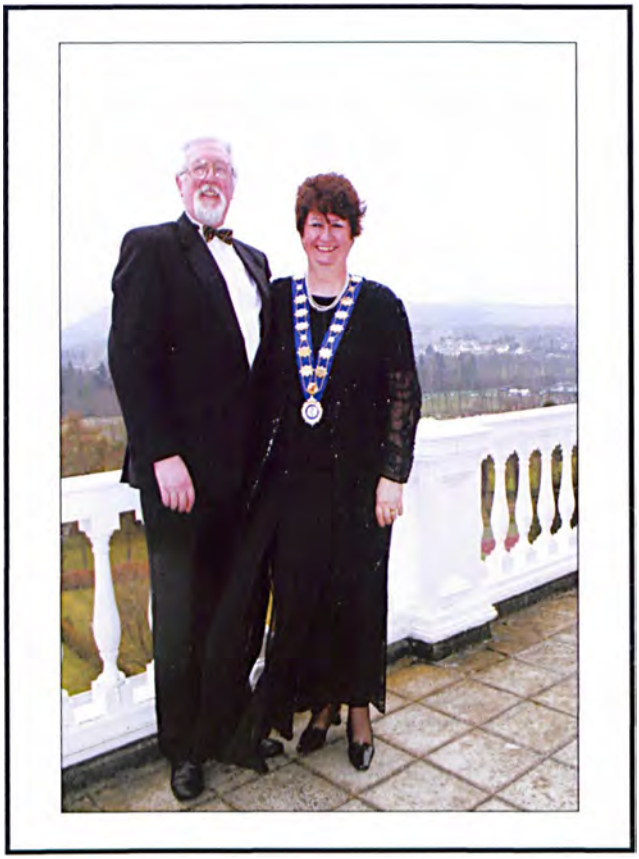
The Annals of The Scottish Society of Anaesthetists 2006-7



2007 Programme of events

April 20th Trainees Meeting at Peebles Hydro
April 20th - 22nd Annual Spring Meeting at Peebles
June 12th - Annual Golf Outing at Rosemount, Blairgowrie
October 19th - 21st Annual Scientific meeting with the South of Ireland Society of Anaesthetists in Killarney.

For details of contacts, meetings, events etc....

www.scottishsocietyofanaesthetists.co.uk

The Scottish Society of Anaesthetists

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Editorial

I'd like to thank the director, the prodoocers, of course the marvellous cast – this is really for them, my mother, her cat doozie.... But seriously folks it's been a pleasure and a privilege to edit the Annals. This is my last and it details a busy and successful year for the Society. Our tenure has seen Peebles survive consideration of other venues and next year the trainees' meeting will move there to form a joint meeting of sorts. The Scientific meeting has just had its second joint outing with the RCOA Scottish Winter meeting and these have proved very popular and worthwhile. Currently the plan is to do this on alternate years to allow the Society to continue to hold meetings in more peripheral DGHs. Though necessarily smaller, these give the opportunity for the "non-teaching" centres to be involved in the core of Society business. Next year we will be guests at a meeting of the South of Ireland Society of Anaesthetists in Killarney, with a joint RCOA meeting in 2008.

As this is going out, the hopefuls' CVs will be being fed into the maw of the MMC computer system. In the meantime we should be grateful to all those who have put so much effort into ensuring that the inevitable disruption will be kept to a minimum and the rest of us can help by being prepared to be flexible when needed to maintain the service..

In this issue Alfie Raffan's reminiscences, for which I thank Iain Levack, give us pause for thought. He describes a different era and as well as some very funny anecdotes, the details outline a very different lot for the anaesthetist. Clearly patients took on much greater risks, often with little in the way of informed consent. Also not just the clinical but the practical and financial aspects of an anaesthetist's life in the pre NHS era were uncomfortable. For example, he refers to "his patient" and "his anaesthetist" meaning the surgeon's and the frantic dashing about he does to get as many cases as possible since he was paid only for cases done and not by salary. Let's hope that the future does not see a return to such insecurity.

In her address, Dr Stockwell talks about the traditional school rules at her alma mater, the John Neilson Institution. These included a ban on gunpowder and firearms - in Paisley! Some things just never change. The Society also thanks the President's husband Ian Gray who has made a wooden box to house the Campbell Quaich.

I see that Anaesthetic Practitioners are now called "Physician Assistants – Anaesthesia". This is somewhat cumbersome. May I tentatively suggest this be abbreviated to PASTAs? As in, "Sister, which Macaroni have I got helping me today?"

Lastly, there is apparently something called the Northeast of Scotland Society of Anaesthetists' Bull. Check it out in Andrea Harvey's update from Aberdeen.

My thanks to all my contributors these past four years and my best wishes to the incoming executive: Liz McGrady, Colin Runcie and Kerry Lichfield.

President's Message

After enjoying a beautiful summer — much appreciated now I have retired — and very happy that I don't have the early morning drive to work in this wet and windy winter, I can look with the retrospectoscope at my Presidential year.

Our Annual Meeting in Peebles was well attended and as usual greatly enjoyed. The guest speakers, Professor Antony Cunningham and the sky-diving Dr Hugh Montgomery were excellent. It's not often we get the chance to hear about the discovery of a gene (from Hugh Montgomery). Now we know whether we can last the pace (or not!) during extreme exercise. The physically less active of us knew all the time that we just didn't have the correct genes (or should that be jeans?).

It was an especial pleasure for me to be part of the giving of the Donald Campbell Quaich to Ewan S. Jack who was the first prize-winner of the Quaich for the best Trainee's Presentation. It was presented by Lady Kay Campbell in memory of Sir Donald. This is now a most important award for any trainee and I do hope that in future the standard and number of presentations will be maintained.

Drs. Choiti Guha and Ewan Jack organised a most successful and well attended Trainees' Meeting in Dunfermline in May where Dr Vishal Gupta won the Poster Prize of £250.

On St. Andrew's Day the Society held the first half of the two day Winter Meeting, with the College organising the second day. My thanks especially have to go to Alex Macleod who worked tirelessly to get the matters organised at the venue — the Scottish National Football Stadium at Hampden. It turned out to be a most acceptable and satisfactory venue although I'm sure the opportunity to have a tour of the stadium was a small (?!) attraction. The speakers on both days were excellent and over 200 people attended, with many compliments being received afterwards.

The Annual Meeting in Peebles this coming April will have an expanded format in that the Trainees' Meeting will take place in the Hydro on the Friday, followed by the Annual Meeting on the Saturday. Your Committee and many trainees felt that the combining of the two meetings would encourage 'les jeunes' to come to Peebles and expand the activities of the Society.

Although the Society is not 'political', I think it is important for the trainees to feel part of the Society because it does provide another forum for their opinions about the way training and job prospects are going. From my perspective it does seem quite depressing about the changes being foisted on the profession and the anxieties being produced by Modernising Medical Careers.

On a brighter note, I would like to thank very much the Committee and especially the Executive members who kept me on the right track (I hope!). The Executive will change next April and I look forward to seeing the new team 'in harness' which will support Alfie Shearer in his Presidential year.

Presidential Address

Music, Medicine and Me

Margaret Stockwell 2006

Among the birthday cards I received on my big 6 was an innocent-looking envelope. Inside was a letter headed the Scottish Society of Anaesthetists, signed by Alistair Michie, inviting me to be the Vice-President, then President in 2006/7. In common parlance I was 'gobsmacked'. This was totally unexpected but I said yes — then the realisation dawned on me….the sting in the tail - THE PRESIDENTIAL ADDRESS.

Well, here it is — 41 Abercrombie Drive, Bearsden, Glasgow G61 4RR!!

Seriously, when I read the addresses given by my predecessors - kindly sent to me by Steven Lawrie - I realised the enormity of this commitment. Accustomed as I am to singing in public, I am unaccustomed to speaking in public. Others said, "Well, just sing your address then!" - Aye right!

To many, the main connection between medicine and music might be thought to consist of that *amorphous effluvium* of mixed sound, classical or otherwise, piped into the operating theatre or played on the ever-present ghetto-blaster. Mozart stressed that silence is also music and more recently asserted it as one of the basic human rights.

In his present series of the Reith Lectures on Radio 4, the pianist and conductor Daniel Barenboim, has certainly made his opinion known of musak. He commented that some think it is very culturally minded to play classical music in the elevator or in the foyers of concert halls before the concert. He has been subjected to hearing Brahms' Violin Concerto in the lift and then having to conduct it in the evening. It doesn't bring one more person to the concert hall and he thinks it is counter-productive. He described one American television advert depicting a company which will clean your toilet quicker than anyone else. The music for this was the Lacrymosa from Mozart's Requiem! Someone wrote to the company complaining about this and received the reply that it wasn't realised that the music had any religious significance - so they're going to use the overture to Tannhäuser instead!

I am, however, not going to discuss what may or may not please, distract or annoy different theatre personnel as reported in Anaesthesia by colleagues at the Western Infirmary in Glasgow. I do have one GRI colleague who cannot listen to Vivaldi's Four 'blanking' Seasons without thinking of his time in one of our Cardiac theatres and having to endure it innumerable times. More later....

I thought it might be appropriate to comment on other associations between music and medicine. The earliest association might be said to have been with the Sun God, Apollo - the Greek God of music, poetry, dancing and healing. A temple built in his honour in Rome in 430 BC bore the dedication 'To Apollo Medicus Salutaris', the god of health. Although Apollo is usually pictured with his lyre, we should remember that it is his name which is invoked in the Hippocratic Oath: 'I swear by Apollo, the Physician, Aesculapius, by Hygeia and Panacea and by all the gods and goddesses that, to the best of my power and judgement, I will faithfully observe this oath and obligation' etc....

In classical antiquity, temples dedicated to Aesculapius were common throughout the Mediterranean, attracting patients in the hope of miraculous cures. Shrines and temples of healing known as Aesclepieia were erected throughout Greece where the sick would come to worship and seek cures for their ills. Sick patients would sleep in the Aesclepieia. In their dreams it would be revealed to them how they could be cured. In the dream, Aesculapius was accompanied by his daughter Hygeia (goddess of healing) and by a serpent, which followed him wherever he went. The serpent would lick the patient's wounds and in the morning, the patient would awaken healed. Snakes seem to have played an important part of the healing ritual and were held to be the sacred servants of Aesculapius.

St Luke

There is a shrine on the Greek island of Kos dedicated to Aesculapius, god of medicine and son of Apollo. It was a renowned curative centre and until recently two fountains provided the site with a constant supply of clean, fresh water - but not on the day that Dr Mellon and I visited it. The healing water was full of dead bees and I don't think it would have done much for her skint toe. Neither of us was much good at cycling!!

Hippocrates was born on the island of Kos. He is supposed to have taught students under the plane tree which he planted and which is still there - well, at least it is very old! He wrote a treatise '*Airs, Waters and Places*' which emphasised the need for good air and water and the holistic approach of ancient Greek medicine which now seems positively contemporary! Apollo was the father of Aesculapius, the god of healing, and had as his companions Terpsichore, the muse of choral dance and song; Polyhymnia, the muse of hymns; and Euterpe, the muse of lyric poetry. Legend has it that Aesculapius was reared by Chiron who was famed for both his surgical skill and musical accomplishments. Pythagoras (of that THEOREM!) regarded music and diet as the correct therapy to restore balance between mind and body and Aristotle spoke of music as a release for pent-up emotions.

St. Luke, the evangelist of the Third Gospel, was not only a physician and painter but also the first Christian hymnologist. It is said that he wrote five of the first hymns of the early Church including the Benedictus, Magnificat and Nunc Dimittis - all of these very much beloved by many composers through the ages. The Church during the Middle

Ages, particularly the big Benedictine and Augustinian monasteries, played a vital role in the development of Gregorian music and also provided the hospitals and dispensaries of Europe. Nearer home, legacies of this include St. Thomas' and St. Bartholomew's Hospitals in London and although Bart's survival was guaranteed (for the political time being at least) because the Health Secretary, Frank Dobson, did not want a plaque on the wall stating: "founded by Rahere 1123, closed by Frank Dobson 1997" redevelopment and PFI may yet interfere with Bart's future.

Mind you, staffing of our modern-day hospitals is slightly different - I hope! In the 1400s, for example, the matron of St. Thomas' was arrested three times for drunken behaviour, while in 1535 an inspection of the same establishment found the "conduct of the master filthy and indecent" in that he kept a concubine and was stealthily selling the church riches while reporting them stolen. When physicians appeared around 1566, surgeons were rated as tradesmen and were only allowed to prescribe under the physicians' guidance. But it wasn't all good news for the new profession - the first physician at Bart's was rewarded for his loyal 20 years of service by being hung, drawn and quartered which certainly saves on lump sums!!

The Elizabethan poet, Thomas Campion after studying law at Gray's Inn, turned to medicine at the ripe age of 35 and he wrote a musical treatise, "A New Way of Making Four Parts in Counterpoint by a most familiar and infallible rule" - certainly an unusual addition to one's CV! Caspar Secundus Bartholinus, remembered because of 'his' gland and cyst, published a paper, "De Tibiius Veterum", with details of the construction of the double flute of Ancient Greece and more recent instruments such as the basset and English horns, the oboe and the clarinet. The original word *tibia* in fact referred to a musical pipe or flute made out of bone, in addition to being the name of the bone of the shin.

The French composer, Marin Marais, was a virtuoso on the bass viol and he composed a graphic musical description of a patient undergoing bladder surgery. The instruments used are the bass viol, harpsichord and continuo (otherwise known as the violincello).

Antonio ****ing Vivaldi!

The patient quails as he beholds the surgical apparatus
He mounteth the operating scaffold
Seized with panic he thinks of fleeing
He reconsidereth
He is bound with cords of silk
The surgeon maketh his incision
The forceps is introduced
Hereupon the stone is brought forth
Here as it were the voice faileth
The blood, it floweth
The surgeon unloosens the silken cords
and now thou art put to bed.
Relief and Rejoicing!!!

Apparently the general merrymaking of the instruments in the finale breathes well-felt sighs of relief and joy! No mention of an acute pain service although I fancy that a large cognac may have been brought into service...

In the seventeenth and eighteenth centuries, there were two great hospital benefactors - Antonio Vivaldi and George Fridric Handel. Vivaldi was known as the Red Priest (il prete rosso), not because of his politics but because of the colour of his hair! He was maestro di capella on the staff of the Pieta, one of four charitable hospitals in Venice, where string-playing probably made its greatest leap forward. These hospitals were not exactly

like ours today - they were institutions founded to house illegitimate, abandoned and orphaned girls who were then schooled in music, both choral and instrumental and some became very expert musicians. The girls were usually known by their Christian names such as Lucietta della viola, Silvia dal violino - a bit like Jones the Plumber or Jones the Grocer in Wales! It was this training, together with their spirit of teamwork, that helped Venetian composers forge that galaxy of string sinfonias, sonatas, concerti, masses, oratorios and other Church music that fill us still today with admiration for their opulence of sound and abundance. Vivaldi, for instance, wrote four hundred concerti for strings, featuring the various instruments in solo and group combinations and furthering orchestral colour with cembalo, mandolin, oboe, flute and tympani. You can appreciate this in the exceedingly well-known "Four Seasons". Forgive me here - I have a confession to make. As I alluded to earlier I now can't hear The Four Seasons without a very old English swearword preface. I worked for some years with David Wheatley who liked classical music played in theatre. Gordon Sutherland also worked with David. There was a fairly large selection of cassettes kept in the theatre but the Vivaldi was played exceedingly frequently. As is not entirely unusual, in GRI there are light sticky fingers and cassettes were nicked - to quote Gordon, "All except Vivaldi's Four F...ing Seasons". It has somehow coloured my thoughts when I hear that music announced on the radio!

The other benefactor, Handel heard concerts performed at these Ospedali in Venice. In 1742, he was in Dublin to present the first performance of the Messiah, the proceeds of which went to the Charitable Infirmary of Dublin and Mercer's Hospital. After he returned to London, he became very interested in Captain Coram's Foundling Hospital - ***the Hospital for the Maintenance and Education of Exposed and Deserted Young Children.*** One of the aims of the institution was to combat "gin which reduced women to depravity and their unwanted offspring to the dubious hospitality of the pavement". Handel presented the Foundling Hospital (now part of Great Ormond Street Hospital) with an organ which he played during a performance of the Messiah and then he presided annually at the hospital Messiah, which greatly enriched funds there and he also bequeathed parts of the score of the oratorio to the hospital.

It was after one of these performances of the Messiah, however, that Handel first sought medical attention for his failing eyesight. He was operated on by Dr Samuel Sharp, who was regarded as one of the first great surgeons of Guy's Hospital. This was not a success and even after total blindness had set in, he underwent *further* surgery by an itinerant optometrist, Chevalier John Taylor. This operation was not a success either - nor was the surgery done by the same gentleman on Johann Sebastian Bach and, in fact, Bach died four months after his operation!

We have a Scottish connection with the 'Father of the Symphony' Joseph Haydn. Papa Haydn was acquainted with the surgeon, John Hunter and his wife, Anne Home Hunter. Hunter's wife wrote poetry and Haydn set several of her poems to music. The most famous of these is the canzonet, 'My mother bids me bind my hair'. It is thought that Mrs Hunter was the original librettist of Haydn's oratorio "The Creation" – a wonderful work which will certainly come with me to my desert island. John Hunter is recorded as having forcibly attempted to remove a nasal polyp from Haydn! Unfortunately there are no details of how this was achieved but Hunter's love of composers was certainly not as great as his wife's. Apparently he returned home late one evening, *after a hard day's fag* and found his drawing-room filled with musical professors, connoisseurs and *other idlers* whom his wife had assembled. He was greatly irritated and walked straight into the room, addressed the astonished guests in the following strain: "I knew not of this kick-up and I ought to have been informed of it beforehand; but as I am now home to study, I hope the present company will retire". His instructions were promptly obeyed. We are not informed of Mrs. Hunter's response!

In 1786 Dr Anton Mesmer, whose alleged hypnotic powers gave rise to a new word in the language, commissioned Wolfgang Amadeus Mozart to compose the short operetta, "Bastien and Bastienne". This was composed by Mozart at the

ripe age of twelve and it was performed in the Mesmer's garden theatre. It is still quite often performed - sometimes with a cast of children. How many of us can stretch to a theatre in our garden - real sponsorship of the arts!

The founder of the medical art of percussion of the chest and abdomen was Leopold Auenbrugger He drew his inspiration from noticing how his father, a vintner, used this method to estimate the state of emptiness or fullness of his wine barrels. He also gave his name to Auenbrugger's sign, a bulging of the epigastrium in diffuse pericardial effusion - not much commented on in today's case histories! His other claim to fame is that he wrote the libretto to Salieri's opera 'Der Rauchfangkehrer'- The Chimney Sweep.

I know you will have heard of Salieri thought by some to have poisoned Mozart with mercury which caused renal failure. The tragedy of the Mozart's final illness, strange death and anonymous burial has long intrigued biographers. It is possible that the oedema was part of a terminal episode of rheumatic carditis, endocarditis and atrial fibrillation. During those extensive and undoubtedly very uncomfortable travels with his children over most of Europe, the composer's father took with him what must have been virtually a small portable dispensary. The ingredients of his two favourite mixtures merit recording as medical curiosities:

MAGRAFENPULVER included magnesium carbonate, peony and iris roots, mistletoe, crushed coral and gold; while the main constituents of SCHWARTZENPULVER were charcoal, deer's antlers, myrrh, coral, earthworms, frogs' heads and placenta.

I'm surprised Mozart lived as long as he did! He died on the fifth of December, 1791 and the records in St. Stephen's Cathedral in Vienna showed that he had a third class funeral to St Marx cemetery which cost a total of 8 florins and 56 krowns with a further charge of 3 florins for a hearse. His grave was later dug up for re-use (a common practice in those days) and the bones were scattered, making impossible any modern chemical analysis of his remains.

The late eighteenth and early nineteenth century Vienna emerges as a remarkable city of musical innovation and clinical medicine. The composers encountered each other and their many patrons, whether they were aristocrats or physicians, such as the Esterhazy family or Dr. Mesmer as I previously mentioned.

Ludwig van Beethoven really wasn't served terribly well by the medical profession. We all know he became profoundly deaf - to such an extent that when he stood up to acknowledge the applause after the first performance of his Ninth Symphony (the Choral), he did so with his back to the cheering crowd and had to be turned round to face the audience by one of the singers! That was before *they* collapsed after the monumental effort required to sing that last movement....it certainly tests every singer's stamina! When he died a very extensive post-mortem was done, which showed cirrhosis, ascites, thickened Eustachian tubes, shrunken auditory nerves and a brain softened by increased fluid. He was exhumed twice more to do further examinations but they managed to lose his temporal bones and the ossicles of the inner ear so we shall never know exactly what did cause his hearing problem.

Two years after Beethoven died, Theodor Billroth was born in Sweden in 1829. After studying at several universities he finally became Professor of Surgery at the University of Zurich. It was here that he became friendly with Johannes Brahms Billroth's first complete surgical resection of the larynx was carried out in 1874, the same year that Brahms dedicated two string quartets to him. I wonder what the patient received? (No mention of any anaesthetic technique!). The first Billroth 1 partial gastrectomy was performed on a 43 year-old woman in 1881 for a pyloric gastric cancer. He wrote 'the operation lasted, *including the slow induction of anaesthesia*, about one and a half hours'. No change then about surgeons' comments about anaesthesia!

He was, in fact, an accomplished pianist - although it would be interesting to know how he played the arrangement for four hands of Brahms' Second Symphony which he was sent....but then *we* know that all surgeons have gifted hands. It's

Brahms and Billroth

just that some like to hide that fact!

In 1875 Albert Schweitzer was born. He first studied theology and philosophy, then music, first at Strasbourg and then Paris, where he was taught by the composer, Charles-Marie Widor of *the* Toccata - much beloved by newly married couples, brought into fashion by Princess Margaret at her wedding - but Schweitzer decided to become a medical missionary and financed his way through college by giving organ recitals and he was regarded by many as the definitive world authority on the organ works of Johann Sebastian Bach.

Here I have a confession to make - Bach Chorales often bore me - the wee three or four bar tune that singers get is then interrupted by the organ playing umpteen bars of florid semi-quavers and so it goes on but his B Minor Mass is something else!

In our West of Scotland fraternity we have a superb young organist (now an anaesthetic registrar) - Malcolm Sim who has played (by invitation) the organ of St Sulpice in Paris where Widor taught and is buried. When Malcolm told me that he was going to be doing this, his concern was that Widor might turn in his grave if he played the Toccata - so he played music by Bach instead!

We are now well into the twentieth century - Widor died in 1938 (aged 90) and Schweitzer in 1965. By this time - 21 years before - there was an arrival in Paisley - moi, petite moi!!! My first experience of hospital life was in Hawkhead Infectious Diseases Hospital in Paisley. I spent two months there as a newly-turned six year-old because of scarlet fever and then chicken-pox. You were kept in one of these glass-walled cubicles not allowed out and more importantly not allowed any visitors - including parents! If they wished they could wave to you from the roadway outside! Toys were taken and destroyed after fumigation! When I was well enough, I was allowed as special treat to sweep the corridors! Thank goodness for changed practice nowadays.

Hawkhead's claim to architectural fame is that it was designed by Thomas Tait. Tait was educated at my alma mater, the John Neilson Institution and then at the Mackintosh School of Architecture in the Glasgow School of Art. He also designed St Andrew's House in Edinburgh and the pylons for the Sydney Harbour Bridge. As an aside, the architect of Canniesburn Hospital (now expensive housing) was James Miller who designed a building not far from here – Peebles Hydro! As you can see it was in a parlous state in 1905, but the replacement built by James Miller (the designer of the Glasgow Exhibition in 1901) was opened in 1907. Only two years - would that building timescales nowadays were as quick!

During my 13 year sojourn at the "Institution" (it was sometimes said a 15 year life sentence but

Maggie, tuning up!

Peebles after the fire in 1905

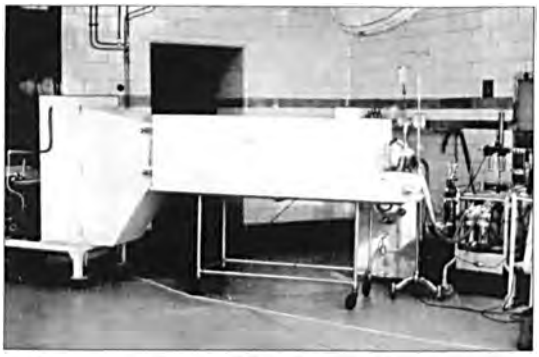
with two years off for good behaviour) at least I didn't break any of the original school rules - NO Lucifer matches were to be used and gunpowder and firearms were forbidden! I then went to Glasgow University to study medicine. Those of my vintage did a six year course which had the long summer holidays when you usually worked in the real world e.g. Marks & Spencer, Goldberg's department store, the Post Office at Christmas. If nothing else doing these jobs made you realise that it would be worth while studying and passing exams. Mind you I did tell one consistent fib during my university course - each year I had an audition at the Royal Scottish Academy of Music for a MacFarlane Scholarship (fortunately successful) which would pay for my singing lessons. The fib was "Oh yes, I plan to give up medicine and take up singing". Well to be truthful I nearly did - after my house jobs in Paisley, I went to London to do just that. My musical education (I never did do the theoretical subject at school) was practical because we had a marvellous group of teachers - flautist, clarinettists violinists - who greatly supported the music department. We had three school orchestras, several choirs and the head of music when I went to secondary school was a man called John D. Macrae who had studied with Edward Bairstow, an English composer and organist at Durham Cathedral. Mr Macrae invited some of us to join Paisley Abbey Choir. We mustered a choir of nearly seventy every Sunday - at morning and evening service. Try that nowadays! Paisley Abbey was the cradle of the Stewart Kings. Marjorie Bruce is reputed to have had a riding accident in Paisley, near the Abbey, and the child she was carrying was delivered, effectively posthumously, by caesarean section (no anaesthetic required) and the child became King Robert III of Scotland.

In London, I did six months Obstetrics and Gynaecology at Chase Farm Hospital in Enfield where Dr David Zuck (well known in the History of Anaesthesia Society) worked. I decided not to take up singing professionally so the question was "What to do?" When I qualified, I had said there were two things I would never do: general practice and anaesthesia.

Basically, I knew very little about either. My university year was the first not to have to give ten anaesthetics and have a book signed. Previously these cases were usually gained during your term studying gynaecology. I did mine in the Samaritan Hospital in Glasgow. The anaesthetist that we met was usually Gordon France who forbade us to watch him anaesthetising patients! In fact, looking back it was absolutely hilarious because the technique of laparoscopy was just beginning to be used. Helen McEwan, the O & G SR (and I'm sure the model for Miss Jean Brodie) would insert the scope when the abdomen had been distended by the gas (I think Helium). The mechanism for inserting the gas was by Dr France sitting on a three litre bag - no pressure monitoring then! The frequent comments thereafter were - "The patient's going off" and "But I'm not finished yet, Dr France" and it was a bit like watching a tennis match with the comments going back and forth.

My only anaesthetic tuition as a final year medical student was two identical lectures on resuscitation by Mike Telfer (we didn't let on we were the same group he had taught a day or two before!) and a visit to the embryo Intensive Care Unit in GRI where there was a 12 year-old lad with tetanus.

There is a saying "That's what for you, will not go by you." Well, there was an anaesthetic SHO job going in Hillingdon Hospital in Uxbridge and after a three hour interview, including afternoon tea and a visit to the local hostelry, I started my anaesthetic career. Dr Hugh John Villiers Morton (Jack Morton) was the boss and said, when I commented that I thought I would give it a try, "Well some people like it and some don't". Try that at an interview now!



Hypothermia machine for cardiac surgery

Hillingdon had been a superb place to start anaesthesia, much to the boredom of some at GRI when I started there as a registrar - "When I was at Hillingdon, etcetera, etcetera....." As a DGH we covered all specialties except cardiac and neurosurgery. As trainees we were well supported and really quite experienced and had a fair amount of exposure to thoracic and paediatric anaesthesia. Family circumstances dictated a return to Glasgow so back north I came.

When I started the Royal as a registrar in 1974 the ITU was well established in Ward 25. I commented to Sister McPherson about the boy with tetanus I had seen when I was a student, she remembered him well and told me he had survived. As you know Intensive Care has come on by leaps and bounds over the years - at least the patients have beds (sometimes) and the medical staff don't have to vacate beds like Mike Telfer and Donald Campbell did when they first started the unit. It is a great tribute to the work done and the training given by DC, 'Save-a-life Mike and wee John Reid and their successors that GRI now has a new intensive care unit but we still need more beds! It's indicative of the variety of major surgery that is now done on patients who previously might never have been accepted as a surgical proposition - and an increasingly older population...now I've got my free bus pass, I must be one of this group!

Shortly after I came to GRI cardiac surgery took off! So did I - to a consultant job at the Southern General but Philip Caves, Professor of Cardiac Surgery ("nobody should die without the benefit of cardiac bypass!") said, "You'll be back," and so it proved. In all honesty the SGH took off too after my departure and now is heading towards being the largest hospital in Scotland, if not the world!

Anyway, I did come back to the Royal and have been involved with the cardiothoracic set-up for the past 23 years. Douglas McLaren in his Presidential Address last year eloquently described the development of cardiac surgery in the West of Scotland, the changes in medical treatment of heart disease and different drugs that we, as anaesthetists, now use regularly which were previously small print stuff. Consequently he pre-empted lots of topics for my address!

I commented in a previous talk about the development of the use of hypothermia in cardiac surgery. The equipment was developed by Professor Alex Forrester, President of this Society in 1963 but the reason I mention this was that one of his researchers was Donald Campbell who will be remembered by younger anaesthetists from this year because of the Campbell Quaich, to be awarded for the best Registrar's paper.

Equipment has improved and multiplied out of all recognition to previous generations of clinicians and nowadays we would not contemplate anaesthetising patients without ECGs, oximetry, capnometry, intra-vascular monitoring and anaesthetic agent monitoring. One aspect Douglas did mention last year was the increasing use of the transoesophageal echocardiogram (the TOE) intraoperatively during cardiac surgery and now sometimes in other surgery (like the caesarean section patient 3 weeks ago who first presented at 36 weeks with severe mitral stenosis). My younger colleagues are now very expert at the use of this equipment and I have been more than happy to ask for their help and advice. It would appear that expertise in the use of the TOE will be a requirement for a cardiac anaesthetist - more exams!

The amount of visual information and with numerical and derived values, is enormous and I'm sure that Ian Donald (son of a Paisley GP) who introduced abdominal ultrasound in obstetrics would have been very happy to know of all the echo developments and even the use of it might have had some therapeutic input for the mitral

valve surgery which he had (on three occasions, I believe) had it been available then. I learned from a friend last week that he did an ultrasound of his own liver when he was in severe heart failure because he didn't have a clip of that!

I think the time has come for me to close this talk but I cannot do so without being extremely grateful to those who have had the job of influencing my medical education, both undergraduate and post-graduate AND to those colleagues in GRI (and not just GRI) who are facing all sorts of challenges from all sorts of sources - but maybe some of them have a potential future in the musical world.

And to quote Dr Jimmy Dickson, an anaesthetist in the Royal Alexandra Hospital in Paisley when I was a JHO there, "Dr Stockwell making a perfect arse of it." I do hope I haven't done so. Thank you all very much and now for a restorative cup of tea!

Donald Campbell Quaich

2007 Trainees' Competition

Up to five trainees will be invited to give a 10 minute presentation of their research, audit or interesting case at the Annual Spring Meeting at Peebles.

As well as the inaugural Donald Campbell Quiach, the author of the best paper will receive a prize of £250 (and will get to go to Peebles at the expense of the Society in 2008!)
There will also be prizes for the runners-up.

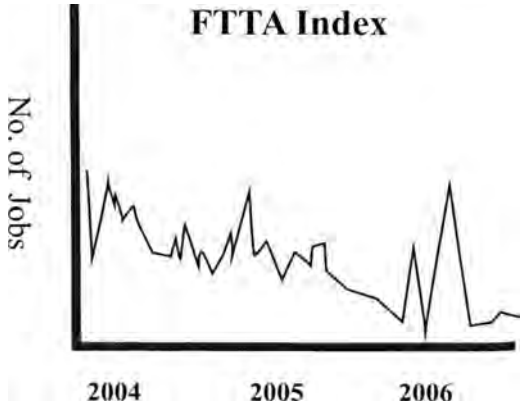
Entries by the end of February please. Details from Secretary, Alistair Michie

The Daily Snooze

Opportunity Knocks for MMC losers

Medical couples who face separation under the MMC placement lottery received new hope today as Health Minister Andy Kerr moved to resolve this most delicate of MMC problems. Trainee anaesthetists Lee Ving Yu and her boyfriend of three weeks, Innes Dreems are worried that a placement in Aberdeen and Dumfries respectively would leave them facing the prospect of windswept romantic trysts in a lay-bye off the A9 and candlelit dinners in the adjacent Little Chef. "I don't know if I can live without him," said Lee sobbing. "I may have to give up medicine and get a job in McDonalds so I can be near him if he gets a post in, like, the Outer Hebrides or Mars or Dundee or somewhere like that."

Now though help is at hand. Through an additional section on the application form, candidates can make other preferences. In the new WLTM section they can specify variables such as height, hair colour, sense of humour, sex - though this is generally taken as "yes", sportiness, a penchant for long walks etc. The same computer matching programme used by MMC then matches up separated couples with new partners. "This is fantastic news," said Innes. " I can hardly wait to see who I get!" Lee is still sobbing.



Health

Doctors are sceptical about the supposed health dividend following the smoking ban. A leading Public Health Consultant, Dr. Hisfiggurs said, "Smokers are now taking more, not less time off sick. We're seeing a whole gamut of new smoking – related disease, from chilblains to frostbite. We're also getting more paranoid symptoms such as a feeling of being watched in a goldfish bowl all the time and persecution complexes."

Sport

News this week about the UEFA cup, sponsored by the MDDUS. Dr Carrie de Canne will face the GMC tomorrow in a dramatic UEFA cup final. Having won through the qualifying rounds against the local complaints procedure and following an early suspension scare Carrie won her final place after her unexpected semi-final trouncing of the Local Affiliate in both legs (Medical and Lay). She has high hopes of beating the rap in the final to clear her name: "They are a tough outfit but sometimes the underdog can pull off a surprise. My story has held up so far and I think I have a chance against the GMC - hopefully I can get a result. Of course there's always the prospect of a replay against the CHRE in the High Court. I'm optimistic but there are so many opportunities to slip up. I could still end up labelled as a f... I prefer the term poor performer."

SL

A letter from New Zealand

From Joe Sherriff

Having been the most distant member of the Scottish Society for 15 years, it's about time I reported back from this remote outpost of the Scottish Empire. Yes, Invercargill is just about as far away from Scotland as you can go - at the very south end of the South Island of New Zealand.

I did most of my anaesthetic training in Dundee in the late '70s along with Charlie Allison, Roger White, Marg McNab and others. As senior registrars we were encouraged to do an overseas fellowship and I opted for New Zealand. This was to satisfy a curiosity about the antipodes acquired from a well travelled grandmother.

It was a fantastic year, both in terms of anaesthetic experience and in exploring a new country.

I had never used a closed circuit and CO2 absorber in Dundee, only reading up about them for the Fellowship exam. Here they were in daily usage. Another novelty was the use of an oxygen analyzer on every anaesthetic machine which of course helped to use low flows. Another simple concept was printed labels for syringes. These were colour coded with yellow for induction agents, red for relaxants, blue for opiates etc. I gather the same system has recently been adopted in UK.

The rotation through intensive care was great for getting out exploring as we did 4 twelve hour days, followed by 4 twelve hour nights, then a whole 4 days off. This gave adequate time for long trips in the mountains. Even when back on the anaesthetic roster, every free weekend was spent doing some adventurous activity.

It would have been very tempting to stay at that time but I had already accepted a consultant job in Barrow-in-Furness, close to the English Lake District.

Eight years of a small understaffed department and the stresses of finding anywhere to park to go climbing in the Lake District made me look at other options. Naturally I had another look at New Zealand. I wanted to return to the South Island with its opportunities for climbing and skiing while working in a unit big enough to have training positions for registrars. I never enjoyed work in teaching hospitals so that ruled out the cities of Christchurch and Dunedin, in fact the only place that fitted the bill was Invercargill which just happened to be short of a consultant anaesthetist.

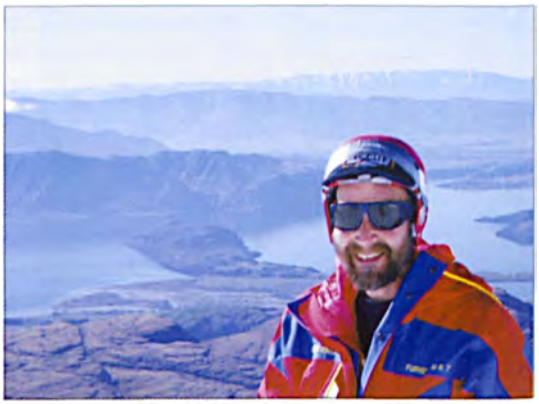
The hospital serves the province of Southland with a total population of about 100,000. Our next nearest hospital is in Dunedin, this has a medical school and most tertiary facilities but is over 2 hours drive away. We thus have a similar degree of size and isolation to Inverness. In the past we escorted our own Intensive Care patients when they needed transfer to Dunedin. This involved a 10 minute ambulance ride to the airport, packing patient, nurse and oneself into a small aircraft, an hour long flight and then a further 30 minutes by ambulance from Dunedin Airport to the hospital.

On a good day the plane would still be waiting when we got back to the airport - it's not a good look to be 200 kilometres from home, without transport or wallet wearing theatre blues! In recent years Dunedin has had its own helicopter retrieval service which is safer for both patients and ourselves.

Invercargill was founded in 1856 as a port on the estuary of the Waihopai, a small river draining the Southland Plains. Unfortunately, as parts of the estuary were drained and reclaimed for farming, the harbour silted up and the town was landlocked. Luckily there was a suitable harbour in the lee of Bluff hill, 20 km to the South. Bluff is New Zealand's equivalent of John O'Groats; its not quite the Southernmost tip of the country, but it's close and is the end of State Highway 1, so that's where the tourists go for a photo by the signpost giving distances to London, Tokyo, Sydney etc.

The Southland plain is a huge agricultural hinterland. Traditionally it was mainly sheep farming but over the past 10 years there has been a massive increase in dairy and deer farming, giving quite a boom to the local economy. It was settled by Scottish immigrants in the 1870's so the phone book has a similar spread of names to any Scottish city. Even the street names have a familiar ring with the city centre streets named after Scottish rivers. Esk, Don, Spey, Yarrow and Leet as you go north from Tay street and Dee, Deveron, Jedd, Clyde and Nith running north.

Beyond the flat agricultural plains are mountains. To the west is the vast Fiordland National park. This is an empty wilderness compared to any British mountain range. With around 300 miles of coast line there is only one public road access to the sea. To the north west is the Takitimu mountain range, this is the remnant of a huge volcano and has lots of easily climbable peaks around 6000ft high. They are off the main tourist tracks and I don't think I have ever met another party while climbing or walking there. To the north lies Central Otago; this area is in the rain shadow of the Southern Alps, having an annual rainfall of around 12 inches, compared to over 300 inches on the other side of the mountains only 40 miles or so to the west. To the east is rolling farmland, forests and the picture book Catlins coast with rocky headlands and sandy beaches.



Joe doing his premeds!

The South has the reputation amongst those in the north of New Zealand of being extremely cold with icebergs in the harbour and penguins in the main street. Come to think of it, I recall that Londoners think the same way about Inverness. It is also not really true, as our climate is similar to that of Devon and Cornwall with a latitude of 46deg: the same as Lyon and Milan. Even in winter snow hardly ever settles for more than an hour or so.

We moved into a brand new public hospital 2 years ago. The old one had evolved rather than been planned. Some parts were quite satisfactory but others were not. Any alterations would have involved massive expense to satisfy current earthquake engineering requirements, so the cheapest option was a complete new building.

Earthquakes are a part of living in New Zealand. In Invercargill we are far from the main fault lines and just get the occasional shake from activity on the West Coast. Despite this, all buildings have to be built to a national code to withstand earthquakes. A typical Scottish house with brick cavity walls would be illegal here as un-reinforced masonry does not do well when shaken. All buildings are either wood framed or based on reinforced concrete. The benefits of this can be seen when a Richter force 6 earthquake can kill tens of thousands in Asia but causes minimal damage here. Schools have regular 'earthquake drills' with the kids getting under their desks as protection from falling ceilings.

A couple of weeks after moving into the new hospital our morning operating was disturbed by a couple of short shocks and the whole building shaking for about half a minute. It all held together and work carried on as usual. It turned out to be a massive Richter scale 8 quake, far out in the Southern Ocean. A precursor perhaps for the Boxing Day Tsunami which hit South East Asia only a couple of weeks later.

We have 5 registrars, three of whom are on the South Island Training Scheme and rotate between here and Christchurch (700km to the north). All training is under the auspices of the Australia New Zealand College of Anaesthetists. Though this is based in Melbourne in Australia it serves New Zealand well. Indeed it has been my impression that it supports smaller hospitals, such as ours, infinitely better than the Royal College of Anaesthetists. The exam structure is similar to that in UK, though the final Fellowship exam is taken a year or two later and is seen as an exit exam.

The public hospital service works in a very similar way to the NHS. There is no private surgery done in the public hospital but we do have a private hospital about 3 miles away in the middle of town. This is run by Southern Cross, the major New Zealand health insurance company. Most of the consultant anaesthetists and surgeons do regular sessions there and I have ended up doing 3 private lists with the remainder of the week in the public hospital.

Income is on paper somewhat less than in UK, however the exchange rate does not tell the whole story. At 3 NZ dollars to the pound or thereabouts a full time consultant salary of around $165,000 does not appear good by NHS standards, however this is boosted by substantial payments for out of hours work. In addition prices are much lower with petrol, insurance etc about half the price of that in the UK and housing also much cheaper. Further north prices are higher, but in Invercargill an excellent house can be bought for less than $400,000.

On the subject of income, billing in private practice appears less of a hassle than in UK. The New Zealand Society of Anaesthetists has a relative value guide, whereby a number of units can be ascribed to each anaesthetic based on complexity of the surgery, anaesthetic time, co-morbidities, age urgency etc. The anaesthetist then sets his or her own unit value and provided that is reasonable, all the insurance companies will pay that in full, direct to the anaesthetist. For the same historical reasons as in UK surgeons get away with charging much more than we anaesthetists.

I like working in small hospitals. The staff are friendly and you need to keep up skills in almost all areas of anaesthetic practice. There is also rapid feedback about quality of care, as almost every list

has at least one patient, known or related to one of the theatre team. The population is also fairly stable. So it is not unusual to find records of anaesthetics given in the 1950s or 60s in the notes.

While the work is stimulating and enjoyable, it is the lifestyle that has kept me here. In Dundee, back in the 70s the department was roughly divided into the golfers and those the golfers used to refer to as 'Boy Scouts'. I was not a golfer but did enjoy, climbing, orienteering, skiing and Munro bagging. During my senior registrar year here I found that New Zealand did all these things even better than Scotland. Every weekend when not on call we were away to the hills with holidays spent doing multi-day expeditions in Fiordland or skiing in the foothills of the alps. After many brilliant trips the highlight of the year was the first Coast to Coast race.

This was the start of multisport racing which has over the years become a national sport. Unlike the rigid combination of swimming, cycling and running of Triathlon multisport can have any combination of road or mountain biking, kayaking and running appropriate to the course. The Coast to Coast goes from the Tasman Sea on the west coast of South Island to Sumner beach by Christchurch on the Pacific Coast. It includes a total of 150km of road biking, 75 km of down river kayaking and a very rough 30km over a pass through the Southern Alps. None of the 60 or so entrants had much idea of what we were letting ourselves into.

Much to mine and everyone else's surprise, I came out the winner in around 14 hours. Since then the race has been held every year, competitors train hard and the winning time is now down to around 11 hours every year. The race has grown and this year, the 30th anniversary will see around 900 taking part. I'll be back, competing with James, my 19 year old son, doing it for the first time. Most will have no chance of a high placing but do it for a sense of personal achievement and life style.

Training is worthwhile for its own sake with long bike rides on almost traffic free roads and kayaking on large fast flowing rivers. A typical trip is one we'll be doing next weekend which involves kayaking for 44km down the Waiau River followed by a hilly bike ride of about the same length to pick up the car. Perhaps when I grow up I'll take up the game of Golf which Charlie Allison tried to introduce me to so many years ago. It would be a good place as annual club membership is only around £100 for an excellent international length course.

Back at work we all registered with the Australia, New Zealand College of Anaesthetists maintenance of standards program. There are a number of conferences each year, on both sides of the Tasman organized both by the College and the national Societies of Anaesthesia. These are always of a very high standard and a good excuse to visit some superb locations. Being such a small country our local meetings have a friendly atmosphere with most of the participants known to each other; something we have in common with the Scottish society.

In short, Invercargill is along way from home, but the life style and balance between home and hobbies makes it well worthwhile for anyone with a 'work hard play hard' philosophy.

Travelling Fellowships

The Society would like to encourage members to teach or learn abroad. Grants of up to £1000 (to a limit of £5000 in any one year) are available. The trip may be, like those here, primarily as aid to less developed parts of the world or possibly to learn a new technique somewhere in the developed world – provided you are not in paid work there. Apply to Dr. Michie, the Hon. Secretary.

Gillies Lecture

Do you want to get better?

Alastair Chambers,
Aberdeen Royal Infirmary

I am greatly honoured by the Society in being asked to deliver the Gillies' Lecture and wish to thank the President and Council for the invitation. John Gillies had a very major influence on the development of our speciality during a time that enormous changes were taking place in health care and the manner in which it was delivered. Although much has been said and written about his professional life, there is relatively little about his personal affairs. The First World War interrupted his undergraduate medical studies at Edinburgh University and during his service he was awarded a Military Cross. This was awarded to commissioned and warrant officers for distinguished and meritorious service in battle. There is no mention in later accounts of his life about what events led to this award but there can be no doubt that he must have acted with exceptional courage to even be considered. It is interesting to speculate on the character and personality of individuals who display outstanding bravery during times of war. Some find it difficult to settle down to 'normal' civilian life after hostilities cease; others appear to have a 'gung-ho' attitude to life which may serve them well in certain situations and less so at other times. Looking at all the John Gillies achieved in his professional lifetime both clinically and politically, neither of the above stereotypes would be in any relevant. All the descriptions of his clinical work mention careful thought and preparation, a keen eye for attention to detail and above all a caring attitude to those under his care.

Gillies lived for many years in Ravelston Dykes, a pleasant tree lined street to the West of the centre of Edinburgh. He will, no doubt have attended the local parish church, Murrayfield, at least on some occasions and I think it likely that he will have been aware of the biblical story of the crippled man who lay by the side of the road, seeking help. When Jesus passed, and was asked for help, he told the man to get up and walk and that is what happened. I wonder if, like many others, Dr Gillies ever thought that it would nice if some of life's other problems could be solved in such a miraculous manner.

Perhaps the most outstanding piece of clinical work, which Gillies published, was the description he and HW Griffiths gave of the technique of total spinal anaesthesia for the operation of thoraco-lumbar sympathectomy. For the benefit of those who have long forgotten their undergraduate anatomy teaching and also those young enough to have obtained a medical degree without such tuition, the sympathetic chain(s) lie along the antero-lateral surfaces of the vertebral bodies in close relation to many major blood vessels. In the late 1940's, the pharmacological treatment of hypertension was limited and some patients did not respond to the available treatments. Sir John Learmonth, Professor of Surgery in Edinburgh, proposed carrying out the operation of thoraco-lumbar sympathectomy in the hope of relieving sustained high blood pressure. Whatever the rights and wrongs of such an approach, and it is easy to be critical in hindsight and with the advanced knowledge of physiology which is now available, Gillies and Griffiths were faced with a truly enormous clinical challenge. In those days, a normal healthy patient would face considerable risk undergoing such a major surgical intervention. To take on individuals with uncontrolled hypertension, few effective agents with which to ma-

nipulate the blood pressure peri-operatively and no invasive monitoring equipment is a task, which the modern anaesthetist can really barely comprehend. The technique of total spinal anaesthesia supplemented with general anaesthesia may appear to be cavalier and in some hands it certainly would have been. At times the patients did not have a palpable radial pulse and the only cardiovascular parameter, which the anaesthetist could monitor, was the apex beat. In those days, operatively mortality meant exactly that. Death at or around the time of the operation could be considered to be related to the anaesthesia or surgery or not as the case may be. Longer term cardiovascular outcomes were not thought to be related to what had happened during surgery. The operation did not confer any long term benefits and was soon abandoned but it is worth looking at the outcomes, which were achieved. To have had any patient survive such a surgical insult would have been considered a worthwhile achievement – to have had a series of patients doing so is little short of amazing and must reflect outstanding clinical acumen and skill.

The clinical problems, which I have faced, recently are small in comparison but perhaps not in nature. We all know that obesity is becoming more common in the Western World and is now a major cause of concern for public health. Or is it? I was in Edinburgh this summer giving a lecture on the peri-operative management of the morbidly obese and at breakfast on the day of the lecture was given a copy of 'The Scotsman'. It contained an article which roundly rubbished the current concern with obesity. As is not uncommon in this sort of article, it contained an number of truths, but contorted with half truths and misrepresented so that the overall tone of the piece was that those who raise concerns about obesity are at best misguided and quite possibly a bunch of spoilsports. I must admit to being fairly disappointed that a newspaper, which would not normally be described as a rag or amongst those in the gutter of journalism, published such a biased article that sought to give quite the wrong impression.

I have been involved in the establishment of the bariatric surgery programme in Aberdeen and it has proved to be an interesting challenge. The problem is not new – the largest patient I have found reported was a 430kg (67.6 stones) man with Pickwickian Syndrome who was anaesthetised in 1986 for panniculectomy. The anaesthesiologists (yes, it was in the US) recognised a number of problems which are still relevant today. They were unable to weigh the patient and had estimated his weight as 385kg. The correct value was only obtained when he was weighed at post mortem. Not surprisingly a number of problems were encountered with ventilation but the terminal event was pulmonary embolism from deep venous thrombus in the leg.

Assessing obesity is not straightforward. It is wise to calculate the Body Mass Index and it may also be useful to calculate the Lean Body Mass, the Ideal Body Weight and the Corrected Weight (Ideal Body Weight plus 0.4 time excess weight). In terms of health risk, the waist circumference and the waist hip ratio are relevant but perhaps not so important for pharmacodynamics. In terms of pre-operative assessment, it is also important to consider the psychological effects of obesity. Stigmatisation of the obese is common and is of both body appearance and character. A recent study of children's attitudes revealed that many consider the obese to be 'lazy dirty stupid, ugly cheats and liars'. They are often perceived to be less active, less attractive, less healthy and weak willed. With patients feeling a sense of isolation and low self esteem is it surprising that they find it difficult to act in a positive manner peri-operatively. As health professionals do we always do our best to help them? The standard hospital theatre gown is a rather unattractive garment at the best of times but if a suitable size of that and other items such as modesty pants are not available that can only make matters worse.

As in any pre-operative assessment, good history taking is vital. The risk of obstructive sleep apnoea or the obesity hypoventilation syndrome is worthy of particular attention particularly as patients with these syndromes are more likely to be difficult intubations. The particular risks involved in the morbidly obese are difficult intubation, aspiration, post operative respiratory complications including sleep apnoea, the presence of co-morbidity as a result of obesity and deep venous thrombosis and pulmonary embolism. The anaesthetic plan therefore needs to encompass a rapid and safe induction, a smooth transition to maintenance, rapid recovery and close observation post operatively. Much of this, of course, is what we would tell a novice SHO to do for every patient.

Most, if not all, of these patients should be induced in theatre to avoid any unnecessary moving. An inflatable transfer mat is a very useful device but needs to be placed on the table before the patient gets on. Indirect blood pressure measurement can be problematic even if appropriately sized cuffs are available and placing an arterial line under local anaesthetic prior to induction is a wise precaution. Although regional anaesthesia, especially spinal anaesthesia, may be appropriate in some cases it can be very technically challenging.

Awake fibre optic intubation may be required but this is by no means common. Induction is usually with a modified rapid sequence technique with pre-oxygenation having been carried out with a slight head up tilt as this delays the onset of hypoxaemia by a greater degree than when it is carried out with the patient supine. Intubation in these patients is often slight easier with a 'ramped up' position of the head and neck rather than the traditional 'sniffing the morning air'. Maintenance can be with some combination of desflurane, remifentanil and a target controlled infusion of propofol. Each method has its proponents and there is little to recommend one over another. The calculations for a target controlled infusion of propofol can be made using the normal algorithms with the patient's total body weight. Problems can arise during emergence and it is wise to transfer the patient to a profiling bed while still anaesthetised, then ensue adequate reversal of neuromuscular blockage and extubate the patient when fully awake and in a sitting/semi-recumbent position. Post operative management may need to include CPAP and close surveillance and early ambulation are essential. The introduction of laparoscopic techniques has revolutionised post operative care, but even in the days of vertical gastric banding being undertaken at open laparotomy, patients were routinely encouraged to get out of bed on the evening of the day of operation.

Not many individual anaesthetists will be involved in a bariatric surgical programme but virtually all will have to manage morbidly obese patients who present for elective or emergency surgery. While the elective situation may allow time for consideration and perhaps even obtaining specialist help, that may not be the case with an emergency in the middle of the night. It is important that all hospitals in which such patients may present to have some sort of local guideline or protocol. This should include advice that all patients should be weighted if possible; information on the weight limits for operating tables and beds; where the large patient equipment is kept – e.g. blood pressure cuffs, TED stockings, boots, gowns etc; transfer equipment such as a hover mattress; and how to arrange CPAP.

One of the first patients who I anaesthetised for bariatric surgery developed an ulnar nerve palsy post operatively and this led me to look into this particular complication in some detail. I was interested to find out if these patients were particularly susceptible to this problem and if anything special could be done to prevent it. My researches produced a number of findings which I found surprising.

So called 'pressure palsy' has been widely recognised for many years and there are descriptions in the literature of damage occurring to a number of nerves in various sites which have been subject to excessive pressure during anaesthesia. Improper anaesthetic care and poor positioning have been implicated in ulnar neuropathies since the 1890's. It is well known that the amount of pressure exerted upon a peripheral nerve and the duration of that insult are related to the degree of damage. What is perhaps less well appreciated is that all mammalian nerves are also sensitive to stretch and that an increase in length of more than 10% leads to damage. Ulnar nerve damage during anaesthesia is usually confined to sensory loss and recovers spontaneously with time. However some patients experience motor symptoms and may be left with permanent impairment. Ulnar neuropathy is more common in men and in the obese.

Anatomical studies on the course of the ulnar nerve around the elbow show that there is considerable variation in the tunnel through which the nerve passes after is passes the coronoid process. The pressure on the nerve there is greater when the elbow is flexed and the nerve may actually be more likely to be damaged then than when the arm is lying extended at the patient's side. There is some interesting epidemiological work on this problem which demonstrated that in many patients who exhibited signs of ulnar neuropathy postoperatively, these did not appear until 48 hours or more postoperatively. In addition a significant number of emergency admissions who developed ulnar neuropathy were medical patients who did not undergo surgery. This strongly suggests that factors other than pressure on the ulnar nerve at the elbow when the arm is lying by the patient's side and perhaps not properly protected play an important role in the development of this complication.

I would now like to turn to medical politics and make a number of comments on the problems we face as a specialty and the lessons we can learn from how John Gillies dealt with similar issues over half a century ago. As President of the Association of Anaesthetists of Great Britain and Ireland he led the specialty at the inception of the National Health Service. One of the great challenges then was that of consultant status. Anaesthesia was not alone in finding this a problem as the initial proposals for the NHS suggested that there would only

be consultants in five 'major' specialties. Fortunately reasoned argument won the day and from the start there were consultants in all specialties, all of whom were employed on the same terms and conditions. This can only have been achieved with the support of those in other specialities, particularly surgery, and it is perhaps here that we can learn most. At present, we are faced with arguments about parity of pay when dealing with NHS patients who are to be treated outwith main stream NHS facilities and the very real possibility of the (re-) introduction of a permanent sub consultant grade (perhaps called specialist). Simply complaining that it isn't fair is unlikely to get us far. How would John Gillies have reacted today? I doubt very much that he would simply complain and moan. He might well lead by example. In the photograph I showed at the start, he was wearing a collar and tie and a jacket. It is hard to imagine he ever went to see a patient less well dressed. Yet today many of our colleagues do not seem to think that it matter – how can we maintain our own self respect far less that of our patients and our professional colleagues if we are not prepared to look and act like senior professionals. If we look and act like technicians that is likely to be the way we are perceived – and paid! We should never underestimate the importance of public perception. We may feel that we are fighting with politicians and civil servants but the latter do what the former tell them, and politicians are always aware of the date of the next election. Public support for the standards and values we should hold dear as a specialty may be a very important political factor in the not too distant future.

What would Dr Gillies thought of Modernising Medical Careers? He might have welcomed a structured training programme with clearly defined entry and exit criteria and no need to move around looking for one job after another. However his eye for detail would have picked up a quote from the MMC website home page: '*We also aim to align the aspirations of doctors with the reality of healthcare in a world of unprecedented medical advancement*'. His astute political mind would have picked up from that, that plans are afoot somewhere to change the way doctors are employed in the NHS in a quite radical way. We should not become paranoid as a specialty about this because it is going to affect all specialties. Outright opposition to any change at all is unlikely to be effective in the longer term but reasoned argument about proposals which owe more to political rhetoric than careful analysis of existing problems might be. What I do find of concern, however, is the potential for anaesthesia as specialty to be dealt with in a manner, which is quantitatively different from most other specialties if not qualitatively. The prospect of a large teaching hospital having a handful of consultant anaesthetists and an army of specialists is not one, which I find at all attractive either as a doctor or as a potential patient. There are a number of ways for us to react to any initiatives, which move in that direction. This would certainly include forceful arguments put forward by the Association and the College. However what is at least as important is the personal and professional behaviour of individual anaesthetists – I come back again to not only appearing to be professional but acting in that manner consistently.

Gillies will not have been aware of concerns about research fraud. It was not an issue in 1950. However in recent years it has become much more so and there have been several high profile incidents reported. It is sad to realise that all such events involve a very basic level of dishonesty by some of our professional colleagues – some we would want to have considered our peers. The pharmaceutical industry has been prominent in the investigation of some of these cases, as they rightly want to insist on high standards in research. However they themselves can hardly be regarded as always having the best interests of patients as their prime concern. Very large sums are spent on advertising and promotion and although many doctors feel that they are not influenced by commercial sponsorship and can use their own scientific knowledge and background to examine the merits or otherwise of different products, one cannot but think that if a commercial organization is putting a lot of money into promotion, they must think they are getting some return on it. A recent article in the BMJ highlighted problems at a major meeting in the USA when a speaker drew attention to the problems of too close a relationship with commercial organisations, which provide sponsorship. Can we really believe all we read or are told – or do we tend to believe what we would like to believe anyway so if the story fits our preconceptions we just accept it.

That brings me to my final point. I don't know if there are any biblical scholars present but some of you may have presumed that what I told you about the crippled man finding he could walk was one of the miracles of Jesus. As ever, one should check the original references rather than relying on second hand accounts and this one is in Chapter V of John's gospel. There is nothing miraculous about it at all – it is not in the same section of the bible that the miracles are described in and no one ever claimed it as such. A closer reading of the text reveals that the cripple had been sitting beside a pool for many years. This particular pool erupted with bubbles every so often and there was belief amongst the locals that the first person to enter it thereafter would be cured of his ailment. Every time that happened someone else managed to get into the pool before this particular cripple. Haven't we all heard that story before – an excuse for failure to do something or achieve something and if

only someone else hadn't got there first. The cripple wasn't asking anyone to cure him – he only wanted someone to help him promptly into the pool. The first thing that Jesus said to him was '*Do you want to get better?*' because if you really do, you don't need me, or the pool or anything else to help you – you can do it yourself. So it is with the problems we face as a specialty – both clinical and political. If we really want to get better in terms of treating patients safely and well the solution lies in our own hands. If we want to continue to have the respect of our patients and our colleagues in other specialties and disciplines, we also have the solution. It lies in our own personal and professional behaviour and it is simply a matter of whether we really want to or are thinking that we want to. The question is simply this – do you want to get better? For the sake of our profession, our specialty but most of all for our patients I hope the answer is an unreserved 'yes'.

The Annals Diary Column

My spies have been busy as usual seeking out those little observations which lighten the load....

More from the bottomless pit of maternity stories: from Glasgow's Princess Royal Maternity comes the tale of a man who runs in breathlessly telling reception staff, "ma partners having a baby!" The receptionist asks, "Name?" "Umm...Not sure." I think he may have thought she meant the baby's name but you never know...

For some poor kids holidays are yet another reason for their pushy parents to make the most of an educational opportunity. A family was overheard going round the beautiful old walled city of Aigues Mort in France. Mum asks, "Why do they put a wall round the city?" The elder daughter pipes up with, "For protection!" (With an implied "Can I have my ice cream now?") Her younger sister mulls this over for a minute then asks, "Why would they want to protect all these souvenir shops?"

More jargon. At Crosshouse the preop assessment nurses now "advice" people. As in, "Smokes 45/day - adviced." Our management take a dim view of this linguistic abuse however. They have a new Policy whereby all documents must be "plain English checked"

Under the heading, "Mustn't grumble" we have the following tale. A patient, fully conscious, being admitted to the ITU was uncomplaining while the lines went in one by one, catheters, monitoring devices of all sorts – you get the picture. Then the nurse pulling on the drip stand popped the giving set out of the pressurised bag attached to the a-line showering the area in saline. Says the nurse to the patient in an exasperated voice, "Do you ever feel that you're having one of those days?"

Now it is in the nature of these things for embellishment to blossom but I feel I have to pass on the tale of SpR Malcolm Sim and the Dutch anti-terrorist police which I'm assured is true. Malcolm was flying to Amsterdam to see a lady friend (called Philippa, I think) and wanted to surprise her. Having checked in, his coupon necessarily matching the passport photo he popped into the loo for a quick makeover involving the addition of facial hair (apparently Philippa abhors anything jaggy especially a moustache). Imagine Malcolm's surprise when exiting the conveniences he found himself surrounded by armed and angry Dutchmen. "Welcome to Holland," they said warmly!

This is not really a medical story, well not any more anyway – a funeral at Alloway Parish Church was underway. A lady at the back looked increasingly uncomfortable. Eventually turning to another mourner she asked, "Is this the Tam O'Shanter Experience?"

Dogs, I'm told, do poorly if they eat chocolate. One such greedy mutt gorged on the stuff and developed inflammation of an upper GI organ. Despite being very ill she recovered. A youngster in the family, explaining the problem to his pal said, "He had pancake arthritis!"

More stories for next year please!

Faking It

Charlie Allison spotted this press announcement of interest to anaesthetists

Channel 4 wishes to announce the 2007 schedule for this popular show, in which members of the public are coached into new careers by experts in just two weeks. You may recall previous series in which a sheep shearer become a top crimper and a Naval officer starred as a cross-dressing club entertainer.

This season we will have a strong doctoring bent, with three of the shows featuring the medical profession. In one a pot-holing bushtucker from Oz becomes a gynaecologist. Another follows the transformation of a Polish plumber into a top endourologist.

The Scottish Society of Anaesthetists may be interested to learn that one programme was recorded in Scotland, featuring several of its members.

We follow Eck, a slaughterhouseman from Turriff as he trains in just two short weeks to become an anaesthesia practitioner. Eck was chosen because stunning sheep & bullocks was somewhat akin to his new chosen career. "Eh ken fit it wuz like tae catch an' hud them doon an' gie them a quick stun, so anaesthetics wuz jis a doddle - though there were some big buggers haein' vasectomies who werena too pleased to be there on the day!"

Eck's mentors were well selected. Alastair Chambers from Aberdeen was chosen as much for his linguistic knowledge of the Doric and understanding of bull, as for his skills in imparting the black arts of anaesthesia. When the two of them were on screen together there was undoubted chemistry, but viewers will be given the benefit of subtitles. John May made Eck "richt at hame" in Inverness as he took him through the rudiments of airway management, instructing him in pressure-volume loops (or "sook an' blaw') with a nifty demonstration on the bagpipes.
Eck was naturally sent to Dundee to polish up his command of English and to learn how to "dress to impress" from Fergus Miller and Mel Thomson. Alf Shearer, himself a son of Alford, was there to offer interpretative skills. Tony Wildsmith sold Eck a copy of his popular local anaesthesia book and told him that he also used live patient probes, but unfortunately his didn't carry 50,000 volts.

In Edinburgh John McClure & Dave Simpson were engaged to explain the finer minutiae of specialist techniques but it was clear that Eck could only be coached in one rough Glasgow anaesthetic - Propofol TIVA, also known as a pint of *GK's Special Milkshake* and a chaser LMA swally.

Next to the West for wider credibility lessons - Alex Macleod & Jim Dougall took Eck out golfing & pubbing so he could speak with authority on the most important subjects that anaesthetists talk about. Paul Wilson made up the four-ball to ensure Eck had a number of excellent jokes should the interview fall a little flat.

Lastly Eck flew to Yorkshire to meet legendary special guest Arthur Scargill. "Reet lad. Even though this is a government initiative, I think that with a job like this there's sure to be conflict with both doctors & nurses, so I'm going to advise you, comrade Eck, on taking up a somewhat militant stance."

On the day of destiny, our two judges were Professor Ian Power, emperor & exemplar, and big Pete from Troon, whose championing of anaesthetic practitioners has been recognised as a Wallace monument. Fooling these two wouldn't be easy, as several FRCA candidates have found in the past.

Faking It will not divulge the result for fear of spoiling your enjoyment, but Eck has now returned to the Turriff Abbatoir with new skills - "ah might be putting lines in for some of the mair delicate beasts" and a love of coffee before, during and after every case.

Any mention of The Royal College of Anaesthetists and their part in this dubious initiative has been omitted for fear of causing grave offence.

Guest Lecture

Survival

Hugh Montgomery
Director, Institute for Human Health and Performance
University College London

Whilst some might focus on issues relating to symptom palliation, most anaesthetists (and especially those working on Intensive Care Units) are concerned with issues relating to survival. Such concerns are themselves multifactorial. Certainly, there are moral and ethical issues which merge with those of professional competence: no one would ever wish to have 'blood on their hands' when this might be avoided. More pragmatically, the advent of 'league tables' has focused some practitioners (cardiothoracic surgeons in particular) on those factors which might be associated with morbid outcome amongst their patients. Whilst none would contest that the implementation of best practice might lower mortality rates, is death always the result of less-than-perfect practice and are all the factors which cause mortality at least theoretically under our control?

Common experience suggests this not to be the case. Further, we seem incapable of recognizing all of the factors which are of influence. How many times have we shaken our heads gravely and pronounced a patient very unlikely to survive, only for them to present the box of chocolates as they walk through the door? How often does the 'modest insult' spiral out of control? Why is it that, when faced with seemingly identical clinical scenarios, one patient will live and another die? Is there such a thing as 'the will to live? Or to die? What, in other words, defines a 'survivor'?

Evidently, some factors will be extrinsic, uncontrollable, and in some way 'random'. If a building collapses nearby, falling masonry may strike one individual and not another in a manner which can-

not be anticipated nor protected against. When a boat sinks, some may be in a position which does not allow escape, or may in fact have never learned to swim. The gravity of any illness or injury may be, quite simply, beyond the tolerances of any human body. However, a growing body of evidence suggests that powerful psychological and biological factors may combine to influence the chances of individual survival.

The Psychology of Survivors

Over the years, a substantial literature has addressed the psychological profile of 'survivors'. Such studies, however, have an inherent flaw: one can only interview the survivors, and not those who died. Nonetheless, a number of personality traits do seem common to those who have survived extreme adversity. Further, the reports of such survivors suggest that many of these traits are absent amongst those who died.

Firstly, it is clear that those who prepare and rehearse (whether physically or mentally) for unexpected events may improve their chances of survival. When Tony Bullimore's boat 'The Exide Challenger' capsized 1,400 miles Southwest of Perth in September 1997, he survived for six days in the upturned hull. Certainly, he was a very tough individual. But he was also prepared and rehearsed: he was wearing appropriate clothing, and had emergency provisions at the ready. Similarly, Steven Callaghan's boat sank on the night of January 29, 1982, leaving him adrift in the Atlantic for some 76 days. As his vessel sank, however, he was at least able to grab his 'emergency bag'-

Tony Bullimore (rear) and rescuer

in which he had placed (amongst other things) the spear gun to which he would ultimately owe his survival. Another feature of survivors, however, is that they often 'start surviving' as soon as problems occur: they are not paralyzed by events, but almost immediately start seeking solutions and planning for the future. Thus, awoken by the 'thump' of his boat striking a submerged object in a storm, and with water flooding into the cockpit of his boat, Callaghan launched a life-raft, kept it tethered close to the boat for as long as possible, and made the bold move of retrieving his 'survival sac' as the boat sank.

Such 'mental discipline' and 'planning for the future also extends throughout the survival experience. Survivors 'tend not to fold'. Callaghan, for instance, set a rigorous daily timetable to which he adhered. This involved not just attention to every small detail on his tiny life-raft (which he named 'Rubber Ducky II'), but also to his own wellbeing: yoga sessions and stretching were a key part of each day. The tribulations of Joe Simpson (in 'Touching the Void') are also well documented. Having sustained horrific lower limb injuries in a fall on Siula Grande (6344m), he was lowered off a cliff face and dropped into a crevasse. On regaining consciousness the next day, however, he immediately set about seeking escape: recognizing that he couldn't climb the crevasse walls, he took the only route open to him - down. It was here that he encountered the thin film of ice and snow over which he could crawl to escape. Meanwhile, the 58-foot yacht, Trashman, sank in October 1982 off North Carolina. Adrift in a small raft without food

or water, Deborah Scaling Kiley immediately began to adapt - gathering seaweed to protect her from the sun's rays. Over the coming days, two of her companions argued increasingly as to who was to blame, while Kiley withdrew and focused on survival. Drawing the sole other survivor to her she survived. The two who bickered became increasingly dehydrated and, one by one, lowered themselves over the side of the boat to seek beer and cigarettes. Kiley listened as each was eaten by sharks.

Focused mental activity also seems important to mental survival, if not physical. Thus, Edward Alan Brudno was captured in Vietnam in 1965, spending 90 months as a captive of the Vietcong. Deprived of paper, he wrote a mental diary as his captivity progressed - entirely in verse. On his release, it took 45 minutes of non-stop recitation to record the work. John McCarthy, imprisoned in Lebanon, played mental games, trying to image a number of random objects in his room, and having to tell a story as to how they got there. With his co-prisoner Brian Keenan, they meticulously planned a llama-farming business to be established in Patagonia. Brudno also designed an entire house during his captivity - right down to the wiring, drainage and last brick.

The ability to retain a sense of humour seems an element of many survival stories. Thus, John McCarthy was in a dishevelled and ragged state when he first met Brian Keenan. Keenan's first words? 'F**k me! It's Ben Gunn!' Whether it is the ability to remain cheerful which hallmarks the survivor, or that this humour aids survival is not clear. However, that mood influences perception of pain, and toleration of unpleasant stimuli, is not doubted [1, 2]. Mood may also have other biological effects: those students with a more 'positive' mood yield a greater antibody response to hepatitis vaccination [3].

Thus, psychological profile may be axial to surviving adverse events. These may operate not just through compensatory behavioural change, but also through biological mechanisms.

The Genetics of Survivors

A growing body of evidence suggests that survivors may be born as well as made. All humans share the same 20,000 or so genes; each of these genes contains a number of small common functional variations, known as polymorphisms. It is the interaction of different environmental stimuli with this differing genetic inheritance which makes us all different and such genetic variation may play a substantial role in dictating the chances of survival for any one individual.

Firstly, genetic variation may influence the chance of becoming ill. The associations between HLAB27 and ankylosing spondylitis are well known. Indeed, in some cases, as single gene disorder can cause a fatal disease: associations between the BRCA genes and breast cancer, and APC mutations and colonic cancer, have all been widely reported. However, genetic variation may also interact with environmental stimuli in complex disease traits to elevate the risk of disease. Variation in the gene for uncoupling protein 2 (UCP2) is associated with elevated cardiovascular risk in otherwise healthy males [4], whilst variation in genes encoding receptors for angiotensin II strongly interacts with hypertension in determining prospective cardiovascular risk [5]. Meanwhile, genetic variation may also offer protection from contracting disease. The CC chemokine receptor CCR5 represents the major M-tropic viral co-receptor. A 32bp deletion in the gene encoding this receptor protects substantially against HIV-1 transmission, and also delays disease progression [6].

Genetic variation may also determine survival once a disease state is established. A common variation in the gene encoding human angiotensin converting enzyme (ACE) has been described in which the absence (deletion, D) rather than the presence (Insertion, I) of a 287 base-pair element is associated with increased plasma and tissue ACE activity. ACE itself has a plethora of cellular functions, regulating cell growth and division, metabolism, and inflammatory responses. The D-allele has been shown to be associated with both development of, and worse outcome from, acute respiratory distress syndrome (ARDS) [7]. It has also been associated with worsened cardiorespiratory and metabolic adaptation amongst premature babies [8], and with poorer outcome amongst

those children infected with meningococcus [9].

Survival in adverse physical circumstances may also be influenced by genetic variation. Thus, the ACE 'I' allele has been associated with elite endurance performance and fatigue resistance, and the D-allele with strength/ power [10] [11] [12] [13] [14] [15]. Faced with prolonged physical activity in order to escape (for instance, the escape across Iraq of the Bravo Two Zero troops, or of Joe Simpson as he crawled down the mountain for days on end), one might anticipate a survival advantage to those bearing or more I-alleles. There are other reasons why genetic variation might also influence survival amongst mountaineers: the ACE I-allele seems over-represented amongst high-altitude mountaineers [10], and is associated with a greater success in ascent of high mountains [16].

The Survival of the Human Race

Whilst of substantial academic interest, the survival of the individual cannot be considered anywhere near as important as the survival of the human species and sadly, this is under immediate threat over a biological (tens of years) rather than geological (millions of years) timescale.

The first life probably appeared on Earth some 6.25 billion years ago, powered by the heat and chemicals of underwater volcanoes or 'black smokers'. However, oxygen levels were far too low to sustain aerobic life at this stage. Further, the absence of oxygen (O_2) also led to a lack of ozone (O_3). And without this ozone 'umbrella', the sun's ultraviolet rays successfully prevented any emergent life forms ascending from the deep. However, photolysis (the splitting of water and carbon dioxide molecules by lightening) did release oxygen and ozone, offering mounting protection. Meanwhile, photosynthesis by cyanobacteria augmented oxygen production. However, available oxygen was rapidly used to oxidize sea-based iron (yielding 'red band' strata in modern rocks), and then land-based elements ('red beds'). Only then, some 1.5 billion years ago, could free oxygen levels rise to support aerobic life.

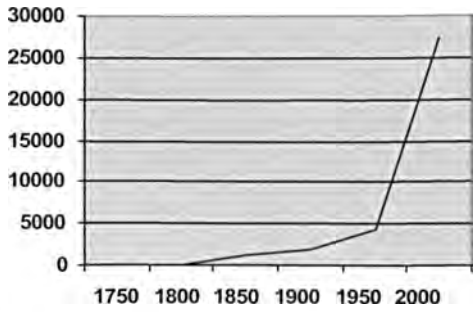
By 540 million years ago, with oxygen levels a mere 0.2%, the first multi-celled life appeared on Earth, and expanded and evolved. However, rapid climate changes led to near-extinction of all life on Earth on not one but five successive occasions. Such events were due to rapid rises in atmospheric carbon dioxide (CO_2) levels- yielding the so-called 'greenhouse' effect: high-frequency solar radiation passes easily through the CO_2, and warms the Earth. The higher-frequency wavelengths radiating from the Earth are trapped by the gas, causing the Earth to warm. Indeed, some 63 million years ago, two massive meteorites struck carboniferous rock near the Mexican peninsula, releasing massive quantities of CO_2. It was thus a global warming event (rather than a 'cooling event' as was once thought) which led to the demise of the dinosaurs - and of every animal weighing more than about 35kg on the planet.

There are, of course, natural cycles which affect the global temperature of the Earth. The Earth goes around the sun once each year, but not in a perfect circle; the Earth's orbit becomes more or less egg-shaped over periods of 100,000 years, its 'tilt' (now about 23 degrees) changes over periods of about 40,000 years, and it 'wobbles' around its axis every 20,000 years or so. These variations make a big difference. In England, the Earth's tilt alone means that you are furthest from the sun in December, when its light comes in from a much lower angle (meaning that much of it is reflected) - making it cold. In June, you are closer to the sun, and sunlight strikes more directly from above making it hot. Imagine those sorts of effects only much bigger and over much longer periods of time (tens of thousands to millions of years). Over the last one million years, these 'orbit' effects have led to a series of ice-ages and warming events. However, it is a feature of such cycles that they occur over very long periods: the last ice-age peaked 18,000 years ago when, with so much water frozen into snow and ice, the sea levels were lower and you could have walked across the bottom of the North Sea to Norway. After that, the Earth warmed: if you'd visited the Sahara Desert only 8,000 years ago, you'd have found wetlands and lakes. On top of these big slow changes, are smaller faster 'wobbles'. In 1607, only four hundred years ago, winter 'Frost Fairs' were held on the surface of the frozen River Thames. Some of these changes are caused by sunspot activity. Sun-

spots are areas of the Sun which are cooler than the rest but, when there are lots of them, the Earth seems to get hotter. The number of sunspots seems to vary every seven years or so, but there are much longer periods when they are much rarer or much more common. Whatever the causes of historical climate change, however, it is worth pointing out that such massive changes (between near total global freezing and warming) occur with only modest changes in temperature of perhaps some 5°C over 10,000 years. Today, the planet faces far more radical changes in climate than this with similar rises in temperature occurring in only a matter of decades.

The creatures whose bodies formed the fossil fuels stored a vast amount of CO_2: oil reserves alone sequestered more than 600,000,000,000 tonnes of the gas. All in all, the amount of carbon dioxide stored in fossil fuels is about 18,000,000,000,000 tonnes. However, whilst it took some 350 million years to store this CO_2, it is only latterly that humans have started to release it: the first modern petrol engine was only invented by Daimler in 1885, and the first 'car for the masses' to use it, the Ford Model T, only appeared 100 years ago in 1908. At that time, there were only 8000 cars and 144 miles of paved road in the whole of America. By 1970, however, there were 216,608,470 cars, trucks and buses in the world, and this number rose to 484 million in 1985, and 600 million in 1999. Meanwhile the first commercial jet service only appeared fifty years ago (in 1952). Now, 16,000 commercial jets carry more than four billion passenger flights are made each year. And this uses a lot of fossil fuel: we use over 4,800,000,000,000 litres of oil each year. Every single day, the UK uses a football stadium-full of oil, while America uses enough to fill an Olympic swimming pool to a depth of a depth of two and a half kilometres (or one-and-a-half miles!), or cover a tennis court to a depth more than three times greater than that at which the wreck of the titanic lies. Meanwhile, we burn 97 tonnes of coal... a second. And we haven't even considered the trillions of litres of gas used.

All of this releases massive quantities of greenhouse gases at an unprecedented rate.

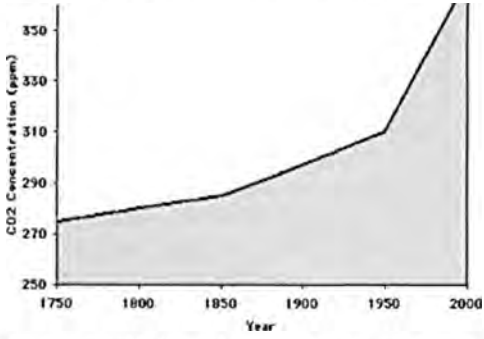


Burning a gallon of petrol releases 10kg of CO_2 – or 2.5kg/litre. Think of that every time you put a litre of petrol in your car. Burning 1kg of coal releases 3kg of CO_2. Commercial jet aircraft alone dump more than 600 million tonnes of CO_2 into the atmosphere annually. In fact, we have poured over 900 billion tonnes of CO_2 into the atmosphere since 1751- with half of these added since 1970. Each year we add 5 billion tonnes of CO_2 from burning natural gas and 900 million tonnes from cement production alone - contributing to a staggering 30 billion tonnes in total each year. The United States released 5.6 billion tonnes of CO_2 in the year 2000 alone. By way of comparison, the UK releases about 570 million tonnes.

As we release all this CO_2, we remove the plants which would otherwise help 'mop it up'. A fast-growing tree can take up 23kg CO_2 each year- the amount released when the average UK car drives for 70 miles. With the average American car producing four and a half tonnes a year, we'd need 12,000 million new trees to mop up the annual CO_2 made by American cars alone! To soak up Britain's annual greenhouse gas emissions, you'd need a new forest the size of Devon and Cornwall planted every year. But instead of planting trees, we are chopping them down: half the worlds forests were destroyed in the fifty years between 1950 and 2000, and the area of twenty football pitches vanishes every minute. And instead of taking up carbon dioxide, the rotting (or burned) plants release it: about 1.8 billion tonnes each year.

All these greenhouse gases are poured into our atmosphere which is a lot smaller than most imag-

ine. The diameter of the Earth is about 12750km. The bottom layer of our atmosphere - the troposphere- is only 11km (7 miles) thick, and contains nearly all the breathable air. Worse still, half the air is actually found in the bottom 5km of the troposphere. Think of where you live, and of somewhere about 3 miles away. Not far, is it?



The net result is that atmospheric carbon dioxide levels are rising fast. Measurements made of tiny air bubbles trapped in Antarctic ice show that atmospheric CO_2 concentrations were steady at 280 parts per million (ppm) for most of the last 1000 years. We've only recently started using fossil fuels and levels have already risen by over 36% since pre-industrial times. In fact, the present level is already the highest in the last 20 million years. It takes so long for the oceans and forests to absorb CO_2 that even if all production stopped today, levels would be above pre-industrial for up to 300 years. But instead, we are adding 30 billion tonnes a year to the air. Each year we also add 350-500 million tons of methane (a third from fossil fuel use and 30% is from livestock: there are 1.3 billion cattle in the world, each of which produces up to 600 litres of methane every day). Add to this the 13 million tonnes of nitrous oxide added annually...and greenhouse gas levels are rising faster than they ever have in the Earth's history and with them, the earth's temperature.

The temperature of the lower atmosphere (troposphere) has risen by more than half a degree Celsius in the last 150 years, and ocean temperatures have risen by 0.14^0C every ten years. And the rate of rise is now almost precipitous. The 20th century was the warmest, and 1990s the warmest decade, of the last 1000 years. Average global temperature in 1998 was the highest since records began in 1860, and the three other warmest years of the last 100 were in 2002, 2003 and 2004. As a result, ice is melting: European Alpine glaciers have lost half their volume since 1850. The glaciers on Mt Kenya (in Africa) lost 75% of their area in the 1900s alone, with 40% of this loss occurring in less than 25 years. The rate of loss of ice from Alaskan glaciers has doubled in 10 years. Soil is thawing and sea levels are rising.

But surely, man will survive?

Sadly, not - unless we drastically change our behaviour now. The rate of temperature rise is already causing a mass-extinction event faster than that ever before in Earth's history. As ecosystems collapse, so too will the animals at the top of the food chain - us. It will be impossible to grow crops when climates are unstable. Extreme environmental events (such as the recent New Orleans Hurricane) will destabilize economies and resource war is almost inevitable: consider the problems of civil unrest when 400 refugees move into a town. Consider what happens when tens of millions are on the move and consider, too, just how long it took new Orleans to descend into uncontrolled chaos. The four horsemen will surely ride the back of global climate change.

And what can we all do? Firstly, think. Every cup of water you boil released 22 cups of CO_2. Filling kettles with more than the water needed wastes enough energy to power all the street and council office lights in Britain. The average car in the UK generates 1kg CO_2 every 3 miles. Do you really need to make that trip and if you do, at what speed? Driving at 80mph increases greenhouse gas production by 40%. Is there ever justification for an 'urban 4 x 4'- which can yield from 250- 350g CO_2 per kilometre? Why not check out your carbon 'footprint'? A simple calculator can be found at www.CO2.org. Note that you should be aiming to yield no more than 0.5 metric tones of CO_2 each year for humanity to survive. How much are you responsible or? Not using is best of all - and thereafter reusing and recycling may have their place. In addition, you can make your money work for good. Your high-street bank lends some £27 for every £1 which goes through your account but to whom? Moving your money for instance, to the Co-Operative Bank or Triodos means that your money is invested in renewable energy resources.

If enough people move, then so too will the investment banks... and then green technologies will really begin to thrive. Meanwhile, move your electricity supplier (www.good-energy.co.uk) such that all your electricity is 'carbon neutral'. At www.CO2.org you can also 'buy' your CO_2 debt. Do these things now. Thirdly, tell others, including your politicians. There is but nothing more important.

In Conclusion

A number of physical and psychological factors influence individual survival. However, human survival is under grave threat in a matter of a few decades unless we act now. If we fail to do so, it is very likely that humanity will be the first species to have documented its own extinction.

References

1. Janssen, S.A., Negative affect and sensitization to pain. Scand J Psychol, 2002. 43(2): p. 131-7.
2. Zubieta, J.K., et al., Belief or Need? Accounting for individual variations in the neurochemistry of the placebo effect. Brain Behav Immun, 2006. 20(1): p. 15-26.
3. Marsland, A.L., et al., Trait positive affect and antibody response to hepatitis B vaccination. Brain Behav Immun, 2006. 20(3): p. 261-9.
4. Dhamrait, S.S., et al., Cardiovascular risk in healthy men and markers of oxidative stress in diabetic men are associated with common variation in the gene for uncoupling protein 2. Eur Heart J, 2004. 25(6): p. 468-75.
5. Jones, A., et al., Genetic variants of angiotensin II receptors and cardiovascular risk in hypertension. Hypertension, 2003. 42(4): p. 500-6.
6. Paxton, W.A. and S. Kang, Chemokine receptor allelic polymorphisms: relationships to HIV resistance and disease progression. Semin Immunol, 1998. 10(3): p. 187-94.
7. Marshall, R.P., et al., Angiotensin converting enzyme insertion/deletion polymorphism is associated with susceptibility and outcome in acute respiratory distress syndrome. Am J Respir Crit Care Med, 2002. 166(5): p. 646-50.
8. Harding, D., et al., Angiotensin-converting enzyme DD genotype is associated with worse perinatal cardiorespiratory adaptation in preterm infants. J Pediatr, 2003. 143(6): p. 746-9.
9. Harding, D., et al., Severity of meningococcal disease in children and the angiotensin-converting enzyme insertion/deletion polymorphism. Am J Respir Crit Care Med, 2002. 165(8): p. 1103-6.
10. Montgomery, H.E., et al., Human gene for physical performance. Nature, 1998. 393(6682): p. 221-2.
11. Montgomery, H., et al., Angiotensin-converting-enzyme gene insertion/deletion polymorphism and response to physical training. Lancet, 1999. 353 (9152): p. 541-5.
12. Myerson, S., et al., Human angiotensin I-converting enzyme gene and endurance performance. J Appl Physiol, 1999. 87(4): p. 1313-6.
13. Payne, J. and H. Montgomery, Genetic variation and physical performance. World Rev Nutr Diet, 2004. 93: p. 270-302.
14. Tsianos, G., et al., The ACE gene insertion/deletion polymorphism and elite endurance swimming. Eur J Appl Physiol, 2004. 92(3): p. 360-2.
15. Woods, D., et al., Elite swimmers and the D allele of the ACE I/D polymorphism. Hum Genet, 2001. 108(3): p. 230-2.
16. Tsianos, G., et al., Performance at altitude and angiotensin I-converting enzyme genotype. Eur J Appl Physiol, 2005. 93(5-6): p. 630-3.

Peebles 2006

Again they came from far and wide to Peebles for the Annual Spring Meeting. This year saw Lady Kay Campbell make the presentation of the first Donald Campbell Quaich for the best trainee presentation. The inaugural Quaich was won by Ewan Jack of Glasgow Royal. The other presentations were also of a very high standard this year and our thanks to all who entered for making this such a fitting start for this annual memorial to Professor Campbell.

The other highlight of the Saturday morning was the presentation by Professor Anthony Cunningham from Dublin on the recommendations for the improvement of vascular anaesthesia services stemming from the NCEPOD report.

The AGM heard of how changes to the charities regulations may require some alterations in the way we use our finances and also of a proposal to visit the scientific meeting of the South of Ireland's Anaesthetics Society in 2007. Little was said about MMC or Anaesthesia Practitioners - perhaps this has been all talked out for the present and we await developments nervously. There were a few Council changes: for the West, Jackie Orr was replaced by Grant Haldane from Hairmyres while from Dundee, Matthew Checketts took over from Fergus Millar and in Aberdeen, Andrea Harvey replaced Brian Stickle. Alfie Shearer was elected vice-president for next year before finally Douglas passed the chain of the Presidency to Maggie Stockwell.

Maggie's memorable address was followed by a fascinating discourse from guest lecturer, Hugh Montgomery on the genetics of survival.

The social side of the weekend was fun as usual. On Friday the golf competition was won by Charlie Allison and Maureen McDevitt with Donald Miller taking the nearest the pin prize. Your Editor did not take part this year owing to a piece of foolishness on the ski slopes resulting in a shoulder injury. Fear not - Crosshouse got it's Booby back anyway following the outstanding efforts of Phil Korsah.

Instead of golf I was one of five entrants into the inaugural "Peebles 5K" - an idyllic jog along the banks of the Tweed. Crosshouse won the Booby for that too, in convincing fashion, with both me and Janie Collie coming in equal last in a time of 40 minutes! Not counting Joe McGuinness from Vygon? who won in 30minutes. Kathleen Ferguson was our budding Olympian with a time of 34 minutes, just ahead of Jane Chestnut in 35. So there it is. The gauntlet has been cast down. The target is not hard to beat. Next year we plan to hold another 5K at about 5pm on the Friday afternoon - bring your kit!

Laser clay shooting proved popular throughout Saturday afternoon. The sharpest shooters were Stuart Wilson and Satchi Swami. Again there were no fishermen and this competition may have run it's coarse.

There was a visit to Rosslyn Chapel on Saturday morning. This seems to have been a success though as far as we can tell no one has started flaying themselves with knotted ropes! For the less mystically minded there was a cookery demonstration though I think the most popular pastime for non-combatants at the meeting is wandering into Peebles for coffee and a spot of shopping.

On the Friday evening at the opening of the Trade exhibition, the Society gave honorary membership to Tom Logan from Smiths Medical. Tom was a professional footballer with Hearts before becoming a physiotherapist and finally joining the Industry sales force for the last 28 years.

The usual dining and dancing followed and the world will be a better place if only our leaders would listen to the advice offered before the bars closed. Talking of advice and bars - youngsters please note - even if you are trying to impress the barmaid, don't tell her you play for the Scottish **under-18** rugby team!

The 2007 Spring Meeting at Peebles will be from Friday 20th April to Sunday 22nd. The trainees' annual education meeting will be held at Peebles on the Friday to encourage intergenerational mixing!

5K entrants - that's 1K each!

As if!

That's it lads, start training early for next year!

Don't worry we'll take her during her comfort break!

Lady Kay Campbell with the President

Charlie gets his prize from Ian Gray, the first Gentleman

I wonder?

Shooters: Swami the winner hiding at the back.

Tom Logan is made an Honorary Member

Is the piper's dram not a malt then?

Campbell Quaich entrants:
Paul Fettes, David Reid, Ruby Pratap,
Ewan Jack and Andy Rae.

Anaesthesia Update, I presume?

Catriona Connolly

On November 20-24th 2006 the first "Scottish" Refresher course on Anaesthesia took place in Queen Elizabeth hospital, Blantyre, Malawi. The course was primarily on Obstetric and Paediatric anaesthesia topics for sixteen Anaesthetic Clinical Officers (ACOs) and four midwives from rural areas in Malawi.

Delegates were fully funded by a grant received from the Scottish Society of Anaesthetists (SSA) and the faculty was partially funded with grants received from the Obstetric Anaesthetists' Association (OAA). The course was organised by Catriona Connolly (Consultant Anaesthetist, Dundee), in conjunction with Cyril Goddia, Head of the School of Anaesthesia, Blantyre. The other lecturers were Pamela Johnston (Consultant Anaesthetist, Dundee), Jo Thorp (Consultant Anaesthetist, Monklands Hospital, Lanarkshire) and Manch Navaratnam (SpR 5, Edinburgh).

The Faculty: Cyril Goddia, Jo Thorp, Manch Navaratnam and Pamela Johnston

The course ran each day from 08.30 until 16.00 and was composed of a varied programme including lectures, scenario-based teaching and small group tutorials on topics that had been identified as requiring updating The programme was adjusted after arrival and discussion with participants

Catriona presents the booby prize!

to take account of particular areas of difficulty. These included management of maternal and paediatric trauma, paediatric inhaled foreign bodies, high spinals in obstetrics, Jehovah's witnesses and lightning injuries sustained during thunderstorms. Revision of cervical spine immobilisation and log-rolling was also requested. This lecture was followed by a practical session of the delegates log-rolling each other – which provided some entertaining moments. The scenarios were well received and helped keep everyone awake in the afternoon heat. Delegates had been primed to come with case histories and discussion sessions of these challenging cases allowed lessons to be learnt by all.

One major problem that we were asked to discuss was the preparation of transfer of patients from the outlying hospitals into Queen Elizabeth Hospital in Blantyre. These patients often arrive without prior discussion, and after hours of road travel. They are frequently dead on arrival. We introduced SBAR (situation, background, assessment and recommendation) as a communication tool. This technique has been recommended by the Institute for Healthcare Improvement through the Safer Patient Initiative in the UK. It is a method of ensuring efficient communication about patients and is particularly useful when time for discussion is limited. (All the ACOs have cell phones that they use for communication with other centres). We ran a workshop, which included an afternoon of role-play, with various delegates having a virtual telephone conversation to negotiate transfer of a sick patient. It proved to be an extremely informative and entertaining session - the volume of laughter matched only by that during the logrolling session!!! We hope it leads to improvement in management of patients who require transfer and we will get feedback on this over coming months.

The management of near drowning is a major problem for several ACOs from certain areas of the country. At 585km long and 100km wide, Lake Malawi is the third largest lake in Africa and 11th largest in the world. In addition to Lake Malawi, there are three other sizeable lakes and collectively they constitute 20% of the surface area of the country. Many of the medical centres are at least 20 minutes drive from the lakeside and patients are usually dead before arrival. Some of the ACOs have been asked to provide teaching on basic resuscitation by the owners of lakeside hotels, so we added a session on near drowning to the course, at their request.

The ACOs are selected for training in anaesthesia after they have been clinical officers for four years. They undergo an eighteen-month training programme before taking up post wherever required. Some of the delegates had attended a primary trauma course in the past, but others had never been to any refresher course since qualifying- ten years in one instance. Many of the delegates were working single handedly or with one other anaesthetic clinical officer. They told us many harrowing clinical stories from around the country and found their commitment and dedication inspiring.

There is a desperate lack of essential drugs and equipment, which is demoralising when they have the knowledge and skills to save lives. The only requested topic that defeated us was the pharmacodynamics of out-of-date drugs! Some drugs, including lignocaine for intrathecal use, can be up to two years out of date.

However, it was encouraging to hear that some aspects of the situation are gradually improving - e.g. nearly all centres have a pulse oximeter - although if the probe or oximeter breaks, it cannot be repaired or replaced and the ACO has to rely on clinical skills. Many transfers of patients from the rural areas occur in ambulances with oxygen cylinders on board, although the patients may be unaccompanied. There are still significant numbers of patients being transported to the central hospitals in the back of pick-up trucks.

Our trip was the first of what we hope will be regular courses run in conjunction with the Scottish Executive and the "Scotland/Malawi Partnership" signed in November 2005 by the President of Malawi and the First Minister in Scotland. We have provided feedback to the International Development Department and the International and Communications Group at the Scottish Executive detailing some practical problems with drug and equipment procurement that are ultimately con-

tributing to unnecessary deaths. There are complex politics surrounding these issues so it is difficult to predict how much we can influence change.

The local organiser was Cyril Goddia and he worked very hard in the weeks preceding the course to help us with planning. His attention to detail whilst we were there ensured all our needs were met, especially while continuing to fulfil clinical demands, preparing to run the final exam the following week and surviving the takeover of by four female lecturers from Scotland!!!.Finally we would like to thank our families for facilitating this trip and surviving without us for nine days. It went so well, the next one will be a breeze.....

Thanks:
We would like to thank the Scottish Society of Anaesthetists and the Obstetric Anaesthetists' Association for their generous sponsorship, without which none of this would have happened.

Advanced Life Support Group: APLS Manuals for delegates and permission to copy MOET manuals.
Dr Iain Wilson: 10 copies of Oxford handbook of Emergency Anaesthesia
Oxford University Press: two copies of the new edition of the Oxford Handbook of Anaesthesia
Dr Mike Dobson: 20 eTALC CDs, Anaesthesia Resource 2
Novo Nordisk: copies of the Oxford Handbooks of Critical Care & of Clinical Haematology and Fast Facts Bleeding Disorders as well as USB sticks and stationery.
Syner-Med: Clinical Anaemia in Pregnancy textbooks and stationery.
Abbott: Regional Anaesthesia books & CDs, stationery and dermatome maps.
Fresenius Kabi: further stationery.
Sapiens Publishing: copies of wall charts for immediate management of PPH & B-Lynch suture; copies of a new book on PPH edited by Christopher B Lynch, launched at the Int. Fed. Of Gynaecology & Obstetrics (FIGO) conference In Kuala Lumpur and aimed at practitioners in the developing world. In an amazing gesture of generosity, the publishers are donating free copies of the paperback version to all clinicians working in developing countries. The publishers donated a hardback copy to the School of Anaesthesia in Blantyre. A pdf version can be downloaded free from www.sapienspublishing.com.

Further Thanks:

Before the trip we received invaluable advice from Drs Moyna Bill, Paul Fenton, Bruce McCormick, Frank Walters and Iain Wilson. Dr Louise Aldridge, RHSC Edin. gave permission to use the paediatric formula charts and Alan Owen- ODA, RHSC, Edin., laminated these to give to our delegates. The medical physics team at RHSC Ed repaired the pulse oximeter probe so that a condemned oximeter could be donated. Grateful thanks are also due to the Physics Department in Monklands Hospital for identifying still useful equipment that could no longer be used locally and which would be jettisoned. Theatre staff in our respective hospitals collected out of date essential equipment which we delivered to QEH. Tayside print works bound the MOET manuals and printed our acetate slide backups. We would like to thank our colleagues for covering our lists in our absence and Professor Stewart Forsyth, medical director in Ninewells, who granted two of us (CC and PJ) special leave for this trip.

We'd like to say a huge thanks to the **British Midland** ground staff manager at Edinburgh airport who allowed us to check in an extra 55kg (in addition to our individual 20kg allowance) of books and equipment for free!

You can help!!

All out -of-date equipment that would usually be disposed of can be used in Malawi. Please collect out of date equipment from your theatres and ICU. These can be shipped out through a secure link from Glasgow city council. For further information please contact me.
If you are interested in teaching on a short refresher course any time in the future please contact me at your earliest convenience
c.connolly@doctors.org.uk.

Alfred William Raffan

Former consultant anaesthetist Aberdeen Hospitals (b 1912, q Aberdeen 1938; TD, DA, FFARCS), d 16 January 2006.

Alfred Raffan (Alfie) went to war in 1939 with the 15th Scottish General Hospital RAMC. Initially in Cairo, he followed the action across N Africa to Italy. Onwards to France and Germany he was anaesthetist in a maxillofacial field surgical team. Later, after repatriation he became a consultant in Aberdeen. In 1967 he became President of the Scottish Society of Anaesthetists and, in 1971 a founder member of the Scottish Standing Committee of the Faculty of Anaesthetists. He excelled in cricket; in later life, many enjoyed his company both on and off the golf course. Pre-deceased by his first wife; he leaves a wife, Pat and a daughter and son from the first marriage.

Iain Levack writes:
Dr Raffan was the senior figure in the Anaesthetics Department in Aberdeen Royal Infirmary during the 1960s until his retirement in 1977. In 1985 he gave to me for safe keeping the following essay. The understanding was that I should publicise it after a respectable period of time. This year, thirty years on after Alfie's retiral, it seems appropriate that his reminiscences should be enjoyed by the readership of the Society's Annals.

The Development of Anaesthetics in Aberdeen and Some Reminiscences
By Alfie Raffan

Before the Second World War anaesthesia was provided by GPs who were given honorary appointments at the various hospitals. Their work was usually limited to three or four hours in the morning covering elective surgery. The emergency cover was provided by the duty house physicians. In the mid 1930s Dr Ross MacKenzie was the first of these 'Seniors' to give up his general practice to specialise in anaesthetics, and in 1937, as chief, he persuaded the governors to appoint the first 'Resident Anaesthetist' - Dr. Rosalind Milne. A second appointment was made in 1938, and

Alfie Raffan

when he, Dr A B Christie, left to an appointment in the Victoria Infirmary, Glasgow, I succeeded him in January 1939 (though I left on mobilisation in September that year).

Although the Boyle's machine with bubble flow meter was introduced in the First World War, the favourite and most convenient method of induction of anaesthesia was with the open mask, the Schimmelbusch or Bellamy Gardner, using ether. Alex Ogston introduced his own version of mask, a Schimmelbusch with a metal frame attached, rising to some five inches and around which was wrapped a folded towel. His paper, read to the Scottish Society in April 1922, " Notes on the administration of ether by the per-halation method" was the first recorded description of his mask.[1] This mask was so popular for its speed of induction that when the house physicians who had used it went further afield, they invariably 'took' one with them. When I attended a course in London after the Second World War one lecturer, Ronald Jarman held up this mask to the audience of about thirty, and gave it a name which I had never heard before. I protested, but he had never heard of Ogston and would have none of it. Even after the Second World War, the Ogston mask was used in the Children's Hospital for induction of anaesthesia before tracheal intubation for dissection of tonsils. Induction with ether alone is slow because of its irritant nature, but when one starts with a few

whiffs of ethyl chloride the procedure is transformed and this was considered to be much safer than the other method – a mixture of chloroform and ether.

John Johnston of Aberdeen was one of the original members of the Scottish Society and a regular contributor to their discussions. He was President on no fewer than three occasions, a unique honour. He delivered papers on varied subjects including, "Evipan Sodium" in 1936. This last paper referred to his experience of 322 cases, with zero mortality although he described one patient's "return from the dead". He had given 6ml of a 10% barbiturate solution when the surgeon was about to enucleate an eye, they noticed that "the breathing became shallow and then ceased, and the pulse was imperceptible". In spite of resuscitation for 45 minutes, no heart sound could be heard, the jaw was bandaged and the patient was prepared for the mortuary. "Fortunately he was kept in the operating theatre whilst the surgeon saw some out-patients and presently a nurse noticed some slight movement of the jaw and a faint pulse was seen in the neck and occasional shallow movements of the chest. Further resuscitation was successful. He was later known to the staff as Lazarus.

In 1939 when I was sent to anaesthetise for Dr Clark Souter, for enucleation of an eye, I gave an intravenous anaesthetic, the ophthalmologists' favourite. Discovering this, my chief Dr Ross MacKenzie said, "Well, you'd better run back to see if he is still alive!" Such was the reputation of intravenous anaesthesia in those days.

In the mid 1930s Ross MacKenzie was the first Aberdeen anaesthetist to forsake general practice to specialise. This was quite a step, for the hospital appointments were 'Honorary' apart from the municipal hospitals, Woodend and the City, where a fee was paid for each operation. (In my time as an 'Honorary' from late 1946 to the start of the NHS in 1948 the fee was two guineas per case) (About £40 in today's money – Ed) This compares with the 10shillings fee for extraction of one to three teeth at the beginning of the NHS.

Ross MacKenzie had a character of his own. Having suffered trigeminal neuralgia, the twitching of his face became very evident when he was attempting intubation, a procedure which was not nearly as simple as it is today with the relaxants now available. One had either to produce fairly profound relaxation with ether which could easily take ten minutes at least, or attempt blind nasal intubation at a lighter level of anaesthesia and with the help of CO_2 as a respiratory stimulant. This latter method required a great deal of practise before one became adept and failure meant an even longer induction.

Aberdeen surgeon G. Gordon Bruce became one of the pioneers of surgery of the thyroid. In these days there was little medical control of the toxic thyroid and the patients suffering from thyrotoxicosis were in a highly emotional state when they came to operation. With the fear of them slipping into a "thyroid crisis" uppermost in one's mind, so evolved the technique of 'stealing the thyroid'. The patients were admitted to a side room opposite the theatre suite some days before the date for operation. Every morning the curtains were closed and they were given a rectal injection of a placebo before breakfast. This was explained as part of the treatment. On the morning secretly selected for operation the same procedure was followed except that a basal narcotic, avertin (tribromoethanol) or paraldehyde, was given per rectum. The patient went off to sleep and was then quietly wheeled on her bed through to the already darkened anaesthetic room. Nitrous Oxide was administered from a mask held off the face and slowly the ether was added. When the patient awakened the operation was over and she was back in her room, her ordeal over.

Gordon Bruce was an excellent surgeon but his temperament was not ideal, and the operating theatre atmosphere was somewhat 'charged'. He had a distrust in these early days of the endotracheal tube in the operation for thyroidectomy, fearing it might cause a tracheal collapse and so one had to hold a face-mask throughout the operation which usually lasted about two hours. This explains the unusual mask which may still be seen in the Royal Infirmary in which the connecting piece between the corrugated tubing and the mask is not angled but comes off the mask flush with the nasal end in order to ease access to the neck.

This then, was an exciting time and one gradually learnt to smuggle a tube under the mask, deceptive but much safer and I have yet to see a tracheal collapse.

Professor J R Learmonth came to the Regius Chair of Surgery in Aberdeen in 1932, straight from research at the Mayo Clinic. His operation for presacral sympathectomy in these early days demanded a great deal of skill from the anaesthetist, there were no relaxants and due to the saturation of ether required to provide a quiet and relaxed abdomen Learmonth developed a speed and dexterity which became a feature of his skill. I can recall being on emergency duty just before 6 pm when I had his first patient in the theatre ready for operation at 17 minutes to the hour, and by 17 minutes past that same hour he had completed two appendicectomies and closure of a perforated DU in a third patient. This may be hard to believe but one had to induce each succeeding patient whilst the first was being stitched up after closure of the peritoneum. Few men in my experience worked as hard as he did. Not only did he continue and advance his research, but his teaching of both undergraduates and postgraduates was quite brilliant, and on top of that he developed a very busy private practice.

Sydney Davidson, by contrast, was a most meticulous surgeon, with a tendency to burst into song when he became bored. To work with him one usually felt the pangs of hunger before his lists were finished, but at least he invariably stayed to the bitter end himself, unlike so many other surgeons. I think I can best quote from a final year dinner menu referring to Sydney:-

"When the tumult dwindled to a calm
I left him practising the hundredth psalm"

George S Davidson, better known as Geoff Davidson, was the first specialist gynaecologist to be appointed to the ARI in 1930. Until then the gynaecology had been done by the general surgeons, and it seems that they were not enamoured of this new appointment. Davidson found that he had some difficulty in getting help from the anaesthetists who were 'sworn' to work with their own particular general surgeons. Geoff told me this himself with the result that in these early days he had to do a lot of his work under local, and when intravenous anaesthesia came in, he even did these himself, on the odd occasion.

William Anderson was a very popular surgeon. His patients loved his couthy approach especially those from the same farming community as he came from. He would tackle anything; indeed he did thoracic surgery before a thoracic unit was established in Aberdeen. Anderson was a man who had 'done everything,' and when he found Max Pemberton, and me doing a splanchnic block for an upper abdominal operation, a technique we had practiced on the cadaver, his dry comment was "We've deen a' that".

One morning William had been doing a mastectomy with James Stewart as anaesthetist giving ether via the Ogston mask. I doubt if William had given much warning when he started to use a diathermy machine. There was an explosion, the patient was killed, the assistant was thrown on his back, Jimmy Stewart suffered rupture of his ear drums. It was perhaps fortunate that the assistant, who was the patient's GP, was also the Police Surgeon. Later when William arrived in another theatre I heard him say, pointing to the diathermy machine, "Sister, tak that thing oot o' here." Jimmy Stewart's only comment in later years when the diathermy was in use was, "I always take my feet off the floor".

These grand figures are now dead, even Harry Glennie, the first Resident Surgeon Officer at the Royal Infirmary. Doing emergencies at night with Harry was never dull even though one might have to spend most of the night coping with a difficult appendix. I think he came to realise that he was never meant to be a surgeon. In these days before the war he was full of fun but with probably the highest surgical morbidity of all time. One day he came breezing into the dining room with great enthusiasm extolling his own success. For the last two weeks or so he had had wound infections, burst abdomens, secondary haemorrhages and a few deaths, but now, "Success at last!" he cried. "I operated on an old man just two weeks ago and it was perfect, I have just discharged him and he is away back to Elgin on the train today." Presently the maid answered the phone and was heard to

say, "Dr Glennie, yes, he's here.." Harry bounded to the phone, "Yes, yes" he lisped. This is Surgeon Glennie speaking..." There was a silence, "Wha' ha'" lisped Harry. The silence continued and he put the phone down, "Jesus Christ, that was the Station Master at Insch, he's died on the train!"

I returned to my old appointment in November 1945 to pick up the threads of civilian life, and around 1946/47 I was appointed an Honorary Assistant at the Children's Hospital which included work at the municipal hospitals, Woodend and the City. I was told I could easily change my appointment to full-time. The salary offered was £1000. (£25 000 at today's prices – Ed.) I was not interested, preferring to get involved in private practice as well as hospital work. In a year or so when we had a proper thoracic department started with the appointment of Freddie Gowar I became heavily involved in that work at Woodend and at Tor-na-Dee which was a Red Cross Sanatorium with a brand new operating theatre. This was heavy work. Thoracoplasties were done under regional blockade which meant a start half an hour before the start of the list. This early start also applied to the thoracotomies because, in these days, I had to set up a drip which meant a cut-down in the ankle.

In the immediate post-war years the waiting list for tonsillectomy in children was over one year and for some years I paid five country visits per month (Banff, Keith, Huntly and occasionally Buckie and Lossiemouth). I recall one adventure with Wilkie Collins. We were invited to operate on one child on the kitchen table at Cairntradlin Farm. It was the time of the foot and mouth epidemic and we were advised to bring our gumboots as we had to leave the car at the gates of the drive and wade through trays of disinfectant before entering the house. On another occasion I had been operating in Keith and when we were finished we were given tea and scones by the Matron, a lethal time for me. I fell asleep at the wheel near Colpy and finished up two fields away and had to get the assistance of the local farmer to tow me out. I was due at the St John at 5 pm, but I was half-an-hour late. George Mavor described the peculiar vision in Albyn Place as he and Gordon Bruce stood looking out from the office window wondering what had happened to me. The tops of the trees were being lit up by my car headlights which had been twisted round by the barded wire fence surrounding one of the fields. I later received a claim from the farmer for repair of his fence.

The second half of the last century saw the gradual extension of the use of general anaesthesia. Progress was slow even after the introduction of the endotracheal tube during the First World War which extended the surgeon's scope immeasurably. However progress accelerated with the introduction of the specialist anaesthetist and the revolutionary change brought about by the relaxants and a light plane of anaesthesia resulting in a dramatic reduction in time spent in hospital after the various operations. Before the War, a simple herniorrhaphy required a stay of two to three weeks in hospital and is now a day case and partial thyroidectomy three weeks to a few days and so on. The saving in financial terms has been one of the features of modern surgery and the anaesthetist has played a large part in this success.

1. Ogston A. Notes on the administration of ether by the perhalation method. British Journal of Anaesthesia, 1924;2: 76-82.
2. Usher CH. Observations on the retinal bloodstream at the time of death. Ophthalmic review, 1896; 15: 339-351.
3. Lawrie R. The reporting of deaths associated with anaesthesia in Scotland. An account of the Scottish Society of Anaesthetists in negotiating revised procedure. British Journal of Anaesthesia, 1962; 34: 124-129.

Donald Campbell Quaich

Cardiovascular parameters continue to change after achieving constant effect site drug concentration.

Ewan Jack[1], J Harten[2] & J Kinsella[3]
University Department of Anaesthesia
Glasgow Royal Infirmary

[1] SpR, [2] Lecturer & [3] Senior lecturer

Ewan Jack

Target controlled anaesthesia is an established anaesthetic technique which has reported benefits. Various pharmacokinetic models for the use of propofol have been described (Ref Marsh, Schnider, Shullter etc.). There is a good correlation between the calculated effect site concentration and the depth of anaesthesia as recorded by various monitors (AEP, BIS, Entropy). Propofol is known to depress the cardiovascular system and the relationship between the effect site concentration and cardiovascular depression has not been extensively studied. A previous study showed that using the Marsh model of pharmacokinetics the maximal cardiovascular depression would happen some 8 minutes after peak effect site propofol concentrations[(1)]. We wished to further this using other measures of cardiovascular output including stroke volume, cardiac index and systemic vascular resistance.

Kay Campbell presents the Quaich

Methods

Local ethic committee approval was given and informed consent from 20 ASA 1 & 2 patients due to undergo elective day surgery was gained prior to recruitment. They had no premed and were fasted for 6 hours prior to the procedure. In addition to routine monitoring they had their cardiac output measured by non-invasive transthoracic bioimpedence (CardioDynamics International Corp., BioZ.com, San Diego, USA). They also had their 'depth of anaesthesia' monitored with the use of a bispectral index monitor (BIS, Aspect Medical Systems Inc, Newton MA USA) They were then anaesthetised using a standard TIVA technique (Effect site concentration target controlled anaesthesia, diprifusor and remifusor), intubated and ventilated to a constant $EtCO_2$ of 5kPa. During the monitoring phase they were not stimulated in any way, nor did they receive any intravenous fluids.

From the time of attaining a steady state effect site concentration of both propofol and remifentanil

Cardiovascular parameters

	Mean at SS	Change (%)	Time of maximal
Heart rate	70bpm	-14bpm (20%)	23mins
MAP	82mmHg	-22mmHg (26.8%)	25mins
Cardiac index	2.76l/m^2	-0.14l/m^2 (5%)	20mins
Stroke volume	71.3ml	+ 18ml (25.2%)	25mins
SVRI	2346dyne/sec/m^2	- 706dyne/sec/m^2 (30%)	26mins

Results

Demographics

	Median	Range
Sex	7 male: 13 female	N/a
Age	40yrs	20 – 62yrs
Weight	70kg	51 – 108kg
Height	169cm	150 – 196cm
Time to 'steady state'	6.5mins	4.5 – 16.5mins

	Minimum	Time to min
BIS after SS	31.9	13mins

we measured heart rate, blood pressure, cardiac index, stroke volume and systemic vascular resistance indexed.

Discussion

We have shown that the time to maximal cardiovascular depression occurs well after that previously claimed, some 20 - 26 minutes. The depression of cardiovascular parameters is most profound in the vasodilatation well known with propofol, the SVR drops by 30% and the subsequent MAP drops by almost 27% from the baseline level measured after achievement of calculated 'steady state' anaesthetic depth. This is probably due to ongoing redistribution of propofol acting at vascular smooth muscle and possibly cardiac myocytes. The reduction in heart rate (20%) is also significant but reflex mechanisms of increasing the stroke volume by a similar 25% ensure that the measured cardiac index changes little (only decreased by 5%). Remifentanil was added to simulate the most commonly used combination of target controlled drugs; it could be that the continuing cardiovascular depression is due to remifentanil but it's extremely rapid distribution and short duration of action would tend against such a conclusion. The only other drug prescribed throughout the experiment was 100% oxygen, some recent work claims that oxygen lowers cardiac output[2] but again the rapidity of its pharmacology would suggest that this is not the offending agent for the prolonged time seen in our study.

Conclusion

These results show that after achieving steady state concentrations of anaesthetic agents patients cardiovascular system continues to become more depressed with a maximal time of depression being some 20 - 26 minutes after achieving calculated steady state anaesthesia and 7 – 13 minutes after BIS levels off

Many research papers have used patients at

'steady state' anaesthesia before measuring the effect that certain drugs or interventions have on the human body. Our results suggest that the ongoing effect of TIVA +/- oxygen on the cardiovascular system may distort many previous conclusions drawn from other anaesthetic papers.

References

Kazama T, Ikeda K, Morita K, et al. Comparison of the effect-site k(eO)s of propofol for blood pressure and EEG bispectral index in elderly and younger patients. Anesthesiology 1999;90:1517-27.

Harten JM, Anderson KJ, Angerson WJ, et al. The effect of normobaric hyperoxia on cardiac index in healthy awake volunteers. Anaesthesia 2003;58:885-8.

The Effect of Spinal Flexion on the Conus Medullaris: A Case Series using Magnetic Resonance Imaging

Paul. D.W. Fettes, Kate Leslie, Sandra McNabb, Peter J. Smith. Ninewells hospital, Dundee

Aim

Anatomy textbooks state that the conus medullaris moves cephalad when the vertebral column is flexed (Gray's 2005; Cunningham's 1981). This could confer protection against spinal cord damage during dural puncture, but has not been demonstrated *in vivo*. We therefore imaged the spine of volunteers using magnetic resonance imaging (MRI) to determine if such movement occurs.

Methods

Ten volunteers underwent MRI in the right lateral position, with the spine in the neutral and flexed positions. The position of the conus medullaris in relation to the superior endplate of the L1 vertebra was determined.

Results

On spinal flexion, the conus medullaris moved cephalad in three subjects and caudad in three subjects, with no change in the remaining four; the median (95% CI [range]) overall movement was 0 mm (4 mm caudad to 1 mm cephalad [3 mm caudad to 1 mm cephalad]; p = 1.0).

Conclusion

This study showed that flexion of the vertebral column does not result in significant cephalad movement of the conus medullaris. Therefore spinal flexion is unlikely to confer protection against spinal cord damage during dural puncture.

References

Romanes GJ: The central nervous system: the spinal medulla. Cunningham's Textbook of Anatomy, 12th Edition. Edited by Romanes GJ. Oxford, Oxford University Press, 1981, pp 625

Difficulty in removal of double cannula fenestrated tracheostomy tube: case report and cadaver dissection.

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Introduction

Double cannula fenestrated tracheostomy tubes allow airway patency to be preserved during tube changes. As the outer cannula remains in situ during inner tube replacement, there is no risk of airway loss or creation of a false passage [1]. We report a case of difficulty in removing a double cannula tracheostomy tube after prolonged use and seek to explain the cause by means of cadaver dissection.

Case history

A 73 year old female smoker, ASA 3 and weighing 44kg , presented with a T3 tonsillar squamous carcinoma extending to the base of skull and inner mandible. During resection and reconstruction with a free gracilis flap, a Shiley 8.0 tracheostomy tube (Tyco Healthcare, Pleasanton CA) was sited between tracheal rings two and four via a Bjork flap. Post operatively, the patient returned to a high dependency area breathing spontaneously. Decannulation was delayed by a streptococcus pneumoniae chest infection, treated with antibiotics and bronchodilators, and poor swallowing. On day 29, after a trial of capping, the Shiley tube could not be removed more than 10mm. Mobile at the peristomal area, a 16Ch suction catheter could be passed freely into the trachea, and there were no signs of respiratory ob-

struction or bleeding. Pilot cuff function was normal. Patient discomfort limited further attempts and a decision to try manual removal under general anaesthesia was made. After inhalational induction with sevoflurane/oxygen/air, gentle pushing and pulling movements associated with side to side twisting eventually dislodged the tube and it was removed along with much debris. Recovery was thereafter uneventful.

Discussion

The cause of difficulty remains unclear and no similar cases have been reported. One possibility is that an inflammatory tissue 'bridge' between the tracheal wall and the tube prevented removal. Like all foreign bodies, tracheostomy tubes elicit an inflammatory response. The di(2ethylhexyl) phthalate used as a softener in the medical grade polyvinyl chloride may enhance this[2]. The prolonged insertion time, at 29 days the uppermost limit consistent with the product's classification as a disposable medical device, may also have contributed to an inflammatory process. Granulation tissue occurs during a proliferative stage of inflammation and is more common after bacterial infection and exposure to oleic acid containing compounds such as salbutamol. Although there are no reported cases of granulation tissue preventing tube removal, it has been associated with airway obstruction and difficulties in tube placement [3,4,5]. No evidence of granulation tissue was found in this patient.

Rather than tissue reaction anchoring the tube, difficulty in removal is more likely to have been mechanical. The patient was of low weight and had a thin neck. The distance from the skin surface to the anterior tracheal wall is then shorter than normal and so the fixed length of the Shiley tube may be inappropriately long if the tube is fully inserted so that the flange rests against the skin. Rather than sitting parallel to the tracheal walls and touching them only at the cuff, the convex curvature of the tube will abut tightly against and stretch the posterior tracheal wall. On retraction, this angulation will result in force being distributed posteriorly as well as anteriorly, further stretching the trachea and causing difficulty in removal, particularly if the tube sticks on a tracheal ring.

Cadaver Dissection To further explore the possibility of mechanical obstruction, a cadaver dissection was performed. Having obtained consent, a 75kg adult male formalin preserved cadaver with a slim neck was used. Although there were differences in gender and weight to the patient described in the case report, the ratio of tracheostomy tube size to patient size was similar to allow comparison.

A Shiley 10.0 tracheostomy tube was sited between tracheal rings two and four. The posterior wall of the trachea was exposed by left neck dissection. Skin and underlying fascia were removed before reflecting sternocleidomastoid laterally from its clavicular origin. Pre-tracheal strap muscles were reflected superiorly and the clavicle dislocated from the sternum. A normal trachea is illustrated in Figure 1. Following insertion of the Shiley 10.0 tube posterior distortion becomes evident (figure 2). Removing the tube induces tenting of the posterior tracheal wall (figure 3), associated with marked resistance to decannulation.

Figure 1.

Figure 2.

Figure 3.

Although the dissection does not provide conclusive proof, its findings are consistent with a mechanical explanation of events. Of note, the marked tracheal tenting visible during decannulation would certainly explain the patient's extreme discomfort. As far as we are aware, this is the first demonstration of the anatomical distortions that can be induced with Shiley tracheostomy tubes.

Conclusions

This case demonstrates the importance of selecting an appropriately sized tracheostomy tube. No commercially available tube is suitable for all patients. In cases such as this, where the skin surface to anterior tracheal wall distance falls outwith the normal range, consideration should be given to using an adjustable flange tube. Confirmation of correct positioning using a fibreoptic scope may be appropriate. Although no evidence of granulation tissue was found in this case, we recommend that the outer tube is changed at two week intervals as a precautionary measure.

References

1. Deutsch ES. Arch Otolaryngol Head Neck Surg. 1998;124:1237-12388
2. Safety assessment of Di(2 ethylhexyl)phthalate (DEHP) released from polyvinylchloride medical devices. CDRH, FDA, 2001
3. Yaremchuk K. Laryngoscope 2003; 113:1-10
4. Benjamin B, Kertesz T. Anasth Intensive care. 1999; 27:596-600.
5. Madden BP, Datta S. J Laryngology and Otology. 2001; 115:743-745

An audit of compliance with National and local guidelines for day case cataract surgery

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Introduction

The introduction of phacoemulsification has permitted cataract surgery to be performed under local anaesthesia in patients with multiple co-morbidities. Guidelines for these procedures were published in 2001 by the Royal College of Ophthalmologists and the Royal College of Anaesthetists[1]. This was followed by the Scottish Intercollegiate Guidelines Network (SIGN)[2] guidelines. More recently the Royal College of Ophthalmologists published a revised set of guidelines in 2004[3]

Aims

To check that local and national guidelines are being followed at Aberdeen Royal Infirmary, to improve compliance and to establish the need for revision of local guidelines.

Methodology

A prospective 8 week audit during Dec 04 and Jan 05. A questionnaire was completed by the nursing staff. The data was entered into an Access database and analysed manually.

Results

100% forms for 175 day case cataract procedures were returned. Some were incomplete. (Table)

Discussion and Recommendations

Local and national guidelines have not been adhered to completely. National guidelines state the time between pre-op assessment and surgery should be less than 90 days. The reasons for non-compliance (23%) were not within the remit of this audit but need to be identified and remedied.

Contrary to instructions, 38% did not take their usual medication and 46% of patients arrived fasted. Patients on warfarin are advised to get their INR checked by

Time between pro-op assessment and surgery	Data for 160(91%) patients. Compliance with the 90 day limit in 124/160(77%)
Ingestion of normal medication on the day of surgery	164 were on medication but only 101 took it as instructed (62%).
Fasting status	80 out of 175 patients (46%) arrived fasted on the day of the procedure.
Warfarin	11 were on warfarin. 7 patients had their INR checked by their GP as recommended. In 2 of these the INR was >2 but surgery was not cancelled.
Diastolic BP on admission	The diastolic BP was greater than 100 mmHg in 5/175 (3%). Surgery was not cancelled in any of these.
Local anaesthetic technique	Data for 168/175 patients (96%).140(83%) had LA eye drops, 25(15%) sub-Tenon's injections and 3(2%) peri/retrobulbar injections.
Venous access	All in the retro/peribulbar group, 3/25(12%) from the sub-Tenon's group and 16/140(11%) with eye drops had Venflons.

their GP yet 27% of patients did not do so. Pre-assessment information may need to be formalised to increase compliance, perhaps with a handout of instructions. A phone call the day before surgery may improve compliance.

Contrary to local guidelines, 2 patients with INR > 2 and 5 with diastolic BP >100 mmHg had surgery. Revised guidelines from the Royal College of Ophthalmologists (Ref 3; p 19) state that the INR can be in the therapeutic range. The national guidelines recommend venflons in the peri- and retrobulbar group only; local guidelines include the sub-Tenon's as well due to the geographic isolation of the Day Case theatre. The audit shows full compliance with the national but not the local guidelines (only 16% of the sub-Tenon's group had a venflon inserted and in the LA eye drops group, 11% had venflons inserted unnecessarily. The local guidelines need to be adjusted in line with the recommendations from the Royal College of Ophthalmologists.[3]

A re-audit would be performed after the necessary changes have been put in place.

References
1. The Royal College of Anaesthetists and The Royal College of Ophthalmologists. Local Anaesthesia for Intraocular Surgery; 2001.
2. Scottish Intercollegiate Guidelines network. 53: Day case Cataract Surgery. A National Clinical Guideline; August 2001.
3. The Royal College of Ophthalmologists. Cataract Surgery Guidelines. London; 2004.

Procalcitonin in the early detection of sepsis – an observational study

A Rae, D Maclean, K Liddell, B Neish.

Introduction
Procalcitonin (PCT) is a 116 amino acid polypeptide produced from the c cells of the thyroid gland. It undergoes enzymatic cleavage to give calicitonin. In sepsis this process is inhibited giving an elevation in the serum level of PCT(1).

A number of recent studies have investigated the usefulness of PCT as a marker for systemic sepsis (2). It has been used to guide antibiotic use and has helped reduce antibiotic prescribing (3). In the ITU setting it can often be difficult to distinguish those patients with non-infective SIRS e.g. post-ops and those with systemic sepsis. It may be a useful marker to help make this distinction (4). It has also been lauded as a useful prognostic marker in both adults (2) and children. (6)

Aims
To evaluate the potential of PCT as a marker of systemic sepsis in our district general ITU setting.

Methods
Over five months we collected daily blood samples from all patients in the ITU. Samples were spun down and stored at -60°C in the lab.

Demographic data was gathered for each patient – WCC, CRP, microbiological culture results, temperature above 38°C and unit/hospital outcome.

From the initial 63 patients we chose 10 to carry out serial PCT assays upon. Patient selection was based upon sample availability and the indices described above. For each of the 10 patients a PCT assay was carried out sequentially on the first 6 samples. We used a Brahms immunochromatografic test to give a semi-quantitative determination of PCT level. The results were initially charted on reference cards supplied with the kit and subsequently graphed. 3 tests were used as negative controls. After the 63 tests were carried out we used 11 of the 12 remaining unused tests to extend the testing period for patients 1, 2 and 10.

Results
One of the controls failed to absorb serum appropriately. The other two gave negative results. All of the subsequent tests functioned appropriately. Three of the sera exhibited some contamination with haemolysed blood – samples 6 and 8 from patient one and sample 5 from patient two. We observed four different patterns of result. The predominant result was that of PCT level being elevated initially then declining – patients 1,4,5,6,8 and 10. Patients 3 and 7 showed elevated results that did not change over the course of testing. Patient 9 showed an initial low level that became elevated during the course of testing. Patient 2 showed a level that rose then declined over the course of testing. PCT level was sufficiently elevated in 7 of the 10 patients to signify severe bacterial sepsis/multiple organ failure – Patients 1-3, 6, 7, 9 and 10. The remaining three patients' levels varied between no and only mild elevation. This would be consistent with a spectrum from normal persons to SIRS, polytrauma and burns – Patients 4, 5 and 8.

Discussion
The results of this small study support some aspects of previous studies and disagree with others. Any conclusions must be limited by its small size. In 6 of the 10 patients the PCT level supported a diagnosis of sepsis/MOF on day 1 of their ITU stay. Only 1 patient had a low PCT level on day1 that subsequently increased to a

significant level. There was no obvious consistent relationship between the PCT level and that of other inflammatory markers – CRP, WCC, pyrexia >38°C. This supports the work of Williamson et al (5) Of the 7 patients who had significantly elevated PCT levels 3 died in ITU, 1 died in hospital post ITU discharge and 3 survived to hospital discharge. Of the 3 patients who had no significant rise in their PCT level 1 died in ITU, 1 died in hospital post ITU discharge and 1 survived to hospital discharge. All three of these patients showed a slight elevation in PCT level that subsequently declined. It is possible that our sampling window has missed the period of significant elevation –i.e. prior to ITU admission.

This study shows no correlation between PCT level and outcome. This disagrees with the work by Clec'h et al (2) but again note the small sample size in this study. All patients had a positive microbiological culture for bacterial pathogens during their ITU stay except patient 9 who died prior to any positive culture result on the 6th day in ITU.

It is likely that a significantly elevated PCT level does correlate with severe bacterial infection, sepsis and multiple organ failure. The inability of this study to completely support this conclusion may be due to an artefact of our sampling period and the lack of availability of samples from the period prior to the patient's ITU admission. The turnaround of the samples that would be needed is 24 hours and it would be impractical to store all such samples awaiting the small percentage of patients who would subsequently require ITU admission.

We conclude that PCT may be a useful adjunct in guiding the decision to commence or withhold a course of antibiotics in the ITU setting. It is likely to be of most value when used in conjunction with clinical findings and other laboratory results. This test is unlikely to be introduced routinely in the near future but would be a useful adjunct in decision making on a case to case basis. Its use may be considered after consultation between senior anaesthetic and microbiology staff. As ever implications of cost are likely to limit its use. Another limiting factor may be the operator dependent nature of result interpretation for this test. Differentiation of PCT level is based upon the interpretation of shades of pink indicator compared with colours printed on the reference cards. Negatives and strong positives were clear, intermediate levels were more equivocal in interpretation.

There may be value in a study, which assesses a correlation between PCT level on admission and unit stay/ outcome. The unused samples are at present still frozen in the lab and could serve as the raw material for such a study.

Acknowledgements
A great big thank you to all nursing staff in ACCU and all laboratory staff at Wishaw General for their help in this project and to the microbiology staff for providing the funds and the bench space to allow this project to be carried out.

Declaration of Interests – nil.

References

Cusack et al, British Journal of Intensive Care Jan/Feb 2000 p.17
Clec'h et al, Critical Care Medicine 2004 Vol.32 No.5 p.1166-169
Christ-Crain et al, The Lancet Feb 2004 Vol.363 p.600-607
Mitaka, Clinica Chimica Acta 2005 Vol.351 p.17-29

Table 1. Outcomes, Microbiology, Pyrexias

patient	outcome	micro	pyrexia					
			day 1	day 2	day 3	day 4	day 5	day 6
1	s	y						
2	s	y						
3	dpi	y			p	p	p	p
4	d	y	p		p	p	p	
5	s	y	p	p			p	p
6	d	y						
7	s	y	p	p	p		p	p
8	dpi	y			p	p		
9	d	n		p	p	p	p	p
10	d	y				p	p	

s-survived to hospital discharge

d-dead in ITU

dpi-dead post-ITU prior to hospital discharge

p-pyrexia >38°C in that 24 hr period

Paul Wilson &
Michael Murray

Graham Bell & Prof. Webster

Keith Anderson

Kevin Fitzpatrick

Malcolm Sim checks
out the formula

Peter Bramley & Ross Carter

Choiti & Ewan

Trainees' Meeting

Halbeath, Dunfermline, May 19th 2006

Kevin Fitzpatrick

Next year the Trainees' meeting will be held in Peebles Hydro prior to the Annual Spring Meeting. (The idea is that the more career-minded trainees will stay on for the main meeting on the Saturday and even get dressed up for the party in the evening - Ed:) This year Halbeath once again proved an excellent venue.

The day began with a welcome from the President, Margaret Stockwell. It promised to be an excellent meeting with a varied programme of presentations to follow.

The first session began with a talk by Professor Nigel Webster of Aberdeen Royal Infirmary titled "ICU – What's hot and what's not" covering topics including ventilation strategies, glucose control, the use of steroids and the potential use of DNA testing technology in the future. This was followed by an interesting, informative but let's hope not useful presentation by Graeme Bell from the RHSC Glasgow on nerve gas poisoning.

Keith Anderson from Glasgow Royal Infirmary began the second session with "Research – What Matters?" which gave advice and explained the procedure from the development of an idea to the production of a paper. Light relief was called for and Michael Murray from the Institute of Neurological Sciences Glasgow concluded the morning programme with an extremely humorous "A-Z survival guide for anaesthetic trainees" which had us rolling in the aisles!

Following the lunch break and viewing of the poster competition, the next session concentrated on gastroenterology with Peter Bramley of Stirling Royal Infirmary giving a lecture on acute liver failure and Ross Carter providing an update on the current management of and survival from pancreatitis at Glasgow Royal Infirmary.

The final session commenced with Paul Wilson from Crosshouse Hospital, Kilmarnock bringing the audience up-to-date on the current position of modernising medical careers and its potential impact on both the training and provision of anaesthesia in this country. The session was concluded with a presentation, both fascinating and funny, on veterinary anaesthesia by Dr Derek Flaherty from the Glasgow Veterinary School, which included a video of a horse being anaesthetised and demonstrated various logistical difficulties which thankfully are avoided while anaesthetising humans.

The winner of the President's Prize for top poster was Vishal Gupta from Dumfries for, "Sodium here, sodium there." The runners-up were Ken Baillie (Dunfermline) for an study of the effects of cleaning anaesthetic equipment and Roddy Chapman (GRI) for an audit on patients' hydration status.

The meeting was organised by trainee representatives Choiti Guha and Ewan Jack and many thanks go to them as well as to the speakers and sponsors for helping to provide an excellent day. The last but definitely not least part of the day was the course dinner held at a local restaurant which was thoroughly enjoyed by all. Get your study leave in early for next year - details on the website!

Annual Scientific Meeting

30th November 2006

The ASM this year was for the second time the first day of a combined meeting with the RCOA Scottish Board Winter meeting. It was held at Hamden Park. The Society team was managed by Alex Macleod and the RCOA XI by Alex Patrick. The SSA won 5-4 in a pulsating match of end-to-end stuff. Attendance was exceptional – indeed the residents of Cathcart thought that the "Hamden Roar" was back in business - at least whenever Gordon Todd came on!

It was St Andrew's Day. Not for us a new Public Holiday then. Instead we were treated to Colin Runcie talking about the management of the circulation – some simple but effective strategies. He had fashioned his talk as if to provide his generalist wife (Liz McGrady) with useful tips from his cardiac anaesthetic practice. In less skilled hands this might have been a risky undertaking but Colin pulled it off with gusto. He demonstrated that static indicators of pre-load are a poor predictor of fluid responsiveness indeed CVP is no better than chance. Systolic pressure variation on the other hand (a dynamic measure of pre-load) is much better at predicting the response to a fluid challenge. When the systolic variation (seen on an a-line trace) disappears then it's time to reach for the inotropes. This then is a useful measure which can be used with even basic equipment. Colin is also keen on using ultrasound to guide his CVP lines and defended etomidate in the light of the evidence from his own outcome figures of over 900 patients.

Colin was followed by Malcolm Daniel who spoke about applying haemodynamic goals from ITU practice in the general theatre patient. Flow measurements are beginning to replace pressure measurements. He tried to draw lessons from the Surviving Sepsis i.e. applying early goal directed CV management and targeted antibiotic treatment. He discussed the potential benefits of aggressive fluid therapy. This should be done using dynamic monitoring such as oesophageal Doppler and should result in a reduction in complications if not so convincingly in mortality. On the other hand... as they say...there is evidence of harm produced by excess fluid and another approach is to restrict fluid! What about elective ß-blockade? He was critical of early trials and said we should hope that a big simple trial like the POISE study might show us the way when it reports. Indeed the only evidence of a favourable outcome he could find seemed to be some ancient black-and-white pictures of Aberdeen beating Rangers! Further work.... indeed.

The next speaker was Dr Allan Gaw. He is the Director of the Clinical Trials Unit at Glasgow Royal and has a distinguished career in lipid biochemical and clinical research. He reviewed lipoprotein metabolism and strategies for lowering and controlling cholesterol. Cholesterol is essential for all cells to function. It is absorbed and transported by lipoproteins or can be made from scratch by the cell itself using an enzyme called HMGCoA which is blocked by statins. This reduces blood cholesterol. Another strategy is to increase excretion by inhibiting the CETG enzyme (look it up!) this reduces CV risk by improving the balance of lipoprotein types. Evidence of good clinical effectiveness is still awaited before this approach can be widely recommended. A third prospect was the reduction in absorption of cholesterol from the gut. There are drugs which can do this or possibly in the future, a genetic approach to altering membrane transport mechanisms might be tried. Allan is to be congratulated for making this biochemical dissertation so interesting and clear to an audience well out of its comfort zone.

Next up was Gordon Todd. In from "ENT to ETT" he reviewed laryngeal trauma, smoking damage and pathology due to infective agents. He discussed some techniques he uses in difficult ENT work which again the generalist might find helpful. These included the use of ENT surgeons' laryngoscopes and Hunsuker jet tubes. He discussed which incidental laryngeal findings we should refer to ENT and also gave some "streetwise" advice on some airway problems including extubation.

After lunch Ian Russell spoke on "Special interests – do they affect day-to-day anaesthetic practice?" He outlined how his early interest in physiology, awareness and spinal anaesthesia led on to his specialising in obstetric anaesthesia. He mentioned how sub-specialty interest in obstetrics seems to make you more likely than non obstetric anaesthetists to do thoracic epidurals awake. He gave us some graphic illustrations of awareness under GA and of inadequate spinal blocks, emphasising the importance of good, detailed records.

Not unrelated to this was Willie Frame's talk entitled "Judgement Day". This was an informative discourse on negligence: when is there a duty of care, a failure to provide this care at an acceptable standard and when the patient is harmed. Poor outcomes can also be due to accident or mishap. Manslaughter proceedings or a fatal accident inquiry even civil action which might follow were all discussed. He gave a detailed account of the procedure and mechanism of the Scottish legal system in negligence claims and advised us on how we might

Gordon Todd

Ian Russell

Allan Gaw

avoid being sued. This was all delivered in his inimitable style, punctuated with jokes – none of which I can remember!

The day was completed by Alastair Chambers' Gillies Lecture and for some a fine dinner in the impressive Òran Mór in Glasgow's West End.

This had been a fine meeting but the College were not to be outdone. The next day's format was of pro and con speakers to various controversial statements:

Cerebral monitoring is the gold standard of anaesthetic depth monitoring
Pro: Professor Gavin Kenny from Glasgow vs.
Con: Ian Russell, form Hull.

All patients undergoing major abdominal surgery should have a thoracic epidural
Pro: Nick Scott from the Golden Jubilee National Hospital ("Clydebank General")
Con: Malcolm Daniel from Glasgow Royal Infirmary

Tight glycaemic control improves outcome in the intensive care unit
Pro: Malcolm Booth, Senior Lecturer, University of Glasgow
Con: Professor Nigel Webster, University of Aberdeen

The Labour Ward is no place for the occasional Obstetric anaesthetist
Pro: Liz McGrady from Glasgow Royal Infirmary
Con: Graeme Hilditch, from arch rivals the Western Infirmary, Glasgow

All predicted difficult intubations should have an awake fibreoptic intubation
Pro: John Henderson vs. Con: Gordon Todd both at Glasgow Western.

Use of hypotonic fluids in paediatric practice should be abandoned
Pro: Pam Cupples vs. Con: Phil Bolton both from RHSC Yorkhill, Glasgow

These debates were delivered with a perfect mixture of venom and humour and each left the audience with much to think on. Which was the better team on the day? It was probably a score draw but I'm the Editor and I'm biased!

Willie Frame

Malcolm Daniel & Colin Runcie

Anaesthesia for Major Vascular Surgery

A Personal Perspective

Professor Anthony J. Cunningham
Dublin

Cardiovascular complications are the major cause of perioperative morbidity and mortality in patients undergoing major vascular surgery. This is related partly to the frequent presence of underlying ischaemic heart disease and the significant intra-operative haemodynamic changes, catecholamine stress hormone responses, blood loss and hypothermia. Although the incidence of perioperative cardiac death and myocardial infarction after elective abdominal aortic surgery has decreased gradually during the past decade, 30-day operative mortality rates of 5 - 6 % have been consistently reported in UK [1] and North American [2] studies, principally from cardiac causes with mortality increased in women, Afro-Americans and patients with existing renal impairment.

Perioperative cardiac complications are caused either by prolonged myocardial ischaemia or by coronary artery plaque rupture with subsequent thrombus formation and coronary artery occlusion. Myocardial ischaemia in the perioperative period may arise from either increased myocardial oxygen demand or reduced supply. Factors that increase myocardial oxygen demand include tachycardia and hypertension resulting from surgical stress, post operative pain, interruption of beta-blocker therapy and the use of sympathomimetic drugs. In contrast, decreased supply may be the result of hypotension, vasospasm, anaemia, hypoxaemia or coronary artery plaque rupture.

The association between prolonged myocardial ischaemia and higher incidence of perioperative cardiac complications has been confirmed in several recent studies. Patient outcome following abdominal aortic aneurysm repair may relate to patient factors such as coexisting cardiac, respiratory, or renal disease; surgical factors e.g. elective vs. urgent; aortic aneurysm (AAA) vs. aortic occlusive disease (AOD); open vs. endovascular repair or institution factors such as case load and surgical expertise.

The National Confidential Enquiry in Perioperative Death (NCEPOD) published a number of recent reports addressing current medical practice:

NCEPOD 2001 – Changing the Way We Operate
NCEPOD 2002 – Functioning as a Team
NCEPOD 2003 – Who Operates When
NCEPOD 2004 – Scoping our Practice
NCEPOD 2005 – An Acute Problem (Medical Admissions to Intensive Care)

In October 2005 NCEPOD published, "Abdominal Aortic Aneurysm: A Service in Need of Surgery?" This was a collaborative effort on behalf of the Vascular Surgery Society of Great Britain and Ireland (VSSGBI), the Vascular Anaesthesia Society of Great Britain and Ireland (VASGBI) and the Royal College of Radiologists.

The haemodynamic response to abdominal aortic

cross clamping and release was comprehensively addressed by Simon Gelman in a landmark review article in Anesthesiology in 1995 [3]. Depending on the site and duration of cross clamp, significant increases in afterload (arterial pressure, systemic vascular resistance and left ventricular end- systolic wall stress) were accompanied by variable changes in preload and, in general, stable heart rate. Patient factors affecting these haemodynamic changes include pre-existing blood volume and LV function. Unclamping may be associated with relative hyperaemia in the pelvis and lower extremities, with decreased arterial pressure, systemic vascular resistance, left ventricular end-diastolic pressure and, depending on the patient's intravascular volume, reduction in cardiac output.

The NCEPOD 2005 study was confined to adults undergoing elective or emergency AAA repair with either an open or an endovascular technique. Hospitals in England, Wales and Northern Ireland were included in the data collection which took place during February and March 2004.

Anaesthesia-related aspects of the study included:

Preoperative management
- Beta blockade
- Statins
- Cardiac investigation

Intraoperative
- Personnel
- Grade
- VASGBI membership

Patient Management
- Blood loss
- Monitoring
- Vasopressors

Post-operative
- EAA
- Destination

Study Findings

A total of 884 cases were reported. Only 7% underwent endovascular as distinct from an open procedure. A 30-day mortality rate of 6.2% was reported for open repair with a mortality rate of 36% for emergency procedures.

The study addressed aspects of pre-, intra- and postoperative patient management. The prevalence of cardiac morbidity and mortality in patients undergoing major vascular surgery prompted the development of practice guidelines and numerous studies attempting to identify patients at risk of cardiac complications. Attempts to improve long-term survival include:

Preoperative assessment
- Optimisation of medical therapy

Modification of anaesthetic technique
- Epidural anaesthesia and analgesia
- Monitoring extended into the postop period

Prophylactic therapy
- Sympatholytic effects – alpha2 agonists
- Vasodilators – nitrates/calcium channel entry blockers
- Control of heart rate – beta blockers
- Lipid-lowering agents - statins

Initial small observational studies of beta-blocking agents suggested that such therapy blunted electrocardiographic signs of ischaemia. Following these observations several randomised European and North American studies examined the effects of perioperative beta-blockade on patient outcome including perioperative ischaemia, myocardial infarction and mortality [4,5]. However in the NCEPOD 2005 study only 35% of patients undergoing elective surgery and 26% of patients undergoing emergency AAA procedures were on beta-blockade medication.

A number of recent studies have reported a reduction in cardiovascular events and 30-day hospital mortality in patients prophylactically treated with lipid lowering statin therapy [6]. Interestingly 57% of NCEPOD 2005 patients undergoing elective procedures and 31% undergoing emergency AAA repairs were taking statin therapy.

Intraoperative Management

The NCEPOD 2005 study considered the current UK experience with endovascular aneurysm repair (EVAR). This technique, developed in the early 1990's by Parodi with limited femoral artery inci-

sions and stent graft placement, is associated with a reduction in intra-operative blood loss and catecholamine responses. Recent prospective randomised studies conducted between 1999 and 2003 of 1082 elective AAA patients in 41 UK hospitals reported 1.6% mortality for EVAR in comparison with 4.6% for open procedures [7].

The Dutch Randomised Endovascular Aneurysm Management (DREAM) trial observed substantial reduction in primary outcome of 30-day mortality and morbidity with endovascular repair as opposed to open repair – 1.2% similar to the UK study. While the risks of EVAR are established, the benefits are less certain. A subsequent publication of the results of a two-year follow up of the DREAM study indicated that the favourable results of EVAR reported at 30 days had diminished at one year within increasing deaths in the endovascular repair group. The preponderance of later deaths in the endovascular group is possibly due to graft leak and rupture.

Postoperative Care

The NCEPOD 2005 study considered the destination of patient following elective and emergency AAA repair. 56% of patients undergoing elective procedures were transferred to Level 3 ICU, 33% to Level 2 HDU while 9% were managed in the recovery room. 32% of the elective and 78% of ruptured aneurysms received ventilatory support in the immediate postoperative care.

The NCEPOD study had a number of limitations, including the fact that the denominator was uncertain - 38 of the 226 hospitals in England, Wales and N. Ireland did not contribute so there was a possibility of incomplete data return. The retrospective nature of the study was an obvious limitation and only descriptive statistical analysis was used - there was no statistical hypothesis testing.

Despite these limitations, the NCEPOD 2005 study did make a number of recommendations.

Summary

The most controversial recommendation was that expertise be consolidated in centres providing elective and emergency AAA repair. As part of that consolidation, preoperative care could be optimized by ensuring that patients are assessed in preoperative clinics by personnel with appropriate training and expertise. Such centres could ensure elective AAA repair patients are transferred to an appropriate Level 2 HDU thereby avoiding cancellation of surgery due to lack of ICU beds. Consolidation of expertise amongst anaesthetists performing a reasonable number of elective repairs could enhance patient care. The possibility of a rota for emergency AAA repair to include anaesthetists with sufficient exposure to elective procedures was also recommended.

References

[1] Bradbury AW, Adam DJ, Makhoomi KD: A 21-year experience of abdominal aortic aneurysm surgery in Edinburgh. Br J Surg 1998, 85: 645-7

[2] Results of elective abdominal aortic aneurysm repair in the 1990's: A population-based analysis of 2335 cases. J Vasc Surg 1999; 30: 985-95

[3] Gelman S: global hemodynamic responses to abdominal aortic cross clamp. Anesthesiology 1995; 82: 1026-40

[4] Wallace A, Layug B, Tateo I et al: Prophylactic atenolol reduces postoperative myocardial ischemia: McSPI Research Group. Anesthesiology 1998; 88: 7-17

[5] poldermans D, Boersma E, Bax JJ: the effect of bisoprolol on perioperative mortality and myocardial infarction in high-risk patients undergoing vascular surgery. N Engl J Med 1999; 341: 1789-94

[6] Kerati MD, Boersma E, Westerhout CM et al: Association between long-term statin use and mortality after sucessul abdominal aortic aneurysm surgery. Am J Med 2004; 116: 96-103

[7] Comparison of endovascular aneurysm repair with open repair in patients with abdominal aortic aneurysm (EVAR 1) 30 day operative mortality results: randomized controlled trial. Lancet 2004; 364: 843-48

[8] Blankensteijn JD, de jong SEA, prinssen M: two-year outcomes after conventional or endovascular repair of abdominal aortic aneurysms. N Engl J Med 2005; 352: 2398-405

What? Who? Where? When? – News from the Regions.....

Thanks to all of my correspondents – plenty of reorganisation woes, new appointments and new babies as well as some sad losses – it has been a eventful year....

Aberdeen - *Andrea Harvey*

The North Wind is blowing again but life in our Aberdeen Department continues to be 'warm and cosy'. This warm feeling however can be almost entirely attributed to the recent increase in consultant numbers, with no reciprocal expansion of our office space... rather than a boost in the heating level or NHS long john provision! At various points throughout the past year we welcomed as new consultants, Alastair Hunter with a General interest, Tom Engelhardt (Paediatrics) and most recently Roxanna Bloomfield (ITU) where she is a welcome addition to the female ranks. We are also looking forward to welcoming Luna Saqr who has an Obstetric interest and Amr Mahdy with a General interest, recently appointed and who start in early 2007. The cosiness of our Dept. must be addictive as no one has retired this year and all our recent appointees have had former links with our department. Tom even returned from Canada!

Aberdeen continues to have good pass rates in both Primary and Final exams ...well done to all those concerned. We have had the usual coming and going of SHOs and are pleased to see those we have trained have moved on to further their careers, whether this will still be possible in the 'new' system, at this stage who knows! Like others we are struggling to come to terms with the service implications for that MMC will impose.

New departmental developments: 2006 saw the inauguration of the Maternity Consultant 3rd on call rota for out of hours cover. The early niggles have now settled and the labour appears to be progressing smoothly. Gordon Byers was recently appointed Director of the Short Stay Unit. This new unit has replaced the Day Case Unit and now provides 23hour accommodation along with an ever-expanding repertoire. Keeping true to form, there are more than just the usual lumps and bumps that require sorting out and Gordon hopefully will enjoy the challenge. Rather surprisingly, there have been no other changes in administrative jobs during 2006.

Donald Macleod completed his year as President of our North East of Scotland Society of Anaesthetists (NESSA) which he carried out with his usual enthusiasm and style. For the second year in a row the sun shone down on Edzell for the annual golf competition and an Aberdeen female (me!) retained the NESSA Bull....which thankfully is not full size or animate but a granite golf trophy!

Towards the end of September, the AAGBI celebrated its 50th Annual Congress in our city, organised in part by our own Alastair Chambers in his role as Association Honorary Secretary. There was a higher than expected turnout, with just under 600 delegates attending from all over the world. This time round the North wind was not blowing and delegates spent 4 days basking in our North Easterly sunshine. As well as a stimulating programme, Scottish hospitality flowed well into the wee small hours (and then some more) particularly at the Dinner & Ceilidh held at a local top hotel. Comments have been favourably received and we are looking forward to hosting the Scottish Society Scientific meeting back here in 2008 (pencil in diaries now please).

Balfour Hospital Orkney- *Colin Borland*

The Anaesthetic office is not big enough for 4 Consultants! This is one of the key outcomes of 2006 for Balfour. Interviews were held midway through the year resulting in the appointment of 3 Consultants to the 2 vacant posts. Long-term locum Malcolm Thompson was one of the successful candidates. Jean-Francois Enault and his wife Christine were persuaded to swap French Polynesia for the beaches and balmy weather of Orkney. At least the weather was exceptionally mild for their first 2 months but October's floods and gale-force winds have brought them down to earth. They are job-sharing a Consultant post and have brought, in addition to their

anaesthetic abilities, a family of talented musicians who I'm sure will benefit Orkney's future artistic scene.

The removal of the air-ambulance contract from Loganair in April has brought both problems and benefits. Compared to the Kirkwall-based Loganair Islander (aka vomit comet!) the Gama Aviation Kingair aircraft is a delight for taking patients to Aberdeen but medical and nursing escorts now have to return from mainland Scotland by scheduled flights. This has resulted in absences of duty anaesthetic staff for up to 24 hours. However, the main losers in my opinion are the population of the outer islands where lifeboats and MOD helicopters have been used to transfer patients into Kirkwall when inclement weather has prevented the designated Eurocopter ambulance from flying.

The need for locums is likely to diminish as the department will be at full strength from mid-December when Malcolm T. returns to Orkney following a months' Paediatric attachment. So I'd like to say a very grateful thanks to all of you who have filled the establishment gaps over the past 18 months. Without doubt one of the locum anchors has been Ion Grove-White. Theatre staff will be extremely sorry when Ion's visits to Orkney come to an end. Not least because he's helped out with lambing, as well as troubleshooting computer malfunctions. He's also a veteran traveller who has a fund of hotel and restaurant recommendations to make wherever I have planned a holiday.

I'd like to end by saying that I'm looking forward to writing next year's report as it will be my last- retirement in some shape or form being planned for 2008!

Borders District General, Melrose - *Tom Cripps*
Having filled our final consultant vacancy with Shona Smith, we have a happy, coherent department. Over the summer one of our consultants, Cath Livingston, honoured her TA commission with a vacation commanding the ITU at Basra. Meanwhile we await the changes/ devastation foretold by MMC with trepidation!

News from the Far North
Caithness - *John MacLeod*
So far so bad. Another year here in Caithness and its still raining: so much for global warming. On a lighter note we're glad to be long way from the chaos of MMC; not having the (mixed) blessing of trainees we can only look on in open-mouthed wonder as the tragedy unfolds.

Our own staffing situation has been transformed with the appointment of a third consultant to a substantive post. Christine Kerr took up her first Consultant post at Caithness General in mid-October. She's almost local, an Edinburgh graduate, she was an anaesthetic trainee in Newcastle and has had further experience working in Australia post accreditation. Unfortunately she has arrived at a difficult time, all major surgery having been suspended for the foreseeable future due to some technical issues with our laboratory and Blood Transfusion Services. We hope that this will be remedied by the beginning of 2007. In the meantime she's joined the local pipe band – a crossover skill for anaesthetists and hopefully a suitable diversion till normal service is resumed.

Mindful of the need to maintain skills, our ongoing CPD requirements and the imminent introduction of revalidation, we continue to strive to build bridges with our colleagues in the 'big' hospital down the road. This seems an uphill struggle and I'm at a lost to explain their reluctance to embrace their country cousins. I do hope that there isn't some unreasonable prejudice against 'out-of-towners'. One hopes that persistence and a spirit of goodwill results in an amicable outcome for all.

Some of you will recall the ongoing saga of our unique obstetric service (Consultant based - 230 deliveries/year - no paediatric input) and the reasonable attempts by our health board to 'rationalise' the service. I'm pleased(?) to report the appointment of two Consultant obstetricians and a third long-term locum, ensuring the continuation of our service as currently configured for now.

With the recent introduction of legislation outlawing age discrimination in the work place, I am delighted that we continue to do our bit. I suspect our consultant colleague Joost Leeuwenberg is approaching exemption from the terms of the legislation but he goes from strength to strength.

Crosshouse - *Chris Hawksworth*
Crosshouse Hospital is now home to the Ayrshire Maternity Unit. This spanking new edifice was christened during its first week of operation by a burst water pipe in the theatre, resulting in emergency caesareans being performed in the Crosshouse main theatre suite. Now the obstetricians know their way to the main theatre suite, they have started dealing with ruptured ectopics laparoscopically here too. This puts even more pressure on our overstretched emergency theatre which is normally full of the trauma list overspill. Suggestions that the trauma list should start at 9am to avoid this overspill have been met with disbelief by all concerned.

The long awaited Health Board plan to concentrate emergency services at Crosshouse was finally announced in October. Judging by the number of trauma cases from South Ayrshire coming our way, this plan had been pre-empted by the Ambulance Service.

The closure of paediatric acute services in Ayr this sum-

mer has also exacerbated the demand for our orthopaedic surgeons' trauma skills. A further knock on effect of the paediatric move has been the death knell of the age old practice of existing consultants cherry picking lists then the new consultants getting what's left in their job plan. Apparently senior management snuck this in over the holidays when no one was looking. Those of us who had spotted the move protested to no avail, being told that this was done to aid recruitment. Our American cousins have a term for this nonsense but it is too rude for publication in an august journal such as this.

Finally, staff changes. Bob Young retired in March this year and is now happily ensconced in Prestwick with his train set. Chris Johnstone was appointed to the consultant body before the sneaky moves discussed above so he does have a few rotten sessions. Sorry, my mistake, he actually wants to be an obstetric anaesthetist! In December we also welcomed back Antonio Martinazzo as a Staff Grade. Numerous trainee changes include Kevin Fitzpatrick moving to an SpR post in Glasgow, and four new starts this summer. Whether they will be replaced in turn by the new seamless trainees remains to be seen. Perhaps the nightmares of first on call for ITU or weeks of night shifts are getting closer to reality.

In the absence of a report from Ayr can I note the retirement of Iain McDiarmid and welcome to Ayrshire Barbara Zydorowicz, Amadeus Ziarkowski and Jillian Hewit-Gray as new consultants. - Ed.

Dumfries & Galloway and Stranraer - *Hugh Brewster*

It is only when I write this annual letter that I appreciate how quickly our Department changes its members. We were delighted to welcome Libor Verner into our Consultant ranks in the summer. Libor is from the Czech Republic though he worked a few months in Whitehaven before joining us and has settled quickly into his post. John Carruthers, one of the pillars of our Department, has been off for some months with back problems and we wait anxiously to see if he will be able to return. Meanwhile Mahboob Khan is filling John's shoes as well as anyone could. Clare Barker is our current SpR and her N. Ireland accent is a reminder that our small Dept. has at least one representative from each of the four home countries. Vishal Gupta, Rosel Talloch and David Christie made great contributions during their times with us as SHOs and it is no accident that they all passed the Part 1 exam with us or soon after leaving us. Avinash Kapoor, Hadi Kharbouch and Ejaz Qureshi will be hoping to emulate them.

So much for the immediate past, now for the future. Will the Health Board agree advertise for a posse of Staff Grades so that we could provide an epidural service in the Labour Ward and reduce Consultant on-call? If so, will there be suitable candidates? We are looking for two new consultants next spring/summer. Why? Who is retiring? For the answers to these fascinating questions order your next copy of The Annals to-day!

Dr. Gray's - *Colin MacFarlane*

This year we are very busy, our catchment area is expanding (120,000), we have a mobile theatre outside in the car park, we are now 7 consultants and one associate specialist, and a cat could not be swung in our office. Doug McKendrick and Bernd Zaunseder are top class new colleagues and we still work in a totally flexible fashion on a one-in-three with frequent trips to outside ITUs by land and air. We specialise in total generalism! Perfect. The major disappointment this year is the end of our much-loved ATLS course that has been running for 12 years. Management has decided that they will relocate our already small postgraduate centre into a matchbox at the bottom of the car park, so no more courses. Education has very low priority these days. Enormous thanks to so many colleagues for supporting us over the years. You know who you are. All the best.

Fife - *Gordon Smith*

The maxim that time goes faster as you get older is certainly true and it also seems increasingly difficult to wax lyrical. However, here goes the news from Fife.

This year has been one of consolidation. The money for new consultant staff has ceased with the total numbers in Scotland still far off that promised by Edinburgh. Two new consultants joined the Fife ranks in 2006: Tony Davis came from the deep south (well Manchester to be exact!) in February then promptly badly injured his back after steering a canoe over a waterfall somewhere in the Highlands. Fortunately he was able to return after only 2 months virtually 100% intact due to the excellent treatment received in Fort William and Edinburgh. Despite dire warnings this adventure has not put him off hazardous sports as he went off to do something similar on the Ganges in November. We also welcomed Andreas Rogowski from Cardiff in October replacing Jeni Meek who retired earlier in the year after 25 years service to Fife. We wish Jeni well in her retirement.

The bombshell of run through numbers from August 2007 arrived in September. Our trainees were to drop from 12 to 5 which would have meant we could only run 1 rather 2 training rotas. Fortunately a lot of lobbying of the Health Minister and the CMO from consultants and trainees alike has led to a reappraisal. Though the final numbers are still not definitive there does seem to have been an element of scaremongering over the provisional numbers. However, I am still certain that whatever happens that there will have to be more input

into the 1st on call rotas from consultant staff in future (hopefully not involving me).

Hospital at Night came into being in Fife in September with a whimper rather than a bang. Despite all the dire warnings little seems to have changed so far. The movement of all acute services to Kirkcaldy is also still on target for 2010 and we are now down to a preferred bidder. Once we see the bulldozers move in some of us will actually believe it is happening at last. However, it looks like Forth Valley will still beat us to it!

In conclusion, I'd like to thank all my colleagues for their help and support to their often beleaguered Clinical Director. Like King Canute battling to stop the tide I would be totally submerged without them. All the staff in the Directorate of Theatres and Anaesthetics have striven very hard to improve the service to the Fife population to the high standard they now enjoy. However, there is still a lot to do. Lastly, I am pleased to announce my mid-life crisis is over and I'm now the proud owner of a large 4x4. RIP Audi TT, old age beckons!

Forth Valley - *Andy Woods*

Its almost exactly a year since Falkirk and Stirling departments joined up, the only split being a separate ITU and General Rota. Plans for the new hospital at Larbert are well underway, and a 16 theatre, 9 ITU and 20 bed HDU complex is expected. Problems still exist, like the changing rooms for potentially 160 people which are totally inadequate, as is the pathetically small coffee room. Only a small number of theatres have natural light, and even then it is onto an empty courtyard and this tends to grind on you. This is all despite surgeons and anaesthetists trying to argue their case till blue in the face. I'm sure that this isn't a unique problem, but why should a manager care for staff wellbeing, when they will inevitably have moved on.

Moaning aside, problems like a lack of space and beds at the acute site (SRI) seem to have settled down, with gradually more and more getting done at Falkirk. Ewan Jack has just been appointed to start in March 07, after shutting off fierce competition from his cousin.

All in all not a very exciting year in Forth Valley.

Glasgow Royal Infirmary - *Stewart Milne*

After last year's unprecedented attack on 'Our Dear Leader', Mike Basler was allegedly advised by his lawyer that he should not compile this year's report.

The department at the Royal continues to grow with 5 new consultant appointments replacing one retiral and another notable transfer to the west of the city.

Maggie Stockwell retired after 23 years as a consultant at the Royal Infirmary. The occasion was marked by a dinner at the Hilton Grosvenor hotel attended by over a hundred of Maggie's friends and colleagues from anaesthesia and surgery. Maggie continues of course as President of the Scottish Society.

Jane Morrison was appointed as a consultant after an extended maternity fellowship and Stewart Milne returned from Dundee after a 3 year regional fellowship! Robyn Smyth joins the Cardiac anaesthesia team while Kerry Litchfield and Ravi Agaram join the Obstetric consultants and Stobhill nomads respectively.

The departure of 'Our Dear Leader' has improved the mood here considerably and the new management structure has been likened to 'a breath of fresh air', which in the East End of Glasgow is high praise indeed.

The Princess Royal Maternity Hospital struggles with its caseload - most of the sick or obese (am I allowed to say that?) patients in the West of Scotland are transferred here making the obstetric rota particularly arduous. This is compounded because Willie Frame is currently off work with a back injury- he is hoping to get Incapacity Benefit soon and is rumoured to be attending the chronic pain clinic disguised in tinted specs.

Chronic pain waiting lists continue to grow. Everyone involved in the pain service is required to make up at a later date clinics cancelled by study leave - annual leave will be next.

The cardiac anaesthetists have started packing ready for the big move to the Health Care International Golden Jubilee National Waiting Times Initiative Cardiac Centre of Excellence Hospital located Clydebank or the 'New West End'. The move may be hampered by the lack of trainee cover. At least 6 experienced SpRs are needed to supervise the patients on bypass while the consultants use the adjacent spa and leisure facilities.

The general ICU has moved to superb custom built facilities. The additional space and light combined with state of the art equipment will greatly benefit patients during their last few days. The new ICU is in close proximity to theatres and A&E thus minimising patient transfers throughout the hospital. Anyone interested in a second hand MICU trolley see Dr Kinsella.

The Institute for Neurological Sciences - *Linda Stewart*

The Institute has established itself as a regional Head and Neck Centre with the addition of OMFS and ENT to the specialities on site. This has meant the anaesthetic department is now well positioned to provide for anaes-

thetic trainees. We have a difficult airway training module and a number of local SpRs have undertaken 6-month attachments to this end. We currently run local study days on difficult airway and taken an active role in the RCA workshops. Regarding Neurosciences, interventional radiology is developing with appointment of a 3rd Interventional radiologist and upgrade of the angio suite. We have a new consultant with an interest in paediatric neuroanaesthesia and are in the process of setting up a method of collaborative working with Yorkhill to improve our Paediatric Neurosurgical services.

In ITU we are working closely with the University of Glasgow to develop a real time breath ethane monitor to detect oxidative stress.

Glasgow Western & Gartnavel - *Colin Runcie*

Little change here at Gartnavel. The most notable event has been Nick Pace's appointment as lead clinician of the West Sector to represent us in the new pan-Glasgow management structure. A true professional should be motivated by conscience and we are confident that Nick's conscience will propel him to great organisational endeavours on our behalf. He has been replaced as Chairman by one of the department's most jaunty and vivacious members, Colin Runcie.

From our SpR group, Chris Johnstone has moved to Crosshouse while Lisa Manchanda and Johann Harten have taken on consultant jobs here. As usual, there has been a pulsating miasma of job shifts at junior SpR and SHO level as numerous young persons join and leave the department each day.

Two substantial threats lurk in the gloom. Gartnavel is increasingly a building site but the new developments do not require anaesthetic cover and contraction of the department is inevitable. As elsewhere, the effects of MMC remain unknown, imminent and unsettling. Despite these problems, members of our department continue to luxuriate in the optimism and warm feelings that derive from excellent leadership and the unity engendered by our communal enterprise.

Hairmyres - *Grant Haldane*

The new Hairmyres goes from strength to strength with an expanding department & new challenges on the horizon. The main development in the last year relates to the highly publicised outcome of the 'Picture of Health' consultation addressing the rationalisation of Lanarkshire healthcare over the coming years. Three acute hospitals will become two acute & one elective care. Although much of the finer points of this process have still to be clarified, central backing was given to this development by Andy Kerr & after extensive consultation Hairmyres is to be expanded & developed as one of the acute hospital sites in Lanarkshire. The transition will be gradual with full implementation planned in 2009.

Other developments include the appointment of 2 trainee physician assistants in Anaesthesia in October as part of the Scottish arm of this national initiative. Both girls are settling in well & keen to get to grips with their new challenges.

We are also seeing more SpRs from the Southern General as Hairmyres has become a rotational option for their trainees, as well as our regular supply of SpRs for thoracic experience.

On the subject of our thoracic service, talks are still ongoing about centralisation of cardiothoracic services to the Golden Jubilee & as I understand it, this is set to happen in September 07. It is unclear if those involved in anaesthesia for thoracic surgery at Hairmyres will choose to move their sessions to Clydebank but this appears to be an option tabled as part of the move.

Our ICU nurses have also been busy this year & put together an extensive submission culminating in the award of a Charter Mark, the UK Government's national standard for excellence in customer service.

On a lighter note, four babies have arrived for members of the anaesthetic department & one gall bladder has been removed – all are doing well!

Inverclyde Royal - *Duncan Thomson*

Skiing, sailing, cycling and golf: the usual preoccupations override concerns about the collapse of our Health Board (not too many tears shed around these parts) and the Glasgow takeover, no really it is a merger…

The department has had it usual share of movement, after many years of service, particularly setting up and running the Chronic Pain service, Carlin Thomas has finally retired and got married, we wish her well. Lew-Chin Chee has returned from maternity leave having had a boy and has taken over as College Tutor from Fiona Munro after a good innings. The Educational flavour continues with Grant Tong as a foundation tutor and Manfred Staber the hospital postgraduate tutor, sadly they are no more able to reassure us about MMC than anyone else. Grant celebrated by doing a superman impression from his bike, alas the orthopods ended up putting metalwork in his clavicle, titanium he tells me.

Tim Winning has picked up numerous air miles in his trips to his second home in Florida and skirmishes with hurricanes are a regular occurrence. John Myles has just returned from a few weeks in Vietnam, his feet are itchy… any remedies?

With winter round the corner Bob Campbell and Manfred will be renewing their annual competition to see who can get the most skiing weeks per season, 3 rarely wins. Manfred is heli-skiing in the former Soviet Union, watch the BMJ, there may be a vacancy soon.

Ben Lartey and Clara Jacks continue to maintain our rotas and our trainees are currently looking around wondering what the future training will hold, don't we all.

From our cycling correspondent!

Tales from Tayside – The Ninewells News - *Matthew Checketts*

2006 has been an eventful year in Tayside with a good deal of coming and going. Just over a year ago I returned from my 7 week "sabbatical" trip around the world and have been pining for New Zealand weather during the soaking we endured in November and December. Talking of New Zealand, Hugh Rorrison is just at the end of his year there and Paul Currant is just about to go for his. David Peat is heading for Australia in February and Robi Zimmer has been back to Germany learning ultrasound guided peripheral nerve blocks with Uli Schwemmer. We are all looking forward to him teaching us and he has just made a special guest star appearance at our inaugural anatomical regional anaesthesia course which was a great success in December. Watch out for the next one in the spring.

Pauline O'Neil has moved to Aberdeen for higher ICU training, and Zoey Dempsey and Sergey Rastopyrov have also moved on. On the consultant front we were sorry that Stewart Milne missed the dreich Glasgow weather so much that he returned to GRI and we hope his webbed feet have now fully re-grown. Tony Wildsmith will retire at the end of March (he assures us) but the identity of his successor remains unclear as the German candidate who was offered the job now seems to have taken cold feet. Alban Houghton retired and will be missed at Stracathro but we welcome 4 new consultants – John Salisbury, Nikki Thompson (from ARI), Shaun McLeod and Paul Fettes.

Iain Levack still leads us on the political front and we're sure the water ahead remains decidedly choppy. I wouldn't quite say that détente has broken out, but our links with Perth have been strengthened by 4 (soon 6) Dundee based consultants now doing regular lists there.

We will soon have the 1st Scottish Independent Treatment Centre on our doorstep at Stracathro and we have grave doubts about the whole concept. We believe anaesthesia there may be delivered by Eastern European Anaesthetists and the identity and credentials of the surgeons is also unclear at the time of writing. What with MMC, EWTD, Agenda for Change and the election looming we are living in strange times in the Scottish Health Service. Good luck to you all in 2007!

Lorn and Islands, Oban - *Jason Davies*

A quiet year in the idyll that is Oban. A new player has joined Colin Wilson and me at the coal-face: David Robinson. He joined us in November seven months after Jenni left for Elgin, not that I'm bitter, things just take time in the country. Now part of Highland, yes yet another change of headed notepaper, we have continued relatively untouched to date. For the future, who knows? I'm keeping my shares in the company that produces our stationary.

Royal Alexandra Hospital, Paisley - *Jackie Orr*

We are now part of Greater Glasgow and Clyde. Another managerial reorganisation but few clinical changes as yet. Indeed any prospect of clinical reorganisation has been put on hold and financially we are being isolated until our debt is resolved. Despite this optimism prevails, hopefully this is not misplaced!

Hilary Aitken became the editor of Anaesthesia News in June demonstrating her excellent journalistic and communication skills. We were fortunate to appoint two new consultants in 2006 - Mike Buttiegieg joined the ICU rota in October and Fergal Burns starts as a generalist with sessions here and in the Vale.

John Dolan impressed us during his 9-month spell as a research SpR. He completed 2 projects on ultrasound guided regional block, presenting at the Association Annual Congress in Aberdeen, and influenced our practice with regard to blind regional techniques.

Our trainees have had a good year on the exam front: 5 SHOs gaining Part 1 and an SpR, Part 2. The proposed introduction of specialty training resulted in fewer experienced SHOs moving on to pastures new in 2006 – a luxury for us. However, many CVs are in press at the moment with some new posts coming up. 2007 may herald big changes with regard to the appointment and balance of trainees in the department. Time will tell…

Perth Royal Infirmary - *Michael Forster*

Some days it seems as if a lot has changed in Perth this year. We have hospital at night (it works). There is now a Foundation 2 doctor with us (he works). Jo Doughty and Sine Steele are our new staff grades (they work wonderfully). There is a new buzz about the place with a big increase in orthopaedic and general surgical throughput- and more pollution on the road from Dundee as itinerant surgeons, anaesthetists and patients head west sporadically, spurred on by charter guaran-

tees.

Away from work, Dave Magahy, Mike Bell, Wil Elsden and Peter Coe all felt suitably proud of the academic achievements of their offspring. Shelagh Winship's trusting nature has fallen foul of builders and her extension has become a work in progress. Arthur Ratcliff is learning Spanish, and Duncan Forbes has relaunched himself on the Perth singing scene. Cliff Barthram manages to remain remarkably normal in spite of all the time he spends with slightly odd I.T. people. Ewan is rowing more than ever, but still waiting for the Steve Redgrave physique to appear. Barbara Reay and Liz Grant both continue to say a lot less than any of us, and still talk more sense than all of us. And I've bought a new bike, and taken up the fiddle.

But on most days in Perth it is all reassuringly familiar. The view of snow topped hills from theatre 1 still lifts the heaviest of hearts. The fish are thriving and the "anaesthetic" coffee is the best in the hospital (when I make it). Gilly's beady secretarial eye is as perceptive as ever. We are all fit and well, but the ski season might see to that. Our trainees and medical students still enjoy their time here and even the rapidly approaching MMC cloud hasn't dampened their enthusiasm too much. Roll on 2007.

Raigmore - *John May*

There have been a few staff changes over the past year. Dale Deacon, one of our stalwart Associate Specialists, retired in July. She and Arthur are currently holidaying in their native New Zealand with a view to possibly retiring back there. They must be mad surely! As the oldest members of the department, myself and Richard Johnston now have an uncomfortable sense of our own "sell by" dates. Ros Lawson resigned her post in October 2006 and returns to Yorkhill. We shall miss her paediatric expertise and elfin charms. Kate Whiteside has a permanent part time staff grade post, and we are now involved with "proper" training having both a new start SHO and FY1 (critical care) doctor. We'll have to mug up on initial tests of competency! That pretty well describes staff changes, unless one includes Nial Hennessy's recent 50th birthday. Congratulations Nial , and welcome to the sixth decade. He arrived at work to find that one of his more boisterous colleagues had left an inflatable gift for him in the anaesthetic room. It was only half way through the morning that he realised that he wasn't teaching a rather shy medical student.

On a more mundane note, we have been given the go ahead for a brand new Day Surgery Unit and our new Medical Skills centre has finally been completed. Some of us certainly chose the right time to recertificate in EPLS and ALS training as the courses have subsequently been held in the opulent surroundings of the Marriot Hotel.

We are still waiting to agree our April 06 job plans but as I always indicate to impatient drivers who toot when the lights go green, relax…you're in the Highlands!

Shetland - *Catriona Barr*

Essentially we are the same department here: Paddy O'Connor, Brodyn Poulton and myself. We have a limited specialist (GP anaesthetist) Andrew Cooper. We are focussing on trying to get anaesthetic assistant training for our nursing staff and also running resuscitation training: we provide the ILS and PLS here now. We are contributing both to the adult ICU data base (SICSAG) and the paediatric HDU audit.

St John's University Hospital-
Duncan Henderson

ENT services moved to St John's earlier this year and are settling in. This finalises the formation of the Lothian Head and Neck Unit, in conjunction with our Plastics and Maxillo-Facial Departments. We welcomed Drs Duncan, Iqbal, Heidemann, McNarry and Simon as visiting ENT anaesthetists. Arnie Arnstein now does the majority of his sessions here. Ross Patterson was appointed into a joint Western General / St John's post in July and is also to be congratulated on getting married.

The Anaesthetic Dept is taking over the building. Simon Edgar has been appointed as St John's first Clinical Sub-Dean, as part of our closer links with Edinburgh University. As I'm currently Postgrad Tutor, and Patrick Armstrong is Chairman of the Medical Staff, we usually have a good idea of what's about to change next!

MMC has been occupying a large amount of our time lately. Ken Stewart has put in a lot of good work, both locally and nationally, with the Transition Board. He recently accompanied 3 trainees to chat with the Health Minister and CMO. The positive nature of the discussion has led to an outbreak of cautious optimism. Time will tell.

Sadly Jo Pahl is returning to her native New Zealand. We'll miss her. Hers is one of three posts we've just advertised.

Southern General, Glasgow – *Kenny Pollock*

Building work continues at a Wembley-like pace at the Southern. A large lick of paint, and some MDF transformed the O&G department, and after much media interest, the John McDonald Surgical Suite opened at the end of summer. Dignitaries declared it was 'fit for another hundred years'. The new hospital will be carbon-neutral, made entirely from melted down glossy bro-

chures telling of the wonderful achievements of GGHB. A large workforce of young, newly trained builders will be recruited on 1st August 2007 under a new government initiative (Modernising Medical Centres, MMC). Strangely planning committee meetings to discuss the new theatres and ITU have stopped. The managers must be organising some sort of secret pleasant surprise.

Joan Prentice retired in September, and had two great send offs, one of which incorporated the inaugural JP Classic golf tournament at Haggs Castle (next year the Algarve). Team Prentice won the event. We all wish her well on her world tour of properties. Magnus Garrioch left Glasgow for the bright lights of Manchester, once again in a blaze of media glory, and Catriona McNeill was appointed to an ITU post, to start on returning from Mat leave. Caroline Harper joined us from a previous post in Sheffield, finding herself on her own C section list a few months later. Kerry Litchfield will soon be taking up a consultant job at GRI, and Jim Ruddie will shortly be returning to Monklands. Happily Gavin McCallum has returned to work after neck surgery earlier in the year, which (temporarily?) prevented him from going on a summer camping trip to Afghanistan. The new parental leave entitlements have created great interest in the department, and travel brochures litter the anaesthetic machines. A revolving door has been installed to cope with the large number of trainees arriving and leaving the department, according to whatever EU directive comes out next.

Stobhill - *Roger Hughes*

Happily for those of us who enjoy working at Stobhill, again there has been no change in the clinical workload in the last year or any immediate prospect of future change. However the new Medium Secure Unit (?Bon Secure) on the hill above is almost complete and once the machine gun nests have been manned, patients will be decanted from Carstairs. Wards 2, 3, and 4 have been demolished leaving a large building site on which the ACAD is due to be constructed in November. Parking spaces will be halved, so working in Stobhill will become less pleasant.

Jack McKellar retired aged 65 in June and a very successful dinner dance was held in his honour- some attending nearly hospitalising themselves. He will be replaced in the New Year. Meanwhile Stewart Milne has returned to a Consultant post between here and the Royal and Lisa Manchanda has taken over Bill MacRae's Chronic Pain work while he has been appointed Lead Clinician for Stobhill and GRI. Lisa will soon go on Mat Leave while Susan Smith and Audrey Chalmers have returned. Audrey has taken over Angus McKee's ICU sessions allowing him off nights - something everyone over 60 should be allowed (heavy hint)!

Finally our junior staff have been pooled with the Royal so we can no longer boast about our much better record in the exams!

Stracathro Hospital - *Charlie Allison*

The core group remains two (Jan Beveridge and me), supplemented by the Dundee Travelling Wilburys" now with Nicki Thomson, transferred at enormous cost from Aberdeen. Our independent treatment centre will open evenings & weekends about now, bringing back joint replacements, supported by a mini HDU and RMOs with two years anaesthetic experience (where will they get them from?)

In the summer I had four months off with a nasty vocal cord carcinoma, successfully zapped by Lesley Colvin's better half Richard Cassasola. Flexible laryngoscopies (without anaesthesia) continue to check all remains clear. Keep healthy, and be lucky!

Victoria Infirmary - *Graham Gillies*

We are still here albeit under new management - now part of a Glasgow-wide Anaesthetic Directorate, within the new NHS Greater Glasgow and Clyde. The organisation has a plethora of new managers coming to grips with their briefs and my email inbox is bulging with urgent messages. Harmonisation is the buzzword and that sounds like a good thing. I am optimistic that when the dust settles, something useful will have happened. Meanwhile, at the coalface, it's business as usual.

The new Day Hospital to be built opposite the Victoria Infirmary, is to be called the Victoria Hospital, presumably to avoid confusion and has now been signed off with the Balfour Beatty Consortium. It is due to be completed in 2009. This announcement carries such an air of conviction as to convert even our hardened nonbelievers. This sizable construction is to have an area of over 30,000 square meters and is expected to treat around 400,000 patients a year. It will have eight operating theatres and a number of 23 hour beds.

The current plan is for the Victoria Infirmary A&E to remain open with acute medical, surgical and trauma receiving, until the completion of the new Southern General Hospital in 2012. In the meantime, the Vic anaesthetists continue to provide anaesthetic services for ENT at the Neurological Institute and split-site working looks to be a long term prospect for many of us in the city. The Infirmary has recently benefited from a comprehensive upgrading of wards and lifts that has left it looking remarkably fresh.

We were saddened by the hasty introduction of the immigration restrictions to non European overseas doctors

and were pleased to find our 4 overseas SHOs were accepted on the highly skilled migrant programme. We await the introduction of MMC with some apprehension and hope it will not ill serve our existing SHOs.

Our congratulations go to Catriona MacNeil on her recent appointment as an ICU Consultant at the Southern General and to Colin Goutcher appointed as a Consultant Anaesthetist at the INS.

Wishaw General Hospital - *John Martin*

It's been a relatively quiet year in deepest Lanarkshire. Restructuring is underway again, complicated by the future demotion of Monklands Hospital to a level 2 unit. We are awaiting, with some misgivings, the effect this will have on our on call workload.

Staffing problems have been helped by the introduction of Eastern European colleagues who are fitting in well, both professionally and socially. Nadia Hodsman is now lead clinician, and will probably move to assistant CD status in the near future. George Harvey has announced his intention to retire next year after 28 years service in Lanarkshire. We wish him a happy and healthy future.

The Chronic Pain service is an ongoing problem. Since I withdrew from this service at the introduction of the new contract, NHSL has "fixed" the matter by using one of our long term locums. This is only a stop-gap, and some serious rethinking will be necessary before QIS look at us more closely.

RHSC Yorkhill - *Crispin Best*

Another year, another communiqué from the hill, although possibly not for much longer. Who knows?

Planning for the new hospital proceeds apace. We have seen the 'artist's impression', we have viewed the plans, we have marvelled at the possibilities of being part of the biggest hospital site in Europe, and we are aware that we still may end up in a reclaimed sewage works. So in the ordure again, then. Plus ca change... All we know for certain is that there won't be enough expensive parking spaces and the next time the Clyde floods we'll be up to our necks in... Well, I leave that to your imagination. That said, we have the opportunity for a brand new unit, purpose built and ready to provide a fantastic service for Scotland's children, and that's a pretty good thing to work towards. It's to be hoped that the powers that be don't interfere with this vision too much, but concentrate on delivering what we need.

As far as local developments go, we've now been officially joined by a whole bunch of 'dental' anaesthetists. Very nice to have a few grown-ups round the place, and I hope we have managed to make them welcome.

On to more personal things. Dr McNicol has finally named the day, and will retire in the spring of next year. He has been a great figure in Glasgow anaesthesia for both adults and children, although his main claim to fame has been his paediatric practice. He will be greatly missed by all his colleagues. We'll be arranging a bit of a 'do' nearer the time, details will be circulated. Lesley McKee has returned after mat leave, another daughter, named Sylvia. Judith McEwen, Tony Moores and Susan McIlveney have now joined us permanently, as has Ros Lawson who is doing another final farewell performance after having spent a few years up north in Inverness. Does she have to give the present back?

PICU goes from strength to strength. We have two more intensivists, Chris Kidson and David Ellis, making a grand total of six. But there are seven people. Dave Hallworth and John Sinclair alternate on a four monthly basis, and so have formed a single being, known as 'DJ' for planning purposes. The place is going like a fair all year - there seems to be a lot of whatever it is about. Cardiac gets busier and busier, we may be doing hypoplastic left hearts next year instead of sending them to Birmingham, so we on the cardiac rota are hoping there is a hospital in the Bahamas that we could go to for training. Lots of training. Lasting a long time.

So good luck all, and I'm going back to my favourite Glasgow winter pastime, which is seeing if the River Kelvin is going to flood Partick. So we can get stuck up a creek without a paddle, presumably.

Old Yorkhill

New Yorkhill

An NHS Glasgow spokesman, known only as "The Doctor" said, "I know from the plans it looks smaller, but it's actually bigger on the inside."

SL

Annual Golf Outing

Gullane, June 20th 2006

Phil Neal of Edinburgh Sick Kids had foolishly allowed himself to be sandbagged into organising this year's golf and since he resides somewhat conveniently next to a fine course at Gullane on the south shore of the Firth of Forth, this he managed and with some aplomb. Many of the assembled company of golfers could be heard muttering anxiously about the dreadful weather forecast while they took in the initial impression of the course. It looked treeless, high and exposed. A challenge then, like that of Henman facing Federer in a bad mood or sitting the Fellowship dressed in a gorilla suit. By no means all were cowed however, as we shall see. Golfers are made of stern stuff indeed!

A fine bacon roll before the off ("second breakfast" for some) then we were sent out to tackle Gullane No. 3. This is the shorter of the two courses we were to play and it was felt that the scoring would be more competitive. At lunchtime we had proper food - none of yer sandwedges at Gullane. The scores trickled in. Eddie (in-the-hole!) Wilson's early posting of 42 points looked good but soon he was joined by Jim Dougall and ????????? also on 42 it was not to be enough however.

The annual golf outing has been going since 1984. It was suggested by Bruce Scott during his Presidency the year before and the task of organising the first fell to the then Secretary, Farquhar Hamilton. That first outing at Gleneagles was won by Alan MacDonald. Then followed:

1985 - Bruntsfield - Sandy Buchan (Farquhar was third that time)
1986 - Lanark - Sandy Buchan - again - in conditions of torrential rain. He received the inaugural Scott trophy which was donated by then President, Alastair Mackenzie in honour of Bruce.
1987 - Scotscraig - Robin Allison. (E/W a draw) This time Dr Mackenzie recorded events on video - Where is this treasure?
1988 - Buchanan Castle - Bill Kerr - (EW draw) (Farquhar third again)
1989 - Glenbervie - Paul Wilson (East won)
1990 - Royal Aberdeen - Greg Imray - (North v South - North won)
1991 - Ladybank - Alastair Masson - E=W
1992 - Ladybank again - but who won - and who was responsible for the report?
1993 - Downfield
1994 - Royal Burgess
1995 - Killermont - Charles Cairns. E/W East won
1996 - Lanark -
1997 - Glenbervie - Iain Taylor
1998 - Downfield - Tony Moores East won
1999 - Ladybank - Tom Goudie - West won
2000 - Glenbervie - Eddie Wilson East won
2001 - Auchterarder - David Marsh East
2002 - East Renfrewshire - Eddie Wilson E=W
2003 - Aberdour - Rae Webster East
2004 - Prestwick St Nicholas - Bob Campbell
2005 - Turnberry - Alex Macleod - E=W

...and so to 2006. The testing conditions finally gave the ex secretary the challenge he craved. After setting the ball rolling all those years ago, at last Farquhar got it in the hole to become the 2006 champion!

The unenvied record of Crosshouse Hospital in Society Golf - that of perennial Booby Winners - was extended for one more year as Alistair Michie again secured the accolade for Ayrshire! There was further misery for the West as the East team won in the afternoon albeit with help from several turncoats from the West playing for their old team!

Failing to observe the no smiling rule

Yours at last Farquhar