
There is no such thing as a 'level playing field' in healthcare. Reforms seem to come and go faster than denials of impropriety by ministers. It is almost impossible to plan if you do not know how the service will be organised in two years time, let alone in ten. The element of 'Big Brother' is getting worse every day with increasing bureaucracy overseeing healthcare in general, and doctors in particular. In Scotland & Wales, the matter is further complicated by the separate Parliament & Assembly. In principle, it should allow we Celts to address problems relevant to local population, but again bureaucracy & lingering vestiges of central control from Westminster certainly hinder that!

In days gone by, management was rather frowned upon as an aspect of an anaesthetist's work, but is much more fashionable. Added to that, there is a growing recognition that anaesthetists generally make good managers with their background of dealing with feuding and dysfunctional surgeons. Certainly changes in the criteria for discretionary points & higher awards support a commitment to management & those with such a bent are to be encouraged. In keeping with so many aspects of life, it is easier to change things from the inside than from the outside.

One key word in NHS management speak is 'flexibility'. Anaesthesia has much to offer in its approach to flexibility in working. Most consultants can 'turn their hand' to most things and the introduction of 'fixed-flexi' sessions allows much better matching of supply to demand at difficult times. However, tempered against this willingness to be flexible, is an ever-constant threat that if you venture outwith proven areas of competence, you leave yourself wide open to litigation, or worse.

Recognition
It is a clear fact that anaesthesia is poorly represented in league tables of higher awards. Why should this be? Anaesthetists in general are no less hardworking than others but in fact much harder working that some!. I would suggest that we are no less meritorious than others, so why is there a problem? Perhaps it is the fact that we are such a large group and when people are judging higher awards they sometimes look at absolute numbers rather than percentages. For example, people may see it as fair that there are 'x' A merit award holders in child psychiatry and so there should be 'x'. A award holders in anaesthesia, conveniently forgetting that there are probably twenty times more anaesthetists than child psychiatrists!

On occasion, it has to be said, we are our own worst enemies in the way we complicate the forms. Anaesthetists are not very good at "blowing their own trumpet" and certainly many of the forms I see submitted are a mere shadow of the real person behind them. The College provides advice to the Higher Awards Committee and the system is as fair as possible, though favouring College activity. Other bodies such as Trusts & the Woman's Medical Federation also have input channels to the Higher Awards Committee. It seems amazing though that the AAGBI has no input to the system - though it is hoped that this will change!

Our Representative Bodies
This brings us to the role played by our two representative bodies - the AAGBI and RCA. Each has its strengths & areas of responsibility. In very simple terms, the College is there to ensure adequacy of training & safe service provision - in effect protecting the public. The Association is more concerned with protecting the anaesthetist but as a side-effect ensuring better care to the patient. The College has statutory responsibilities but some feel some of these are under threat with the proposals for an overall training body for all medical specialties that could sideline the Royal Colleges (perceived by politicians as a thorn in their side!)

What must concern us though is the clouding of responsibilities of the two bodies. It should not be beyond the wit of all involved to ensure that they work together symbiotically to benefit the specialty & the public. In some respects, that is true at present, but in other respects, there seems conflict, with duplication of roles, facilities, committees, etc. Perhaps it is time to address these problems and explore a closer link between the two vital bodies where each can provide better support to the other. The strength of anaesthesia as a specialty over the years has always been in its solidarity - we must not forget that!

The Way Ahead
No body can believe that the way ahead will be easy. We must keep our 'eye on the ball' and ensure that as changes come, we are ready to respond to them. We have always been in the forefront of forward-thinking and, even if we are heading for manpower & other major problems, the sooner we tackle them, the better. We have to look at what the future holds and start planning for it now. One thing is for certain - if we take the approach of the ostrich & place our heads in the sand and hope it all goes away without affecting us, we will certainly end up in the same state as the Christmas turkey ....... stuffed!
A 'slimline' one-day meeting was held on the 31st May. Attendance was reasonable, with around 40 delegates.

Peter Wallace opened the meeting with an interesting & humorous talk on the myths & realities of outreach Critical Care, littered with a generous helping of anecdotes from Glasgow & beyond. Peter No.1 was followed by Peter No.2, Peter Shirley, an SpR with HEMS in London. His fascinating lecture described (and displayed) his experiences in out-of-hospital retrieval in Kosovo, Australia, London & Inverness. To borrow a phrase from a weel-kent sports firm, Peter's message to trainees considering this type of out-of-program experience was "Just do it!"

After coffee, the meeting heard about current developments in the Scottish Audit of Surgical Mortality from Harry McFarlane, an experienced SASM campaigner. The past, present & future of the audit were all considered in his wide-ranging presentation. Alastair Chambers, who amongst his many other roles is a member of the council of the Medical & Dental Defence Union of Scotland, followed, shining a bright & informative light into the darkness of the medico-legal world. Completing the session, and again from Aberdeen, was Amr Mahdy, one of our senior SpRs, who kept everyone's minds off lunch very successfully with a fascinating look at Risk Perception; our own & that of our patients. Treading just that bit more carefully over bags & coats, delegates then proceeded to lunch, which was to the usual high standard of our hosts, the Stirling Royal Infirmary Education & Conference Centre.

In the post-prandial session, the audience was treated to a 'How to...' Guide focusing on research & audit. The session was introduced by Nigel Webster (who has a little research experience himself) and was joined by trainees from three corners of the country, each describing their own routes into and experience of research & audit. John Wilson, currently a Lecturer in Edinburgh, talked about his time in a large & productive pain research group. Ian Mellor & Malcolm Wilson, SHOs from Dundee & Glasgow, described in helpful detail how they had carried out simple independent audit & research. Afterwards, there was an animated panel discussion with several forthright contributions from the floor, many expressing the view that good research & audit take time, an ingredient in short supply for anaesthetic trainees in most parts of the country!

In the closing session of the meeting, we heard from Sonny Mowbray, relating how he has transformed his self-designed Anaesthetic Log Book from a slog into a useful source of data informing his everyday practice. Here is the first proper evidence that trainees cramp your style...

For the final lecture, the Society was pleased to welcome Douglas Justins from the College's Education Committee. Despite being charged with explaining the new competency-based SpR Training to the assembled audience, a subject that even its enthusiasts might describe as 'dry' at the end of a busy day, his talk proved so far from dry as he ranged over this topic & many more in a highly entertaining & informative presentation. At the end of his lecture Dr Justins was presented with a Scottish Society tie and a decent bottle of malt, as is customary.

During the meeting Kerry Litchfield, from the Western Infirmary in Glasgow, was elected to join Bernhard Heidemann as the trainee representatives on the Council of the Scottish Society of Anaesthetists.

Thanks to the Medicine Publishing Company, Abbott Pharmaceuticals, Baxter Healthcare, Organon Technika & Pharmacia for their kind sponsorship.
The classical approach of Labati and the posterior approach appear to be the most commonly used techniques to block the sciatic nerve. Both these approaches require significant patient positioning which may be avoided by using the anterior approach described by Beck3. The anterior approach is associated with a high failure rate, up to 40%, because the nerve lies posterior to the lesser trochanter of the femur at the level of needle insertion. However, previous work using cadavers demonstrated that internal rotation of the leg renders the nerve more accessible to the anterior approach. We wished to see whether the same relationship existed in vivo and so designed a study using magnetic resonance imaging in healthy volunteers.

**Methods**

After ethics committee approval, five male and five female volunteers were recruited and consented to undergo a series of magnetic resonance imaging scans. Volunteers were excluded if there were any contraindications to MRI scanning or if they were pregnant. Prior to scanning and in the neutral position, a vitamin E marker was placed on the surface where a needle would have been inserted for an anterior approach to the sciatic nerve. This marker was not moved between scans. Three scans were then performed, one with both legs in the neutral position, the next with maximal bilateral internal rotation at the hip and the third with maximal bilateral external rotation at the hip. The scans were then examined with a consultant radiologist. The line of sight from the insertion point to the sciatic nerve was examined, and the distance from the skin to the nerve measured, as were the distances from the line of sight to both the femoral artery and nerve.

**Results**

The mean age was 30 years (range 21 to 44) and the mean body mass index was 24 (range 19.5 to 28). The male volunteers were older, taller and heavier than the females. Other results and measurements from the scans are shown opposite. (Table 1)

As the thighs rotate from external to internal rotation, both the femoral neurovascular bundle & lesser trochanter of the femur move away from the needle path. This improves the success rate from 1/20 in external rotation to 17/20 in internal rotation. There was little change in depth of the sciatic nerve during external to internal thigh rotation, whilst the average distance from needle passage from the femoral artery & nerve increased.

Despite this increase in average distance, the needle still passed through the femoral neurovascular bundle in three out of 20 instances in internal rotation compared to 11 out of 20 instances in internal rotation. An example of a scan taken in each position is shown opposite.

**Discussion**

These results correspond with the findings in cadavers that, as the thigh is moved from an externally to an internally rotated position, the sciatic nerve becomes more accessible by the anterior approach. The results also correspond with the findings in cadavers that in 40% of the cases the sciatic nerve lies posterior to the lesser trochanter at the level of Beck's approach with the leg in the neutral position. Unfortunately, maximal internal rotation does not seem to guarantee nerve accessibility by the anterior approach, and the scans would also imply that the technique of 'walking' the tip of the needle off the lesser trochanter would lead to excessive medial displacement and be unlikely to result in an effective nerve block. In addition, maximal internal rotation does not seem to guarantee that the femoral structures will not be in the needle's path and susceptible to damage.

In conclusion, internal rotation does improve the chance of success by the anterior approach but does not guarantee it and the risk of femoral artery or nerve puncture is reduced, but not eliminated. The problems of this technique should therefore be balanced against the difficulty and discomfort of the more commonly used approaches.

**Acknowledgement**

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**References**

3. Beck GP, Anterior approach to the sciatic nerve block. Anesthesiology 1963; 24: 222-4
5. Hadzic A, Stines W, Dillerovic E, April EW, Kroom R, Thys DM, Vloka JD. Rotation of the leg influences ability to approach the sciatic nerve from the anterior approach. Reg Anes & Pain Med 2001; 23: May-June supplement: 38
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<td>Direct Line of Sight (LOS) through Femoral Artery</td>
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<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Direct Line of Sight (LOS) to femoral nerve</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Distance from skin to sciatic nerve</td>
<td>106</td>
<td>108</td>
<td>107</td>
</tr>
<tr>
<td>Distance from LOS to femoral artery</td>
<td>7</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Distance from LOS to femoral nerve</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

**TABLE 1** Results are given as numbers (out of 10) or mean distances (mm)

*EXTERNAL ROTATION*

*MRl Scans of a Female Volunteer*

The white lines on the scans illustrate the measurements taken and lines of sight used to evaluate whether a needle would pass unobstructed by the lesser trochanter. It can be seen that as the patient moves from external rotation to neutral position, the lesser trochanter swings laterally, away from the line of sight whilst the sciatic nerve itself moves little. Continued movement from neutral to internal rotation displaces the lesser trochanter further from the line of sight thus facilitating needle passage.
Phil Neal, Edinburgh (Runner-up)
Audit of Standards of Documentation for Caesarean Section

The Royal College of Anaesthetists has identified the importance of complete documentation during anaesthesia for Caesarean section. Medical & legal inquiry following this procedure is more common than for many others & exact timings may be critical. 1

Pain during Caesarean section is the commonest cause of litigation against obstetric anaesthetists in the U.K. 2

Caesarean section is a relatively short operation, but one which can generate much paperwork. Anaesthetists may rightly feel that patient care takes priority.

An audit of standards of documentation during anaesthesia for Caesarean section was carried out. We focused on the recording of block height, the timing & method of testing, and the documentation of pain or its absence during the operation. The results were publicised, and a simple sticker for use on the anaesthetic chart was produced, as an aide memoire and to make recording of essential information easier. One month after its introduction the audit was repeated.

On each occasion, 50 anaesthetic charts were examined. After introduction of the sticker there was increased recording of time of block testing (12% to 65%), time of anaesthetic (66% to 75%), time of delivery (64% to 76%), documentation of block height (33% to 72%) and recording of pain or its absence, or any offer of treatment (2% to 20%). The stickers were not always used, but when they were, studied variables were more reliably recorded.

This presentation looks at the issues involved in documentation during anaesthesia for Caesarean section, including the medicolegal implications, our attempts to raise awareness of these issues & simplify recording of the information, and reports the results of an audit of that documentation.

References:
1. Royal College of Anaesthetists. Raising the standard.
2. Macdonald R. Problems with regional anaesthesia: hazards or negligence?
BJA 1994:73:64-68

Valerie Lochhead, Victoria Infirmary, Glasgow
Anaesthesia for Short Procedures in Children
with Haematological Malignancy

As a result of increased use of risk-directed treatment regimes, there is a regular requirement for short-lasting but painful procedures to be performed on children to aid in diagnosis or treatment. The aim of any anaesthetic technique is to provide analgesia & amnesia with minimal side effects & early return to former activity level. We review the pathology and implications of haematological malignancy in children, with regard to anaesthesia and the consequences arising from both the disease & its treatment. We outline some current anaesthetic techniques in use and review the advantages & disadvantages of each.

Thomas Englehardt, Aberdeen
Acute Neuronal Nitric Oxide Inhibition
Reduces Propofol Requirements in Wild-type & type I Nitric Oxide Synthetase Knockout Mice

The nitric oxide (NO)-cyclic GMP pathway is thought to play a central role in mediating the effects of anaesthesia. Acute inhibition of nitric oxide synthase (NOS) with non-isomor specific NOS inhibitors reduces the minimum alveolar concentration (MAC) of volatile anaesthetic agents by up to 50%, associated with reduced cGMP production in the brain. We tested the hypothesis that acute isomor specific inhibition of type I NOS activity with 7-nitroindazole (7-NI) does lead to a reduction of propofol requirements in wild-type mice but has no effect in type I NOS gene deleted ('knockout') mice.

Wild-type and type I NOS knockout mice were injected intraperitoneally (ip) with 120mg/kg 7-NI suspended in arachis oil or arachis oil alone 1 hour prior to injection of propofol. Untreated animals served as controls. Propofol (200mg/kg) was injected ip in the untreated & arachis oil animals. Propofol (200mg/kg) was injected ip in the 7-NI pre-treated animals. Loss of righting reflex (LRRR), response to tail clamping and time to return of righting reflex (RRF) was determined.

The LRRR was significantly faster in both the wild-type & type I knockout 7-NI pre-treated animals. The 50% reduction of propofol dose in 7-NI treated animals did not lead to a statistically significant difference in neither the time to response to tail clamping nor the return of RRF in type I NOS knockout and wild-type mice.

We present further evidence that the nitric oxide-cGMP pathway is involved in the modulation of the effects of anaesthesia. In vivo models of genetically modified possible anaesthetic targets may prove to be far more complex than initially anticipated.

Niall Purdie, Dundee
Comparison of patient-controlled Epidural Bolus Administration of Levobupivacaine with Fentanyl and Ropivacaine with Fentanyl for Labour Analgesia

The epidural administration of dilute solutions containing local anaesthetic & opioid is popular for labour analgesia. A recent study comparing 0.075% bupivacaine and ropivacaine with 0.0002% fentanyl in labour suggested the preparations are clinically indistinguishable. 1 Levobupivacaine is a new local anaesthetic agent of similar potency to bupivacaine. 2 Our study aimed to compare the onset of analgesia, motor blockade, delivery outcome & hourly drug consumption using 0.1% levobupivacaine and ropivacaine with 0.0002% fentanyl in labour.

Following ethical approval & informed consent, 60 healthy primigravidae in early labour underwent standard epidural catheter placement. Women were randomised to receive either 0.1% levobupivacaine with 0.0002% fentanyl (Group LF, n=30) or 0.1% ropivacaine with 0.0002% fentanyl (Group RF, n=30). Analgesia was established with 15 ml of study solution to achieve a VAS < 30 mm within 30 min (repeated if VAS > 30 mm) and maintained with PCEA (5 ml bolus with a 5 minute lockout). Motor block was recorded hourly. Drug consumption per hour was measured retrospectively at delivery. Statistical analysis was undertaken using appropriate parametric, non-parametric and Chi-squared methods.

Results
Data are expressed as mean (SD) or median [IQR]. Two women in LF and four in RF were removed from analysis due to protocol violation. Patient characteristics were similar in both groups. The onset of analgesia was 37.5 [18.75-51.25] and 30 [15-45] min in LF and RF respectively (P = 0.33). Nine women in LF and eight in RF developed motor block characterised by an inability to SLR against gravity (P = 0.91). Hourly drug consumption in LF and RF was 17.8 (4.5) and 18.6 (4.9) ml respectively (P = 0.56). There were no significant differences in labour outcome between the groups.

Conclusion
We conclude that 0.1% levobupivacaine and ropivacaine with 0.0002% fentanyl are equally effective for labour analgesia and are associated with a low incidence of minimal motor blockade when using PCEA. Hourly drug consumption failed to detect a significant potency difference between the preparations.

References
1. Owen MD, Thomas JA, Smith T et al Ropivacaine 0.075% and Bupivacaine 0.075% with Fentanyl 2µg/ml are Equivalent for Labor Epidural Analgesia. Anesthesiology & Analgesia 2002; 94: 179-183.
TRAINEES PRIZE ENTRANTS 2002
NIALL PURDIE, THOMAS ENGLEHARDT, COLIN MOORE, PHIL NEAL & VALERIE LOCHHEAD

DATEX-OHMDA'S BOB GRAY PRESENTS THE WINNER'S CHEQUE TO COLIN MOORE
HISTORY OF OBSTETRIC ANAESTHESIA

Labour has always been painful, and many have sought to make childbirth more pleasant. References were made in Ancient Greece & Rome to the use of ground scarab beetle applied topically to the abdomen and, more promisingly, to the use of systemic alcohol & poppy leaves.

In the UK there were various references to the use of laudanum, an opioid, though it is likely that the average mother received no pain relief. Being shaken by a ploughman, particularly one ‘fresh from the plough’ was perceived to be helpful, but it is not clear to whom.

Sir James Young Simpson, Professor of Midwifery in Edinburgh, pioneered obstetric anaesthesia when he administered ether to a mother in 1847. He subsequently favoured the use of chloroform, as it was easier to use, with fewer apparent side-effects, and was portable.

The use of pain relief in labour was controversial, with radical statements from the clergy over possible misinterpretation of the Book of Genesis: ‘in sorrow thou shalt bring forth children’.

‘Chloroform is the decoy of Satan . . . in the end it will poison society and rob God of the deep earnest cries that arise in the time of trouble’

This seems a little overstated, with the medical profession, inherently conservative, throwing in contributions such as ‘pain is to the mother safety, its absence her destruction’.

Perhaps some concerns were justifiable or well-meaning, after all chloroform did have its down-side. In the paternalistic society of the time, criticisms of obstetric anaesthesia were made by men, who didn’t appear to consider their inability to experience labour might cloud their judgement.

Chloroform continued to be used however and became more acceptable when given to Queen Victoria for the birth of her seventh child in 1853, although it is unlikely that it was available to the majority of the population.

It remained popular through the first half of the twentieth century, probably in part because it was so easy to use in the home, where most women delivered, 10-12 drops being sprinkled on an open mask.
An important development was the introduction of Nitrous Oxide to obstetrics in the 1930s, and Dr. Minnitt developed an apparatus for the administration of 50% air with 50% N₂O, which became popular. However, as mothers were receiving only 10% oxygen its disadvantages soon became apparent and prompted the search for safer techniques. More risky apparatus was designed to give 100% N₂O for the first three breaths or 2.5-3L, to speed the onset of analgesia.

An apparatus developed to provide 50% N₂O with 50% oxygen became popular, and was named the Lucy Baldwin apparatus after the wife of the then Prime Minister Stanley Baldwin. She was a pioneer for improvements in maternity services in general and for improved provision of pain relief in labour in particular, and was instrumental in the appointment of the first anaesthetist to the Glasgow Royal Maternity Hospital. The machines were popular, but cumbersome, and the next breakthrough was the development of Entonox by Dr. Mike Tunstall, the Aberdeen anaesthetist who pioneered the development of pre-mixed cylinders. Entonox is of course still widely used in the UK today.

**Caesarean Sections**

As far as obstetric anaesthesia, in contrast to analgesia, is concerned, this evolved alongside the development of the caesarean section operation. In the late nineteenth century this was a rarely performed & controversial operation, with a high mortality rate for mother & child. The population of Glasgow had expanded hugely in the 19th century, primarily due to immigration. The slums were overcrowded and rickets was common, with its attendant problems for the obstetric patient due to contracted pelvis (Fig. 5). In those days both mother & child would die during childbirth, or there would be destructive surgery of the fetus, allowing the mother to survive.

In the Glasgow Maternity Hospital Dr. Murdoch Cameron performed & published a series of caesarean sections; his first successful case, where both mother & child survived, was undertaken in April 1889 and published in the BMJ in 1889. The mother, who was just over four feet tall, was 'put under chloroform at 4.30pm, ether being afterwards used' and received 'a half grain morphia suppository' for analgesia. She appeared to have a normal recovery and was discharged home over a month following delivery.

Other points of note were that the anaesthetist was administered by Doctors Fox & Connal, and the mother received champagne for nausea. By October 1890 the BMJ had published Cameron's 14th successful case.
Committee minutes, which are a model of tact, there was on this occasion Mrs P.H. Coats, a trustee of the Coats Trust, forces against the doubters. Probably not universal support for the scheme, but stronger were accepted. Reading between the lines of the House of views' the idea was shelved. It was raised again in 1930, possibly this led to concerns about general anaesthesia. Mendelsohn's Syndrome was described around this time and by this time there seemed to be stronger forces at work in the surroundings', but, if not, some IV Pentothal was given, 'a very small dose' (not more than 0.25g!). An injection was made into the proposed incision line, and further injections made throughout the rectus sheath. One can only speculate on why it was performed, though some IV Pentothal would be considered a reasonable general anaesthetic induction dose. Mendelssohn's Syndrome was described around this time and possibly this led to concerns about general anaesthesia.

Appointment of Specialist Anaesthetists

In the monthly Minutes of the House Committee of GRMH there is reference, in April 1924, to the possible appointment of an anaesthetist to the maternity hospital, but after a wide exchange of views the idea was shelved. It was raised again in 1930, and by this time there seemed to be stronger forces at work in the shape of Mrs Lucy Baldwin and other influential ladies. As the funds raised by these ladies' charitable work was essential to the survival of the hospital their views were not disregarded.

On this occasion Mrs P.H. Coats, a trustee of the Coats Trust (Coats being the Paisley thread manufacturer) volunteered to find funds for the appointment of two anaesthetists to the hospital. Mrs Baldwin herself wrote to the Lord Provost of the City on the matter and sent a telegram of congratulations when the funds were accepted. Reading between the lines of the House Committee minutes, which are a model of tact, there was probably not universal support for the scheme, but stronger forces were against the doubters.

Two anaesthetists were appointed, Drs A M Brown and Anne Laird, on a salary of £100 per annum. From that time 'specialist anaesthetist' were appointed to GRMH, and presumably similar practice was adopted throughout the country.

RECENT ADVANCES IN OBSTETRIC ANAESTHESIA

All obstetric anaesthetists have their favourite 'recipe' for epidural analgesia in labour, but till recently evidence to support one technique has been lacking.

Problems which have hindered obstetric anaesthesia research include the following: how valid is consent in the labouring mother? is it ethical to randomise women to a group where they will receive inferior pain relief in labour, i.e. systemic opioids compared to an epidural?, will women agree to be randomised to any given group when so many have firm views on the type of pain relief they would like?

However there have been a number of large studies recently which confirm what many have thought for some time, i.e. that the use of epidural analgesia in labour does not increase the incidence of instrumental delivery with appropriate obstetric management and that a technique for epidural analgesia which minimises motor block can reduce the need for instrumental or operative delivery.

Low Dose Epidural Techniques

The COMET study (Comparative Obstetric Mobile Epidural Trial) of >1000 primigravid women compared three epidural techniques for labour analgesia. Women were randomised to receive either 0.25% bupivacaine top-ups throughout labour, or Combined Spinal Epidural (CSE) with an initial intrathecal bolus followed by top-ups of 0.1% bupivacaine & fentanyl or to receive an epidural infusion of 0.1% bupivacaine & fentanyl. Women in the latter two groups, who received low dose epidural techniques (0.1% bupivacaine with fentanyl 2mg/ml) had significantly higher vaginal delivery rates. The authors concluded 1 in 4 instrumental deliveries might be avoided by using mobile techniques.

Both CSE & epidurals alone can be used for 'mobile' epidurals. Low dose 'top-ups' rather than infusions may be the optimal technique, as a 'top-up' technique can halve the bupivacaine & fentanyl requirement. This study received a lot of media attention - it is the first big study to show conclusively that the old 0.25% top-up regime contributed to higher instrumental delivery rates.

Comparison of Epidurals with Systemic Analgesia

Loughnan et al randomised 614 primigravid women to receive either IM pethidine or epidural analgesia in labour. This was the study that obstetric anaesthetists had argued for many years couldn't be done for ethical reasons. There was no difference in instrumental or caesarean delivery rates between the two groups, though it is important to note that this study was undertaken in a hospital which has an 'active management of labour policy'. This policy has strict criteria for the diagnosis of labour, and once the diagnosis is made women receive syntocol as required to achieve a set rate of cervical dilatation.

Most obstetric units do not have such an aggressive policy, and units which use this type of management seem to achieve very low operative delivery rates. Though it is difficult to extrapolate these results to all units, it is evidence that epidurals do not necessarily alter mode of delivery if labour is actively managed.

Combined Spinal Epidural technique (CSE)

While some units use CSE for all caesarean sections (CS) & labour epidurals, most take a more selective approach. The main advantage of CSE is the ability to 'fine tune' a regional technique. When used for section women are more haemodynamically stable than with single shot spinal techniques (SSS). Though a case could be made for routine use of CSE there has to date been no large RCT comparing CSE with SSS for CS.
Women who would particularly benefit from CSE for CS include those in whom block height with SSS may be too high (multiple pregnancy, obesity), or too low (IUGR, prematurity), or in whom surgery may be prolonged.

Women with severe pre-eclampsia or cardiac disease are also ideal candidates, as the onset of sensory block is slower and hypotension less common. Small intrathecal doses of local anaesthetic can be given, and the block gradually extended using the epidural catheter.

Women who may benefit in labour are those who are severely distressed or in whom operative delivery is thought to be required in the near future. Concerns about infection and neurological problems limit routine use in many units.

References

Acknowledgements: Historical information was gathered from The Rottenrow, by Derek A. Dow, Parthenon Press, 1984; Dr C.B. Lunan, Consultant Obstetrician Princess Royal Maternity; the Glasgow Archives, Mitchell Library, with the assistance of Mr Alistair Tough.

A Letter from Duncan Ferguson
Retired Consultant Anaesthetist, Glasgow Royal Infirmary & Royal Maternity Hospital

Stuart McGowan’s interesting article on the History of Regional Anaesthesia in Scotland (Annals 2002) has jogged my memory. He remarks that interest in spinal anaesthesia in obstetrics reappeared around 1980.

This was indeed the case: I append a table showing the percentage of Caesarean sections utilising this method at Glasgow’s three main Maternity Hospitals during 1980-84

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<tbody>
<tr>
<td>Royal Maternity</td>
<td>0</td>
<td>&gt;1</td>
<td>4</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Southern General</td>
<td>0</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Queen Mother's</td>
<td>n/a</td>
<td>&gt;1</td>
<td>2</td>
<td>&gt;1</td>
<td>3</td>
</tr>
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This demonstrates increasing popularity at “the Rottenrow” where in 1984 the 30% meant 188 spinals, and where total deliveries were 4254. It is believed enthusiasm waned at the Southern General because of headache.

Combine the above information with Dr. McGrady’s excellent Obstetrical Anaesthesia review at Peebles including her description of combined spinal & epidural anaesthesia (CSE) through the same interspace. Such a technique was introduced in the Royal Maternity Hospital in 1981 and was referred to as a ‘thru spinal’. In general, having located the epidural space with an 18 gauge Tuohy needle, a 25G Steriseal needle of 110 mm length was passed through this ‘introducer’ and 2 mls. of Bupivacaine injected. Cannulation of the epidural space followed. The flexibility this allowed in dose, onset & duration will be appreciated.

At that moment of time the writer had no previous experience of spinal anaesthesia in obstetrics. While attempting to gain the benefits of the combined form of regional block, the efficacy of a ‘straight’ spinal was soon emphasised and therefore pursued. However, while exact figures are not to hand, many of the spinals logged above were of the combined variety. Latterly this technique was reserved for specific indications as mentioned by Dr. McGrady

In 1982 Coates published the first report of the same interspace, needle-through-needle technique, but in orthopaedics. It was not until 1984 (Carrie & O’Sullivan) that a series was published relating to obstetrics.

I trust rotating trainee anaesthetists benefitted from this relatively early introduction to spinal anaesthesia in obstetrics, a serendipitous by-product of the ‘thru spinal’ it is believed!

References
1982 Coates M B. Combined subarachnoid and epidural techniques. Anaesthesia; 37, 89 - 90
1984 Carrie L E S and O’Sullivan G M. Subarachnoid Bupivacaine 0.5% for Caesarean section. European Journal of Anaesthesiology; 1, 275 - 283
Isobel Mackenzie welcomed 65 members with relief, after a few organisational ‘hiccups’ including the first venue being flooded. The President thanked local hosts Ian Johnston & Isobel, who Peter described as having been an unhappy bunny weeks earlier.

Peter Shirley (London) gave a most comprehensive talk on Pre Hospital Care & Patient Transport, detailing many facets of the organisation & delivery of emergency management. He outlined optimal preparation & ‘packaging’ of patients for transit to prevent secondary physiological insults. He advocated training for this high risk endeavour, comparing Australian excellence with higher critical incidents in transfer shown in UK papers. Peter outlined his ‘wish list’ for an ideal transfer, and thought the arguments of Stay & Play or Scoop & Run were often fanciful as circumstance would dictate, but he did advocate low volume resuscitation to improve outcome. Peter reviewed cases of life-saving on-street thoracotomies in penetrating chest trauma - fortunately less common here than South Africa or the U.S. He alerted us to the U.K. being rather ill-prepared in Major Incident Management, including chemical or biological threats.

David Simpson (RHSC Edinburgh) continued on this theme in discussing “Stabilisation & Transport of the Critically Ill Child”, estimating that paediatric intensive care had lagged behind adult & overseas practice by many years. Provision of “an intensive care bed on the move” required a well-trained team with state of the art equipment & communication. Retrieval was optimised where senior staff had been involved in resuscitation at the referring hospital. A predictive Paediatric Index of Mortality (PIM) score could be derived from 8 first-contact variables.

Jane Peutrel (RHSC, Glasgow) looked at new developments in Regional Anaesthesia in Children, in particular extending the duration of caudals with added ketamine (0.5mg.kg^-1) or clonidine (1-2ug.kg^-1), which may also allow for lower L.A. concentrations to lessen motor blockade. Caudal catheters were another option, but not without snags - tunnelling may reduce soiling and Xray/ ultrasound should be used to confirm position. Jane also advocated peripheral & compartment space blocks as effective and possessing inherently less morbidity, utilising nerve stimulator mapping to outline tricky anatomy in young kids.

Ian Russell (Hull) thought his paper Medicolegal Implications of a Painful Delivery under Regional Anaesthesia should come with a health warning - it had caused consternation recently in London. He looked for reasons why more patients had been successful in suing their doctors - partly due to a more litigious society partly also to less experienced trainees, but chiefly due to changes in the law from Bolam through Bolitho, which meant consent must be informed and treatment must be acceptable & logical to judges! Ian compared contrasting surveys on epidurals in labour (one before & one during labour) and advised comparing risks with car travel to give them meaning. He advised comprehensive sensory testing of spinal blocks including touch modality and concluded by pleading for us not to shoot the messenger.

Andy Tomlinson obviously enjoyed life-enhancing experiences Down & Out in Katmandu in practising Anaesthesia in Nepal, a country with outstanding scenery & people, but great poverty. He described anaesthesia problems where turning on an oxygen concentrator may switch off theatre lights, and where patients brought in their own ethyl chloride/ether. In contrast, private-funded heart surgery was performed at the University hospital, but even here there were only two pulse oximeters & the only blood gas analyser in Nepal. A sick strangulated hernia patient was carried from his village by bearers, but too late to be saved delayed by rice planting. There was a challenging 1 yr old with a big sacral tumour successfully anaesthetised with Ketamine. Sadly, rebels have made travel & work there less safe.

Peter Forsythe, in discussing Blood Transfusion in the Highlands: thought he was like Liz Hurley’s dress designer - “Less is More”. BTS had a rising demand for a diminishing resource but there were big regional differences in the use of donations. Efficient & effective use could be achieved with lower Hb trigger levels and the use of group & save in place of cross-match, particularly as blood could be rapidly available. Clinicians now have a greater appreciation of benefits vs risk, in an era when giving blood might bring adverse immunological or infective problems. Jehovah’s Witnesses had been useful in managing marginal cases.

Ian Kestin (Gartnavel) moing in Appraisal & Assessment of Competence, looked at statistical techniques like CUSUM analysis which started in munitions factories to spot dud shells, but could now be applied in anaesthesia to detect poor performance, certify excellence and inform patients of quantifiable risks. The problems are that the system depends on self-reporting and larger numbers of cases than may be available will be required to reach firm conclusions of trainee competence. It could also be difficult for a C.D. to deal with a good colleague who has had a cluster of failures. Ian also challenged the concept that if nothing goes wrong then everything’s alright, by showing a 95% upper confidence level of incidence of complications may be high.

The President introduced Ian Calder to deliver the Gillies Lecture (which follows) Although primarily a neurosurgical anaesthetist, Ian was widely renowned as “the difficult airway man” with his work to identify and deal with awkward patients safely.

A marvellous ceilidh was held at Buncrew House in the evening - haggis, neeps & tatties and rousing Scottish country dance music brought a memorable Highland meeting to a conclusion.
SPEAKERS STEP OUT TO TAKE THE FRESH INVERNESS AIR WITH SSA PRESIDENT PETER WALLACE AND ORGANISERS ISOBEL MACKENZIE & IAN JOHNSTON

OUR PIPER JOHN MAY LEADS GUESTS INTO THE CEILIDH WHERE THE GIRLS WERE BIRLING AND THE JOCKS WERE STRAPPING
IAN CALDER RECEIVES THE GILLIES BOWL FROM THE PRESIDENT
Jet engines are more efficient at altitude, so that flight plans for offensive strikes generally have a "high, low, high" profile. Several analogies between aviation and anaesthesia have been made and my one refers to the way I believe an anaesthetist should embrace technology. Safe anaesthesia involves a number of low-tech concepts and manoeuvres, which should be enhanced by a familiarity with high-tech devices, but a return to basic principles must never be delayed. High-tech equipment can confuse and distract the operator.

I think it likely that Dr John Gillies would support me, since he had an interest in safety. He was born in 1886 and went through the First War without serious injury, remarking subsequently that he emerged with "one consolatory worthwhile asset - a mature knowledge of mankind, which would have taken twenty years of civil life to acquire".

Dr Gillies was appointed a consultant anaesthetist to the Children's Hospital and to the Royal Infirmary in Edinburgh in 1932. He became President of the Association of Anaesthetists of Great Britain & Ireland in 1948. Perhaps his interest in anaesthetic safety stemmed in part from his experiences in the Great War, where he must have witnessed much unnecessary suffering and death.

My own career has been less dramatic and much safer. I attended Liverpool medical school and began my anaesthetic training there. I saw Professor Cecil Gray & Gordon Jackson Rees in action, both remarkable men who transformed adult and paediatric anaesthesia by their introduction of muscle relaxants.

Even today, with more airway-friendly agents available, I have more trouble with airway reflex activity (coughing, breath-holding, laryngospasm) than anything else. Anaesthesia must have been extremely nerve-wracking before muscle relaxants allowed us to override misplaced airway reflexes.

### Causes of Airway Difficulty During Anaesthesia

1. **Reflexes**
2. **Stiffness**
3. **Deformity**
4. **Swelling**
5. **'High Tariff' patients**

*patients who cannot be managed in quite the way one might want because of some factor. The late Queen Mother and other VIPs are examples, as are vulnerable or uncooperative patients.

I was an SHO in Whiston Hospital, where I was successfully shepherded through the Primary with the immense help of Dr Norton Williams. His textbook was not available then, but perhaps the effort of repeating principles of pharmacology to the likes of me encouraged him to write it all down.

Current trainees may be interested to know I was sent to anaesthetize a list of caesarean sections in an isolated unit after only eight months of training and may not be surprised to hear that I nearly came to grief.

The patient was rather small and dumpy, and was the last of a list of four C.A. sections. I scanned the case-notes but did not find the anaesthetic note from her appendicectomy the year before. We did not have oximeters then, so I cannot tell you how low the SpO2 went during my attempts to intubate.

I learned a lot, it could all have been a tragedy; in particular I learned that it is dangerous to file away the fact that a patient can't be intubated by normal means and not tell the patient. It seems inevitable that a successful civil suit will be brought against an anaesthetist who failed to communicate such important information.

I was appointed a consultant at The National and Royal Free Hospitals in 1981. The National is in Queen Square, Holborn. At the south end of the square there is an arts centre, which was a girls school until about 15 years ago. That school was attended (in 1778) by the daughters of one of my heroes, James Boswell, who lived nearby. Boswell wrote a diary, not intended for publication, which contains some of the best and most amusing writing I have ever read. It is owned by Yale University and has been published in several volumes.

Shortly after my appointment, a surgical colleague (Alan Crockard) decided to try and help patients with rheumatoid cervical spine disease. Some of our initial attempts were attended with serious difficulty with intubation, and we had episodes of prolonged hypoxaemia & hypotension.

Fortunately, the Olympus LF-1 fibreoptic laryngoscope became available at that time and we gradually learned how to intubate these unfortunate patients without serious desaturation. To begin with we used a spontaneous breathing technique (halothane) instead of using a muscle relaxant as we normally would have for intubation.

There was a feeling then, which still exists, that spontaneous breathing is safer than muscle paralysis in patients with 'difficult' airways. In practice, we had problems with laryngospasm & hypotension. Our lowest saturation was 17% - the patient rescued with suxamethonium. 
We did not realize just how irritant lidocaine is to the glottis, nor how dependent we had become on relaxant-induced areflexia. We learned, or rather re-learned, that glottic reflexes must be obliterated before laryngoscopy, either by muscle relaxants or topical anaesthesia applied in a incremental fashion.

Perhaps our most useful contribution was the introduction of the combination of the LMA & flexible fibrescope, which should, in my view, be the next step when direct laryngoscopy proves impossible. A 7mm Mallinckrodt Flexilum tube will pass through a size 5 LMA (although 4cm of the LMA shaft needs to be cut off so that the tube is long enough). A 6mm Flexilum will go through a 3 or 4 LMA, and the LMA need not be cut.

Continuous rotation ('drilling') of the tube as it is passed is vital. I thought I had invented this 'black & decker' manoeuvre, but was deflated to read the same advice in the first reported series of fibreoptic intubations by Stiles et al in 1972.

Flexible fibreoptics endoscopy had been of enormous help to us in our management of the difficult rheumatoid patients. I looked into the development of the technology by looking up what I believed to be the first publications on the topic, which appeared in the same issue of Nature in 1954.

In the article by Hopkins and Kapany from Imperial College, there was a reference to work by J.L. Baird in 1926. On investigation, I found J.L. Baird was the same John Logie Baird of Helensburgh, who demonstrated television for the first time on 21 November 1926. 1926 was a big year for Baird since as well as demonstrating television, he patented flexible fibreoptics and demonstrated 'Noctovision'.

Baird's Noctovision was a night vision device using infra-red radiation. Baird discovered that infra-red radiation penetrated cloud & fog poorly, so he substituted a radio wave source for the infra-red emitter. He displayed the reflected radio waves on a television screen and patented the device in 1928 as a "Reflected radio wave television system" (British Patent 292185). Radio detection of objects later became known as radar.

We learned a lot about the management of patients with cervical spine disease because of our attempts to treat rheumatoid cervical myelopathy. Sadly, the message that emerged was surgery has little to offer patients with serious myelopathy.

We were surprised to find that the Mallampati examination emerged as the best predictor of difficult laryngoscopy, and which patients were likely to be difficult (patients with CO-3 disease, and/or associated TMJ disease).

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Items of practical significance emerged from our endeavours with rheumatoid patients. We learned to handle flexible fibreoptic technology, which is extremely useful when direct laryngoscopy is difficult; and which patients were likely to be difficult (patients with CO-3 disease, and/or associated TMJ disease).

We were surprised to find that the Mallampati examination emerged as the best predictor of difficult laryngoscopy in cervical disease. Dr Mallampati's explanation of the mechanism of his test is that difficult patients have enlarged bases of tongues, but we believe it is simply that difficult patients cannot extend their heads on their necks, which normal subjects always do during mouth opening.

Normal subjects whose head is placed in a position of slight flexion lose about 40% of their mouth opening. The Mallampati may well be better regarded as a test of cranio-cervical extension.
The other is oesophageal intubation. Unfortunately since it engenders excessive reliance on the method: Its commonly-applied description as has led to at least two deaths in recent years. It is a very useful as confirmation of tracheal intubation is a sadness to me, and difficulty in spontaneous breathing, or ventilation (intensive care).

Nevertheless, I think intubation (particularly rapid sequence) of these sizes are probably inappropriate for prolonged periods secretions demands a bigger tube) without problem. I accept some ten years, almost (the occasional patient with copious clinical insignificantly higher when "small" tubes are used. 23

Simple investigation showed that inflation pressures were \(\text{p} \times 10^{-5}\) atm for women and 7mm tubes for men for I have used 6mm tubes for women and 7mm tubes for men for many rheumatoid patients could be said to have had “unstable” cervical spines. The matter of whether direct laryngoscopy is neurologically risky in patients with cervical disease is of interest. We believe that direct laryngoscopy is unlikely to be the cause of neurological deterioration during anaesthesia because:

1. It is a short procedure.
2. It causes little movement in the spine, even in unstable spines.
3. It raises the blood pressure.
4. Experimental myopathy due to trauma requires either prolonged deformation or major displacement.
5. There are many reports demonstrating that minor degrees of spinal cord deformation applied for a sufficiently long time can result in cord damage.
6. The published reports (of laryngoscopy induced damage) are unconvincing.\(^2\) The state of anaesthesia itself is hazardous to the spinal cord, as it is to peripheral nerves, because normal protective reflexes are obtunded; it is dangerous to believe that by getting the intubation right the patient is not at risk.

We are not designed to stay still for long periods.

Perhaps the most useful advice I can offer as far as management of difficult direct laryngoscopy goes, is that if the patient might require a nasogastric tube, get the patient to swallow it before inducing anaesthesia. Few experiences are more humbling than to pull off a super awake intubation and then to struggle fruitlessly to pass a nasogastric tube!

With discussion of passing nasogastric tubes we are back down at low altitude. When up in the clouds with the fibrescope, I realized that we always contented ourselves with considerably smaller diameter tracheal tubes than usual. It gradually became clear to me that the sizes I had been accustomed to use were unnecessarily large - and unnecessarily difficult to pass. A fairly simple investigation showed that inflation pressures were clinically insignificantly higher when "small" tubes are used. 23

I have used 6mm tubes for women and 7mm tubes for men for some ten years, almost (the occasional patient with copious secretions demands a bigger tube) without problem. I accept these sizes are probably inappropriate for prolonged periods of spontaneous breathing, or ventilation (intensive care). Nevertheless, I think intubation (particularly rapid sequence) of a female with an 8mm tube is unwise. The use of smaller diameters of tube may help to decrease the incidence of failed intubation - one of the two principal causes of airway mortality. The other is oesophageal intubation.

The over-reliance of some of my colleagues on end-tidal CO\(_2\) as confirmation of tracheal intubation is a sadness to me, and has led to at least two deaths in recent years. It is a very useful technology, but all anaesthetists should practice simpler methods of confirmation and be aware of the pitfalls of end-tidal CO\(_2\). Its commonly-applied description as “the gold standard” is unfortunate since it engenders excessive reliance on the method:

**Disadvantages of end-tidal CO\(_2\) when used to confirm correct tracheal tube placement.**

- **General**
  - Expensive
  - Not very portable
  - There is a delay in the capnogram appearing especially in side-stream capnographs
  - Need to ventilate possibility of ventilating stomach

**False positives**
- Previous mask ventilation causing insufflation of the stomach with carbon dioxide - containing gas
- Previous consumption of materials (carbonated drinks, antacids), which may release CO\(_2\)
- Tube overlying but not passing through glottis

**False negatives**
- Equipment malfunction
- Large leak around the tracheal tube
- Severe bronchosppasm
- Cardiopulmonary arrest
- Obstruction of the tracheal tube (cricoid pressure, plug, kink)

The point that must be grasped is that no one method is foolproof, certainly not end-tidal CO\(_2\), so more than one method should be deployed.

To my mind the oesophageal detector device, described by John Nunn, represents "the best buy" \(^2\) - an almost instantaneous answer without the need to inflate; cheap, portable, independent of power, light, or cardiac output, which fails 'safe'. Nevertheless it has not become popular in the UK (better in the USA) largely, I suspect, because it is too low-tech for modern anaesthetists, who spurn anything without diodes, unless it's an LMA.

In conclusion, I thank you for the opportunity afforded me in addressing you today. It has been a great honour. I have particularly enjoyed the opportunity to talk a little about two of my great heroes, John Logie Baird and James Boswell. Both men's reputations have flourished in recent years and I hope that the same will be true of John Gillies.
Dr Mackie was born in 1815 at Sauchope, Crail, son of a farmer; his two younger brothers were also doctors. He was educated locally, graduated from St Andrews University and began his large practice in Cupar in 1836. Five years later he purchased a chemist & druggist business in The Laboratory at 24 Crossgate, Cupar from its long-established owner and retained the assistants to continue the business. The site is still in use today, partly occupied by a firm of solicitors.

On 25.2.1847, Dr Mackie became one of the very early users of ether as a general anaesthetic, perhaps encouraged by his experience as a druggist. The Fife Herald is quoted by Dr Hendry in an article describing a "Painless operation from the inhalation of Ethereal Vapour", thus:

On Friday last we were present at an operation which was performed in this town by Dr Mackie, while the patient was placed in a state of insensibility from inhaling the vapour of ether. This substance is remarkably volatile and under ordinary atmospheric pressure rapidly assumes a gaseous form, which when breathed into the lungs exerts a powerful sedative effect on the nervous system. It has only been recently used for this purpose. The discoverer in this respect is a medical gentleman of Boston in North America, and it may be considered the most useful discovery of modern medicine and perhaps the greatest boon that science has conferred on suffering humanity.

When we entered the patient's apartment, we found him in a half-recumbent position placed on a table with the foot hanging over it. The machine for administering the vapour to the patient was a tin vessel, bulging at the bottom and completely closed excepting two orifices at the top - one funnel shaped to admit air & the ether which was poured in, and the other gave insertion to a flexible tube about three feet with a mouth piece at the end of it which was applied to the patient's mouth with the nostrils compressed. We may here state that the tube contains self acting valves which preclude the return of air which has already been breathed from the patient's lungs to the inhaling machine, thus always keeping up a fresh supply.

In about three minutes the patient was completely insensible. This was tested by pricking him and pinching him. His breathing became as it were deeper and his pulse rose in frequency and his eyes turned upwards and the pupils dilated. The operation was then quickly performed. It was of a painful character and well adapted to test the efficacy of the ether-amputation of the great toe and front of the foot for caries of the bone.

During the whole time the patient made no complaint of pain, and seemed to feel nothing but lay perfectly insensible. After he had become completely etherised, the nose was relaxed and the patient allowed to breathe by it thus diminishing the steam so far - it being found that after a person is under the influence of ether, he will remain so for a few minutes.

The cutting now all over, and the wound sewed up, the steam was withdrawn from the patient, and in about a minute he looked up and rubbed his eyes. He stared wildly about him and seemed to wonder at seeing so many about him.

He was then told he had lost his great toe; he could hardly be convinced of this till he saw the blood and the wound. He expressed great delight that he had got rid of his old enemy and declared he had not felt any pain. He had been dreaming - about what he did not say - but he stated that the dream was of a pleasant character.

It had been resolved to omit one stitch in the sewing up of the wound after he was insensible so as to thoroughly test the power of the ether, and the medical gentlemen delayed purposely two or three minutes to allow of complete restoration of consciousness. The needle was drawn through and the sufferer gave ample tokens of complete sensation, declaring it was very sore and painful.

There were several medical gentlemen present, including Dr Graham of Cupar, Dr Hill of Leuchars and Dr W Methven RN etc. They all expressed themselves highly satisfied with the success of ether allaying pain. We understand that Dr Graham & Dr Mackie had previously performed some other operations of a very painful nature while the patient was under the ether influence. We learn that our friend is doing well and we are informed that, in proper cases the use of ether is not at all attended with risk. Horses & cows have been made insensible with it and when their lungs & throat were quite filled with the gas, tapers were applied and went out (ceased to burn)

We see that the French Medical Academy has been trying experiments in the physiological effects produced in animals by inhaling ether and they find that even the spinal marrow may be pricked and torn without causing the least uneasiness, whilst it would immediately occasion convulsions and death. We understand it has also been used in a case of spasmodic asthma with instant effect.

We are glad that the medical profession are taking up this cause, and wish them and all their patients great benefit from its use.

Sadly, Andrew Mackie died later that same year of typhus, leaving a widow & three infant children. His obituary noted that in his capacity as Medical Officer of the Parochial Poor Board: 'Dr Mackie had to visit many of the most wretched hovels in the place and had to face disease aggravated by all the evils that never fail to accompany filth & poverty'. 'In ministering to the sick, his mind was kind & gentle to a degree scarcely conceived by those who met him in the normal intercourse of life'.

His marble head stone in Cupar cemetery was erected by Friends 'as a tribute of respect to his private worth and in grateful acknowledgement of his talent & zeal displayed by him in his professional duties; in the faithful discharge of which he fell victim to a fever while ministering to the wants of the poor'.

This is a remarkable description of events from those days. Clearly, anaesthetic ether was employed very soon after its arrival & not just in the cities - the Fife Herald reported its use by a Dr Paterson in Markinch & Dr Thomson in Stonehaven.

Reference
1 Hendry D.W.W Cupar Doctors and their families. Cupar 1992
CUPAR OLD PARISH CHURCH & ANDREW MACKIE'S COMMEMORATIVE TABLET
DANGER!
BEWARE OF
GOLFERS ON
THE FIRST TEE

THE EAST RENFREWSHIRE CLUB
SEEMED FOREWARNED
ABOUT THE ABILITY
OF SCOTTISH SOCIETY MEMBERS
ON THEIR ANNUAL GOLF OUTING
The annual golf outing of the society took place at East Renfrewshire Golf Club on 20th June. Fifteen enthusiasts took part from all over Scotland with one from south of the border.

After several weeks of rain the course was heavy with no run on the ball and the midges were in abundance. The weather in the morning was mixed with some very heavy showers but the afternoon was bright and sunny.

The morning Stableford was won by steady Eddie Wilson from Dundee with a commendable 34 points.

Rae Webster from Northampton was the runner up on 33pts. Hopefully her success will encourage other lady members of the Society to take part next year!

Charlie Allison’s initial excitement on the short 13th of missing the hole by 18 inches was dampened somewhat when he missed the putt and took three!

The afternoon East v West match was drawn 2-2 and the nearest the hole competition was won by David Marsh, again at the 13th.

Refreshments and high tea followed in the clubhouse, during which the prizes were presented, in the absence of the President Peter Wallace, by immediate Past President Farquar Hamilton who graciously expressed some words of thanks to the organiser and to the club for hosting the event.

The services of Eddie Wilson were prevailed upon, during his warm glow of achievement, to organise next year’s event which will head back East.

The 2003 S.S.A. Golf Event will be held at Aberdour G.C. on Wednesday June 11th. Meeting at 9am for a 9.30am tee time

Organiser: Eddie Wilson, Ninewells Hospital
INVERNESS  Isobel MacKenzie

It has been an eventful year in the North. A year of goings & comings and extraordinary weather. First the goings - OCHONE for us, but for him, well the Admiral was piped off the bridge of the good ship *Anasthesia* and has gone aboard the yacht *Gallant* with hardly a backward glance. Howard is free at last! Always the consummate performer, he’s continued retirement while there are still pensions! We wish him joy on water, on groomed pets, in the kitchen pots, on the dance floor and anywhere else he chooses to be. The impression is of a feisty stallion galloping in green pastures, rather than a dotted old dog staggering kennelwards. And (no surprise) it’s taken twenty-eleveths to fill his position in the department.

Now the comings. We have been fortunate to appoint the still-cherubic Charles Lee, a not-so-long-lost SHO with a weighty ICU CV, and the distinguished, pretty Ros Lawton, poached (much to their distress) from Yorkhill. To Caithness came John Macleod, who has a chronic pain string to his bow which will be much in demand. We wish all three a happy and fulfilling time in the Highlands.

Next, the extraordinary weather - lightning storms & torrential rain caused unprecedented flooding. Having printed the programmes for the Scientific Meeting, we were(a)ghast to see guests of the Tiree Hotel evacuated from our carefully-chosen establishment by the coastguard in rubber dinghies. There followed a clifftopper - they would be ready, no they wouldn’t.

With six weeks to go, the Lachadd kindly obliged – a perfect fit for the small, hardy band who turned out at uneasily hours to brave Drumochter the flooded A96 at Elgin, the air above the Minch & the Ord of Caithness to join us. The meeting proved highly enjoyable, even for the organisers who at one stage thought having no venue didn’t matter too much since nobody was coming anyway! The *Dundee* Celidh was great fun - we were joined by our favourite surgeons, who danced with almost as much vigour but not nearly as much élan as Dr Spenceley, dancer of the Decade

Coming and going now (to London) will be Ian Johnston, elected to the Council of Alcoholics Anonymous [AAGBI] – funny, we didn’t think he was that big a drinker. Seriously, we are impressed, delighted & wish him well with his arduous tasks ahead. Our spanking new MR1 scanner clonked into life and we are soon to be initiated in the mysteries of its portfolio files won’t be trampled into fine ash by the Horsemen of the Apocalypse. Plague wider horizon, we hope appraisal forms continue to run the department, though Charlie thinks he does (Study Ed.)

ABERDEEN  Kathleen Ferguson

"Forties, Cromarty Forth, Tyne Dogger, Fisher, German Right...."

The format of the sea area forecasts is steady, but the picture they paint is of a changing world - sometimes calm, sometimes stormy, occasionally unbearable. The coastal stations report similarly. And as a parable of hospital life in the acute sector, this scenario has a ring of familiarity.

We have noted a few sunny intervals in Aberdeen over the last 12 months with the coming of SPOID (Scottish Practice OCSE Day) which gave us the opportunity for a picnic in the Clinical Skills Centre, at least the trainees enjoyed it, didn’t they? The passing of the College Study Day provided a pleasant outing that stimulated some erudite discussion, and not only about the weather. A following wind brought new starts at SHO & SpR levels - welcome progress greeted with pleasure, Joining the prevailing wind we welcomed Fiona McCallum, Bryce Randall & Graham Wilson.

Meanwhile we wish future success to Jas Pal-Kerr who has gently breezed into the Borders. In some respects, we have had a settled spell with no retirements and have had the chance of relative stability to consolidate responsibilities & working practices. The horizon is of course infinitely variable giving opportunity for development as well as observation. In our case, the view from theatre is such that darkness & light are second hand information. None the less, those who stray beyond the horizon will sing the boasting song, and we shouldn’t worry too much.

Cases keep flooding in here like everywhere and the sandbags are out in an attempt to prevent engulfment. Contractual changes, senior & junior, appraisal, revalidation, talk of foundation programmes and role extension are buffeting the system with, at times, rather disagreeable sensations that call for determined grounding of loins & urgent calls for action. In the face of the climate, I don’t think we have taken the risk of the Fifties.

The climate in which we survive and dare to thrive remains temperate even when we are tempted ourselves to be less so. Naturally the environment is always changing and, despite ourselves, we adapt to it and so we can predict bright spells & squalls, successes & difficulties. Michael Fish, where are you now?

STRACATHRO  Alastair Houghton

The Strachathro service area sign used to warn motorists that the garage was "NOT 24 HOURS". The hospital now has a similarly restricted role as a purely elective ADTC (Ambulatory Diagnostic & Treatment Centre). Some patients do stay overnight as the ADTC suite of operations includes Oscillotomies & Lap. Cholecystectomies. A £10m revamp will include on-site MRI & CT scanners - so bring on the PathPals (the Obesity risk factor code in the College’s Critical Incident form).

Ivon Grove-White has positively retired from full-time practice, we think. He can take great satisfaction in guiding us through Strachathro’s glory days as a major joint-replacement centre. (Ninewalls may cope with the transfer of these cases eventually.) We are also indebted to Ion for his political acumen - for example, the contractual issues of 1990. Even as a S.R., he helped to negotiate the original "UIMT contract". As a two-centre consultant, Ion often used his undoubted networking skills to good effect. Latterly in Dundee he was the recognized expert in paediatric ENT airway cases and way-back-when provided a postop. epidural service for the occasional, but successful oesophagectomy at Arbroath Infirmary. We all wish Ion and Pat a happy retirement.

Both Ion’s and Donald Thomas’ jobs have been transferred to full-time Dundee posts. Meanwhile in Angus, Annie Donald & Ian Beveridge continue to run the department, though Charlie thinks he does (Study Ed.)

To make amends, may I say your Editor gave me a faultless anaesthetic when Pete Rickhuss winkled out your reporter’s mensal fragment.
This does beg the question: how can they claim to make a loss in Inverness, discipline the requester. Apparently the RCA felt that, having provided Jon Bannister, Neil Mackenzie, and obstetric/general colleagues - Pamela Johnston & Catriona Connolly. The local background of all these appointments is testimony to the need to ensure a steady flow of good quality trainees to manage expansion & fill consultant vacancies. Congratulations to Pamela for being successfully appointed to implement the new ICM SpR post, and Mo Al-Haddad took up a similar slot in Edinburgh. Frank Mackay was previously a Dundee consultant & latterly worked as a locum in Fife. His wealth of experience has already proved very useful. He'll be sorely missed by all of us, as well as by his pain clinic act following Mike B as the ICU trouble-shooter.

There has been much progress over the last 12 months. We have continued the integration of the two previously distinct departments at Dunfermline & Kirkcaldy into one Fife Division of Anaesthesia. There is much more cross-county working, with the majority of consultants doing sessions at both ends of Fife. With much hard work from our Rotamaster Hany Mina, we now have a single rota for the whole of Fife incorporating Senior & Junior anaesthetists available 4 weeks in advance & fully computerised!

Fife has now presented its outline business case to the Health Dept. to initiate the move to one acute hospital site at Kirkcaldy, but we are still a long way from this We will, therefore, continue to have problems with providing obstetric services on an isolated site for at least the next 5 years and will still have to cope with a split of acute medical & surgical services and the problems this causes over this period. Some of us will be out to pasture full-time by the time all this is finally resolved.

We've had changes in our consultant staffing. Joyce Stuart left us to try her hand at ICU in the Western General, Edinburgh. This cut down her travelling considerably, but we'll miss her wit & enthusiasm. In her place we appointed two consultants: Bob Savage, who has a major ITU interest, is originally from Ayrshire, but latterly has been trying to understand the 'modernisation' gobbledygook thrown at us by our Party's health spokesperson! Frank Mackay was previously a Dundee consultant & latterly worked as a locum in Fife. His wealth of experience has already proved very useful.

We said goodbye to Fife's longest serving consultant, when Callan Wilson decided to look for pastures new by taking early retirement. He made a tremendous contribution during his 25 years at Kirkcaldy. At times controversial, Callan stimulated many a heated discussion over coffee, at both ends of Fife. With much hard work from our Rotamaster Hany Mina, and urological patients. In his place we're fortunate to have appointed Moira Simmons, who left Inverclyde after 8 years to continue her major interest in obstetric anaesthesia. She'll prove a tremendous asset when the Fife obstetric unit at last moves from Forth Park to the new acute hospital at the Victoria.

Lastly I would like to thank all my fellow anaesthetists in Fife for their support to me over the last year, which is much appreciated.
FORTH VALLEY Gordon Wardall - Crawford Reid

We have little definite to report at present. At last some movement seems probable in acute service reorganisation, with paediatrics & obstetrics likely to be centralised due to junior doctor shortages in these specialties. Unfortunately, these staffing problems may be replaced by even more severe ones resulting from a lack of anaesthetists. The new maternity unit requires a new resident anaesthetic rota - staffing this looks problematic.

Falkirk & Stirling struggle just to maintain an inadequate single resident rota at each hospital, often dependent on locums. A long-term strategy for acute services exists since 2003 and there is hope that this will entail a single new acute hospital (hopefully a reasonable size). However, worsened medical staff shortages make it certain there will be reorganisation on the current two sites long before this is operational.

Vine Desurkar is to be congratulated on passing his Primary FRCA at the first attempt. Germany continues to provide us with good anaesthetists - currently SHO Nik Mangold at Falkirk & our long-term staff grade locum Paul attenuation in Stirling, as well as being as Grade 4 at Staff Grade - at present she is on maternity leave & we wish her well.

Also at Stirling we say a fond farewell to Jane Duffy (Western, Glasgow), Sarah Aturia (Midhurst, Hants) and Andy Crockett (Ninewells, Dundee). Thank you all for your help. We have been joined by Parag Desai & Vinny Shantti from India. There have been no changes at consultant level.

EDINBURGH ROYAL David Kay

After our multiple expansions, this year's a period of consolidation. At Consultant level, Julie Watters increased the female representation in cardiothoracic anaesthesia. Susan Nimmo & Alexandra Stewart have taken advantage of the Bosman ruling to arrange free transfers from RIE to the Western. Susan Kemio has taken up residence in Staff Grade at WGH & has been selected as Consultant at Haemry, Brighten, Doncaster, Sheffield & Adelaide. Trainee numbers continue to increase, bucking the trend in other regions. Splits increased in the School of Anaesthesia & we have just had approval to increase SHO numbers by four to achieve New Deal compliance.

The City & Princess Margaret Orthopaedic Hospitals closed, with work relocated to the new RIE & WGH. Building work is well advanced, increasing new & expensive losses in Edinburgh dramatically. As well as these changes, colorectal surgery was centralised at WGH with upper GI based here. So far these arrangements are working well, but the CEPOD theatre has not yet noticed any reduction in workload.

We successfully opened Phase I of the new Royal Infirmary last Spring. To date things are working reasonably well & most colleagues are very happy with the new equipment. Phase 2 will be occupied in a phased programme in late April, with the present RIE vacated by the end of May. We all look forward to the move albeit with fond memories of the old site.

Further equipment is being purchased, so we'll have modern machines & monitors in all anaesthetic locations throughout the new hospital. Agreement has finally reached with the local council to increase the number of parking spaces at the new site, but cyclists are currently being riled at the Trust's proposal to charge them for secure facilities.

Consultant appraisal is well advanced - all should have completed this year's process soon. Feedback is generally positive and most have found some time to review their practice, and it is interesting to note that our own NHS IT systems find it to provide appropriate information for appraisal. It is still not clear how the information recorded will assist with revalidation, but maybe this will change with greater experience.

With all this going on, no-one's had time to consider the potential impact of the new contract - no doubt more will appear in next year's reports.

WESTERN, EDINBURGH David Wright

Another year of change & 'rationalisation.' ENJ moved here from the City Hospital but operations are carried out in the old theatre suite in less than ideal, though (we're assured) temporary, surroundings. Arnie Arthur & Gordon Pugh transferred sessions & on-call and Ellis Simon comes from the Royal one day a week. A realignment of surgery in Edinburgh saw Upper GI centred at the Royal & Lower GI here. Several surgeons moved from the Royal to the Western and vice versa. Susan Nimmo transferred her sessions & an interest in acute pain to the Western.

Murray Carmichael retired, but is still doing a locum while Lesley Colvin is on maternity leave. We hope his replacement will be appointed soon. Lynne Campbell, a locum here, was appointed a consultant in Brighton. Susan has just obtained her final exit interview, assessment and Joyce Stuart came from Kirkcaldy, with her major interest in Critical Care. This brings the number of our consultants up to 25. John Wilson has been with us as a Lecturer from the Academic Dept. - a welcome development. He leaves soon for a year in the Antipodes and we look forward to the academic presence being continued.

Those with administrative responsibility now include Charles Walle, who succeeded Lynda Rutledge as Lead Clinician, Peter Andrews (CAR for Critical Care), Talat Aziz (Main Dept. CAR) and Rob Sutherland (CAR for Neuroanaesthesia). Dorothy Leighton retired as our Department Secretary and replacing her has proved a challenging task.

We've had another year of positive development. If you listen quietly you can still hear certain elements of the Grand Plan, slumbering, waiting for their moment to arrive. Or is the noise the distant rumble of much more significant changes to come? We wait to see what the future holds.

ST. JOHN'S LIVINGSTON Duncan Henderson

Margaret Lonsdale has transferred to scupper climes in Eastbourne. We are sad to lose her as she made a big contribution to the department and also played a key role in the burn's unit. We interview for two consultant posts in December. Office space will take longer to sort out.

Simon Edgar had a new addition to his family and sports the tired new parent look. Meanwhile, Alan Watson (WGH) will soon be the C.D. of surgical services. Mike Fried is kept busy as chairman of the medical staff committee and Donald Calloway is our new college tutor. The Primary courses run by Elaine Martin. Simon Edgar & myself remain popular; we're also happy to be involved in the Scottish OSCE group & look forward to hosting the next OSCE in January.

MONKLANDS Peter Patterson

In the midst of talk, rumours & fears regarding contracts, compliant rotas, European Working Time Directive and the impending third world war, we consider we are still managing to provide a quality anaesthetic service at Monklands. Most of the things we need to seem to be quite enjoying our daily grind (though perhaps less so the night-time bit!)

After the major reorganisation of Lanarkshire services in the previous year, there have been no major-plus happenings during the last 12 months. There have been some staff changes. At consultant level, Caroline Harper joined us from Sheffield to replace Marion Brink. We've had a few staff grade changes. Susan Chomnaly joined us and SHO Andy Ody moved into the grade. One of our staff grades, Gypsy Matthews, was recently appointed to an SpR post in the West of Scotland. Although we know such moves are theoretically possible, its very heartening to see it happen in practice. We have had the usual coming & going of SHOs. We're pleased to see those we have trained move on to further their careers and delighted that we continue to replace them with high quality recruits.

WISHAW GENERAL John Martin

Our tribe of anaesthetists has now been integrated into the promised land of Wishaw, and the old country of Law is a distant, but heartwarming, memory. Meantime, not only the fabric of our department but also the personnel continues to change. Since my last report, Marsha Haetzman came down from Aberdeen to join our consultant ranks & add to the obstetric specialists among us. Another appointment is in the offing; in the meantime Alison Simpson is in post as locum consultant.

At the other end of a professional career, Scott Redpath has had enough and retired at a very young age (still in good/rude health). He is joyfully counting the days (& nights) till freedom. Kit Eatock is looking to the future and, after a short sabbatical, intends to commute (and be on-call!) from Inverness, where his wife Roz is taking up a new post. The fact that it is nearer his beloved hills has no bearing on the matter...

Our department has given birth twice this year. Janie Collie safely delivered her second son Hugo in the late summer, and one of our SHOs, Kirsten McCullough had her first child Phoebe earlier in the year. Mums and babies are well & thriving.

On the professional front, we're battenning down the hatches in preparation for the forthcoming storm that will be the New Contract. No doubt you've all had enough already on this topic, so no regional comments from Wishaw. In face of the hassle of appraisal/revalidation/justifying your existence etc., we're burying our heads in the sand and hoping it all a bad dream which will go away. Unfortunately it won't!

The folly of having three district hospitals in Lanarkshire continues to be a bad dream which will go away. Unfortunately it won't!

FORTH VALLEY Gordon Wardall - Crawford Reid

WESTERN INFIRMARY, GLASGOW Colin Kinzie

The most notable event of the last year at the Western has been Peter's elevation to President of the Association - we wish him success in his new role. On a different note, Leyla Sanai - recently profiled in the BMJ - remains in poor health and we send her our best wishes. There has been no movement at consultant level, but we have appointed many SHOs as we try to make our numerous rotas comply with the New Deal.
GLASGOW ROYAL  
Travis Mckillop

Although the years are flying by ever more quickly, the pace of change at the Royal, in structural matters at least, is as slow as ever. Alex Patrick wrote last year that Canssoburn Hospital, the Regional Plastic Surgery & Burns Unit, would be closing and that we would be moving into the new Emergency Receiving Centre, Plastics & Burns (ERC&P) building on the GRI site during 2002. This building will contain a new SpRs department, medical receiving unit/CCU and all inpatient orthopaedic beds, as well as the Plastic Surgery & Burns Unit. Unfortunately, although the building is up, due to various factors the move has not yet happened - but we're sure it will soon, perhaps even by the time you read this - honest! One further development in the rationalisation of Glasgow's hospital services has been the departure of maxillo-facial surgery to the Southern General.

Brian Maule has taken over as Department Chairman and Willie Frame continues as C.D. Andy Woods has been appointed to a split consultant post between Stobhill & the Royal. We have seen many of our SpRs appointed consultants - congratulations to Phil Korsah, Karen Reynolds, Kevin O'Tiure, Steve Noble & Barbara Crooks. Those who like watching medical documentaries may have seen Barbara & her triples in Baby-Ear. Stuart Grant & Stuart Milne have both gone over the pond for a few years having got their CSCTs. All these appointments have meant a lot of new faces and the pace of change seems to be getting ever faster. Hopefully even the more bemused of us have managed to make them all welcome.

SOUTHERN GENERAL  
Philip Cotes

There have been few Consultant staff changes in the last year, Tim Parke, who is an A & E Consultant, decided that one lot of on-call was enough and ended his contribution to our ITU rota. While we are very grateful & sad to see him go, I'm sure it is for the best. At least for Tim's sanity! We have been fortunate to get Daphne Warren as a locum and hope to have a new colleague in the next few months.

Tim left with fond farewells and after quite a few beers. His departure however, has left A & E with only one junior doctor at the moment. This is a peculiar time for the medical profession: a time when we have nearly 60% of our medical students in post, but our trainee numbers are falling. We have got ourselves up to 99 A & E doctors, but how much more can we expect? We hope to have a new junior doctor in the next couple of months.

Stobhill Roger Hughes

The slow loss of services at Stobhill continues with Orthopodics now centralised at the Royal; ENT & Ophthalmology plan to go to Gartnavel and Gynaecology to the Southern. However we remain a busy hospital with at least another five years of Acute Medicine & Surgery projected.

Two new consultant appointments, jointly with the Royal: Andy Woods, back from Australia, shares an office with me for his sain, and Barbara Crooks, who promptly left to have triples (all well). Carol Murdoch is currently on maternity leave (they're trying to combat the falling Glasgow population!) & Lyne Carragher is doing her locums. We hope to advertise a sixth critical care post shortly. Gordon Peters & Laura McCarrin passed their Primaries & still nurse hangovers. After three years stalwart service, Francis Tajard departed to become a SpR in Aberdeen.

I, at 55, voted for the Contract. I await the money but understand my 40-year old colleagues' unhappiness. By the time this is published, events will have certainly progressed much further. Interesting times...
If you telephone us, you can still be sure of a cheery welcome from Lynn Grundy or Jenny McClelland in the office. They have recently been joined by the equally cheery Lesley Hudson.

Despite hospital closure rumours (circulating before I arrived in 1989) our workload & commitments have steadily become greater until we find ourselves no longer able to cope with the roles and responsibilities of the anaesthesia team. We now find ourselves exposed. The long-awaited CT scanner now really appears to be just around the corner - a contract has been signed and the first scan is targeted for a week or so. It should reduce the time that anaesthetists have to spend in the hospital at night.

All in all, it has been a somewhat unsatisfactory year for the hospital (which has resulted in a number of high profile resignations & early retirements) but it does now look as though the Health Board is at last demonstrating some commitment to us. We are optimistic for the coming year.

CROSSHOUSE Alexander Michie

Another year ends with our Trust (which includes Ayr of course) recently acquiring a new Medical Director and currently awaiting the arrival of a new Chief Executive & General Manager for surgery services - so who knows what lies ahead? At the time of writing, no Ayrshire consultants have been appointed, but we'll do so soon, hopefully! We're drowning under a sudden tidal wave of waiting list initiatives to meet political targets - but enough moaning (a prerequisite for being CJD)

So to the good news - we welcomed two new Consultants. Philip Konsh joined us from Glasgow Royal and added his undoubted talents & skills to the ITU team, as well as to other areas of the department. Agnesiska Devine relocated to the West of Scotland with her husband, a Maxillofacial Surgeon in Glasgow, having previously been a consultant for 5 years at the Royal Liverpool. She replaced Catriona Thomson, who has retired in our Pain Clinic working along with Charles Martin. I know that her input is already appreciated. We continue to have a good and happy (I think) bunch of trainees, with lots to offer them.

Chris Heskworth organised an ITU 'team-building' weekend to Arran with a good mix of consultants, trainees & nurses. There are plans to repeat the event at a different venue in 2003.

We look forward to building starting soon on our new Day Surgery Unit & Theatre refurbishment; and await the green light from Edinburgh to relocate the Maternity Unit from Irvine to a new-build facility here.

SOUTH GOTHAM CITY (AYR) lain Taylor

My worthy colleagues have informed me that any further references to them as elves, dwarves, hobbits, Jedi Knights, princesses and mobsters will be met with severe physical repercussions.

Accordingly, I feel that it is my duty to reveal their real identities & roles in this world. Their roles as anaesthetists are to be believed, dedicated to fighting criminal activity and upholding the ideals of anaesthetic perfection, against the assaults of management and surgeons alike (and they are very alike).

Our new leader is Superman (Ken MacKenzie) who flies everywhere in the world in the blink of an eye and knows all things. His sidekick Batman (Robbie McMahon) is likely to postpone his planned retirement in the light of the benefits of the new superhero contract. We can only benefit from his experience for a few years more before he hangs up his cape and trades in the Batmobile for a Merc.

Wonderwoman (Ruth Jackson), still protects our citizens from mental illness by cranially electrocuting them on a biweekly basis.

Captain America ( Boyd McKeeljohn) continues to minister to the chronically injured with his needles & potions and Robin (Paul Wylie) heroically supports the trainee superheroes with tutorials on the use of their awesome powers.

Wolverine (David Ryan) is again terribly handsome, having recently flirted with facial exposure. He soon relented & covered up again, to the great relief of the local populace & a slump in the international shaver industry.

Mr. Fantastic (Iain MacDiarmid) continues as the gravely bass-voiced heart & soul of lateral thinking in the department, never saying what anybody else ever considered as a sane response to a situation. He sure keeps the bad guys off-guard!

Spiderman (Ian Taylor), the nifty spiderman, weaves his web and patrols his ICU-like nest with obsessive dedication.

Superman (Ken MacKenzie) continues to protect our citizens from mental and physical harm. He trades in the Batmobile for a Merc.

Our new leader is Superman (Ken MacKenzie) who flies everywhere in the world in the blink of an eye and knows all things. His sidekick Batman (Robbie McMahon) is likely to postpone his planned retirement in the light of the benefits of the new superhero contract. We can only benefit from his experience for a few years more before he hangs up his cape and trades in the Batmobile for a Merc.

DUMFRIES Hugh Broucher

Despite everything, the daily work continues.

The good news of the year is that we now have a spanking new site - the Maternity Hospital, opened by the Princess Royal last spring. No longer cars seen hurtling from the Infirmary to the old Cresswell building.

One other benefit is that James Neil has been able to start using spinal opiates for obstetric cases. The new Day Case Unit has not been such a revolution, but we shall probably continue the Dumfries way of having in-patients and day patients on the same list.

Despite everything, the daily work continues.

ITU uprooted itself to the surgical floor for some weeks at the end of the summer while major refurbishing took place but is now back to normal. Dewi Williams & his colleagues are to be congratulated on recruiting the first patient in the entire UK to the FACMAN trial with Willie Peel collecting the champagne.

Despite everything, the daily work continues.

Major management changes imposed on us all had Clinical Directors (including our David Bell) becoming extinct, to be replaced by Speciality Team Leaders (Willis Peel for Anaesthetics & Dewi Williams for ITU/HUD) working under four Associate Medical Directors, who include Bryan Webbon for Acute & Emergency Care.

Despite everything, the daily work continues.

A Management Team was brought in to point out to us poor dopes how we could increase our theatre throughput by 7% in order to keep up with waiting list demands, with no increase in staff or accommodation. Two months later their changes are absolutely zero.

Despite everything, the daily work continues.

BORDERS Janet Braidwood

We are currently seeing some changes in our consultant cohort. Chris Richard, who was previously an Associate Specialist with us, has now taken up a consultant post here. We have been joined by Ian Pinkerton and welcome him to the department.

We wish a happy retirement to Colin Beighton, who first joined the Department when it was at the Peel Hospital. Ian Youngswells left here at the end of the summer. We hope to see two new faces among our consultant numbers in the months to come, when the successors to Colin & Ian have been appointed.

Let us know if you have any plans, or would like to be considered as a candidate by the Society, if we were to be approached from abroad.

Please contact your regional council member in the first instance.

The Scottish Society is always keen to help members wishing to undertake good work abroad.

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Sevoflurane

**Presentation:** Amber bottle containing 250ml sevoflurane.

**Indications:** Use of sevoflurane in adult and pediatric patients for inpatient and outpatient surgery. Dose: MAC sevoflurane usually produces surgical anesthesia in less than 2 minutes. Induction in adults up to 5% sevoflurane usually produces surgical anesthesia in less than 2 minutes. Up to 8% sevoflurane can be used for induction in unpremedicated patients. Maintenance concentrations range from 0.5-3%. Elderly: lower concentrations normally required. Administration: Deliver via a vaporiser in an oxygen or oxygen-nitrous oxide mixture. Full details in Summary of Product Characteristics.

**Contraindications:** Known or suspected genetic susceptibility to malignant hyperthermia. Experience with repeated exposure is very limited. Until further data are obtained, sevoflurane should be avoided in patients with malignant hyperthermia. Levels of Compound A (produced by direct contact with CO2 absorbents) increase with increase in core body temperature, increase in anaesthetic concentration, decrease in gas flow rate and increase in end-tidal CO2 with the use of low-flow rather than sodaline 

**Interactions:** Potentiation of non-depolarising muscle relaxants. Sevoflurane is a sensitizer to the myocardiun. In the arrhythmogenic effect of adrenaline, local anaesthetics may be required following one of an IV anaesthetic. Sevoflurane metabolism may be induced by CYP2E1 inducers, but not by barbiturates. Side-effects: Bradypnea, respiratory depression. Hepatitis has been reported rarely. Convulsions may occur extremely rarely, particularly in children. There have been very rare reports of pulmonary oedema. Most adverse events are mild to moderate and transient, nausea, vomiting, increased cough, hypotension, agitation and bradycardia.

**Use in Pregnancy and Lactation:** Use during pregnancy only if clearly needed. Sevoflurane metabolism may be induced by CYP2E1 inducers, but not by barbiturates. Side-effects: Bradypnea, respiratory depression. Hepatitis has been reported rarely. Convulsions may occur extremely rarely, particularly in children. There have been very rare reports of pulmonary oedema. Most adverse events are mild to moderate and transient, nausea, vomiting, increased cough, hypotension, agitation and bradycardia.

**Use in Children:** Use in children should be avoided. Sevoflurane concentrations should be reduced in patients with CNS depression, hypothermia, hypotension, hypovolaemia, or any condition that reduces cardiac output or increases the risk of circulatory collapse. Anesthetics should be used with caution in patients with renal insufficiency. Levels of Compound A (produced by direct contact with CO2 absorbents) increase with increase in core body temperature, increase in anaesthetic concentration, decrease in gas flow rate and increase in end-tidal CO2 with the use of low-flow rather than sodaline.

True 24-hour 5-HT₃ control of post-operative nausea and vomiting with once-daily dosing¹

Effective in both prevention² and treatment³ of PONV

Long duration of action¹³

High 5-HT₃ receptor selectivity compared to ondansetron⁴

Well tolerated¹², with a favourable side-effect and safety profile

¹Compared to placebo

Brief Prescribing Information (Oncology and PONV Combined)

KYTRIL (granisetron) indications: Prevention or treatment of nausea and vomiting induced by cytostatic therapy and prevention and treatment of post-operative nausea and vomiting. Dosage and administration: Kytril ampoules are for intravenous administration only. For details of administration including suitable infusion fluids, please refer to the full prescribing information. CYTOSTATIC-INDUCED NAUSEA AND VOMITING: Intravenous: Adults including elderly: 3mg given either in 15ml infusion fluid as an intravenous bolus over not less than 30 seconds or diluted in 20 to 50ml infusion fluid and administered over 5 minutes. Prevention: In clinical trials, most patients have required only a single dose of Kytril over 24 hours. Up to two additional doses of 3mg may be given within a 24 hour period. Patients have received daily administration for up to 5 consecutive days in one course of therapy. Kytril should be given prior to the start of cytostatic therapy. Treatment: Dosage as for prevention, with additional doses at least 10 minutes apart. Maximum daily dosage. Do not exceed three doses (9mg) within 24 hours. Efficacy may be enhanced by the addition of dexamethasone. Children: Prevention: 40mcg/kg body weight from the ampoule (up to 3mg) diluted in 10-30ml infusion fluid administered over five minutes prior to the start of cytostatic therapy. Treatment: Dosage as for prevention. Within a 24 hour period one additional dose of 40mcg/kg (up to 3mg) may be administered at least 10 minutes apart from the initial infusion. Oral: Tablet formulation only indicated for prevention in this age group. Oral: Kytril tablets 1mg, each containing 1mg granisetron. 10 tablets: £87.32. Kytril Tablets 1mg, each containing 1mg granisetron. 10 tablets: £87.32. Kytril Infusion, each ampoule containing 3mg granisetron in 3ml isotonic saline. 5 ampoules: £171.90. Kytril Infusion, each ampoule containing 3mg granisetron in 3ml isotonic saline. 10 ampoules: £343.80. Kytril Ampoules, each containing 1mg granisetron in 1ml isotonic saline. 5 ampoules: £57.30. Kytril Paediatric Liquid, each bottle containing 30ml of 200mcg granisetron in 3ml isotonic saline. 5 bottles: £156.60. Kytril Paediatric Liquid, each bottle containing 30ml of 200mcg granisetron in 3ml isotonic saline. 10 bottles: £313.20. Kytril Paediatric Infusion, each bottle containing 3mg granisetron in 3ml isotonic saline. 5 bottles: £117.50. Kytril Paediatric Infusion, each bottle containing 3mg granisetron in 3ml isotonic saline. 10 bottles: £235.00. Kytril Paediatric Tablets, each containing 1mg granisetron in 1ml isotonic saline. 5 tablets: £57.30. Kytril Paediatric Tablets, each containing 1mg granisetron in 1ml isotonic saline. 10 tablets: £114.60. Kytril Paediatric Tablets, each containing 1mg granisetron in 1ml isotonic saline. 50 tablets: £573.00. Kytril Paediatric Tablets, each containing 1mg granisetron in 1ml isotonic saline. 100 tablets: £1146.00.

REFERENCES:

Further information is available from: Roche Products Limited, 40 Broadwater Road, Welwyn Garden City, Hertfordshire, AL7 3AY. Further information is available on request. KYTRIL is a registered trademark. Date of Preparation: January 2002.