

THE SCOTTISH SOCIETY OF ANAESTHETISTS



Annals 2012



Crieff, May 2011

President Dr Paul Wilson is congratulated by his successor to be, Dr Charles Allison, the new Vice President

Table of contents

Page

1	Editorial
3	Presidents Message
5	Presidential Address
15	Regional Reports
32	Meetings Reviews
36	Gallery
38	Anaesthesia & Resuscitation on the Western Front
48	“Crossing the Chasm” The Gillies Lecture
53	Trainees Presentations Competition: The Donald Campbell Quaich
58	Poster Prize Competition: James Macgregor Imray Salver
72	Golf outing report

THE SCOTTISH SOCIETY OF ANAESTHETISTS



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Editorial

Welcome to the 2012 edition of the Annals. This is my first attempt as Editor so I hope you enjoy reading your way through. I'm sure Donald MacLeod put my name forward as to take over as Editor of the Annals because it's known I have a good number of cameras and have been seen using a computer. I have to, as I think is normal and right, thank the various contributors, the regional and hospital reps who annually tread the tightrope between information, entertainment, libel and fact to provide the regional reports. I'm encouraged that all but one feel able to put their name to what they've written! Unless Lance De Boil is a real person of course - then, apologies!

Previous editors have often used this forum to deliver what have been, in my opinion, highly thoughtful and insightful commentaries on the state of Scottish Anaesthesia as they see it. I don't feel qualified to carry on that tradition. This disinclination of mine to regale you with my thoughts is reinforced by the fact that this year's Presidential Address covers most of the points I think I would want to make. And much better than I'd do it too!

I have included the Presidents address in a minimally edited form. It was a very personal trip through President Wilson's career, a history of Scottish Rugby and the current challenges of the profession in Scotland. I feel Paul's voice comes through loud and clear and didn't want to lose that.

We also feature a "commissioned" article by Dr Anne Robertson. Anne is one of several medical experts in Aberdeen on the First World War. Her article "Anaesthesia and Resuscitation on the Western Front" is beautifully well written and absolutely fascinating. I know you will enjoy it. It is

my hope over the next few years to have more articles of this type. I know you're a talented bunch. If anyone has, or knows of anyone who has, an area of expertise and the ability and willingness to write an article for the Annals please get in touch.

I have gone for a slight reduction in the number of papers and presentations included and concentrated this year on the entrants for the Registrars Prize competition at the Crieff meeting which had a record entry of 74 papers. A truly remarkable figure. The organisers of trainees meeting Dr Vishal Uppal and Dr Sarah Cross can take a great deal of credit for the increasing success of the trainees meeting and the burgeoning competition. However reproducing all these entries would have meant the Annals coming out in a number of weighty volumes. I've therefore included the top 20 ranked papers from this year and have not gone to other societies for their prize winning papers. A secondary reason for this move is that I have noticed that over the past few years many papers get entered for multiple competitions and published more than once (sometimes in the Annals - see if you can spot this years "doubler").

I'd like to congratulate Paul Wilson on a great year as President. Paul has provided adept and sure leadership. Like most Presidents he found the first forty five minutes of his reign the most stressful. However once his excellent address was delivered (reproduced below) he has I think, gone on to enjoy his time in office hugely. I'm sure I speak for all the executive when I say he has been extremely helpful and responsive. Enjoy the rest of your retirement Paul.

I have expanded the role of the Editor of the Annals a bit by also taking over the maintenance of the Website from Steve Lawrie. I'd like to publicly acknowledge the work Steve has done over the years in maintaining the Website. It is no small task. It is my intention to make the website more and more useful to the society with information about events and downloadable forms and hopefully meeting summaries and presentations. We also have all the contact details of the executive and council. There are some historical articles also with room for much more. Suggestions are welcome but remember I am an amateur web designer. We may one day get to online booking for meetings etc but I think that's a long way off for now. I'll crawl before I can walk before I run.

The website address remains:

www.scottishsocietyofanaesthetists.co.uk

Lastly: As you will probably know, we have a new executive, Myself, Gordon Byers and Andrea Harvey, all based in Aberdeen. We can only hope to maintain the efficiency and high standards of the previous incumbents whose sadness at being free of the weight of office is plain in the picture in the centre pages (in case you're too lazy to look, they are grinning their heads off). Well done guys and thank you from all the Society for a very difficult job, very well done, for four years.

I hope you enjoy the Annals

Brian Stickle



Presidents Message



Dr Paul Wilson

The Scottish Society of Anaesthetists continues to go from strength to strength with last year seeing Jim Dougall, my predecessor, continuing to guide the Society forward with his boundless wisdom and experience. It is a huge privilege and honour that I have followed him in a year that has seen some significant changes.

There has been a change of executive with the “Glasgow Three” finishing their term of office being replaced by three eminent Aberdonians, Gordon Byers, Andrea Harvey, and Brian Stickle, who have all kept me on the straight and narrow and I wish them a very successful term of office.

To quote the Proclaimers, “Peebles - No More!” After many memorable years in the Borders the move to Crieff Hydro this year was a huge success thanks to the unerring work and organisation of Liz McGrady and Kerry Litchfield. The tried and tested format of the long weekend starting with the Trainees Meeting continues, this year organised by Vishal Uppal and Sarah Cross. Attended by over 70 trainees, with an exhibition of over 40 Trainee Posters, the meeting was a resounding success. The Society cannot overemphasise the importance it places on Trainee participation and we were delighted to see so many Trainees on the Friday of the weekend. We would encourage more trainees and their families to stay and enjoy the whole weekend. On the Saturday the Keynote Lecture was given by Dr Irwin Foo from Edinburgh and the Guest Lecturer was Professor Tim Hales from Dundee. Two excellent addresses were very well received. The oral presentations for the Donald Campbell Quaich were of outstanding quality with the prize going to Dr Pete O’Brien. The winner of the poster competition, Dr A Clark, was presented with the James Macgregor Imray Salver.

The AGM showed the Society is in excellent shape and is continuing its successful remit of the promotion of education in Scottish Anaesthesia. There was some concern aired about the lack of Scottish elected representation on UK national bodies, however this year has seen the well deserved election of Dr Kathleen Ferguson and Dr John Colvin to the councils of the AAGBI and the RCOA respectively. Dr John Colvin and Dr Alistair Michie were in the hot seats at the lively Open Forum, answering questions mainly about service provision and job planning. The Society continues to represent its views on the Scottish Standing Committee and the Scottish Advisory Board.

The Annual Scientific Meeting at Seamill Hydro was organised by Caroline Whymark and Lynn Newman. The meeting addressed all aspects of safety and quality improvement in anaesthetic practice in Scotland. Dr Malcolm Daniel delivered an excellent Gilles Lecture. The meeting was followed by a much enjoyed dinner and Caroline and Lynn should be congratulated and thanked for organising such a well-received event.

In early February the Royal Society of Medicine(Anaesthesia Section) in association with the Scottish Society hosted a meeting in Glasgow, the “Four Professors”. This demonstrated that academic anaesthesia is alive, well and prospering in Scotland. Our guests from London were given a Civic Reception at the City Chambers and a convivial dinner at the Royal College of Physicians and Surgeons of Glasgow. Dr Crawford Reid, President of the RSM Anaesthesia Section, organised this excellent event.

Our centenary in 2014 draws near and I will be passing the chain of office to Charlie Allison. He tells me that this will be the seventh chain he has had to wear and I am sure that it will be in safe and proud hands. It remains for me to thank the executive again for all their help and wish them, the new President, and the Society well for the future

Paul Wilson, President, Scottish Society of Anaesthetists 2011-12



Previous President, Jim Dougal passes on the chain of office to the newly installed Paul Wilson.

Presidential Address

The following is the text of Dr Wilson's presidential address of May 12th 2011 at the Societies Annual Spring Meeting at Crieff Hydro Hotel

Dr Paul A. Wilson "Past History to Present Solutions"

As I prepared this Presidential Address I have experienced many thoughts and emotions, not least being; can I learn to play the bagpipes in a year! I was hugely honoured to be proposed as President of the SSA but my delight rapidly turned to increased trepidation when I considered the task ahead. Past Presidents have all been eminent individuals in their field of expertise with so many being erudite and eloquent scholars, speakers and of course music makers. Many were my teachers and mentors when I started my anaesthetic career and have now become friends, though I still have a subconscious reluctance and fear of calling Dr Margaret Stockwell; Maggie. There are a few of my seniors whom I could never address except as DOCTOR, one I admire greatly is Dr Winfred Finlay, you felt like standing to attention when speaking to her on the phone!! But I learned so much from her, not only about anaesthesia and intensive care medicine but about professionalism, leadership and the importance of supporting one's peers and trainees in the workplace.

Reviewing previous Presidential addresses I have been impressed by the variety of the subjects covered, but the main themes remain the same; some personal history, a review of the president's personal interests, their contribution to the specialty and on occasion their view of the future. In recent years the Society made the decision that its main aim would become educational as opposed to political, although maintaining its representation



on the various national committees which would deliver annual reports at the Society's AGM. However the political landscape at Government level, within medicine as a whole, and within the specialty of Anaesthesia has changed markedly in the past decade, more so in Scotland. We as Scottish professionals are under constant scrutiny and need to respond to maintain our professional standards in all aspects of Anaesthesia, to plan the future of the Specialty and to fulfill the aspirations of the trainees. The success of this task is dependent on communication and teamwork, commitment, representation with leadership, and the ability to respond to change. Perhaps this Society should become a little more politically involved in Scottish Anaesthesia in view of our devolved health service. It's is my intention therefore to touch on several of the above subjects in my address, by sharing some of my past and interests, exploring some common themes which have occurred through my professional and personal life and expressing some of

my concerns for the future of Scottish Anaesthesia.

My friends and colleagues know my past involvement in Anaesthesia as a whole but they also know my passion for competitive sport especially rugby(yes I know that's hard to believe at present) and my enjoyment of live performance especially live classical music. To be successful at rugby and music you need many of the attributes required in anaesthesia, commitment, teamwork, leadership etc. I plan to speak about Scottish rugby but I will say little about music for two reasons, time will not allow and my family all of whom, unlike myself, are music makers will give me a hard time.

So, what about me?

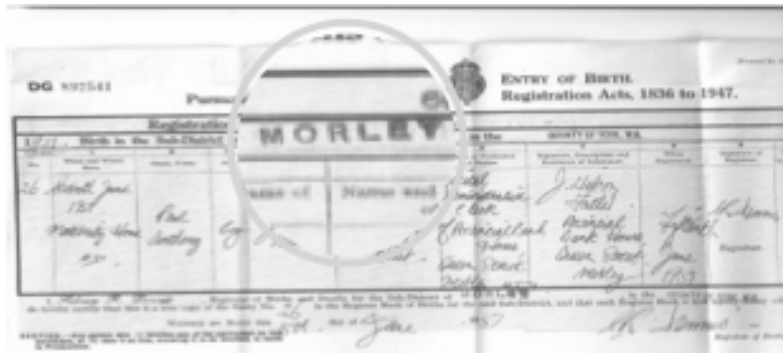
The confession that I am about to make will come as a great shock to most of you; the new President of the SSA is an Englishman, born and partially bred in Yorkshire. And as with all situations today I hear you demand where is the evidence! Well there it is below.

However at an early age my family moved to Scotland presenting me with a long running quandary. Am I Scottish or am I English. The problem was solved by Dr John Vance who encouraged me, at a very early stage in my anaesthetic career to apply for a Senior Registrar post in Leicester. This I duly did and was shortlisted. At the interview the chairman,

Professor Graham Smith asked the opening question, do I consider myself Scottish or English? I was born in England but my culture is Scottish through and through was the reply: and suddenly I was very aware of my identity and to this day I consider myself a Scot.

My family settled in the West of Scotland and following my schooling in Ayr at Holmston Primary and then Ayr Academy where I received a modern education in the nineteen sixties, I was accepted into the medical school at Glasgow University. I qualified in 1976 along with some other eminent individuals. I realised that I had reach a pinnacle in my career when following one of Cammy's late evening heated telephone debates about training, following a long silence, he conceded defeat!

Following pre-registration posts I was able to gain experience in acute and emergency medicine. 18 months in the old gate house at the Royal Infirmary under "Big Eck" and Bob Simpson gave me extensive experience in acute care and it was while here that I read my first anaesthetic book. I taught myself to do axillary blocks to manage distant limb trauma, you never could get hold of the emergency anaesthetist at the Royal, don't know if things have changed much!!! It was working with anaesthetists in the emergency department, a large proportion of who were female, which inspired me to follow a career in anaesthesia. I even married one!



I applied to the Glasgow anaesthetic training programme, succeeding in obtaining interviews at the GRI; WIG and the Victory Infirmary. One did not have to accept an offer till all interviews were complete, holding or declining any offered posts. Well there's an original idea!!

I accepted a senior house officer post at Glasgow Royal Infirmary in August 1979 where I received comprehensive training in clinical and academic anaesthesia including the use of Dr Geoffrey Parbrooks' series of tape slides for the Primary Examination, I think it's called e-learning today. Because of my clinical experience before starting anaesthesia I was able to complete the Final Exams sooner than expected thus allowing me apply for senior training posts as I mentioned before. While I enjoyed all aspects of anaesthesia I had developed a particular interest in the use of local anaesthetic techniques and intensive care and to further this I looked abroad to find a senior training post. I obtain a post in Sweden but political regulations prevented this and I was fortunate to be offered a post in Belgium at very short notice. So just after Christmas in 1983, I and my family moved to Bruges and I took up the post of Chef du Clinic in the Department of Resuscitation and Intensive Care in A-Z St Jan Hospital.

I was able to gain experience in the use of local anaesthesia in orthopaedic and urology lists, this being facilitated by a patient population with an inherent suspicion of general anaesthesia. However my main clinical commitment was to the critical care service. This was based in a 28 bedded unit comprising 12 ICU beds and 16 high dependency beds all in single rooms with the ability to change between Level 2 and Level 3 care. The unit was a multidisciplinary unit admitting all patients including neuro and cardiac and had a nursing staff of 140 critical care practitioners who worked to strict protocols and care plans.

A-Z St Jan was a tertiary referral centre and the Critical Care Department offered a retrieval service to other medical centres and ran an emergency pre-hospital care service. One of the consultants or the Chefs du Clinic was allocated daily to man the service which was busy with several call outs per day. The calls ranged from pre-hospital medical emergencies and trauma to retrievals from other hospitals. The whole of West Flanders was covered and therefore air transport was available.

For a long time I was the only individual in the West of Scotland actually trained in Emergency Medical Retrieval and Helicopter transfer, and you can keep it!!

The whole of the critical care service was staffed 24/7 with fully trained doctors, a mix of consultants or chefs du clinic who were independent staff members awaiting consultant jobs. They were nationally registered practitioners, licensed to work in West Flanders and that included me following a lot of effort. The trainees were supernumerary working in nationally numbered and financed posts in a four year training programme but with the option to be in the post for a longer period if the hospital would pick up the salary. This situation could lead to some trainees not progressing and becoming cheap labour. This was a similar situation we may have in the UK in the near future if we are not careful.

At the end of my contract I returned to the West of Scotland in early 1984 and experienced two major events, I manage to secure a Senior Registrar post at the Western Infirmary, but more importantly Scotland won the grand slam.

I spent the next two years doing my higher professional training based at the WIG anaesthetic department and doing the various specialty rotations that still exist today. I especially enjoyed working in the intensive care gaining experience from a multidisciplinary team, watching the research group ie the shock team at

work and being encouraged by the enthusiasm of the new consultant, Dougall was his name if I remember correctly. Due to the experience and some misplaced autonomy I was afforded in Belgium I felt very comfortable in the unit which often allowed Dr Wallace to get to the infamous egg sandwiches a little sooner. I completed my training with my district rotation to the Royal Alexandra Infirmary in Paisley of which I have many fond memories including Friday lunches "across the road". David Steele was the captain of the ship and it was from him I learned an important fact, it may take at least 3.5 mls of heavy bupivacaine to successfully undertake an elective section in an ample Paisley Buddie.

Don't work in Ayrshire was a statement made several times during my training, however at my final "RITA", my final HST review I was told that Ayrshire required a locum. I was duly dispatched to Ayrshire with some reservation. My concerns were totally unfounded as I found myself in a department which was practising at the forefront of anaesthesia with the most modern equipment and monitoring, using advanced pain techniques which the central hospitals were merely talking about. There is no doubt that the true pioneers of post operative epidural analgesia in Scotland were Drs Duthie, Everley and Macdermid from South Ayrshire. Following this experience I decided that I wished to work in Ayrshire and started in South Ayrshire in 1986. Over the ensuing years I was able to alter my sessions ending up at Crosshouse with my intensive care commitment. It was here that thanks to the department that I was able to pursue my involvement in postgraduate medical education.

However my first consultant job plan was not typical although it did resemble a modern 9:1 contract

Before the Ayr Hospital opened in 1991 emergency surgical services were

delivered from 3 hospital sites and it had been decided that the trainee rota would be concentrated at Crosshouse Hospital. When I started as a consultant I was first on call from home for the out of hours general anaesthetic service including transfer of critically ill patients. This did have some downsides but overall there were very strong positives. The emergency service was well planned during the day, my sessional allocation strictly allowed for out of hours work and all emergencies were done by senior medical staff. Ayrshire now has three typical out of hours rotas with intermediate grade staff supervised by consultants which are now under great pressure and having adverse effects on training like many other places in Scotland.

Living and working Ayrshire has allowed me ample opportunity to enjoy and be involved in my leisure activities.

From an early age I have loved sport, especially the game of Rugby Football which I have played, coached and organised at different times. I know that competition it is not popular with everyone but sport and especially team games provide individuals with a number of important life skills; encouragement and competition, teamwork, leadership, commitment, and coaching skills. These are all essential aspects of being successful today. Over the past few years there has been a move to dumb down or remove competition within education, but life is full of competition and individuals like to win or succeed. Winning is not everything I hear but that's at the end of the game!! I often remember the notice we had in the changing room at Marr Rugby Playing fields where I coached the S1 and S2s; "Winning isn't everything but losing isn't anything".

How did Rugby come to and develop in Scotland? As with most things the sport has many roots some of which go back millennia. It is known that for recreation the occupying Roman legions in Britain

played a hard ball game called Harpastum

It is claimed that this led to the well known Border Ba' games which are recognised as the origins of Border Rugby. This is conjecture, but there is a strong case for this belief as the main route into Scotland was across the Cheviots on to Melrose and Jedburgh where they still have an annual symbolic game.

The Border Ba' games were the roots of football in Scotland; I use the term football because the word rugby was not used officially till the 1920's. These kind of games were part of the leisure time of local people from Medieval times onward. When a game was planned two teams were formed, there were no playing fields the game being played in the street.

Teams were formed usually by local geographical areas eg the uppies against the doonies. The object of the game was to carry the ball, about the size of a tennis ball made from leather, with all brute force required and touch an object or target at the far end of the opposition area. Kicking was usually impossible because of the mass of bodies and would usually result in injury.

The advent of the 19th Century with the growth of industry and long working days leisure time became more restful and football games went into decline. Football would have disappeared completely if it had not been taken up by schools and universities as a recreation. Many of these institutions developed kicking and handling games the earliest being recorded at the High School in Edinburgh in 1810. Many of the former pupils and students went on to form clubs and teams thus organising and governing the game in its formative years.

A cohort of new schools were formed in Scotland in the first half of the 19th century. Edinburgh Academy in 1824 to Glasgow Academy in 1845 with Glenalmond following in 1847. From old

school records it is known that all these schools played a crude form of football with kicking and handling. It was however in Edinburgh Academy that the handling game became established. This was due to the Crombie brothers, Francis and Alexander who came to the academy in 1854 from Durham School and brought with them the rules of football as played at Rugby School. Ironically neither of the boys had played football at Durham but both started playing in Scotland, Francis becoming school captain and Alexander becoming one of the founder members of Edinburgh Academicals Rugby Club. During the same period a new pupil from England named Hamilton came to the High School of Edinburgh in 1856 and brought with him the "Rules of Rugby Football". This document was the foundation of the High School adapting their crude handling game to its new more recognisable form of today's game. I wonder if this is the first record of Scottish Rugby teams using import players of dubious origin, they must have had a Scots Grannie!!

The natural progression of these handling games were inter-school matches. The first took place on the 13th February 1858 between the High School of Edinburgh and Merchiston. The teams had 20 players a side but the games had two main problems. Firstly the quality of the footballs which were to quote "monstrous inflated globes of vast circumference and ponderosity" and secondly there was no uniformity of the rules, each institution having their own variation of the laws.

The footballs improved but the variation in the laws continued to cause problems, with multiple disputes and challenges being robustly debated and prolonging games, just like today's Old Firm matches. Gradually over the years the game approached some uniformity similar to that played at Rugby School. However the state of affairs could not continue and finally in 1868 following a number of meetings led by Edinburgh

Academicals Football Club, the Laws of Football as played by the Principal Clubs in Scotland or the Green Book was produced. Alas no copy now exists. The word "Rugby" was not included in the title and the Scottish Football Union formed in 1873 did not alter its name to the Scottish Rugby Union till 1924, the year prior to the opening of Murrayfield.

As school and club football developed both in Scotland and England a series of international games of football between the two countries was organised in 1870. All games were in London and followed the Association type of game with eleven a side, England won everything!! This led to a group of Scots players issuing a challenge in the Scotsman newspaper and Bell's Life publication in London to play an England XX at the carrying game.

The challenge was accepted and the first Rugby International between Scotland and England was played on Monday 27th March 1871 at Raeburn Place. It was a well advertised event as evident from the notice of the game in the Scotsman. Half a column inch with the text :-

"INTERNATIONAL FOOTBALL MATCH. This MATCH will take place today on the ACADEMY CRICKET GROUND, RAEBURN PLACE at Three O'Clock. Admission One Shilling. Academicals are requested to present their card at the gate"

The Scots won the game by a goal and a try to a solitary try scored by England, the system of points scoring had not yet been devised. By 1873 the Scottish Football Union had been formed and a change to 15 a side from 20 players introduced. The International Rugby Football Board was formed in 1886 and by 1889 a points scoring system was instigated.

The upper class game of rugby thrived across the central belt of Scotland and many international games were played at

Raeburn place with increasing numbers of spectators.

However while all this was going on in Edinburgh and Glasgow throughout the mid to late 1870s onwards another almost parallel world of club rugby was growing in the Scottish Borders. This was a different brand of the rugby, always 15 a side brought from Yorkshire on the back of the thriving woollen industry supplied by the Border sheep farmers. As there was no association football, rugby clubs such as Gala, Hawick, Selkirk, Jedforest and Melrose thrived and became the focus of the farming communities producing top class teams from a very small population base. Unlike the other rugby communities the Border teams were not wealthy and at times struggled and fund raising ventures were always needed.

Ned Haig (below) a butcher to trade and member of Melrose RFC suggested a tournament of seven a side rugby with games 15 minutes long to raise funds for the club. The first Melrose Sevens tournament took place on 28th April 1883. The ladies of Melrose donated a cup, known as the Ladies Cup which still played for today at the Annual Melrose Sevens.



By the early 1900s club rugby was well established in Scotland with International games still being played at Raeburn Place.

However disquiet was growing from other sports about the use of grounds for international rugby and the SFU

eventually purchased land at Inverleith in 1897 making Scotland the first home union to own its ground. It cost £3800 and the funds were raised from the sale of debentures. The need for expansion to accommodate larger crowds forced the SFU to look for alternative accommodation and in 1922 they bought 19 acres at Murrayfield to build a new stadium.

The SFU changed its name to the SRU with Murrayfield its new headquarters. The last game was played at Inverleith on the 25th January 1925 when Scotland beat France 25-4. The first game at Murrayfield took place on 21st March 1925, before a crowd of 70,000, against England. Scotland won 14-11 and having beaten the other home countries gained their first grand slam.

With the exception of the war years the five nations and now the six nations have played international rugby annually for the various trophies and titles. The Scottish international team was underpinned by an expanding number of rugby clubs which competed in the "Unofficial Championship". This was a very unbalanced competition with some clubs playing more games than others and some clubs having to face stiffer opposition than others. The resulting league table was unbalanced and difficult to comprehend.

In the last unofficial championship of the 1972-73 season the young pretenders from the Ayr did well with a team that contained a few talented players.



The next season 1973-74 saw the start of the present day leagues which have been through numerous re-organisations and by the mid nineties the professional game was established. This period has not been harmonious for the SRU with increasing debt and internal disagreement. With over two hundred amateur clubs now formed in Scotland usually at odds with the leadership of the SRU and times feeling disenfranchised, it has been difficult to cope with change and in some respects Scottish Rugby is struggling.

I feel that there are similarities in anaesthesia and I would like to share some of my concerns with you. I have been in anaesthesia and critical care for 32 years and I consider myself lucky and privileged to have been part of the huge developments that have taken place in clinical anaesthesia and patient safety.

I am not going to dwell on this, but today the end result, administering general anaesthesia, is extremely safe, even I survived a general anaesthetic early this year and that was without a bariatric table! We continue to rise to the increasing clinical challenges of complex surgery in older and sicker patients. This has come about because of many aspects; the pharmacological developments which have made drugs much safer with fewer side effects, development of patient monitoring and anaesthetic equipment; the introduction of advanced pain techniques; and the development of critical and high care areas. These are the obvious reasons but Anaesthesia has also been at the forefront of many other generic aspects which collectively have added to patient care and service delivery and it is these areas I wish to mention.

As a specialty we have always been very organised and proactive on the whole when dealing with problems and improving standards, not just locally, but on a national level through the RCOA and the AABGI. Both organisations led

the way in the early days improving patient care and safety by producing evidence based standards in care, recommendations for clinical and professional working practices and most importantly standards of training long before other medical and surgical specialties acknowledged the importance of these. Anaesthesia really has led the whole concept of patient safety from the start. 30 years ago as a trainee I was using checklists, critical incident reporting became the norm and the whole of my clinical work was focussed on the patient.

For the past fifteen years successive governments through their health departments have exerted increasing control on the delivery of healthcare within the United Kingdom. Many of the professional roles and standard setting undertaken by the Royal Colleges and Professional Associations have been transfer to government bodies and quangos . There has been an almost reinvention of the terms standards of care and patient safety. With the negotiation of the new time sensitive consultant contract , the creation of PMETB now GMC to take charge of training, and finally the MMC debacle one could say that the political mission was accomplished and that the medical profession including anaesthesia is well on the way to being de-professionalised and controlled.

But we have responded to these changes constructively and cohesively for the overall good of anaesthesia but like other organisations that have developed and expanded (like the SRU) I have concern that our speciality is fragmenting.

We will have to wait to see if the new faculties within the RCOA enhance the speciality of Anaesthesia or restrict its development. Over the years there has been a considerable increase in the number of specialist societies all of whom have contributed by developing specific standards of care but at the cost of the

loss of the holistic side of general anaesthesia. My favourite is SOBA , the Society of Bariatric Anaesthetists, one must be careful where one puts the adjective in titles. This trend can also be seen in training where individuals feel that one must be working in a specific module to be trained and gain experience in a particular skill. We must remain general anaesthetists with the broad range of skills that exemplify anaesthesia.

As departments of anaesthesia expand and the demands of the service targets exert pressure we must not become inward looking, change needs to be managed collectively and based on the best evidence available. While we must maintain our own strong national advisory structures in Scotland it is most important we have Scottish representation on UK national bodies.

From the RCOA we have national training standards and a national curriculum, from the AAGBI we have national recommendations and guidelines and these affect what happens in Scotland. However once Ian Johnston steps down from the council of the AAGBI Scotland may have no elected members on either of the two councils. I know that we have co-opted membership from the Chairs of the Scottish Advisory Board and the Scottish Standing committee who represent us extremely well, but as history has shown especially from the RCOA these groups could be put under threat. We should also be concerned that there are no elected Scottish Anaesthetists on the council of the Intensive Care Society or on the Board of the new Faculty of Intensive Care Medicine. I feel that this situation may have been compounded by devolution. My plea to you today is we must be prepared to put forward and support prospective candidates who will require local department support, and not let apathy prevent our full representation on these important bodies which have significant influence on Scottish Anaesthesia.

Scottish Anaesthesia is in good shape at present with Anaesthetic departments that have expanded consistently in response to service needs, we are very fortunate to have four successful academic departments and organisation and delivery of training is well managed. This has been achieved with some of the attributes that I have mentioned earlier, mainly commitment, teamwork, leadership and our ability to cope with change.

However we cannot become complacent as next five years will see even more significant and lasting change which comes against a backdrop of significant cuts in public spending. We have very aggressive senior management at all levels now prepared to impose change if engagement by the profession is not forthcoming.

In Scotland we have very robust advisory structures at the present which allow us to feed advice into the various SGHD committees to do with healthcare delivery and workforce planning. We have managed to maintain a direct link with the CMO through an annual meeting with the Scottish Advisory Board. There is however another powerful group which is emerging and beginning to exert significant influence, the Management Steering Group or MSG. This originally began as a self appointment quango of Health Board CEOs and some Medical Directors to address manpower issues and was responsible for the start of the 9:1 consultant contracts. It now has a mandate from the Scottish Government to look at all aspects that affect healthcare delivery; this now includes some aspects of the delivery of training. I recommend that you all should look at its website in the near future. The profession is not well represented on this group at present but NES Scotland and the BMA are beginning to forge links which makes me immediately suspicious. In the next five years one of its main remits will be to deliver healthcare with a

trained medical workforce that is affordable.

Anaesthesia in Scotland is well placed to meet this challenge and we must not have solutions imposed on us. We are fortunate that the old Scottish Standing committee of the RCOA began manpower planning and thanks to Tony Wildsmith, whose numbers were doubted but are not far off the mark today, and now thanks to Eddie Wilson, we have good data. We know that trainee numbers must reduce which will leave a service gap. With the MMC bulge producing excess CCTs the main fear was that there would be an expansion of Specialty Doctors but this option is not favoured by all parties. We must therefore explore what options are available. The effects of the EWTD are now very apparent, the amount of service the trainees can deliver is at its limit if not already exceeded and we are now seeing the effect on training which was predicted. We have a new curriculum, which is task and competency based and with cumbersome assessment to satisfy the GMC code rather than give an overall professional opinion of the trainees. When this is put together with the effect of the EWTD, the result is significant loss of experiential learning evidenced with trainee logbooks. As this situation continues we have to question what does a CCT actually mean. Are individuals really trained to take on the responsibilities of a consultant? I think that some individuals may be but that there will be a considerable number who will require further support in the early years post CCT.

The problems of training and service delivery are not mutually exclusive and may have common solutions. It is the loss of experiential learning which is the root problem, not only the clinical experience but the accompanying professional experience which has been accepted as an integral part of the curriculum. We can increase this experiential training either pre or post

CCT. and at the same time provide some solutions to an affordable workforce.

If this is done pre CCT then this will mean lengthening training. With uncoupling of the training programme, one option that is being explored is the delivery of CT1&2 over a three year contract. While this does have some attraction especially with the Primary Exam it does mean that relatively inexperienced doctors will be supplying more service albeit with appropriate supervision. I personally have some reservations as resources to pay the salaries will be taken from potential post CCT jobs. As trainees will be able to apply for ST3 at different times it will be difficult to administer and there is the potential to create another lost tribe with the potential exploitation of trainees which I witnessed in Belgium; having said that this maybe part of the solution.

The other pre CCT solution would be to introduce a period of service in the later years of training the main threat to this is the introduction of Mid-point credentialing which could deny access to some higher training modules. Despite this the service would be delivered by more advanced trainees. The real challenge in the future would be to obtain this experience post CCT. There has been much discussion about post CCT fellows but there are problems with defining the posts, supervision and terms and conditions of service resulting in these posts being less favourable. There is a widespread desire to use the present consultant contract which I personally feel is the way forward. New consultants would start on the present 9:1 contracts with a clinical commitment which will have a great proportion of out of hours work which would change with experience. Anaesthetic departments must have the responsibility to supervise and mentor new colleagues on a more formal basis and advice and standards for this task could come from the RCOA and AAGBI. As consultants take on more non clinical duties then job plans would be reviewed

and adjusted. To make this affordable may mean introducing lower starting increments in the consultant salary scale which is the biggest challenge. I do like the term sub-consultant grade but this will mean a junior consultant/staff member you can pick the term. This will lead to a new career structure post CCT and may encourage consultants move posts more than at present. I know that this would not be popular and it is easy for me to say this especially as I am retiring but please remember what I said about the MSG who are engaging with the BMA.

To finish, I have a history of a career in Anaesthesia in the UK and Europe where I have worked in different ways from the conventional NHS consultant and have experienced many of the problems facing you in the future. I have outlined some of the solutions for the future of Anaesthesia and feel that it will be a combination that will be the answer. We have the leaders and the advisory structures to meet these challenges and the Scottish Society has its role to play; but they need your collective support. I have enjoyed an excellent career in Scotland, I am proud to be an Anaesthetist but most of all I am proud to be called Scottish.

REGIONAL REPORTS

Gossip and scandal from
around the Country

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Who said tabloid journalism was dead! Our dedicated network of intrepid and utterly amoral reporters from around the country has again been rooting through the bins of of the anaesthetic world. Sitting on doorsteps etc etc..... well you get the picture.

Aberdeen

Donald MacLeod

The last year in the Aberdeen anaesthetic department has been noted for the nine maternity absences, happy events of course. I'm informed that this is to be expected in times of war and austerity.

Dr Gillian Adey has retired after approximately forty years in the department. Also Drs Szalai, Van der Horst and Doonan have left us in the last few months. We wish them all well, and welcome back to the dept Drs David Seath, Peter Faber and Zuzana Kusnirikova on consultant appointments.

We have a new clinical director in Dr Brian Stickle, and Prof Alastair Chambers has become chairman of our regional senior staff committee.

There has been a number of changes at SSA council with the Aberdeen trio of Gordon Byers, Brian Stickle and Andrea Harvey taking on executive duties.

Congratulations to Dr Rona Patey on being appointed to the post of Head of Division of Medical and Dental Education, Aberdeen Medical School.

The Emergency Care Centre now looks like a hospital and will be opening in 2012. It is the very large building dominating the rest of Foresterhill which is obvious when you drive towards Aberdeen from the south or are arriving by plane.

Lastly we were all saddened by the death of Dr Mike Tunstall earlier this year. There was a very well attended funeral at Muchalls with superb celebration of his many achievements, and for those interested there was a full page obituary in the BMJ (www.bmj.com/content/343/bmj.d4977.full) as well as the Times, the Scotsman and the Herald.

Balfour Hospital -Orkney

Dr Colin Borland

It was not obvious at the start of the year, but from its icy beginnings 2011 has ended on a very positive note in Balfour Hospital.

During the year we again required locum support to keep us (Marek Wolanski and Colin Borland) functioning on all fronts. But June brought summer sunshine and Dr Anne Wake from Aberdeen to provide a refreshing breeze of youthful enthusiasm, up-to-date anaesthetic information- and an Orcadian husband !

Marek and Anne have brought our anaesthetic assistant staff to the point where 3 have been able to complete their competencies.

As the year ends we look forward to arrival of Dr Aneta Sowinska from Warsaw who after a long locum tenens appointment earlier in the year has been appointed to a permanent Consultant post. Our HDU has 2 functioning beds (at last!) and Theatre, HDU and acute Wards have seen the installation of IntelliVue monitoring and WardWatcher capability.

After a year in a temporary capacity John Trainor has been appointed as Hospital Manager and would you believe that NHS Orkney have been informed by the Scottish Executive that John will have a new hospital to manage- by 2016 at latest.

In addition to signing-off anaesthetic competencies there have been other significant theatre nursing staff events: an engagement (Jenny), pregnancy (Erika) and recent birth (Fiona). Also newly arrived, we have received an addition to our family of Drager Primus anaesthetic machines bringing us to a full-house of 3 of these excellent machines.

Appointment of a Theatre Manager is a work in progress with interviews expected early in 2012.

All that we're missing is a further fulltime (or even jobshare) consultant colleague. Might 2012 be the year when we achieve the full quota of permanent Anaesthetic Consultants? Watch this space, or even better apply to fill the vacancy!

Crosshouse Hospital.

Chris Hawksworth

The department said goodbye to a couple of anaesthetic heavyweights this year with the retiral of sometime Yorkshiremen Roger White and Paul

Wilson. Much has been made of Paul's new found passion for railway photography, but rumours that he spends his time on the end of platform 12 at Glasgow Central with notebook, flask and duffel bag are unfounded. Roger was last sighted skulking in the undergrowth near Prestwick's Pow Burn complete with camouflage jacket and hunting rifle, clutching a decoy duck. At least that's what he told me it was. Their collective experience, wisdom and support will be missed by all at Crosshouse, not just in the anaesthetic department.

There has been an outbreak of pregnancy among the trainee anaesthetists here, leaving the department even more understaffed than expected. Suggestions from the College Tutor and rota secretary that we spike our water cooler with oestrogens to prevent further pregnancies were rejected on the grounds that some of the men had big enough moobs as it was.

We welcome two new consultants to our department in the shape of Paul McConnell, well kent cage fighter and intensivist (sometimes both at the same time), and Peter O'Brien who will also be working in ICU. These gentlemen are replacements for the aforementioned Doctors Wilson and White. Although they have a lot to live up to, I'm sure they will be worthy successors.

Dr Collie keeps reminding me that I am now in the older half of the department which could explain why my new consultant colleagues appear to look younger and younger. However, I was surprised to find that one of the boys who share my office still has problems dressing. I thought even the most uncoordinated boys could manage to put their own socks on by age 10, let alone 30, but apparently not. One pair had been left under his desk for so long that a fellow obstetric anaesthetist posted them home to him so his wife could dress him for work properly. I suppose we should be grateful it was just his socks.

Finally a big thank you to Sylvia, Fiona and Margaret, our erstwhile secretarial team, for keeping us in order and generally running the show. We couldn't manage without them.

Ninewells Hospital Dundee

Fiona Cameron

Life in Ninewells remains busy as usual. Pressure on beds and operating capacity has pushed our service and thanks to Fergus Millar's rota management and Praveen Manthri's guidance we have been able to cope with the additional demands. Without the flexibility of our department we couldn't have managed this. Neil Mackenzie stepped down this year as Clinical Director and Eddie Wilson has taken on this challenge. We are grateful for Neil's sustained hard work over many years. His shoes will be hard to fill. Eddie's term as RA and TPD has finished and Willie McClymont has moved into these important training roles at a time when there are major changes to our curriculum and his steady hand will guide the trainees through these important changes and ensure that we continue to provide training to the high standard we have delivered previously. John Colvin has been successful in being elected to College Council. It has been some time since we have had an elected Scottish representation on Council.

As usual we have seen several staffing changes. Tayside trainees have secured Consultant posts this year. Harish Kathuria has gone to Nottingham. Peter O'Brien was snatched from us by Crosshouse. Lesley Crichton has been appointed to Tayside and Lois Fell has secured a substantive post.

The Institute of Academic anaesthesia continues to go from strength to strength under the guidance of Tim Hales. Basic and translation research is flourishing both in Prof Hales lab and with increasing work with imaging and bioengineering.

Congratulations to Shilpa Munirama for winning 1st prize at ESRA UK. Paul Fettes won the FAME prize for his contribution to undergraduate teaching.

Our trainees as usual are jetting round the globe. Linda Dubiel is spending a year in Oz and Megan Dale has returned from her year there. Closer to home Fiona King has been successful in her application for an academic post.

Last year we were unsure as to how Stracathro would develop with end of the Netcare contract. There has been expansion of the regular NHS work carried out there and several of our Consultants regularly work there in addition to the Stracathro incumbents.

A big change in our department this year was the retiral of Gill Grimshaw our departmental secretary of over 20 years. Gill was the ultimate multi-tasker and was a constant feature of our department. We will all miss her.

As usual we will be expected to deliver an efficient quality service with increasing budget constraints and further pressure on operating capacity next year however I am sure we will rise to the challenge.

Dr Grays Hospital - Elgin

George Duthie

Well, it's been another eventful year at Dr. Gray's, Elgin. After months and months of meetings, numerous emails, letters etc management finally removed our local switchboard. This was despite unanimous opposition from medical staff. Apparently "local knowledge is not important". We also saw a reduction in our surgical bed numbers due to infection control issues amongst others.

On a brighter note, our preassessment unit is now almost in full swing with even some of the sceptics starting to enjoy sessions in the clinic!

We are also starting on the road to using the enhanced recovery programme in general and orthopaedic surgery with visits to the Golden Jubilee Hospital etc.

With a complement of nine consultants but with no supporting junior staff, staff changes are higher than normal. Dr Philippa Armstrong, who has an interest in Chronic Pain is leaving after a short stay to take up a post in York. We wish her well. Dr Judith Kendell has replaced Dr Doug McKendrick as departmental head.

Finally, time marches on and some of us are starting to look at retirement issues that are looming in the not too distant future!

Forth Valley

Judith Wilson

Well another year has passed, and this one has been very eventful for Forth Valley....In fact you could say it has been our major life event, and we all know how stressful they can be!! The final phase of the move into the new Forth Valley Royal Hospital (FVRH) occurred with all acute services moving from Stirling Royal Infirmary into the new building at Larbert during the month of July.

Now that all services are together we have more opportunities now to meet together, especially as a department. Unfortunately the Chronic Pain Team continue to have their own separate department at Falkirk Community Hospital, however we still see each other on a much more regular basis than before.

Since my last report we have had two new additions to the department. We welcome Dr Michael Money Penny as a new consultant appointment (now, no 007 jokes please! I think Michael has heard them all before). He has a special interest in orthopaedic anaesthesia. We also welcome Dr Azfer Usmani, who has

joined us from London. His special interest is Chronic Pain and he has replaced our most recent retrieval Dr Robin McKinlay, who retired at the beginning of the year.

We all look forward to working with our new colleagues for many years to come.

It is with regret that one of our staff grades, Dr Ankie Moesker died suddenly earlier this year. She was an integral and hardworking member of the department and will be sadly missed by all who knew her.

Two of the consultants in our department have taken on important national roles. Dr Andy Longmate has become vice chairman of SASM and Dr Crawford Reid has become only the 3rd domiciled Scot to become president of the Royal Society of Medicine's section of Anaesthesia.

Now Forth Valley is known for many things, but did you know that one of our department is in the Guinness Book of World Records? Dr Ewan Jack ran the Edinburgh marathon in 2hr 53min and 11 secs and beat the record for the "fastest marathon dressed as a doctor." He beat the previous record holder by over an hour, which was held by an orthopaedic surgeon. Well Done Ewan!!!!

Fife

Gordon Smith

Phase 3 of the Victoria Hospital is now at last ready for business receiving its first patients on 19th December 2011. From the anaesthetic perspective the key dates are the move of obstetric/paediatric services from Forth Park on 9th January 2012 and the move of all acute services from Queen Margaret Hospital on 16th January. From the following week this hospital will become a Diagnostic and Treatment Centre with around 40 day surgical lists a week.

Our new facility is of high quality and a huge improvement on our present facilities. The closure of our isolated

obstetric unit and the centralisation of Intensive Care services in Fife are the top two benefits. It has been a long time coming (it was being talked about when I came to Fife in 1980), but I am certain it will improve patient care in Fife.

The above changes mean our anaesthetic rotas, both senior and junior, will change. We will have 3 trainees on call, CEPOD, obstetrics and ICU and eventually probably only three consultants on call, a first on call for CEPOD/obstetrics with a second on call back up and an ICU consultant. We are hopeful, that at least in the short term, trainee numbers will hold up to allow us to do this though it remains to be seen what happens in August 2012. We have also been utilising our four Physician Assistants-Anaesthesia one day a week in two adjoining Day Case theatres with one consultant overseeing. This two to one working has been a great success and saved us a couple of consultant sessions.

There have been a few changes in staffing this year. Fiona Barron who joined us last year from Edinburgh has decided to move to Australia for family reasons. I would like to thank her for the tremendous contribution she has made to Fife in her short stay particularly in the obstetric arena. Three new permanent consultant posts were created earlier this year to try and prevent our agency locum spend. Simon Bolton who had worked with us for 12 months as a locum secured a permanent job at the second time of trying. He was joined by Ben Slater from Manchester who has joint accreditation in ICU and anaesthetics and Malcolm Broom who will join us from the Glasgow rotation in February 2012. His Higher Obstetric training will prove useful in replacing Fiona especially as financial constraints have prevented us filling her vacant post. There remain a lot of individuals with CCT and very few jobs and though the Scottish Government has said that the NHS in Scotland has been protected from the financial woes, I don't

believe many of us at the coal face would agree.

Our new management structure of three Clinical Directorates has bedded in and the move from Clinical Director to Clinical Lead in Anaesthetics has not changed the amount of work that requires to be done. As I demit this post in April 2012 I can look back at all the management restructuring which has taken place during my consultant career and wonder why our patients experience has remained the same. Finally, as is my custom, I would like to give a big thank you to all my colleagues who make coming to work a pleasure (well most of the time!)

Glasgow Western & Gartnavel

Colin Runcie

Another quiet year in the Western and Gartnavel. There have been numerous personnel changes. No more consultants have retired but we have just advertised a new job to increase orthopaedic capacity. Many of our trainees have taken up consultant jobs elsewhere - Linzi Millar has taken up a post in Wishaw, Judy Todd in Ayrshire and Jane Duffy in Hairmyres. Another talented group have been appointed as consultants and submitted their notice. James Limb will soon work in Darlington, Malcolm Broom in NHS Fife, Michael Brett in the Victoria Infirmary and Alastair Meikle in Crosshouse. We wish them well in their consultant careers.

Regular readers of the Annals may remember my anxiety some years ago when the formation of the North Glasgow Trust threatened the department's autonomy. Nothing really came of that but we are now caught up in more significant changes. The new South Glasgow Hospital (or NSGH) is springing up with remarkable speed, covering an area larger than some small countries. When it opens, the Western Infirmary will close. Gartnavel is lined up to undertake

whatever surgery cannot be squeezed into GRI and the NSGH – a known unknown as Donald Rumsfeld would say. The NSGH anaesthetic department will include consultants from the Western and Victoria Infirmarys and the Southern and Gartnavel General Hospitals. Including trainees, total numbers will be in the tens of thousands. There have been tentative attempts to begin to plan the structure of the new department and hopefully they will bear fruit. The need for early, cohesive action is highlighted for some by experience of the brutal, reputation-shredding dysfunctionality which attended the early months of the new department in the West of Scotland Heart and Lung Centre.

In the meantime, West sector workload increases without pause. We currently run 4 orthopaedic theatres each day and will soon be running 5. All Glasgow and Clyde vascular emergencies now come to WIG and there are plans to expand our catchment area for vascular emergencies to include most of Western Europe. Our teaching capacity was likewise stretched by the arrival of 9 new starts in August 2011. As before, the arrival of enthusiastic, competent young persons lifted the mood of the department. With so many, the effect was even greater than usual.

Thus we begin 2012 in good heart. Our 7 new(ish) consultants and 9 new trainees have begun the process of renewal once more. Our more senior consultants – including 2 CD's, a lead clinician and rota consultant, the WoS TPD and Head of School, 4 College Tutors and 2 FRCA examiners – continue to display a remarkable combination of vigour, leadership and cheerfulness. Margaret, Kirsten and our anaesthetic and recovery nurses and PAA's provide essential support. We remain cohesive, positive, enthusiastic and mutually supportive.

Hairmyres Hospital

Andrew Mitchell

Another year has passed at Hairmyres hospital and working life here has seen extremes - just like the weather in 2011. Congratulations to all the staff who managed to get "up the hill" in the arctic conditions of December - many even opting to stay overnight rather than risking a return to the cosy warmth of their homes! The employment of Laura and Donna as Critical Care Practitioners heralded the sun-less summer and the wind swept autumn – who would have realised what was happening outside as the ITU calmly ticked over regardless. No doubt it was all these challenging conditions that helped to entice Dr Jane Duffy and Dr Suzie Farrell to become our latest consultant recruits. All this tumultuous weather has, not yet, convinced Dr Weetch to relinquish his post retirement sessions and, indeed, it has resulted in the welcome return of two of our consultant colleagues from long term sick. Dr Shona McConnell will be back in the New Year following the birth of Baby Talia. This brings me to the inevitable forecast for 2012! – It will be a much steadier state of affairs with a full compliment of consultant staff (the first for many years.) This does not include the Trainees, who unlike consultants, are forecast to become rarer as the year progresses. A big thank you to all the trainees we have had as they have been an enormous help. I hope they enjoyed their training and stay with us.

NHSL has had a management overhaul in 2011 and as a result I have dipped my toe into management as Deputy CD for Anaesthesia, ITU, Theatres and Surgery for Hairmyres hospital. There has been a "cabinet reshuffle" within the department which sets us up nicely for our venture into 2012.

The hospital may look like a war zone, with large numbers of one legged patients smoking at a safe distance from the entrances. However, this is a result of the centralisation of the Lanarkshire Vascular Service and the increasing amount of trauma performed. Where

once thoracic patients helped fill our ITU it is now vascular patients. Once the ITU is full it is increasingly difficult to find ward beds – I'm sure a common problem everywhere!

The winds are settling, the snow melting and the sun almost visible – well, we can but hope for better in 2012

Institute for Neurological Sciences

Linda Stewart

Another busy year at the Institute. Following an external review of Paediatric Neurosurgery, the Health Board is supporting a transfer of services from the INS to Yorkhill hospital. This has been a huge undertaking for all staff involved. Craniofacial surgery successfully transferred in July, and remaining cases are expected to follow in spring of 2012. Difficult Airway teaching continues apace, with ongoing Gaslab courses. Dr Valerie Cunningham took over the helm of the Glasgow RCoA Airway Course, and delivered a very successful meeting in October.

In ITU we have upgraded all our monitoring systems and are very excited at securing funding to introduce Carevue into the unit. The hardware is all on-site and we are busy configuring the system with the intention to "go-live" early next year. We have completed a pilot study with our medical physics colleagues measuring brain impedance in an attempt to measure ICP non-invasively and are about to start a patient study, with the device, in traumatic brain injury. We have continued to contribute detailed data to RAIN, the ICNARC run audit of outcome in head injury and have also been contributing to the AVERT-IT project that is developing a neural network to predict secondary insults before they happen.

In staffing, Dr Kevin Fitzpatrick joined the team of 15 consultants in August, filling the vacancy followed by the retirement of Dr Janet Pollock in December 2010. Dr

Simon Young has undertaken a 3-month sabbatical in paediatric anaesthesia at Alder Hey and has rejoined us as one of 2 named consultants with a paediatric interest.

Inverclyde

Lance De Boil

A year of some staff changes, Eashika Knox has returned from maternity leave, congratulations, and Everard Lee has recently joined, bringing to four our complement of Specialty Doctors, with Ben Lartey and Clara Jacks.

This helps to strengthen our middle grade cover, the all important out of hours cover which used to be done by trainees, ah the old days. As we all now know, the trainees learn from daytime work, doing as many cases as possible, night cover is wasted time...its true, I've been told it many times.

The Consultant body ages gracefully, some more than others it is true. Lew-Chin Chee and Fiona Munro both seem immune to the mid life crisis evident in the lycra clad cyclists, Manfred Staber, Grant Tong (no injuries this year though) and Duncan Thomson. Artur Pryn prefers rubber, scuba is the excuse. Bob Campbell models ski suits and a golf swing, not one piece at least and John Myles, his boiler suit covered in oil from the continual land rover deconstruction. Martin Schwab has at last given in and joined the property ladder amongst the Kilmacomites, and may join the peloton to work although he has yet to be seen at the golf course.

For the future:

Overall things roll on, talk of strikes are heard amongst the Nursing staff. At least the BMA today are campaigning on our behalf, however proposing banning

smoking in cars may not be uppermost in the minds of members.

A few wistful eyes are rolled towards those entering retirement. At a reasonable age. At a reasonable return. At a reasonable contribution rate.

Ah well. At least we still have a wonder drug for septic shock...oh we don't. Looking forward to 2012, the year where we all get to experience the Olympics, but only on TV, thanks Lord Coe, roll on 2014 in Glasgow!

National Waiting Times Centre

Isma Quasim

Nestled against the banks of the Clyde, with a magnificent view of the Erskine Bridge in one direction and the Clydebank Titan crane in the other, is the Golden Jubilee National Hospital. A jewel in the Scottish Government's crown, this national waiting list hospital also houses the adult heart failure unit, adult congenital heart disease unit and the pulmonary vascular unit.

Due to a parliamentary directive stating that every adult has to have at least 2 lower limb joints replaced (regardless of need) annually, the orthopaedic department is now working at a rate that would make Ronald McDonald's eyes water. It's no wonder that locally the hospital is called "The Golden Nugget" and it's especially ironic seeing as it seems to be quicker at sticking in a hip than it is for a spotty youth putting 6 pieces of battered chicken in a box.

The length of stay of the orthopaedic patients is now the shortest in the country which is due to the magnificent efforts of all involved in the perioperative care including anaesthetists, Acute Pain Nurses and physiotherapists.

Other surgical work trickles in dependent on other Health Boards' waiting lists such as general surgery, plastic surgery, spinal

surgery and the occasional "chunky" bariatric patient

The cardiothoracic work continues to be challenging and ever changing. Valve replacement work has started to overtake coronary artery bypass grafting as being the most common operation performed due to the sterling work carried out by the interventional cardiologists. With stealth and cunning that a ninja would envy, coronary stents are inserted with abandon into teeny-weeny vessels. We are thankful that they have retained their humility!

However it does mean that the cardiac surgeons are now left with thin pickings – redo cases, multiple grafts, and older, sicker patients!!! The sight of a "CABG x 1" on a weekly theatre list is rarer than a panda in Scotland.

The Thoracic unit at GJNH is now one of the biggest in Europe and last year Dr Mark Steven along with his thoracic anaesthetic colleagues launched the Glasgow "One Lung Course"; the course has been designed for applicants to learn or refresh the skills required for successful single lung ventilation and has had very positive feedback. Further courses have been planned for 2012 and demand has been high.

Mechanical Circulatory Support is now the "next big thing" in heart failure; over the past year we seem to be tripping over patients with balloon pumps and the words "VAD" and "ECMO" are said in the same hushed tones as "he who must not be named"!!

The work is long and bizarrely seems to be mostly nocturnal – we have long lost our fresh-faced looks and our new job plans are offering SPA sessions that really are spa sessions. Botox is also on the cards – hopefully at a reduced rate.

As usual we have been very fortunate with the anaesthetic juniors that rotate through the hospital; their technical abilities and enthusiasm to learn continue to impress us.

Our Cardiothoracic fellow Andrew Sinclair has been a stalwart member of the department and has been involved in all aspects including audit, research and teaching as well as theatre work. He has been successful in his ECHO exam and we will be sad to see him leave at the end of January.

Perth Royal infirmary

Michael Forster

Perth Royal Infirmary reports all well. Good news includes the births of Matilda, Jo Doughty's second, and Ka, May Mok's third. Maternity leave has been one of the reasons for a heavy use of locums this year, with all the challenges this entails. We have welcomed Dora Paal as a substantive Specialty Doctor and Dave Peat as a longish term locum, both great to work with.

Arthur Ratcliff stopped being Rotameister after more than three tireless years "at the desk." Cliff Barthram took his turn and lasted about three weeks, before giving it up before he really got started. Alas, I now do the rota. Duncan Forbes continues as Clinical Leader, and Ewan Ritchie has stepped back into the College Tutor shoes until May Mok returns from maternity leave.

The department was reminded that the standard NHS irritations are not really so important, when a pregnant May Mok landed in Tokyo just as the earthquake struck. She spent several frightening days in a swaying hotel room while the nuclear crisis developed, before spending a fortune on a flight out. And Mike Bell arrived in Oslo on the afternoon of its bombing and massacre. They are both safe and well.

The trainees continue to be a hard working and fun bunch, in spite of the pressures they face. With the full time male becoming a rare species, reasons for leaving work have changed accordingly. My favourite this year was "I have to go home now because our

nanny's getting a fake tan." Have you heard better? As we go to press, Will Elsdon is on the wind down to a well deserved retirement (unless they change the rules before January). Looking younger and fitter than ever, he is just back from another trip to the Himalayas. His cheery, lycra clad and always helpful presence will be remembered fondly, and we all wish him a happy retirement. Our fish remain well, having survived several algae attacks. And we may be about to return to our refurbished department soon, leaving the old labour suite behind. Outside work, our annual Hebridean sailing trip expanded to two yachts this year. Then rapidly shrank to one when we lost a propeller in Loch Hourm- (too much prop-off-fall?). And my personal thanks to Graham Wilson, an Aberdonian anaesthetist, for helping scrape me and my pal off the road when I crashed during the Bealach-Na-Ba cycle event in September- pride in pieces, important bits intact. Best wishes from all in Perth, for a good 2012.

Royal Alexandra Hospital, Paisley

Hilary Aitken

You know the scene towards the end of "Lord of the Rings" where the hobbits are slowly, painstakingly making their way up Mount Doom, hoping against hope that the eye of the great power Sauron will be turned elsewhere, and they will escape notice? That's what it feels like working in Paisley at times. We are the plucky wee hobbits, and the evil eye is... well, that's enough of this analogy.

We are of course, all part of Greater Glasgow and Clyde now, and the horizontal management structure can lead to interesting challenges. For those who like esoteric contractual issues, there are a number of locally agreed variances to the consultant contract that former Argyll and Clyde Consultants have and others don't. These are protected by statute, and it doesn't half confuse our pan-Glasgow management structure. On

a less esoteric level, it means on a really snowy day (we've had a few the last couple of years) there is nobody on our site who feels sufficiently empowered to make a judgement call about cancelling elective admissions, and when you run out of green needles or theatre hats, it's impossible to trace what the problem is. So we soldier on like the hobbits, just trying to do the best we can!

Possibly not entirely unrelated to the above, we've had a spate of retirements this year. Jim Canning had been off with ill health since last year, and unfortunately it was felt that early retirement on medical grounds was appropriate. Anaesthetists all over Scotland (and beyond) seem to know Jim and I'm sure will join us in wishing him well. Here in Paisley we miss the banter and were exploring whether a one or two PA contract for him to come and sit in the anaesthetic office and entertain us would be possible, but it seems not... we have a new batch of trainees now who have never met Jim, and are missing out on an important part of their Paisley anaesthetic experience.

Tom Ireland reached the magic six-oh, and was last heard of training a new puppy. Jackie Orr, my predecessor as your Paisley correspondent, is not nearly as old, but decided to go anyway. Adrian Tully also took early retirement. Adrian was our last remaining Vale of Leven consultant colleague, so that closes another chapter - all anaesthetic services at the Vale are now provided by Paisley anaesthetists. Consultants still feel a great loyalty to their hospital, and I think the positive way in which Adrian and his colleagues responded to being swallowed up by the "big" hospital in Paisley has not always received the credit it deserved. Needless to say, on the rare occasions one of our recently retired colleagues pops in they look ten years younger than the rest of us still at the coalface!

The good news is that most of these posts have been replaced, so we have some new young blood. Ahmed Almaki was poached from Lanarkshire, and since he still lives there is really pleased the new M74 extension has opened! We have also appointed Jenny Edwards, who did some of her training with us, and Roy Williamson. Roy is a West of Scotland boy who went off to Liverpool for a training number before the onset of MTAS (good move) but has now returned so his children can have their Scouse accent beaten out of them before it's too late (his words, not mine). Our most recent appointment is Michael Brett, who will take up his post in the New Year. He was a baby SHO with us seemingly only ten minutes ago - I'm definitely getting old!

We've had an anaesthetic wedding this year - Angela Jenkins and Craig Urquhart first clapped eyes on each other at Paisley so although they're both currently working elsewhere, we claim the credit and we wish them much happiness for the future.

We also have our own Professor now - Kevin Rooney was appointed Professor of Care Improvement at The University of the West of Scotland, and has recently moved to a suitably professorial mansion, about three doors away from his non-professorial house.

For those of you who haven't seen John Dickson lately, he's half the man he used to be. He has lost an incredible amount of weight, amounting to more than the weight of Pauline O'Neil, our most sylph-like consultant. Since we have technically lost a consultant equivalent, we will be applying to have a replacement, and await HR's response. John has become a gym bunny, and claims he is frequently at the David Lloyd at 6am when the doors open. Since none of the rest of us are there at that time, we can only take his word for it.

St John's, Livingston

Duncan Henderson

Our new Day Surgery Centre has been fully operational since January. It's running fairly smoothly and throughput is increasing. Arnie Arnstein is doing a fine job of keeping things on track. We are delighted to welcome Richard Burnett and Audrey Jeffrey to new Consultant posts. Bridget Podmore is doing an excellent job as a locum Consultant. Devesh Ramsahok has just joined us as a Specialty Doctor. Chris Hoy and Rahul Sirdar have left Specialty Doctor posts with us to go to ST training posts. We wish them well.

Simon Edgar has been appointed Director of Medical Education for NHS Lothian. Mike Fried is President of the Scottish Intensive Society. Ken Stewart has been elected to the Scottish Board of the RCoA. Karen Watson and Rachel Harvey (ST 5) are leading the coordination of airway training and ACID training, assisted by the arrival of our new Sim Man mannequin.

Sam Moultrie undertook her 2nd Caledonian Challenge this year for charity. She's not going to do it again (that's what she said last year). Shona Neal has represented Great Britain in the European Team Gym Championships in Sweden. Having earned her GB tracksuit, she is now "resting" from training. Annual injury list - Richard Burnett – toe (kitesurfing, Barra) and Duncan Henderson – ribs (mountain biking, Fort William).

Stracathro

Charlie Allison

The hospital continues to thrive, with an expanding repertoire of risk-assessed procedures (joint replacements, lumbar discs, lap nephrectomy, hiatus hernia repair & prostatectomy - some day hospital eh?) They are all day-of-surgery-admission - how topical is that! - and lengths of stay are consistently less

than bigger institutions, attributed to good collaborative care, particularly nursing & physiotherapy. A 50 bed psychiatric facility opened in November - no more all-weather drives over the hill to Sunnyside, but we do anticipate our ECT sessions expanding. Our anaesthetic team is a happy legion of regulars from Dundee who back up Jan Beveridge & myself and our two overseas colleagues Michael Bohm & Wojciech Borowski.

I am departing in July with Stracathro near the top of her game - changed days from the doom & gloom of 10 years ago - a miraculous reinvention, with Tayside management backing the trust of the loyal Angus public.

Western General Hospital

Susan Midgley

It has been a fairly quiet year at the Western General Hospital. There has been another change in management structure in Lothian and Talat Aziz is now our clinical director. Halia O'Shea went off to Australia for a year and has decided not to return. Claire Baldie continues in the locum post.

In ICU Charles Wallis has been replaced by Stuart McLellan as clinical lead. Pete Andrews is grant holder for the Eurotherm trial investigating the effects of therapeutic hypothermia in brain injury. Ross Paterson leads the Critical Care Quality Improvement Team and is working hard on the Scottish Patient Safety Programme.

The re-provision of neuroscience services on the Royal Infirmary site is now back on. It will be a joint build with the Sick Children's Hospital and will incorporate a joint theatre suite. It will be funded through the non-profit distributing model, the new name for PFI. Completion date autumn 2016. Meantime, the neuro theatre is to have a face lift in order that it is up to scratch for any health environment inspections. This will require the theatres to decant into

temporary accommodation for a short period.

In the main department the colorectal surgeons and urologists are keeping us as busy as ever. There are increasing numbers of laparoscopic hemicolectomies and laparoscopic prostatectomies being performed. Team 65, an initiative set up by Irwin Foo together with medicine for the elderly, has seen the length of stay for colorectal patients reduced by up to 2 days.

Within the department, our secretary Lynda Lord, keeps us all on the straight and narrow. She keeps us entertained by holding a weekly caption competition.

Raigmore

Ross Clarke

The two main subjects of discussion in our department this year have been babes and bikes. Sandy Hunter started the ball rolling with the birth of Sarah last Christmas. Morven and Ross Jaffrey (some you will know her as Morven Wilson) produced a bouncing baby boy called Samuel in July and has been enjoying her maternity leave ever since. The department isn't the same without her around (not just the lack of home baking.) Dan Baraclough and Kristina High went one better and had twins, Olly and Freya. This development led to such an increase in our departmental caffeine use that the machine broke and had to be replaced with an industrial model. Charu Agrawal is about to head off on maternity leave and we wish her well and look forward to hearing her happy news in due course.

While all this has been going on the rest of the department has been experiencing perineal trauma of a different kind. Brand new saddles have been leaving their imprint as new bikes pop up all over the department. Clothes have been looking more spacious than before and the talk in the offices is of carbon, titanium, gear ratios and the like. The sight of all these MAMILs (Middle Aged Men In Lycra)

striding into work in the morning has certainly not helped the feelings of nausea amongst our pregnant colleagues but one or two herniae have been incidentally detected and dealt with so it is not all bad.

There have been a few changes to the composition of the department. I am sorry to report that Deepak Mathur has jetted off to Singapore to make his fortune, his cheery (cheeky) grin is missed. We look forward to welcoming two new (to us) Consultants in the New Year, Dr Emma White (trained in Aberdeen) and Dr Mike Duffy (joining us from Plymouth). This year we have been delighted to be joined by Dr Hamish Hay who has been with us as a Locum Consultant covering Morven's maternity leave. His wealth of experience in war zones has served him well in our monthly departmental meetings. As always our thanks go to Morag Ritchie, our Secretary, without whom our department would fall apart at the seams.

Royal Infirmary of Edinburgh

Ian Armstrong

Whilst musing over this article, wishing to change channel from the rather tedious inside of a shoulder joint, I was visited by the ghost of Christmas past in the form of a drip stand. There, neatly inscribed on its base, were the words 'E.I.M.H. Labour Ward'. For readers for whom the significance of this may not be immediately apparent, E.I.M.H. stands for Elsie Inglis Memorial Hospital, which included a small and very pleasant maternity unit at the rear of Holyrood Palace and closed over 20 years ago! Yet here it was, still standing, in one of the trauma theatres in the new Royal Infirmary of Edinburgh – a tribute to long service to the NHS. In a similar tribute but I am sure with longer service, we said goodbye to David Brown who retired this year. David has most recently been a steadying hand as Clinical Director for Anaesthesia in Lothian, shielding us from some of the excesses brought on by a

well intentioned management structure some of us believe must live in a parallel universe. He was an enthusiast but also a realist and excellent teacher who is a good friend to many. His cheery demeanour stalking the theatre corridor will be sorely missed. That said, his golf is being severely curtailed, like some of our surgical colleagues who have also retired, by regular requests from the hospital to undertake additional work! If and when he is allowed to retire, we wish him well.

Brian Cook has taken over the position of 'clinical director', but in one of these moves designed to give the impression of change and innovation, has been given the title of Associate Director of Medical Services for Anaesthesia, Critical Care and Pain Medicine. A new door for his office is currently on order. Meanwhile David Watson continues as administrative head but now has the title of Clinical Director for Anaesthesia with twice as much work and no resource, and Mike Gillies takes over a similar role in Critical Care. They all have our unswerving support, as many mutter 'phew!'. Alastair Thomson, however, takes on the important task of signing off leave requests and Kate continues to hold the whole place together and make it work.

Entering this fray most recently we are delighted to congratulate and welcome Kate Theodosiou, Karen Darrough, Laura Fitton and Gary Morrison to consultant appointments within the department. Both Kate and Karen have taken on a significant role in obstetric anaesthesia, whereas both Laura and Gary have that rare interest, anaesthesia. Laura has already made her mark, politely telling us where we went wrong and what needs to happen, organising the M&M meetings.

Our trainees remain as enthusiastic as ever, increasingly giving you that look which implies 'just get out and let me get on with this'. It is with some regret however that my own personal review

revealed that I only worked with 1:10 of our trainees for a maximum of 3 lists over the last year. This may reflect my own attributes! Both they and their supervisors are to be congratulated on the recent extremely high success rate in final FRCA. Colin Young continues at their helm as Regional Advisor, ably assisted by David Semple, John Wilson and Ishrat DeBeaux in the Royal Infirmary.

Car parking is one of these issues which is almost guaranteed to unite medical staff within a hospital, and it came to the fore again this year as two car parks were temporarily closed to allow the surveyors in. This rather worrying development signifies that the move of the Sick Children's Hospital to the Royal Infirmary site might actually go ahead, despite the bankers. Dress code has emerged as another unlikely unifying force amongst medical staff, with the Medical Staff Committee giving infection control a rather serious and public dressing down this year. The resultant reinstatement of ties and long sleeved shirts in some situations has boosted morale no end. I suspect this has more to do with striking a blow for the proletariat than shirts and ties. Anyway, who would have thought it! In another new development we have seen the return of the 'portacabin' with the opening of a new midwife led birthing unit outside the maternity end of the hospital. Some more historically minded readers may recall the old Queen Mary's Hospital in Chalmers Street as the front end of the Simpson's on the old Infirmary site fulfilling a similar role in the early 50's ! A commemorative name of some sort may have been in order but Elsie Inglis was a doctor and so we have arrived at the imaginative Lothian Birthing Unit. For obvious reasons members of the department have been unable to report on the insides of the unit but some have been overheard to mention words like flying squad. What goes around comes around!

Infection control would probably have a tonic clonic seizure if they saw my drip stand, but I've grown rather fond of it. It has come to represent a certain stability in the order of things and all being well, will continue to hold up the Hartmanns for many years. Meanwhile I wait to have my skin surveyed under new HSE rules by specially trained theatre personnel and will let you know the outcome, if only Jeff would get a move on.

RHSC Edinburgh

Alistair Baxter

With the issue of funding for our new hospital still unclear, we have had a year of comings and going here at the Sick Kids.

Firstly the goings.

After over 20 years of dedicated service to the children of Edinburgh, Dr Louise Aldridge has finally walked off into the sunset and a well earned rest in her Cypriote villa (although with a few trips on the Mercy Ships, planned it will not be a particularly quiet time). Louise has been a pillar in the field of paediatric anaesthesia, not only in Edinburgh, but nationally through her vast knowledge, kindly nature, extensive publications and support for the APA. She did whatever it took to help support the RHSCe, whilst bringing up her own 4 children, and will be missed by us all (most especially for the cakes and tray-bakes in the coffee room). We wish her and Roger all the best for the future.

We have also benefited over the last 12 months from a couple of locum consultants who are sadly leaving us. Dr Corina Lee (most recently from Tayside) is heading to Great Ormond Street, to further her career, and Dr Emma Whyte (Aberdeen via Vancouver) has been appointed as a consultant in Inverness. It has been a pleasure working with both these talented anaesthetists and we again wish them well for the future.

What of the comings, well apart from the afore mentioned locums, we have

recently appointed Dr Karen McGrath as a substantive consultant after 2 years in our department as a Locum Consultant. Now she can get on with planning her wedding.

The department continues to thrive, now under the directorship of Dr Mary Rose, who took up the reigns from Dr Dave Simpson (who it is rumoured is thinking of hanging up his stethoscope soon) and Eddie Doyle, who has moved up the management line. Good luck Mary.

So are we moving to the New Royal or not? With the Scottish Government allocating funding to the new Forth Crossing and the relocation of Yorkhill, we have been left sourcing other avenues for the funds, possible in a combined move with the DCN from the Western. Plans have been drawn, and decisions are being made, perhaps by this time next year we may be a little clearer where we will all be working, and when!

RHSC Yorkhill

Ross Fairgrieve

Salutations from the world of Yorkhill. We are coming to the end of a year which has seen some significant changes.

As ever first on the agenda is our move to the Southern General campus on the south side of the River Clyde. Things have been strangely quiet with regard to progress on the planning front which no doubt means the die has been cast. The latter half of the year saw the release of some fantastic computer generated images of the new build. These were primarily of the public concourse. They did indeed look splendid and the sense of space and atmosphere was fabulously impressive. Of course this is completely juxtaposed to the reality of the rest of the hospital where doctors and nurses will work and children (and now also young adults) will be looked after. Fewer beds, fewer staff facilities, insufficient theatre space, lack of offices and car parking are

real concerns. Oh and where is the coffee bar? Is this a sneaky ploy to force Dr Best into early retirement?! This really should be a time for unbridled optimism but I have yet to meet a clinician who feels this way about our new hospital.

On a more positive note we have seen considerable progress on the paediatric craniofacial and neurosurgery front. Following the result of our peer review process last year, craniofacial services moved to Yorkhill in June and we are expecting the formal transfer of paediatric neurosurgery to occur by early March 2012. Hooray!

There has been much angst of late in our theatre suite in anticipation of our Health Environment Inspectorate visit. Now that it is over the nursing staff are to be applauded for their huge efforts. They really did bend over backwards to make the suite shine. And forwards for the floors, and sideways and under the cooker and behind the fridge and in the oven too! I can't help feeling that this perhaps was above and beyond the call of duty and beyond nursing remit but I guess the management should also get a pat on the back for not having to pay cleaners to do this!

The anaesthetic department has seen some significant departures this year. Firstly we said a very fond farewell to Jane Peutrell who has retired to the good life in Yorkshire, and then to Dave Hallworth also, who has retired to indulge his passion for big diggers and tractors and mud, oil and spanners. The department wishes them both long and happy retirements. John Currie has also taken the first steps in the same direction albeit in a staged fashion to oversee the transfer of the paediatric chronic pain service. From the surgical side the department would like to wish our colleague Jim Pollock best wishes for his retirement from paediatric cardiac surgery. A farewell also goes to Amir Azmy who died in March of this year after

a short illness. He is sadly missed by all who worked with him at Yorkhill.

The department also says farewell to Jonathan Richards from Stirling Royal Infirmary who was with us for a year and wishes Ewan Jack a warm welcome as his replacement and also hearty congratulations on becoming the world's fastest stethoscope wielding marathon runner! As many of you will know Ewan has secured himself a place in the record books for the fastest marathon run dressed as a doctor.

Finally the department wishes Rob Ghent warm congratulations on his recent marriage to the very lovely Shobi.

Shetland

Catriona Barr

2011 in Shetland started with snow and the weather at this end of the year continues to look challenging. Anaesthetic activity in the department continues much as usual with Jacek, Brodyn and Catriona being joined by Anne Wake (remote and rural fellow) for a couple of months from October. The novelty of having a (very experienced) junior in the department is a welcome and refreshing change, and we hope very much that she finds her time with us valuable.

As always events in the surgical department in Shetland impact greatly on our working lives and we are once again looking at interviews for a third surgical consultant in November.

Just a few new anaesthetic arrivals to mention: Blake and Jenny, Jacek's new canine colleagues and a new portable ultrasound machine which promises us consistent visualisation of the needle tip. What could be better?

Southern General, Glasgow

Kenny Pollock

The Southern has turned into a massive building site over the past few months. After what seemed an eternity of foundation works concrete has emerged from the ground into the skyline. We've now got a new Lab building for Glasgow hospitals, due to open in months, and a new car park – so that our traffic wardens can harass us in comfort. The main hospital is at full height and there are more cranes on site than at a Miami Vice intro. Sadly at the start of the year the pipes fell apart at the recently refurbished Gynaecology building, and our Gyn services have decanted to the Royal for 6 weeks, or was it 13 months? – I get confused. Our HDU is busier than ever, and more difficult to get into than the Olympic Opening ceremony.

This year has also seen the deregulation of anaesthetic services across Glasgow, thanks to those management bright sparks. If you have a car- you can give an anaesthetic! New and old faces from all over the city come and go around all hospital sites in Glasgow on a daily basis, according to who has phoned in sick that day or had a busy night. "If it's Tuesday – this must be Paisley" is a familiar cry. It's great to see those cheery faces that haven't seen our department, or it's anaesthetic machines, for such a long time. GGC is to buy an anaesthetic gangmaster truck and whistle – if the truck stops outside your door at 0730 and you hear the whistle – there's work for you today!

The reins of power have been handed over by Regina O'Connor to Neil Smart. Regina has definitely had a spring in her step ever since. Neil looks troubled. Our Maternity building is busier than ever (and predictably, than planned) – now touching the high 5 thousands. Those of us on the general rota offer smug empathy.

Our world of work – like most others' – is determined by waiting time targets, bloody infection control (I can't even go down the corridor for a coffee), start/stop

times, squeeze an extra case on, new sessions, extra (unpaid) lists, pressure on SPAs, and no more disco. The heating in our department is broken, the telly is knackered, our Christmas lights have blown a fuse, and the coffee room carpet stinks. But we remain upbeat.

We've now got quite a cosmopolitan feel to our department with Elia del Rosario, from Spain, Victor Trebugov, from Russia (via St Mary's), and Kevin Fitzpatrick, from Lanarkshire, all joining us. Claire Barker will return soon, after baby number 2, and Theresa McGrattan and Angela Baker will be joining us early next year. After a troubled year of trainee vacancies, we (nearly) got back to an even keel in August, but the decline has started in earnest again, thanks to Consultant posts here and abroad.

Sadly Pete Mackenzie passed away in July, aged 47. Pete's great sense of humour sustained him, and us, at his retirement night, just weeks before this death. He'll be greatly missed.

Victoria Infirmary, Glasgow

Neil Smart

Once again, the Victoria Infirmary is in the vanguard of social and professional change.

Now that the Government tells us that we're all going to live so much longer – 60 is the new 40 apparently – you might as well do something you really enjoy.

So Ronnie Glavin (corrected age 12 $\frac{3}{4}$) has retired from the NHS to pursue other interests in education and simulation. Ronnie is a true Renaissance man, writing book chapters before breakfast, simulating several critical incidents before lunch, and helping everybody – trainees, consultants, and NES – with educational issues in the afternoon. This in addition to travelling the world in his many educational roles.

Likewise, Arthur Dell has left the Victoria to take up an anaesthetic post which is also in Victoria, but this time Australia.

Like Ronnie, Arthur also enjoyed teaching but rather than hi fidelity trainers had a particular, indeed eponymous, style. We are all so jealous!

Welcome to Ajit Panikhar and Andy Mackay who joined us as new consultants, and to Theresa McGrattan, Angela Baker and Kathy McDowall who were recent appointments not yet in post. All being well, you'll be able to read quite a bit more about them until their retirement in 2085 or thereabouts.

A little closer in time is the completion of the 14 floor New South Glasgow Hospital. According to the website, it has a physical link to the maternity and neurosurgical buildings by means of a pneumatic tube. I think I'll just walk thank you.

In the run up to the merging of departments which will happen at this time, we are seeing consultants following the service and travelling to work with us from faraway places like the Royal Infirmary and Gartnavel General. Not all consultants enjoy covering these lists for absence. When asked what it's like, one of our secretaries said, 'Well, its just like the bingo when they run out of biscuits!'

Meetings

In case you didn't couldn't make it to the meetings the following summaries will show you what you missed.

Trainees Meeting

Crieff Hydro

13th May 2011

This year's meeting was the first one at our new venue of Crieff Hydro! There was a good turnout from trainees from all regions with the incentive of an easier central location and the promise of excellent facilities...

The scientific programme started with an interesting talk by Prof. John Kinsella about recent trends in Intensive Care Medicine. He updated us with the best practice in the speciality and the evidence behind it. He also encouraged us to keep questioning the current practices as this leads to improvement in clinical care. This was followed by the most fascinating talk by Dr Steven Young. He gave us various innovative ideas of designing and publishing interesting clinical studies by taking a simple example of comparing apples and oranges. The audience was left stunned!

This was followed by a coffee break. The delegates got a chance to catch up with their friends and an opportunity to visit interesting trade stands and posters.

Next was debate time. The motion was "This house believes that European working time directive is a blessing in disguise". Proposer was the Dr Michael Murray and Dr Ken James spoke against the motion. The debate generated some hot exchanges. Luckily there were no

knives or guns accessible; therefore there were no casualties. Well, the discussion continued among the delegates as they enjoyed the delicious lunch.

Taking the challenge of the first afternoon slot was Dr Jon McCormack from The Royal Hospital for Sick Children in Edinburgh. He gave us a run down of some of the recent changes in Paediatric Anaesthesia, such as ETT design and use of TIVA and remifentanyl infusions. There was also some important advice on the transfer of critically ill children and where to get up to date information about drugs and doses for emergencies. See www.picuretrieval.co.uk and check out resources! Dr Dermot McKeown from the Royal Infirmary of Edinburgh followed with a talk on Transplant Services – Supply and Demand. There were some sobering statistics but also some useful advice on the management of donors prior to the transplant team's arrival.

There was a last chance to look at the wide variety of posters displayed over coffee before presentation of The James McG Inray Memorial Prize. This went to Dr A Clark as winner of the best poster presentation 'Are we pushing and twisting?'. Runner up prizes went to Dr Euan Black for his poster titled 'Maintenance of medical records' and Dr Dominic Strachan for 'The STOP-BANG screening tool'.

The last session of the day started with the much-awaited talk by Dr Willie Frame. As a medico legal expert he gave us tips on how to avoid being in courts or behind bars. His sense of humour kept the

audience entertained. The intense day ended with a talk from Dr Ellis Simon. He gave us a brief account of the interesting and challenging charitable work done by him and his colleagues on their trips to Nepal.

The energetic people made it up the local hill on the 5 km run before the champagne reception on the President's balcony started the evenings' proceedings.

Thanks to all the speakers, trade sponsors, hotel staff and executive committee members who helped to make this meeting such a great event. We look forward to continuing success at Crieff Hydro in 2012.

Vishal Uppal & Sarah Cross
Trainee reps

Annual Spring Meeting

**Crieff Hydro
14th May 2011**

All traditions have to start somewhere. After many, many years with the annual spring meeting being held in Peebles, this was the first year of what we hope will be many Annual Spring Meetings to be held in Crieff.

The meeting was opened by the outgoing President, Jim Dougal and he had the pleasure of introducing the first Keynote speaker, Professor Irwin Foo of the Royal Infirmary of Edinburgh. His lecture, entitled "The Silver Tsunami", was an exposition on the problems posed by the demographic time bomb that is our ever expanding elderly population. It was plain we are all going to have to think hard about how we can ensure quality services for this group of patients. Current practice in most Scottish hospitals probably does

not serve our elderly population as well as they deserve.

This was followed by the Registrars Prize Presentations, consisting of ten minute presentations of the top five ranked abstract entries. It is routine in reporting these events to eulogise about the quality of the competitors. However, given that the five papers presented were the best from an entry of seventy four, I feel it is more than justifiable to state that the standard was extremely high this year and that any of the five would have been worthy winners. However, there can be only one, and the judges retreated to consider their verdict which was to be announced at the close of play of the afternoon session (see below).

This was followed by the open forum "debate" with John Colvin and Alistair Michie, chairs of the RCoA Advisory Board and AAGBI Scottish Standing Committee respectively. A large number of topics were covered, including the likely future pattern of, especially new, consultant contracts, the recent threat to the Discretionary Points system. The future of consultant appointments continues to be a battleground and both the College and the Association are working to ensure that CCT'd anaesthetists have viable consultant posts to go into. Training generally was of course also a huge topic. A great deal of effort is put in by each generation of anaesthetists to ensure that the next generation have as good a chance to prosper as they did. What an altruistic bunch we are. When I was a trainee, I was blissfully unaware of the all the battles fought and efforts made to ensure I could have a decent career as a consultant. Despite the potential for focussing on the dooier and glooier aspects, this was a positive session. It was reassuring to see we have such capable and committed representation.

The Afternoon session began as always with the installation of the new President. Paul Wilson, once installed proceeded to

deliver his presidential address, a very personal journey through Scottish anaesthesia and rugby. It was wonderfully crafted and delivered, maintaining the extremely high standard of Presidential Addresses. I've seen a considerable number over the years and am always impressed by the enormous amount of thought and effort which is plainly brought to bear. The Presidential Address is reproduced on pages 3-14 (with only a small proportion of the illustrations - print costs!)

President Wilson then got to introduce the penultimate act of the day, the Guest Lecture, delivered this year by Professor Tim Hales of Ninewells Hospital Dundee. Entitled "Mechanisms of Anaesthetics: Lessons Learned from Creatures Great and Small" Professor Hales gave us a fascinating insight into some of the more technical aspects of laboratory research into mechanisms of anaesthesia with particular reference to the use of animal models. The lecture was interspersed with examples from Prof Hales own career with some wonderful and (I thought) gruesome anecdotes from his own career. What is a scientist doing in an abattoir anyway? This was a riveting and beautifully delivered description of a field of research that only a tiny proportion of us ever see. However it was delivered with wit and pitched with skill and perfect precision to its audience.

Finally came the results of the Registrars Prize and the award of the Campbell Quaich. The winner, was Dr Peter O'Brien, for his paper and presentation entitled "Gentamicin dosing in surgical antibiotic prophylaxis: Improving the accuracy of dosing". Not only a well thought out, executed and presented project but the demonstration that a very simple idea, implemented properly, can will bring very real patient benefits. Congratulations again Dr O'Brien.

The AGM and educational meeting part of the day over, the crowd dispersed to regroup, scub up and re-gather in the

evening for the Presidents reception and the Gala Dinner in the Ferntower suite. Crieff Hydro, probably as part of a cunning plan to lure us back again, put on an excellent evening. Prizes were handed out for a wide range of activities. As Editor of the Annals I obviously have the power to omit to mention that Donny MacLeod of Aberdeen got the booby prize for the Golf. But I did.

It was in all an absolutely wonderful evening. And we all I'm sure are looking forward to returning to Crieff Hydro this coming May. Hope to see you there.

B. Stickle

Winter Scientific Meeting

**Seamill, Ayr
17th & 18th November 2011**

The Winter Scientific Meeting was organised by the Crosshouse Department in Kilmarnock and was held in the Seamill Hydro Hotel in West Kilbride. The two day program was extremely varied and given the location of the meeting we had a slightly late start to allow travel from the rest of the land.

The opening session focussed on Enhanced Recovery (ER) and was covered by two speakers. Dr Janie Collie gave an account of the experience in Crosshouse Hospital of introducing an Orthopaedic ER program. One thing that is plain is that the introduction of ER is not straightforward even when you have several departments all agreeing and working together.

Susan Nimmo of Edinburgh Royal Infirmary added some further general insights and looked into some of the problems and practicalities of a colorectal ER program. The two speakers joined

together for a very useful 10 minutes of Q&A to close the session.

The first afternoon session focussed on failing doctors. Unfortunately, Dr Ruth Mayall who was to speak on Doctors and Addiction was ill and could not attend. The other two speakers however stepped up and filled in. Professor Brian Williams, Associate Dean from Glasgow, spoke on "Doctors in Difficulties". Sadly it seems that those who fail early in their career usually continue in the same vein. Retrospectively the warning signs were often there early and it seems likely that the pattern begins in medical school. It was slightly depressing that we seem unable to do anything about these doctors to either help them sooner or get them out of the way of the public faster.

Professor John Kinsella had a less gloomy topic and spoke about the Scottish Anaesthetic Research Network. Research has become more remote and less achievable for the huge majority of clinicians over the past 10 years in particular. It's good to know there is still a great deal of support out there to support research.

The third session of the day following tea was the Gillies lecture. As always safety themed, this years speaker was Dr Malcolm Daniels, a sound Aberdonian lad lured to Glasgow many years ago. Malcolm has long been prominent in the areas of quality improvement and patient safety. He was therefore burdened with quite high expectations for this years lecture. He did not disappoint. The lecture is reproduced below.

On the Thursday evening we enjoyed a very pleasant meal held in the Hotel. Given that the weather could only be described as horrible it was a real boon that the meeting, accommodation and meal were all in the same building! As usual this was a very pleasant and social evening, enhanced by the fact that most of us had a very short journey to our beds.

A good nights sleep and short walk to breakfast produced a bright eyed audience for the first session of day two which focussed on the most recent CEMACE report on maternal mortality. We were given an obstetricians and then an anaesthetists view by Dr Jane Ramsay, a consultant Obstetrician from Ayr Hospital and our own Liz McGrady from GRI. It's the unfit mother that is unsurprisingly, most at risk. Problems were highlighted in the areas of recognition of problems, failure to institute immediate action and call seniors and communication generally. All sadly familiar themes.

The second morning session comprised of a debate. The motion was "This house believes same day admission should be the norm for all elective surgical patients" and Dr Jane Burns (pro) and orthopaedic surgeon Mr Gavin Tait (con) slugged it out in a robust but fair fashion. There wasn't a formal vote and I'm not sure who "won" but the point of these debates is closely examining an issue to provide insight from differing viewpoints and this certainly succeeded.

The final session covered two topics. Firstly, Jane Chestnut provided an update on DNA CPR policies, focusing on the problems of predicting the terminal phase of illness with varying arcs of disease progression. Jane provided an excellent update and overview of a very difficult subject. Finally Dr Catherine Bagot, a consultant haematologist from Glasgow Royal gave an overview of the new, new and newest anticoagulant agents. Clearly the the pharmacologists didn't have regional anaesthesia in mind when developing a generation of drugs which while being excellent anticoagulants, have no antidotes, can't be dialysed and have nice long half-lives! What fun.

All in all, a fantastic meeting. Congratulations again to the organisers.

B Stickle

Gallery

Pictures from the Annual Spring Meeting in Crieff and the Winter Scientific Meeting at Seamill, West Kilbride.

Liz McGrady, Colin Runcie and Kerry Litchfield demonstrate their terrible sadness at no longer forming the executive of the Society.

We all owe them a tremendous amount of gratitude for all their hard work over the last four years.



The top table at the Spring Meeting Gala Dinner do their Last Supper impersonation

Go on. Entertain us then!

The sight greeting speakers at the Spring Meeting. The very definition of a tough crowd. Note the firmly set jaws and closed body posture of a large number of delegates.





The winner of the Campbell Quaich was Dr Peter O'Brien of Ninewells Hospital Dundee, seen here receiving his prize of a (literally) massive cheque from a representative of MP Locums who kindly sponsored the competition.

John Colvin and Alistair Michie field questions at the AAGBI and RCOA Q&A session at the Spring Meeting.



Paul Wilson Presents Malcolm Daniel with his memorial quaich following the delivery of the Gillies Lecture "Crossing the Chasm" at the Winter Scientific Meeting in Seamill, West Kilbride.

Dr Jane Burns and orthopaedic surgeon Mr Gavin Tait join in debate at the Winter Scientific Meeting.



Anaesthesia & Resuscitation on the Western Front

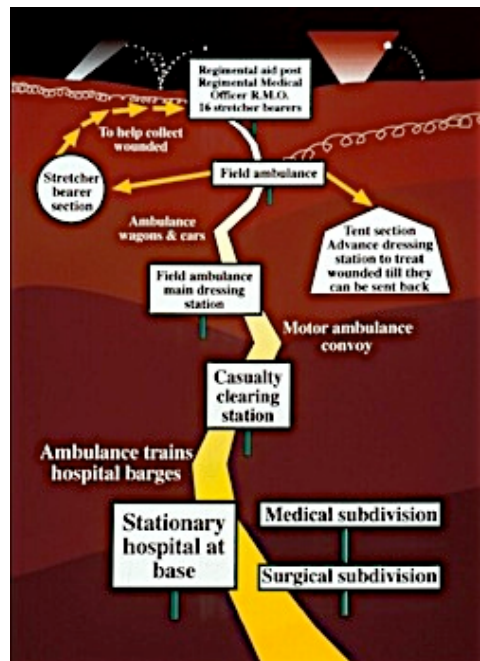
E.A.Robertson

Anne Robertson is a Consultant anaesthetist in Aberdeen She is the President of the North East of Scotland Society of Anaesthetists.

This article formed the basis of a Presidential Address given to the North East of Scotland Society of Anaesthetists on November 10th and a lecture given in Dundee on the 24th February at the Scottish Standing committee Open Meeting.

A full account of the subject is to be found in Ann's chapter on Anaesthesia, Resuscitation and Blood Transfusion in "War Surgery". This book which is edited by Tom Scotland and Professor Steve Heys is published by Helion & Co. and will be released In April 2012.

In August 1914 the war that was to be over by Christmas began with the German invasion of France through Belgium. On the 21st August 1914 two British reconnaissance cyclists were dispatched to find the German Army. When they encountered a cavalry patrol one of them went off to notify his superiors whilst the other stayed behind to fend off the Germans. His name was John Parr, and he became the first British soldier to be killed on European soil in what became known as the Great War. A bicycle might seem a ridiculous form of transport during war but it is a great way to view the First World War battlefields of the Western Front. Since retirement an orthopaedic surgeon with whom I worked for many years, Tom Scotland has taken groups, of mainly male surgeons, on cycling tours of the battlefields of France and Belgium. In September 2010, I joined the first tour to include women.



The terrible slaughter that took place was not foreseen, and medical personnel were quite unprepared for the severity and numbers of wounded.

A regimental aid post (RAP) staffed often by a newly qualified young doctor, the

Regimental Medical Officer (RMO) was situated right up close to the front line providing the first medical aid. Wounded were carried there by the 16 regimental stretcher bearers. The regimental medical officers were frequently killed

themselves. Noel Chavasse was a regimental medical officer serving with the Liverpool Scottish, a territorial battalion of the King's. On the 31st July, 1917, at the commencement of the 3rd Battle of Ypres, he sustained a penetrating abdominal wound from shell fragments. He underwent a laparotomy but failed to survive the surgery. He was posthumously awarded a Victoria Cross, his second, the first having been awarded on the Somme in 1916. He became the only serving officer on the Western Front to receive two VCs in the Great War.

Behind the Regimental Aid Post was the field ambulance, which was a mobile hospital which had a tent section and a stretcher bearer section. The tent section was responsible for establishing an advanced dressing station (ADS) and a main dressing station (MDS) where the wounded were treated. The ADS was always a couple of miles behind the front line, and was designed to be mobile, moving forward when the troops advanced, and backwards when they withdrew. It so happened, of course, that for the greater part of the war the front was static and so too were the field ambulances. The field ambulance also had a stretcher bearer section, whose responsibility was to go forward to the RAP and bring the wounded back to the ADS. The field ambulance was really where triage was carried out and the wounded divided into three groups, those that wouldn't survive, the lightly wounded and those with severe but survivable wounds in need of the most urgent surgery. Robert Graves who later wrote "Goodbye to All That" was badly wounded on the Somme in 1916, when a shell fragment penetrated one side of his chest wall, and came out the other. It was decided that he would not survive his wound, and he was given morphine, and put aside to die. His commanding officer sent word back down the line that Graves had bought it. However he did survive and got to England in time to read his own obituary in the Times, and he put an

announcement in the Times to inform his friends that he was very much alive. (1)

From the ADS, seriously wounded soldiers would be taken to the appropriate casualty clearing station (CCS). The CCS had originally been intended to be just that, to sort out the wounded before putting them on trains and sending them to the base hospitals for definitive surgery. The war was fought, however, in agricultural land contaminated with spores of clostridium welchii and tetanus so by the time the wounded reached base hospitals they were not infrequently dying of gas gangrene. Thus Sir Anthony Bowlby, consulting surgeon to the expeditionary force and a veteran of the Boer War, decreed that it was necessary for radical wound excision to be carried out before the patient was sent by train to the base. (2) The CCSs were far enough away from the front line to be out of range of shell fire, and close enough that by motor ambulance wagon they could be reached relatively quickly. So it was at the CCSs, as the war developed that an ever increasing percentage of major limb and life saving procedures were performed. During the 3rd battle of Ypres in 1917, 30-40% of the surgery was performed at the CCSs. (3) It is worth noting that Role 3 unit in Camp Bastion in Afghanistan serves as a modern version of the casualty clearing station carrying out life saving surgery with the wounded transported without delay in airborne intensive care units to the Queen Elizabeth Hospital in Birmingham which serves as the base hospital.

The casualty clearing station was thus the first place where definitive surgery could be carried out in a calm setting away from the front line. Those with minor wounds went to a minor operating theatre. Those with wounds not requiring immediate surgery were put straight onto trains and sent to the base. Those with limb or life threatening wounds went to a major operating theatre for immediate surgery.(4) CCSs dealing with chest

wounds, abdominal; wounds and compound fractures of the femur were dealt with in CCSs closer to the front at a range of around 10,000 yards. CCSs were situated near railway lines so that as soon as the life saving surgery was completed and the casualty well enough to travel they were transported to base hospitals.

Experience in the previous conflict the Boer War had shown that 64% of the soldiers died from disease, mostly typhoid, many more than from wounds (5). Sir Almroth Wright had developed a vaccine for typhoid that was given to soldiers in WW1 and the death toll from disease was decreased to less than 5% of the total on the Western Front.

Essex Farm ADS has been preserved until the present day. Initially used by the Canadian Expeditionary Force, it was here that Col. John McCrae penned his famous poem "In Flanders Fields" thus making the poppy an enduring symbol of the war. Eventually it became concreted and then used by the 51st Highland Division during the 3rd Battle of Ypres which began on 31st July 1917, and culminated in the mud at Passchendaele on 6th November, 1917.

The CCSs were grouped together in twos or threes, and those grouped together had similar areas of interest and expertise. They took in 150 – 300 cases



Essex Farm Advanced Dressing Station Today

at a time, before passing "on-call" to the adjacent one. The busiest period for a single CCS was 3rd July 1916 at Gezaincourt on the Somme when 5346 casualties were received.

Near the town of Poperinghe in Belgium not far from Ypres lay a huge group of Nissan huts, stretching as far as the eye could see. There were four casualty clearing stations here in 1917, namely British 10 and 17, and Canadian 2 and 3. They were at a farm called Remy Siding (6). The inside of theatres in the CCSs were organized to enable teams of surgeons to work between two and later three operating tables. They had to be efficient to deal with the huge number of casualties and the overall death rate in CCSs was 3.7% of all admissions (7). In the early years, anaesthetics certainly contributed to the death rate, since patients were not able to survive the shock of trauma followed by the shock of surgery and anaesthesia.

The Great War was a war of artillery. A soldier defending a trench was hit by exploding shells of two types. High explosive shells detonated on impact, or burrowed into the ground first before detonating sending large and small fragments of shell casing in all directions. Shrapnel shells were primed with a time fuse, designed to explode over the trench, showering the occupants with iron balls. When men went over the top, then machine gun fire caused casualties. They had no protection other than a steel shrapnel helmet.

Sir Anthony Bowlby, consulting surgeon to the expeditionary force and no doubt a force to reckon with himself having commended surgery at casualty clearing stations perceived that there was a problem associated with a high death rate of wounded due directly to anaesthesia and approached Geoffrey Marshall, a colleague from his London days, and a budding respiratory physician and physiologist by profession. Marshall was having what he

described as a perfectly lovely time working on a hospital barge with a couple of RA nursing sisters when Bowlby drove up in his Rolls Royce and said "Marshall you've done some work on anaesthesia before the war, I want you to go to Remy Siding and sort out the problem" (8).

Marshall had been working as a demonstrator in the department of physiology at Guys where he had been researching the effects of anaesthesia – he was exactly the right man to be approached.

The idea that training in anaesthesia should be systematic and included in every medical student's curriculum was advocated in 1892 by Frederick Silk, assistant anaesthetist to Guy's Medical School. Writing in *The Lancet* he argued that improvements in surgery required improvements in anaesthesia that would only be brought about by properly trained doctors devoting time and energy to the subject(9). Not only was equipment becoming more complicated but doctors were beginning to realise the importance of understanding the physiological effects of anaesthesia and surgery on the human body. In addition, Silk felt that the medical profession should do all in its powers to make it as safe a process as possible. The fact that having an anaesthetic was safer than a railway journey was not an excuse for the occasional death. Over the course of the next twenty years or so specialist anaesthetists were appointed to many hospitals but even in 1901 Buxton, anaesthetist at University College Hospital, was still trying to get the teaching of anaesthesia included in the curriculum of every medical school(10). A bill proposing that all general anaesthetics be given by medical personnel was put before Parliament in 1909 but it failed and only in 1912 did the General Medical Council include anaesthetics as the last of 16 subjects to be included in the medical curriculum of all medical schools (11).

There were some career anaesthetists but not nearly enough and when the Rev Leonard Pearson arrived at CCS no 44 presumably to give spiritual support for the dying and a decent Christian burial for the dead he found himself with a very different job. His photographs were rescued from a skip and are now held at the Bodleian library but when interviewed for the book "The Roses of No Man's Land" by Lyn MacDonald he confessed that he had spent most of his time giving anaesthetics (12). He recognised that he had no right to be doing this but there was no choice. Soldiers were dying in huge numbers and somebody had to deliver anaesthesia whilst life saving surgery was attempted.

So Geoffrey Marshall was packed off to CCS No 17 at Remy Siding and set about investigating the effects of various anaesthetics on wounded soldiers(13). When presenting his work in 1917 to the RSM he said "A correct choice of anaesthetic is of the first importance; the patient's life will be as much imperilled by faulty judgement on the part of the anaesthetist as by a wrong decision on the part of the surgeon".

He had at his disposal a Riva Rocci mercury sphygmomanometer and a Haldane haemoglobinometer. Blood pressure monitoring was only just finding its way into clinical practice and to employ it in a busy CCS would have taken a lot of enthusiasm and hard work. He had at his disposal the following anaesthetics:

1. Ether & Chloroform by the open method
2. Ether & Chloroform by Shipway's warm vapour apparatus
3. Intravenous ether
4. Spinal anaesthesia
5. Nitrous oxide and oxygen
6. Local infiltration

A full description of his work is beyond the remit of this article but of note is his work with spinal anaesthesia. Spinal anaesthesia was originally carried out

with cocaine but its effects were variable and therefore not clinically useful. However when stovaine became available so called after its inventor Furneau which is the French for stove it became a viable alternative to inhalational anaesthesia.

Spinal anaesthesia was simple to give and was thought to protect from the effects of shock. Using a Riva Rocci sphygmomanometer to measure blood pressure he showed the effects of spinal anaesthesia on three groups of patients:

Class A. Men operated on within 40 hrs of receiving their wounds whose blood was dilute i.e. haemoglobin under 100%

Class B. Men operated on within 40 hrs of receiving their wounds whose blood was not dilute i.e. haemoglobin over 100%

Class C. All cases in which a greater interval than 40 hrs had elapsed between wounding and operation, whether the blood was dilute or not.

Initial blood pressure and pulse rate

	Class A	Class B
Average Initial BP	130mm	129mm
Range of Initial BP	90-182 mm.	115-150 mm.
Average Initial pulse rate	105	88
Range of Initial pulse rates	70 to 140	64 to 140

He felt that the initial pulse and blood pressure gave no clue as to who would do well but instead saw the haemoglobin as being the measurement that determined who would do well and who wouldn't. When spinal anaesthesia was administered to the first group of patients whose wounds were recent and the blood dilute there was a profound drop in blood pressure. The effects of shock and their compensatory mechanisms were poorly understood and these patients not surprisingly decompensate once a spinal is given. It is a testament to youth that

some of them managed to survive a period of time with a virtually unrecordable blood pressure. However if the haemoglobin was greater than 100% then even if the wounds had been inflicted recently the drop in blood pressure was slight. Once the wounds were older then despite a very low haemoglobin there had been time for the vascular compartment to fill and a spinal could be given to anyone. In Marshall's table of initial blood pressure and pulse I think it is possible with hindsight to see that the patients in Group 1 had a larger range of initial BPs from those already decompensating to those who are maximally compensated.

Marshall also looked the provision of anaesthesia to very shocked patients. Chloroform lead to death very quickly being a cardiac depressant whereas ether which is a cardiac stimulant initially improved patients before they deteriorated. The only suitable anaesthetic was gas and oxygen. In other words soldiers close to death from bleeding and shock were given a quick whiff of gas and the bleeding dealt with.

He invented his own apparatus for giving nitrous oxide and oxygen, initially just a couple of bottles with a water sight feed to enable the relative quantities of nitrous oxide and oxygen given to be observed. Coxeters of London then designed a machine for him and they encouraged him to take out a patent because "someone had borrowed their blocks". This someone was Boyle. Boyle carried the design forward so that the modern anaesthetic machine became known as the Boyle's machine. As Marshall had no desire to be remembered as an anaesthetist he was indifferent to this act of piracy (14).

Another aspect of his work worthy of mention is his understanding of the need for warmed gases in abdominal surgery. Abdominal wounds were thought to kill by infection, which indeed they did after two to three days when gram negative septicaemia caused multi-organ failure. It

was originally thought that there was little point in even considering surgery and so initially were not operated. However, post mortem studies carried out by John Fraser a surgeon from Edinburgh showed that many of these soldiers were bleeding to death shortly after being wounded, and the principle cause of early death was bleeding and not sepsis. These patients needed an urgent laparotomy at a Casualty Clearing Station, specialising in the treatment of such wounds. Gas and oxygen was insufficient for a longer procedure but warmed ether given from Shipways warm ether apparatus proved invaluable (15).



The apparatus photographed for me by the Association of Anaesthetists has I think been put together incorrectly. The hand bellows which is hidden behind the right hand bottle should be connected to that bottle. That would contain ether and in front is a Junkers bottle that could be used for chloroform. By regulating the levers air can be pumped through the two bottles in various proportions and then directed through a warming chamber i.e. a vacuum flask.

If the anaesthetist was skilled at using the bellows a very uniform anaesthetic mixture could be delivered. The ether was contained, thus improving the conditions in the operating theatres and

the patient was saved from losing valuable body heat. When ether is dripped onto a mask, the mask gets colder and colder and eventually the ether is reluctant to stay as a vapour. Many of the soldiers suffered from bronchitis, having been out in the trenches in all weathers and their incidence of post-operative chest complications was decreased by using warm ether.

Understanding of shock at the beginning of the Great War was rudimentary and confused and you have seen from Marshall's work just how limited understanding was.

A number of personalities became involved with trying to solve the mystery of the shocked patient so the MRC Committee put together a committee consisting of surgeons, laboratory doctors and physiologists in an attempt to solve the problem that was killing so many young soldiers. They first met on August 17th 1917.

The committee was chaired by Ernest Starling famous for his law of the heart and the first man to coin the term hormone. Doctors at the time were just beginning to grasp the relationship between venous return and cardiac output and the application of physiological principles to the sick and wounded was in its infancy.

There were a number of theories to explain why trauma victims became cold and clammy with a weak pulse (16).

George Washington Crile an American surgeon working with trauma victims in Ohio developed what he called his kinetic theory of shock. He believed that the brain became bombarded with stimuli from the wound and the operation as a result of fear and that this exhausted the parts of the brain that maintained blood pressure. As a result of this he developed infiltration with local anaesthetic around the wound with a light nitrous oxide anaesthetic in order to say amputate an

injured arm; not a bad way of dealing with the situation.

Yandell Henderson (from Yale)'s acapnia theory suggested that the hyperventilation seen after a wound is inflicted resulting in lowering of carbon dioxide resulted in the failure of the brain to maintain blood pressure. CO₂ lost from the surface of the intestines when the abdomen is open compounded the situation. He suggested breathing slowly through a long narrow tube or irrigating the abdomen with warm saline with dissolved CO₂. Henry Dale, director of the MRCs department of biochemistry and pharmacology knew that histamine produced shock and believed that it was produced by injured muscles and that a substance to block histamine would be the answer.

Before the committee had been convened Ernest Cowell, a London based surgeon, who would be knighted for his army work during the second world war did some valuable work as close to the battlefield as possible (17). He looked at the physiology of the fighting soldier, travelling as far forward as the regimental aid post. He noted how blood pressure changed when soldiers were exposed to fear. He also realized that they were short of fluid as water was rationed, and that they were very cold before and after being wounded.

Cowell monitored the blood pressure on the journey back to the Casualty Clearing Station. He coined the phrases primary and secondary shock and showed how a soldier whose blood pressure seemed reasonable after injury deteriorated on the journey back from the RAP to the ADS and CCS.

By 1917 Cowell was working at CCS 23 at Lozingshem and was joined by Walter Cannon an American physiologist where they investigated the use of different intravenous solutions at the suggestion of Professor W M Bayliss, Professor of physiology at UCL and brother in law of Starling.

Cannon and others became obsessed with looking for the lost blood – exaemia (18). After all, when they left the ADS many of the wounded were in a reasonable condition but when they arrived at the CCS they were obviously shut down. The blood must have gone somewhere. Shocked patients were pale and cold and clammy – quite obviously the blood wasn't in the skin but where was it? The concept of third space losses was not considered.

Cannon felt that the blood might be sequestered in the intestines so he was keen to see the effects of pituitrin, a potent vasoconstrictor on the body and when casualties came streaming into Casualty Clearing Station no 23 he persuaded Cowell to let him try it. He injected the pituitrin intraperitoneally. It didn't work and post mortem studies showed that there was no pooling of blood in the splanchnic circulation, something that Cowell himself had known for some time. Cannon then did some work with John Fraser and others in Bethune leading him to believe that blood was stagnating in capillaries and if only it could be returned to the circulation all would be well (19). More studies showed that wounded soldiers became acidotic and Cannon concluded that this must be the cause of shock.

Sir Almroth Wright, the innovative scientist who had introduced typhoid inoculation to the troops was a laboratory doctor working with a young Alexander Fleming at one of the base hospitals. He realized that acidosis was the result of and not the cause of shock, and came about due to under perfusion of the tissues (20).

W M Bayliss was paramount in introducing colloids to restore blood pressure. He loved science and experimentation and did much of his work in a laboratory at the end of the garden. A quiet unassuming man he

travelled to France and saw what Cowell and Fraser were doing at CCSs.

Early attempts at fluid replacement had focused on saline, administered subcutaneously and rectally. Marshall, working at CCS No 17 demonstrated by post mortem studies that in the shocked patient, the saline was not absorbed. Needless to say, even when it was absorbed it only resulted in a transient improvement before things were worse than ever as the saline left the circulation.

Understanding the importance of colloid osmotic pressure in keeping fluid in the intravascular compartment Bayliss realized that a fluid which stayed where you needed it was necessary. Gelatin had the disadvantage of clotting and often, apparently contained tetanus spores. Gum Arabic however was inert and could be injected. Thus he invented the first colloid solutions and correctly concluded that it was better to have dilute blood at a high pressure than concentrated blood at a low pressure (21).

With this gradual realization of the physiology behind shock came a strategy for dealing with it. Firstly it was important to keep the soldiers warm. Ambulance wagons were fitted with a device for keeping patients warm and there were many other strategies such as stretchers with warmed blankets kept at regimental aid posts.

Secondly the wounded needed fluids. It was important to restore circulating blood volume and one must remember that soldiers were dehydrated to start with, before they were wounded, as water rations in the trenches were limited. Warm fluids were initially given by the oral or rectal route with intravenous infusion only used if they were not tolerated

Naturally blood itself would prove an advantage but there were three problems

to overcome before blood transfusion could be used.

Blood groups and compatibility were a work in progress at the time but a way of grouping people into four different groups and testing for compatibility was invented. To avoid clotting, transfusion initially was directly from patient to patient but the amount couldn't be measured so methods were devised whereby syringes were interspersed with flushes of saline. These were time and personnel consuming. Lastly transmission of infection particularly trench fever and syphilis had to be avoided. The first transfusions were carried out at base hospitals in cases of secondary haemorrhage.

When Rifleman Charlie Shepherd arrived at an American base hospital with a minor wound, where a volunteer donor was requested, and seeing that most of the other casualties had both legs blown off, he offered his services. He was rolled into the operating theatre head to tail with the recipient and watched whilst his blood returned the colour to the face of the badly wounded soldier. This made him something of a hero and he was given champagne on his return to the ward. The best part was to be sent back to England for convalescence, when his own wound necessitated no more than two weeks out of the front line (12).

Bruce Robertson of the Canadian Army brought blood transfusion into a Casualty Clearing Station in 1917 and reported its use in 57 patients. He grouped the donors, lightly wounded individuals ahead of time. He measured blood pressures and gave blood and fluid accordingly trying to get soldiers into the best condition for surgery but without delaying (22, 23, 24).

Results were good (36 of the 57 patients survived) but in essence a few soldiers received 500 or at the most 1000 mls of blood a paltry amount by our standards but enough to remove some of them from

the dangers of shock. Of course bleeding donors and transfusing the wounded was a time consuming process when the battle casualties were numerous and stored blood would be an advantage. Citrate was known to prevent blood from clotting and Oswald Robertson from the US army collected blood at times of inaction in large bottles that were stored outside. He successfully transfused 20 individuals with blood that had been kept for as long as 26 days (25).

Another Canadian, Norman Guiou took blood transfusion further forward into the field ambulance. Perhaps not many soldiers were helped but the boost to morale of these efforts must have been enormous (26).

In early 1918 a shock centre was set up at the Casualty Clearing Station at Gezaincourt with teams of doctors in effect processing patients for surgery, warming them and transfusing intravenous fluids and blood. A further boost to morale came with the Australians who set up resuscitation teams attached to main or advanced dressing stations. An anaesthetist would transfuse and resuscitate and an experienced surgeon would carry out life saving surgery (27).

As I cycled down through Sausage Valley on the Somme, towards the village of la Boisselle, where the 34th Division sustained the heaviest losses of any division on the 1 July, 1916, for once not at the back I couldn't help but contemplate that there were over 6000 casualties in this small part of the front line. Over the course of the war there were more than 2 million battle casualties on the Western front, three quarters of whom were treated by the medical services. Many more battle casualties were saved than died as over the course of the war tremendous strides were made in caring for them.

The influence of the war in stimulating improvements in anaesthesia continued well beyond 1918. Harold Gillies a plastic surgeon worked to restore the faces of badly wounded soldiers at The Queens Hospital for Facial and Jaw Injuries at Sidcup in Kent. Here he was joined by Ivan Magill and Stanley Rowbotham who worked as anaesthetists. They devised a method of insufflating warm ether from Shipways apparatus directly into a tube placed in the trachea but expired gases mixed with blood and secretions and there was frequently an anatomical obstruction to expiration. As a result breathing might become laboured and end tidal carbon dioxide would increase along with intrathoracic pressure causing haemorrhage (28). On one particular occasion Magill relieved the problem by placing another tube in the trachea to allow the escape of gases. Eventually he realized that the placing of a single endotracheal tube would allow to and fro respiration (29). A new era in the administration of anaesthesia had begun and an invention that was initially greeted with scepticism became firmly established as a necessary part of the anaesthetists armamentarium still in use today.

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The Gillies Lecture

This years Gillies Lecture at the Annual Scientific meeting in Ayr was delivered By Dr Malcolm Daniel of the Western in Glasgow. Malcolm has been at the centre of the development and delivery of patient safety in Scottish anaesthetics for many years and was a wonderful choice to deliver the safety themed Gillies Lecture.

Crossing the Chasm

It is an honour to be asked to deliver the Gillies Memorial Lecture. John Gillies was one of the pre-eminent anaesthetists of his generation and was a foundation member of the Faculty of Anaesthetists. He was the Simpson Reader in Anaesthesia in Anaesthesia at Edinburgh University and a previous President of this Society as well as the Association of Anaesthetists of Great Britain and Ireland and of the Anaesthesia Section of the Royal Society of Medicine.

The Gillies Lecture is the highlight of the Scottish Society of Anaesthetists Winter Scientific Meeting. I first came to this meeting in 1989. I was a first year trainee and Greg Imray was President that year. I was encouraged to attend. I came to Glasgow and heard W Macrae give the lecture that year. The following year I remember listening to Alastair Spence extol the virtues of spontaneously breathing. A few weeks earlier, I am on a surgical ward looking for a person's medical notes, from behind me a voice booms "Have you come to see the patient you murdered?" I turn round and it is the patient's consultant surgeon, and the finger of blame is pointing directly at me. My heart, like yours, was in my mouth. Thankfully, there was some surgical over exaggeration, the patient was alive but in

no way thanks to me. Two days earlier I provided anaesthesia care for a woman undergoing emergency bowel resection for inflammatory bowel disease. The surgeons wanted to feed parenterally in the postoperative period. They asked me to insert a central line to provide access for intravenous feeding. I agreed and used the central line I was given. I arranged for a postoperative chest X-ray. I handed over to the trainee on for overnight, but did not wait to check the chest X-ray myself. Nor did anyone else. The parenteral feed was started, but central line was too far in. One day later 250 ml of the fluid required to be evacuated from the pericardial cavity. This affected me. I changed my practice; both in terms of type of line I used, and always checking the chest X-ray myself. It hasn't happen again to a patient I have provided care to. A simple search on Medline using the terms "catheterization, central venous" and "cardiac tamponade" however demonstrates how common this adverse event remains. Yes, I committed an error. 20 years ago I did not appreciate that this was in part a system error. There were multiple points at which we could intervene to prevent this particular adverse event happening. More importantly we could have taken the learning from this episode to prevent this happening to other patients.

This is not a talk about central line complications. I use this dramatic personal example as an illustration of a major healthcare challenge of learning

how to improve safety on a system but not just individual basis.

At the same time in 1990, Curing Health Care (1) is published following completion of the National Demonstration Project. In short, 21 arranged marriages were conducted.

Twenty-one quality improvement experts from industry were paired with leadership teams in 21 American healthcare organisations. They started to think about how to improve the healthcare delivery. Ten key lessons were obtained and remain relevant to us today. Some of these we heard in this morning's presentations. 1) Quality improvement tools can work in healthcare. 2) Cross-functional teams are valuable in improving healthcare processes. 3) Data useful for Quality Improvement abound in healthcare. 4) Quality improvement methods are fun to use. 5) Costs of poor quality are high. 6) Involving doctors is difficult. 7) Training needs arise early. 8) Non-clinical processes draw early attention. 9) Healthcare organisations may need a broader definition of quality. 10) The healthcare, as in industry, the fate of quality improvement is first of all in the hands of leaders.

At the end of that decade, the Institute of Medicine published the To Err is Human report (2). The report provided a national estimate of harm from adverse events. This was based on 2 previous studies. The incidence of adverse events in the two studies was 2.6 and 3.6%. Adverse events contributed to a patient's death in 6.6 and 13.6% of these incidents. Applying the data from these two studies nationally estimates the rate of death due to adverse events being between 44,000 and 98,000 per year. Using the lower figure ranks the rate of death due to adverse events as the eighth leading cause of death. This makes patient safety a public health issue.

Our first reaction may be that this is a problem of the US healthcare system. Charles Vincent's retrospective study in 2

UK hospitals (3) demonstrated 10.8% of 1014 patients experienced an adverse event. One in twelve of these adverse events led to death, and 48% of adverse events were judged preventable. These figures are remarkably similar to those derived in the earlier report.

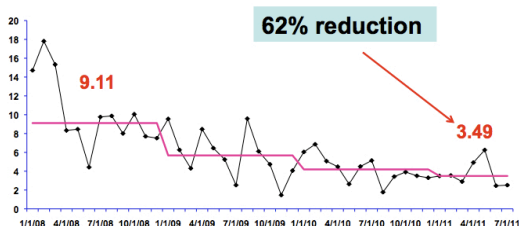
Ten years on we might ask have we got better yet? A 2007 BMJ report from one UK hospital (4) showed a rate of adverse events causing harm of 10.9% still remarkably similar. Last year, the Office of the Inspector General published data gathered from Medicare patients (predominantly those over 65 in the USA) (5); this demonstrated an adverse event rate of 13.8%, with 11% of these contributing to patient death. This would project out to accounting for 188,000 excess deaths per year. 44% of the observed adverse events were considered preventable.

If we take the estimate of a 10% risk of adverse event rate for hospitalised patients and apply this to the number of patients admitted to Scottish hospital per year. 27 is the number of patients who sustain an adverse event in Scotland each and every hour. At the time I am giving this talk today, it is likely that 432 people have sustained an adverse event already today. The one piece of good news is that over 200 of these are preventable and the challenge is for us to work out how to do this.

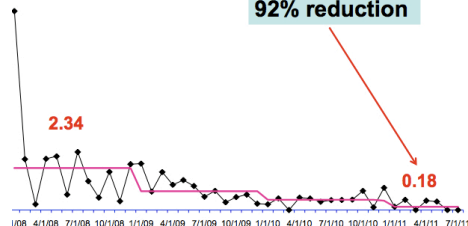
This is where the Scottish Patient Safety Programme comes in. The aims of the programme are to accomplish a 30% reduction in adverse event rate and 15% reduction in hospital mortality over the 5 years of the programme. It is now three years since Brian Cowan mentioned the Scottish Patient Safety Programme in his 2008 Gillies Lecture; what progress have we made in the time since?

There has been some considerable progress particularly in the critical care workstream. Across Scottish ICUs the rate of ventilator associated pneumonia has reduced by 62% and there has been

VAP rate
(per thousand ventilator days)



ICU Central line infection rate
(per thousand line days)



a 92% reduction in the rate of central line related blood stream infections. For three months this year there were no central line infections in any ICU. To date the hospital standardised mortality rate has been reduced by 7% (8.4% by the end of November 2011). In all progress has been good, but not uniform across the workstreams. Nor should we expect it to be.

There is more to safety programmes than just the results. It is often what you learn as the project that is most important. Tracking a series of publications from the Keystone ICU Project's work on reducing central line infections in ICU patients illustrates this point. The initial results emphasised four broad achievements (6). These were education of staff; development of a cart containing required equipment; use of a checklist; and use of feedback data. In their "Reality check for checklists" article (7) the authors reflect that the focus on checklists at the time of initial publication was actually a distraction. They highlight that to improve the safety of care delivery we need to focus on three broad areas. The three areas are to summarise and simplify what to do; measure and provide feedback on outcomes; and improve culture by building expectations of performance.

This year in "Explaining Michigan" (8) the authors again revisit this work. They move from whether the programme worked, that is got the results intended, to asking why and how the programme

worked. They conclude there were six broad factors at play.

These range from why the ICUs in different hospitals were attracted to this voluntary programme and how this affected their actions to framing the topic of central line infections as a social problem. This highlights that changes are required in human action and behaviour and that this was not a problem with a simple technical fix. A group of networked communities existed at all levels between the hospitals involved. While the checklist functioned as a recording device, it also helped make clear the difference between actual and the "ideal" practice. The collection and open reporting of data on both process reliability and outcomes had an effect both within and between ICUs. While the programme was voluntary, "hard edges" was made use of. If a hospital failed to submit data, the chief executive was phoned and asked for the data. If the data was not forthcoming the hospital was asked to withdraw from the programme, no hospital withdrew. Recognising that role of the nurse checking whether the checklist had been followed was a major change. The programme leaders asked nurse to phone if they were unable to stop a doctor deviating from the agreed insertion procedure. While no nurse did phone, at the forum meetings nurses reported using the threat of calling as a means of preventing poor practice. In

summary, it takes more than a checklist to achieve organisational change.

I have so far side stepped one important set of results that challenges how we think. The Safer Patients Initiative (SPI) was funded by The Health Foundation, and ran from 2005 to 2006. It involved one hospital in each of the four countries of the UK. This was a forerunner to the Scottish Patient Safety Programme. The external evaluation was published earlier this year. First, let us acknowledge that each of the four sites did show improvement in rates of ventilator associated pneumonia and central line blood stream infections in ICU, a reduction in adverse events due to anticoagulants, crash call rates and surgical site infections (9). The external evaluation (10) asked the wider question of whether participation in SPI led to improved organizational performance. The researchers looked beyond the pilot areas in the hospitals. While the impact of SPI was welcomed at strategic level, there was limited spread to other clinical areas. There was improvement in one of eleven measures of staff perception of safety climate, and in only one of eight clinical monitoring measures.

The external evaluation tells us that transformational change in the hospital setting takes more than just working on a safety project in a few pilot areas in a hospital over 18 months. The Scottish Patient Safety Programme both with its duration and extent of all hospitals wards aims to enable the changes. While the improvements in rates of specific nosocomial infections in ICU are impressive. It is what we learn from solving these patient safety problems that will help us in the future. The NHS Scotland Healthcare Quality Strategy (11) mentions changing culture. This term is used frequently, and often without a clear definition.

Culture can be defined simply as “the way we do things rounds here”. A more extensive, and more useful description is

the one proposed by Edgar Schein (12): “The culture of a group can be defined as a pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and internal integration, which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems.” As you read this, insert “patient safety” before “problems” to get a sense of what we are aiming to accomplish.

I started with one dramatic story; I am going to finish with a contrasting one. Let us fast forward from autumn of 1990 to spring 2011. I am in another hospital. I have been learning how they conduct their leadership rounds; the medical director suggests I may be interested to come with him. We go to the orthopaedic unit and meet one of the nurses. She tells us two days previously a post-operative patient was about to get a receive a unit of blood - the nurse was at the bedside about to hang up the unit blood - when the patient asked "has that blood been irradiated?"

Irradiating blood reduces the risk of Graft-Versus-Host-Disease in people who have previously had a bone marrow transplant. The patient had indeed previously received a bone marrow transplant. The nurse informed the orthopaedic surgeon of this. He was concerned and asked "do we have a system in place to prevent this happening to another patient?" Yes - I'll just repeat that an orthopaedic surgeon asked about a system issue.

Later the medical director confided that previously the surgeon would have looked for someone to blame. The work of the organisation developing staff and focusing on improvement has shaped thinking about how to improve care provided to patients. The work in the organisation changed the surgeon's response to safety problems. I am standing in a different hospital, in a

different continent, at a different time, and I know this is type of place we would all like to work in. My talk has come full circle. Would it not be ideal if our organisations could also turn full circle and make a similar fundamental shift in the way we do our work and respond to patient safety incidents?

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Annual Trainees Competition

Crieff 2011

The Donald Campbell Quaich

The following 5 papers were presented at the Annual Spring Meeting at Crieff on the 14th of May 2011. They are ordered here in their ranking in the competition. Papers 4&5 were ranked equally.

Gentamicin dosing in surgical antibiotic prophylaxis: Improving the accuracy of dosing.

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Following publication of the Scottish Intercollegiate Guideline Network (SIGN 104) on surgical antibiotic prophylaxis, NHS Tayside changed its local policy, which involved the increased use of gentamicin [1]. The policy recommended gentamicin be dosed on actual body weight (4mg/kg) unless deemed overweight, in which case ideal body weight (IBW) should be used. This policy required prior knowledge of the patient's actual weight, expected weight and ideal body weight, a height-based calculation. The aim of this clinical audit was to ascertain the current prescribing practice of gentamicin in surgical prophylaxis. A trial of an innovative gentamicin dosing tape was introduced to ascertain whether this could improve the accuracy of gentamicin dosing.

Methods

The local ethics committee deemed approval unnecessary. The Tayside Antimicrobial Group approved a policy change that dosing of gentamicin for surgical prophylaxis be based on IBW for all patients. Current practice was audited during June 2010. For all cases of gentamicin use, the patients' sex, height, and dose administered were recorded. The difference between the actual dose received and the dose based on IBW was then calculated. The novel dosing tape displayed the gentamicin dose alongside the centimetre markings. This was then implemented. The chi-squared test was used for statistical comparisons.

Results

One hundred and eighty seven patients received gentamicin during the one-month period. Forty one (22%) patients received a dose that was +/- 20mg of the IBW calculated dose. Twenty six (14%) patients received a dose less than that required and 120 (64%) patients received a dose greater than that required (range -100mg to +306mg). Following implementation 66/69 (96%) of doses were within +/-20mg of the IBW calculated dose ($p < 0.0001$).

Conclusion

A gentamicin dosing tape based on IBW simplified the calculation process and improved the accuracy of gentamicin dosing for surgical antibiotic prophylaxis.

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Time from CT scan to surgery in traumatic brain injury. Room for improvement?

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Introduction

Traumatic brain injury (TBI) accounts for 15-20% of deaths between the ages of five and 35 in the UK [1]. In patients presenting with acute subdural (SDH) or extradural (EDH) haematoma there is evidence that a delay in neurosurgical decompression of greater than four hours can adversely affect outcome [2]. We performed a retrospective audit of patients with TBI transferred for surgery to identify if unnecessary delays were occurring.

Methods

We identified all patients admitted to Western General Hospital (WGH) ICU with TBI between 2008 and 2009 using the WardWatcher system. The time and date of CT scan prompting neurosurgical referral was obtained from the TrakHealth system. The time of admission and departure from A&E and transfer to the neurosurgical department were obtained from similar electronic records.

Results

95 patients were admitted to ICU with a TBI over a 2 year period. 20 patients from 7 different hospitals were transferred to the WGH for immediate neurosurgical decompression. 13 had a SDH, 6 had an EDH and 1 had an intracranial haemorrhage (ICH). Average time from CT scan to theatre was 4.5 hours (range 2 to 14.3). 40% of all patients had definitive intervention over 4 hours after their CT scan with 2 patients taking over 10 hours.

Discussion

This audit suggests that within our region a high proportion of patients with TBI experience significant delays in receiving definitive neurosurgical intervention. It has highlighted the need for further education regarding the importance of reducing all operative delays (including rapid referral and safe but prompt transfer) in our A&E, critical care and neurosurgical departments. In addition we have scheduled a joint anaesthetic and neurosurgical meeting to discuss these findings in the hope of improving the referral system.

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Critical phase distractions during anaesthesia and the sterile cockpit

Concept

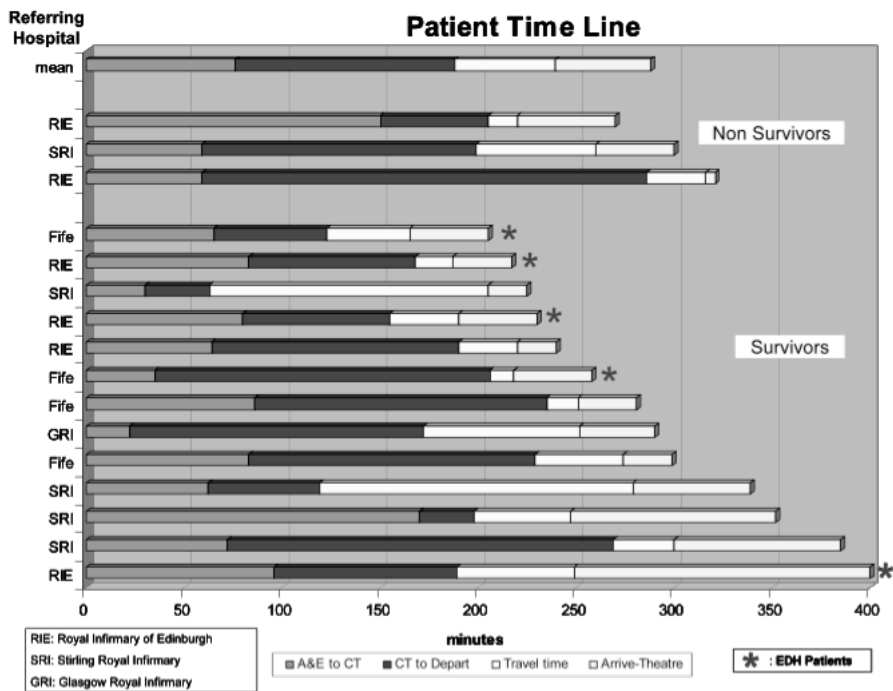
M.A.Broom¹, A.L.Capek², P.Carachi³, M.A.Akeroyd⁴ and G.Hilditch⁵

¹Specialist Registrar ^{2,3}Specialty Trainees ⁵Consultant Department of Anaesthesia, Western Infirmary & Gartnavel Hospitals, Glasgow, UK. ⁴Section director, MRC institute of Hearing Research (Scottish Section), Glasgow Royal Infirmary, Glasgow, UK.

Introduction

In aviation, the sterile cockpit rule prohibits non-essential activities during critical phases of flight, take-off and landing [1]; phases analogous to induction of, and emergence from, anaesthesia. We studied anaesthetic distractions during these phases.

Method & Results



Data was recorded for 30 inductions, maintenances and emergences. Mean (SD) noise during emergence 58.3 (6.2) dB was higher than during induction 46.4 (4.3) dB and maintenance 52 (4.5) dB; $p < 0.001$. The difference between mean noise levels during induction and emergence was 12 dB, corresponding to at least a doubling of subjective loudness. Sudden loud noises occurred most frequently at emergence: events >70 dB totalled 9, 13 and 34 respectively through each phase. Equipment alarms and music playing showed similarly increasing trends towards emergence. Median (IQR [range]) staff entrances or exits were 0 (0-2 [0-7]), 6 (3-10 [1-18]) and 10 (5-12 [1-20]); $p < 0.001$ for induction, maintenance and emergence respectively. Conversations unrelated to the procedure occurred in 28/30 emergences. Data demonstrate increased distractions occurring during emergence from anaesthesia in every aspect studied. These may give rise to opportunities for patient harm.

Discussion

Excessive noise has several potentially detrimental physiological and psychological effects [2]. Apart from direct distraction to the anaesthetist caused by excessive movements, a busy theatre may impact on important non-verbal communications and may also hamper the calm emergence from anaesthesia of the patient. Distracting concentration will impact on anaesthetists situational awareness. Studies in aviation have shown correlation between situational awareness and performance [3]. Interruptions have been reported as a significant contributory cause in 7% of aviation incidents. Recognising and minimising distraction should improve patient safety. Applying aviation's sterile cockpit rule may be a useful addition to our clinical practice.

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Safety and efficacy of age guided reduction in patient controlled analgesia (PCA) bolus dose

Riddell LM, Ramage K, Haldane G

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Introduction

The benefits of PCA are well documented [1]; delivering superior analgesia and satisfaction scores [2] in addition to reduced nursing time [3]. There is however conflicting evidence surrounding any reduction in total morphine usage or side effects [1]. It remains routine practice not to reduce the PCA bolus dose in the elderly, despite evidence that age is the single best predictor of morphine consumption following major surgery [4], that this population is at most risk from respiratory depression [5], and that a reduction in PCA bolus dose should be considered [4, 5].

Method

Following ethical approval by the hospital committee we conducted a retrospective observational study of all patients prescribed morphine PCA from January 2008 until December 2009. PCA patients are reviewed daily by an acute pain nurse specialist where a daily audit form is completed and the results logged onto a computer database. Recordings include; age, operation, morphine usage, average pain scores and adverse events (average pain scores = combined 24 hour total of 6 VRS on a 0-3 scale). Standard protocols have patients over 70 yrs of age receiving morphine PCA with bolus dose 0.5mg and lock out 5 minutes, while those under 70yrs have their bolus set at 1mg. Data were analysed with Mann-Whitney and Chi squared tests where appropriate.

Results

977 patients data were available, 636 (65%) < 70yrs and 341 (35%) ≥70yrs.

Table 1 shows the other results.

	< 70 yrs age	≥70yrs age	P value
Morphine consumption (mg)	68.5 (n=364)	35.4 (n=185)	0
Average Pain Score	6.53 (n=559)	5.93 (n=284)	0.03
Adverse events (%)	24.7 (n=636)	18.5 (n=341)	0.035

Discussion

Age guided reduction of morphine PCA bolus dosing is safe, efficacious and appears to be advantageous as compared to 1mg bolus dosing in a comparable group of < 70yr olds.

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A survey of advanced airway equipment in the UK.

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Introduction

The RCOA's 2010 curriculum includes a compulsory higher airway module [1]. Trainees are required to be able to perform awake fiberoptic intubation (FOI), demonstrate correct use of high frequency jet ventilation (HFJV) and use novel methods of laryngoscopy including videolaryngoscopy (VL). Training issues in FOI have previously been reported [2]. However, considering present financial constraints, we wondered if trainees could access some of the devices. We surveyed UK hospitals to assess availability of the airway equipment.

Methods

We contacted all UK hospitals with surgical services. We asked i) number of separate theatre suites and number of theatres ii) how many fiberoptic scopes per suite, iii) how many video laryngoscopes (VL) they owned or had on trial, iv) if the theatres had a HFJV, v) if difficult airway trolleys were standardised across the site, vi) if low frequency jet ventilation (LFJV) was available, and vii) if there were maxillo-facial or ENT services on site.

Results

We obtained data from 208 hospitals (73%). Despite 151 sites providing ENT services, only 61 hospitals had HFJV. The majority (182, 87.5%) had LFJV on their difficult trolleys and 186 hospitals (89%) had standardised trolleys across the site. 117 hospitals (56%) had access to VLs, only 103 hospitals owned them. Access to FOI equipment was possible on majority of sites, with the mean scope to theatre ratio being 0.4, ranging from 0.09 to 1.

Discussion

Our survey is limited by a lack of validation of the information provided. However, if we assume this data is representative, delivering the variety of equipment exposure required will be difficult. Fiberoptic scope availability varied widely with smaller hospitals having a higher ratio. With less than 60% of sites possessing VL, education with these devices will be variable. Most limited is the availability of HFJV. Therefore, delivering the new curriculum will be challenging, despite the skills and enthusiasm of trainers.

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Poster Prize Competition

James Macgregor Imray Salver

The following papers were the top ranked entries in the Poster Prize Competition from the Trainees Meeting of the 13th of May 2011 They are presented in ranking order. The first paper by Drs, Clark, Ball and Jefferson won the James Macgregor Imray Salver

Are We Pushing and Twisting?

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Introduction

Disconnection of anaesthetic breathing systems from anaesthetic apparatus is dangerous [1]. The conical 15mm/22mm tapered fitting is commonly used as it is simple, inexpensive and allows for rapid disconnection. Correct connection requires a push followed by a quarter turn. Anaesthetic breathing systems include approximately ten connections all of which are at risk of disconnection [2]. This audit aimed to review current practise of the push and twist technique in a clinical setting.

Methods

Institutional approval was granted. An axial pull was carried out against the fitting between a coaxial Bain (Mapleson D) system and common gas outlet, using digital weighing scales attached to the APL valve. The reading at disconnection was recorded and used as a surrogate measure of force. The test was performed following a routine theatre list and subsequently following a standard push and quarter twist. These measurements were repeated over four weeks at weekly intervals by a sole operator. Statistical significance was calculated using a Mann-Whitney U test.

Results

Forty results in total were recorded, twenty prior to and twenty following a standard push and quarter turn. Median reading required for disconnection before was 5.6kg (interquartile range 3.5-8.4kg) and following standard push and turn 15.6kg (interquartile range 14.9-18.1kg). The difference between each group median was 10kg ($p < 0.05$).

Discussion

We have shown that all tested connections have not been optimally secured making disconnection more likely. The connection tested is in a well observed area and therefore undetected disconnection is unlikely. However, if similar weaknesses were to occur at other hidden connections or in other hospital areas, disconnection may go unnoticed potentially leading to a critical incident and patient harm.

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Maintenance of Medical Records by means of an Electronic System in an Intensive Care Unit: an Audit.

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Introduction

Maintaining high quality medical records is a fundamental component of good clinical practice. The Audit Commission in 1995 found record-keeping to be of poor quality and recommended an increase in its priority [1]. The Healthcare Commission's Annual Health Check (2008) found that records management had the lowest compliance of all its core standards [2]. The purpose of this study was to examine the quality of notes made by medical staff in our Unit.

Methods

We retrospectively analysed record-keeping within the electronic database used in each of our two Intensive Care Units during March and May 2010. For each patient we detailed documentation of: admission, daily ward round, daily examination and daily plan.

Results

In ICU1 we analysed 80 case notes totalling 107 patient days. There was documentation of admission in 61/80 (76%), ward round in 105/107 (98%), examination in 38/107 (36%) and a daily plan in 100/107 (93%) cases. In ICU2 we analysed 48 case notes totalling 207 patient days. There was a record of admission in 42/48 (88%), ward round in 201/207 (97%), examination in 141/207 (68%) and a daily plan in 200/207 (97%) of case notes.

Discussion

This study suggests documentation is suboptimal in our unit. Potential reasons for this include: recent change to an electronic based medical record, reduced trainee numbers or the fact that ICU1 is viewed as being an extended recovery service. The medical record is crucial to communication between specialists, helps to facilitate decisions and can be used in audit processes [3]. Furthermore, it is vital in dealing with medico-legal issues. There are many perceived advantages to the use of electronic records: reduced storage space, easy retrieval, improved legibility and standardization of forms. Clearly, these benefits are ineffectual without adequate documentation. We propose to survey staff in order to elucidate barriers to maintaining medical records.

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STOP-BANG screening tool for Obstructive Sleep Apnoea.

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Introduction

There is a significant risk of undiagnosed Obstructive Sleep Apnoea (OSA) in patients with increased Body Mass Index (BMI)[1], which may be a cause of concern especially after general anaesthesia. Recently updated guidelines[2] suggest the use of appropriate screening tools in preoperative assessment, especially for identifying patients suitable for Day Surgery. The STOP-BANG questionnaire[1] is validated for screening for OSA. It is recommended that all patients with a STOP-BANG score ≥ 3 are deemed at high risk for OSA and should be referred for formal respiratory review and assessment for OSA. The aim of this audit is to assess the number of patients identified as high risk for OSA who would require further investigation prior to surgery.

Methods

Patients assessed at the Preoperative Assessment Unit (PAU) during October 2010 were asked to complete the STOP-BANG questionnaire. These included day surgery/ 23 hour stay patients and those scheduled for inpatient procedures.

Results

415 patients attended the PAU during this period. 319 (77%) had a STOP-BANG score calculated and were included for data analysis. Of the patients screened, 162 (50.8%) had a STOP-BANG score ≥ 3 . 49 (15.4%) of patients had a BMI of >35 , of which 41 (83.6%) had a STOP-BANG score ≥ 3 . Interestingly, of the 69 patients who scored =3, 15 (21.7%) did so purely on physical characteristics alone.

Stop- Bang Score	<3	3	4	5	6	7	8	Total
No of Patients	157	69	52	58	8	4	1	319
BMI >35	8	10	12	10	5	3	1	49

Discussion

Using the recommended STOP-BANG score of ≥ 3 as a trigger for referral for further investigation would swamp our service; thus preventing timely investigation prior to surgery. It could be useful, however, to identify high risk patients with associated co-morbidities who would benefit from urgent referrals for sleep studies.

References

- 1 Chung F, Yegneswaran B, Liao P et al STOP Questionnaire: a tool to screen patients for obstructive sleep apnea. *Anesthesiology* 2008 108:812-21
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Challenges to introducing remifentanyl patient controlled analgesia (PCA) in an obstetric unit

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Introduction

Remifentanyl PCA in labour is an alternative to more established analgesics. We were keen to promote its use in our department but usage rates remained low and so experience was limited. We aimed to ascertain if midwife attitudes to the PCA played a part in this and to compare them with a unit with an established PCA service (unit B).

Methods

A standard questionnaire was devised and midwives were questioned by two interviewers.

Results

60 midwives were interviewed (30 in each unit). 70% midwives in unit A had used the PCAs (median=1 use) compared with 97% of unit B (median=3).

Unit A midwives were less likely to suggest positive aspects of PCA use. 28.6% of unit A responders thought PCAs were a good technique, 28.6% average and 42.9% bad. However, 68.9% of unit B thought it a good technique, 24.1% average and 6.9% bad.

The lack of widespread use was the most common reason for unit A midwives not having used PCAs before.

Reason for use	No. midwife responses Unit A	No. midwife responses Unit B
Maternal request	1	23
Patient declined epidural	0	12
Epidural contraindicated	17	10
Intrauterine death	5	10
Failure to site epidural	1	3

Discussion

Unit A midwives were less experienced in remifentanyl PCA use and there were more negative views on its use. It was more commonly used in a 'negative' situation when a patient was expecting an epidural but was presented with fewer analgesic options. In unit B, PCA use was more likely to be a positive choice by the mother. Further education is vital for staff and patients. Armed with this, improved knowledge and a potential change in attitude may break the cycle of inexperience and negativity thus presenting a positive analgesic option for labouring women.

Reference

1. Hill, D. Remifentanyl patient-controlled analgesia should be routinely available for use in labour. *Int J Obst Anesth* 2008; 17(4): 336-339

Prescribing analgesia – the role of pre-printed charts

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Introduction

Before 2010 our obstetric unit used pre-printed drug kardexes for post-natal analgesia. Pre-printed charts have been shown to increase compliance with protocols[1,2]. Following unilateral withdrawal of pre-printed charts by our pharmacy, we audited prescribing practice in this setting.

Methods

Forty-nine blank charts were randomly selected from operative deliveries in 2010. Twenty-nine pre-printed charts were randomly selected from elective caesarean sections in 2009. Frequency and dose of analgesics were recorded. Each prescription was evaluated for compliance with local protocol and the two groups were compared using Fishers test.

Results

Causes of non-compliance	Pre-printed n (%)	Blank n (%)
Incorrect Dose	4(11%)	6(12%)
Incorrect Interval	0(0%)	7(14%)
Failure to prescribe an indicated analgesic	0(0%)	4(8%)

All charts were compliant for paracetamol prescription. Forty-five (92%) blank charts were compliant for ibuprofen, with 100% compliance in pre-printed charts. Dihydrocodeine compliance was observed in 21(54%) blank charts and all pre-printed charts, a statistically significant difference ($p < 0.005$). Total opiate compliance was

observed in 25(89%) pre-printed charts and 39(80%) blank charts, ($p<0.5524$). Although our protocol suggests tramadol as a second line opioid, we found it was prescribed for 21(72%) patients in pre-printed charts and 37(76%) patients in blank charts. We also observed large variations in the interval between the immediate post-partum dose and subsequent dose of both NSAIDs and paracetamol.

Discussion

Despite a trend towards pre-printed charts improving compliance, this audit did not demonstrate a statistically significant difference. This may represent an underpowered study. The frequent requirement for prescription of a second line opioid may indicate inadequate analgesia with dihydrocodeine, and this has prompted a formal review of our analgesic protocol. Consideration should be given to the re-introduction of pre-printed kardex.

References

1.Brackbill ML, Kline VT, Sytsma CS, Call JT. Intervention to increase the proportion of acute myocardial infarction or coronary artery bypass graft patients receiving an order for aspirin at hospital discharge. *Journal of Managed Care Pharmacy*. 2010;16(5): 329-36.

Long term follow up after Non-Technical Skills simulator training

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Introduction

The Crisis Avoidance and Resource Management course (CARMa) introduces participants to anaesthetic non-technical skills (ANTS) using presentations, videos & case based discussion to explore theory, and participation in scenarios with debriefing using the ANTS framework to develop skills. Further development of such skills will rely on support and use in clinical practice. This questionnaire based study was designed to explore participants' use and attitudes to ANTS after the course.

Methods

CARMa participants for the previous two years were surveyed electronically. Follow up questionnaires were sent to non-responders.

Results

A questionnaire was sent to 52 participants from 7 courses run over the preceding 2 year period with a response rate of 50%. Respondents felt that the course improved their: NTS knowledge 24/26(92%); ability to recognize NTS 23/25(92%); NTS awareness 26/26(100%); NTS application to clinical practice 25/26(96%). Using ANTS in clinical practice was identified by 20(77%) as a way to further improve personal NTS. Most 23(88%) participants used ANTS in their workplace and felt that ANTS should be a compulsory part of training 25(96%), assessment 22(85%) and revalidation 15/24(63%) in the future. 7(29%) participants worked in departments where no consultants were using ANTS for teaching, 16(67%) <50% of consultants, and only 1(4%) in which all consultants used ANTS.

Discussion

The course raises awareness, recognition, knowledge and application of NTS, for 92-100% of participants and most believe that ANTS should be incorporated into training, assessment, and revalidation. While NTS and Human Factors appear in the Curriculum for CCT for Anaesthetics 2010, current levels of awareness and application of ANTS within departments is low and this must be tackled for improvement.

Anaesthetic assistance in the obstetric unit: a national survey

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Introduction

Skilled anaesthetic assistance in the obstetric unit is of paramount importance [1]. Assistants should have national accreditation and assist on a regular basis to maintain competencies [2].

Methods

A survey was sent to 218 lead obstetric anaesthetists with OAA approval in December 2010. Questions focused on numbers of anaesthetic assistants, experience, dedicated obstetric provision, additional roles and consideration of future workforce planning.

Results

Duty	%	(n)
Assist with epidural insertion	18	(21)
Epidural infusion set-up	9	(11)
Recovery assistance	37	(43)
IV cannulation	13	(15)
Set-up PCA	16	(19)
Fetal blood sampling assistance	1	(1)
Other	5	(6)

Response rate was 47% (102 replies). Anaesthetic assistants comprised operating department practitioners (68%), nurse assistants (26%) and midwife assistants (6%). Only 19% were dedicated to working solely on the obstetric unit but nearly a quarter (24%) did not receive regular exposure to non-obstetric work for professional development. Anaesthetic assistants not normally working on labour ward covered maternity regularly in 15% of hospitals, occasionally in 28%, rarely in 29% and never in 28%. In 71% of hospitals prior obstetric experience is essential to work in maternity. 26% mostly seek experienced assistance and 3% may consider inexperienced assistants. Additional duties are summarised in the table below. Assistance was considered optimal by 80% of responders. 13% felt it was sub-optimal and 7% were unsure. 28% anticipated staffing problems in the near future while a further 26% were unsure if such issues were on the horizon.

Discussion

Encouragingly most anaesthetic assistance is provided by operating room practitioners. A majority maintain skills through exposure to non-obstetric anaesthesia. Additional duties outside theatre illustrate an extended role. It is concerning some assistants with no obstetric experience may work on labour ward. A significant percentage foresee future staffing problems. Competent and experienced anaesthetic assistance is invaluable in the challenging environment of labour ward.

References

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 Association of Anaesthetists of Great Britain and Ireland and Obstetric Anaesthetists' Association. Guidelines for obstetric anaesthetic services. AAGBI, London; May 2005

Antenatal anaesthetic review and maternal obesity: Are we doing enough?

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Introduction

CMACE/RCOG recommend that pregnant women with a booking BMI \geq 40 should have antenatal anaesthetic consultation and a management plan for child birth [1]. This audit investigates the correlation between anaesthetic clinic management plan and the actual management during child birth.

Methods

Data was collected retrospectively from clinic letters, case notes and local database over a period of one year. Descriptive statistics was used for analysis.

Results

Clinic: Eighty one women attended the clinic. The average BMI was 42.2kg.m⁻². Early epidural was advised in 23 (28%) patients. Senior involvement was recommended for 11 (14%) patients if regional anaesthesia was required and for six (7%) patients if GA was required. Difficult regional blocks (no palpable landmarks) were predicted in four (5%) patients. Third trimester weight was checked in 25 (31%) patients.

Table: Intra-partum course

Delivery	N ^o	Anaesthetic Interventions
SVD	39	11 Epidural, 3RemiPCA, 1Remi-Epidural
Elective Caesarean	14	14 Spinal
Emergency Caesarean	15	4Epidural, 5Spinal, 1Epidural-Spinal, 1Epidural-GA, 1Spinal-GA, 1GA
Instrumental	13	8Epidural, 1Spinal, 3Epidural-Spinal

Outcome: Two (50%) out of four patients with predicted difficulty for regional blocks developed complications (dural puncture, inadequate epidural). Nine (30%) epidurals were inadequate requiring resiting or conversion to spinal or GA for operative delivery. Three (4%) had GA, two of which were due to failed regional blocks. Eight (33%) had early epidurals (cervix <5 cm dilated). Senior involvement for regional anaesthesia, where recommended (\geq ST-6) was followed in two (18%) patients.

Discussion

Fifty six (66%) patients required anaesthetic intervention which reflects the importance of ante-natal clinics. Epidural failure rate (30%) was higher compared to non-obese population. Following advice for senior involvement, early epidurals and performing third trimester weight were sub-optimal. We suggest standardised clinic letters, weighing patients on arrival to labour suite, reminders of management plan (alert stickers) and a clear definition of "senior" and "early epidural" in the ante-natal management plan.

Reference

1. Centre for maternal and child enquiries (CMACE). Maternal obesity in the UK: Findings from a national project. London: CMACE, 2010.

Epidural Abscesses – A Retrospective Audit of incidence and the significance of Catheter Tip Microbiology

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Background and Objectives

Spontaneous epidural abscesses occur but are rare. A recent review¹ and NAP3,2 acknowledge that whilst still rare, the incidence is probably in the order of 1 in 47,000² to 1 in 100,000.² Our aim was to get an incidence of infection related to epidural insertion from a nine year period and to see if there was any relationship between a positive tip culture and infection.

Method

The Acute Pain Database was searched from 1st May 2001 to 31st December 2009 for all patients who had an epidural for surgery. Of these patients, the total number with positive tip cultures were found and the total number with any infection including superficial/deep tissue and epidural abscesses.

Results

There were a total number of 1510 epidurals sited, of which there were 80 positive catheter tip cultures and 4 infections. This gives an incidence of colonisation at 5.3% and infection at 0.264%. Of the total colonised, 55 were coagulase negative staphylococci. There were no epidural space infections. There were 4 cases which developed localised infections at the site of insertion, these responded to treatment with organism directed antibiotic therapy, see Table 1. These cases all had a good outcome with no neurological sequelae.

Table 1.

<i>AGE</i>	<i>ASA</i>	<i>Immuno-compromise</i>	<i>Attempts</i>	<i>XS Top-ups/ Manipulation</i>	<i>Duration (hrs)</i>	<i>Symptoms</i>	<i>Organism</i>	<i>I&D</i>
42	II	N	2	N	96	Y	MRSA	Y
56	II	N	1	Y	72	N	S. Aureus	N
80	III	N	1	N	72	Y	MRSA/ Pseudomona	N
22	II	Y	1-resited	Y	96	Y	MRSA	Y

Discussion

With this data we can argue that contrary to other studies we have found it useful to send all catheter tips for culture. At £15 per patient, this is still cost effective.

Catheter tips may become contaminated on removal, probably representing colonization of the skin insertion site.³ Our data, does not aim to claim otherwise. However, if there are any signs of early or late (primary care) infection, appropriate organism directed therapy can be instituted immediately which can ultimately affect outcome. This case series has re-inforced that our practice is safe and that the incidence of both superficial infection and epidural abscess is rare.

References:

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2. Royal College of Anaesthetists 3rd National Anaesthesia Audit 2010.
3. Simpson RS, Macintyre PE, Shaw D et al (2000) Epidural catheter tip cultures: results of a 4-year audit and implications for clinical practice. Reg Anesth Pain Med 25(4): 360–7.

Audit of overnight admissions following day case shoulder surgery.

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Introduction

Day case surgery has advantages to patients and healthcare providers by reducing waiting times and easing pressure on hospital beds.

Development of arthroscopic techniques has allowed for the expansion of day case shoulder services, however post-operative pain control is a limiting factor. Regional anaesthetic techniques have remained underutilized in the day case setting [1]. Advantages of regional anaesthesia include better control of postoperative pain [2].

The British Association of Day case Surgery (BADs) recommends that 80% of therapeutic arthroscopy shoulder patients should be discharged on the same day of surgery [3].

Methods

All day case shoulder surgery patients in Dumfries and Galloway Royal Infirmary (DGRI) from April 2009 until October 2010 inclusive were investigated to see if BADs targets were being met. Total numbers of overnight admissions of day case shoulder surgery were calculated and case notes were retrospectively analysed with reasons for admission documented. If pain was the factor for admission then intra-operative and post-operative analgesia including regional blocks were noted. The data gathered was analysed and strategies to improve targets implemented.

Results

From April 2009 to October 2010 there were 75 therapeutic arthroscopic shoulder procedures. Of the total number of procedures (n=75) 25 patients required an overnight admission. Therefore only 65% of patients were discharged on the same day, thus not meeting BADs target of 80%. Of the 26 patients admitted overnight, 13 were due to pain and none of the admitted patients had received a regional block.

Discussion

Currently DGRI is not meeting BADs targets for day case arthroscopic shoulder surgery. Pain is the main factor why patients required overnight admission. The use regional techniques may reduce pain and decrease the number of overnight admissions. Therefore all patients, unless contra-indicated, who undergo shoulder surgery will receive an ultrasound guided inter-scalene nerve block and the number of overnight admissions re-audited to see if improvements have been made and BADs targets are being achieved.

References

1. Dexter F, Macario A. What is the relative frequency of uncommon ambulatory surgery procedures performed in the United States with an anesthesia provider? *Anesthesia and Analgesia*. 2000;90(6):1343-7.
2. Neal JM, McDonald SB, Larkin KL, Polissar NL. Suprascapular nerve block prolongs analgesia after nonarthroscopic shoulder surgery but does not improve outcome. *Anesthesia and Analgesia*. 2003;96(4):982-6.
3. [http://www.nodelaysscotland.scot.nhs.uk/Resources/ResourceGuideltems/Pages/BADsInformationSystem\(BIS\).aspx](http://www.nodelaysscotland.scot.nhs.uk/Resources/ResourceGuideltems/Pages/BADsInformationSystem(BIS).aspx)

Back pathology: the impact of antenatal anaesthetic clinic

Assessment

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Introduction

Back pathology is a referral criterion for the antenatal anaesthetic clinic. Neuraxial blocks can be a significant challenge in this heterogeneous group of patients.[1] This audit was designed to compare anaesthetic assessment and advice with actual management, delivery outcome and anaesthetic complications.

Methods

Data was collected retrospectively from case notes and clinic letters over a period of one year.

Results

Thirty four women with back pathology attended the anaesthetic clinic during the audit period. Thirteen (38%) had previously undergone back surgery and 21 (62%) had not.

Table 1: Summary of results

Back Pathology	No.	Delivery outcome	Anaesthesia
Microdiscectomy	4	1F, 3SVD,	2 Epidurals
Spinal fusion	4	4CS	4 Spinals
Rod insertion	2	1CS, 1SVD	1GA, 1Epidural
Abnormal curvature	5	1CS, 4SVD	1Spinal
Mechanical back pain	8	4CS, 4SVD	3Spinals, 1Epidural
Prev vertebral fracture	4	3CS, 1SVD	2 Spinals, 1Epidural
Disc prolapse	3	1CS, 2SVD	1Spinal
Others	4	2CS, 1F, 1SVD	1GA, 1Spinal

[SVD-spontaneous vaginal delivery; CS-caesarean section; F-forceps delivery; GA-general anaesthetic]

Two women were advised not to have any neuraxial block and four not to have an epidural. This advice was strictly adhered to. Senior assistance was advised for neuraxial block in three women. Two of these women were managed by Consultants, the other one did not require anaesthetic intervention. Three/five (60%) epidural blockades were not fully effective.

Discussion

The findings support current practice that women with back pathology should be assessed by an anaesthetist antenatally. Anaesthetic involvement in this particular patient group was 56% compared to 40% in the general obstetric population. Serious anaesthetic complications were absent. Safe conduct of neuraxial blockade in this challenging group was possibly supported by clear management plans formulated antenatally.

References

1. Smith PC, Wilson RC, Robinson APC et al. Regional blockade for delivery in women with scoliosis or previous spinal surgery. International Journal of Obstetric Anaesthesia 2003; 12: 17-22

Multicentre audit of anaesthetic practice in intrauterine fetal demise (IUFD)

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Introduction

Abnormal coagulation is not uncommon in IUFD: 3.2% of patients presenting with IUFD and no other co-existing disease have an abnormal coagulation, rising to over 50% in association with abruption. [1] Although the safety of neuraxial blockade in IUFD is controversial, a national survey found that 93% of respondents provided regional

anaesthesia for IUDF, and 41-76% offered epidural infusion analgesia (EIA) routinely depending on gestation, [2]

Method

We retrospectively audited the delivery summaries in three West of Scotland obstetric units from January-December 2010. We recorded incidence of IUDF, analgesia used, maternal trauma, and theatre interventions.

Results

There were 12632 deliveries in total and 54 (0.43%) cases of IUDF. Where recorded, analgesia was provided by Entonox alone in 33.3%, intramuscular diamorphine in 53.3%, and by morphine patient-controlled analgesia in 13.3%. EIA was not used. Perineal trauma was recorded in 23 patients (42.6%), with 16 (29.6%) theatre interventions of which 15 (27.7%) received neuraxial anaesthesia.

Discussion

The incidence of IUDF is similar to previous series. The majority of our patients receive opioids for labour analgesia. EIA is not used locally, and we speculate that a safety concern is one of several possible explanations for this. However, maternal trauma is actually very common in this patient group and many of these women receive neuraxial anaesthesia for a theatre intervention.

References

1. Maslow AD et al. Prevalence of coagulation associated with intrauterine fetal death. *Canadian Journal Anaesthesia* 1996; 43: 1237-43.
2. Sreelakshmi T et al. Intrauterine fetal demise – a national survey if pain relief in labour. *International Journal Obstetric Anaesthesia* 2010; 19: S9.

The disconnected epidural catheter: a survey of current practice in Scotland

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Epidural drug delivery demands sterility. However, the junction between catheter and connector forms a weak link in the delivery system, with relatively low tractive force causing disconnection and subsequent loss of sterility. National guidelines¹ do not address this complication, apart from advising that management plans be available. We conducted a scenario-based survey to assess how anaesthetists in Scotland respond to epidural catheter disconnection.

Results

Three hundred and twenty six responses were obtained. There was clear divergence in management, with 56% opting to reuse a disconnected epidural catheter and 44% preferring to remove and resite it. Of those cleaning the epidural catheter prior to reconnection, more than two-thirds (71%) would use an alcohol wipe. Chlorhexidine, saline and povidone iodine were advocated by increasingly small minorities (19%, 6% and 4%, respectively). In cutting the epidural catheter prior to reconnection, the majority (71%) would remove up to 5cm of catheter with only 2% of respondents removing in excess of 15cm. Measures to reduce the risk of disconnection were routinely taken by 63% of respondents.

Discussion

This survey of national practice confirms the divergence in management of the disconnected epidural catheter seen in previous smaller studies². Where reconnection is deemed appropriate, the little evidence³ available suggests that cleansing with betadine or chlorhexidine is preferable to alcohol swabs and up to 20 cm of catheter may need to be removed to eliminate bacterial contamination. Further research is needed to inform management of this dilemma, as it is likely to be a growing problem with epidural analgesia enabling ambulation and delivered in non-critical care settings.

References

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3. Langevin PB, Gravenstein N, Langevin SO et al. Epidural catheter reconnection: safe and unsafe practice. *Anesthesiology* 1996; 85: 883-8

Challenges to introducing remifentanyl patient controlled analgesia (PCA) in an obstetric unit

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Introduction

Remifentanyl PCA in labour is an alternative to more established analgesics. We were keen to promote its use in our department but usage rates remained low and so experience was limited. We aimed to ascertain if midwife attitudes to the PCA played a part in this and to compare them with a unit with an established PCA service (unit B).

Methods

A standard questionnaire was devised and midwives were questioned by two interviewers.

Results

60 midwives were interviewed (30 in each unit). 70% midwives in unit A had used the PCAs (median=1 use) compared with 97% of unit B (median=3).

Reason for use	No. midwife responses Unit A	No. midwife responses Unit B
Maternal request	1	23
Patient declined epidural	0	12
Epidural contraindicated	17	10
Intrauterine death	5	10
Failure to site epidural	1	3

Unit A midwives were less likely to suggest positive aspects of PCA use. 28.6% of unit A responders thought PCAs were a good technique, 28.6% average and 42.9% bad. However, 68.9% of unit B thought it a good technique, 24.1% average and 6.9% bad. The lack of widespread use was the most common reason for unit A midwives not having used PCAs before.

Discussion

Unit A midwives were less experienced in remifentanyl PCA use and there were more negative views on its use. It was more commonly used in a 'negative' situation when a patient was expecting an epidural but was presented with fewer analgesic options. In unit B, PCA use was more likely to be a positive choice by the mother. Further education is vital for staff and patients. Armed with this, improved knowledge and a potential change in attitude may break the cycle of inexperience and negativity thus presenting a positive analgesic option for labouring women.

Reference

- Hill, D. Remifentanyl patient-controlled analgesia should be routinely available for use in labour. *Int J Obst Anesth* 2008; 17(4): 336-339

Cardiac Arrest....where?

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Background

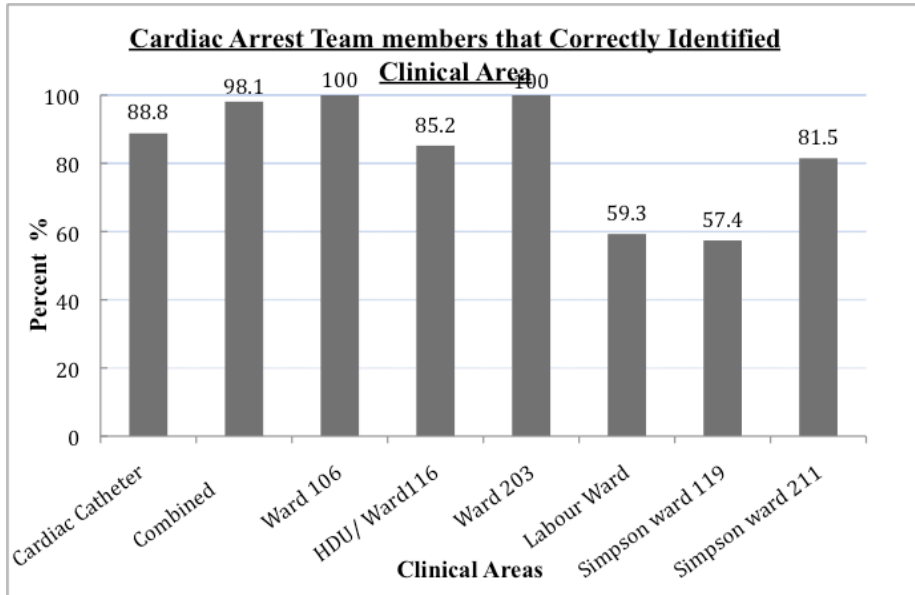
The Confidential Enquiry into Maternal and Child Health sets an audit target that 100% of cardiac arrest team members 'know where the maternity unit is and how to gain immediate access to it'. All maternity areas at the Royal Infirmary of Edinburgh are housed within the Simpson's building. This has previously proven difficult for the emergency staff to find and access, leading to delay managing seriously unwell patients.

Methods

We designed a form that included a map of each floor of the hospital. All current cardiac arrest team members were asked to mark several locations, both maternity and general, on the map without using any reference materials.

Results

There were 61 people currently working on the cardiac arrest team. 54 (89%) returned correctly completed forms. Overall the ability to locate maternity areas was poor. Variation amongst staff groups was apparent with only 20% (1/5) of CCU SHO's and 25% (6/24) of ALS trained nurses correctly identifying all 3 maternity areas, compared to 75% (6/8) of anaesthetic trainees.



Conclusion

We are currently failing to meet the target of 100% of cardiac arrest team members being able to find the maternity areas. Particular staff groups require focused orientation to the location of the maternity areas.

References

1. Lewis G (ed) 2007. Saving Mothers Lives: reviewing deaths to make motherhood safer - 2003-2005. London: CEMACH.

Variation in the Regional Anaesthesia Practice At Royal Hospital for Sick Children, Yorkhill (Glasgow)

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Introduction

Anecdotally a large variety of techniques and unlicensed drugs are commonly used in the practice of paediatric regional anaesthesia. This study was aimed at finding variations in regional anaesthesia practice among anaesthetists in order to reflect the current state of practice.

Method

Questionnaire about regional anaesthesia practice (consent, technique, drugs etc) was circulated in the department.

Results

This showed poor discussion (50%) & documentation (38%) of risk associated with regional blocks. Betadine was preferred for skin preparation before epidurals and chlorhexidine (0.5% & 2%) for caudals. Full aseptic technique was carried out for epidurals & caudal catheters but 'gloves only' technique was preferred (68%) for a single shot caudal injection. The commonest device used for caudal was a cannula (78%) with 65% using a 22G needle. Only 54% of anaesthetists believed in the risk of implantation of dermal tissue into the caudal extradural space. The most common additives for caudal were ketamine (76%) & clonidine (18%) whereas opioids were preferred for epidural.

Discussion

The use of 'gloves only' for single shot, use of unlicensed ketamine and 18g needle for caudal is mostly dependent on the anaesthetist experience. The results raised awareness regarding consent and documentation as suggested by AAGBI. Although the NAP 3 report showed no adverse effects in paediatric caudals, it stressed full asepsis for all central neuroaxial blocks [1]. A few case reports of arachoiditis with 2% chlorhexidine raise questions about its use for central blocks.

Conclusion

This survey provides a snapshot of current regional anaesthesia practice at a tertiary level hospital and we hope to raise awareness among current & future trainees regarding the controversial issues in paediatric practice in relation to asepsis, drugs used and the role of ultrasound. We also hope that this survey acts a useful reference for the development of new techniques and equipment in the future.

Reference

1. T.M.Cook. Major complications of central neuraxial block: report on the Third National Audit Project of the Royal College of Anaesthetists. British Journal of Anaesthesia 2009 102(2): 179-190

Annual Golf Outing, Forfar Golf Club June 2011

Forfar Golf Club hosted the Society's golf day in June 2011 with your Vice President Charlie Allison making most of the arrangements. The sequence of Crail/ Edzell/ Lanark in recent years has been so successful that we opted for more of the same. Like those courses, Forfar is not a British Open blockbuster (and so can be comfortably played twice in one day) but has roots in the history of Scottish golf and numerous enjoyable and challenging holes.

The course was laid out in 1871 by Tom Morris of St Andrews, one of the titans of golf's early history. Initially, refreshments were provided at a room rented from Lochhead Farm until a clubhouse was built in 1889. In 1920 the club was able to purchase the land on which the course sat for £700. 5-time Open champion James Braid, another giant of the game, was approached to alter the course in 1926. The club's web-site hosts a scanned copy of the actual letter he wrote detailing his suggestions. It is something of an understatement to say this is a million miles removed from the multi-million dollar industry that golf course design has become.

Forfar has undulating fairways lined by Scots Pine and lovely views towards the Angus Glens, in some ways similar to Edzell in 2009. As at Lanark and Edzell we were fortunate with the weather, with rain on only one hole all day. The morning Stableford saw Tony Moores from Yorkhill emerge as the victor with a fine 39 points. He was pressurised relentlessly by the outgoing Executive with Liz and I both competitive on 38 points. Of interest, Tony's golf was informed by his handheld golf navigation system, which provided all sorts of data. Initial scepticism amongst his playing partners was soon replaced by, "How far is it to the green from here, Tony?", "How far is it to get over the bunker, Tony?", etc, etc. Oh how we laughed.

After a tasty lunch, we implemented our new afternoon format, a Texas scramble with 4 persons per team. This perhaps lacked the historical weight of the old East v. West rivalry but was quick, highly enjoyable and provided a real flavour of team golfing. The top 3 golfers from the Stableford came together with Donald Macleod and proceeded to victory with a score of 66, prevailing by a single stroke from Paul Wilson and his team.

Another fine meal concluded the day and arrangements are already in hand for June 2012.



Left:
Colin Runcie Presents
the Morning Stableford
Winner Tony Moores
with the Shield. No sat
nav in sight!!

Below:
Pictures from the day.



www.scottishsocietyofanaesthetists.co.uk

Society Website

Includes:-

- Up to date information about meetings, membership and outings.
- Programmes, booking details and forms.
- Forthcoming attractions
- Membership forms
- History Articles
- The Annals: downloadable version

Bookmark it now!

The screenshot shows the website's navigation menu (WELCOME, THE SSA, JOINING, GRANTS, SPRING MEETING, TRAINEES MEETING, WSM, GOLF OUTINGS, OFFICE SECRETARIES) and a blue header with the society's name and logo. A red-bordered box highlights the 'Annual Spring Meeting and Trainees Meeting Registration Now Open!!' announcement. Below this is a portrait of Dr. Paul Wilson, President of the Society, with a brief history of the society (founded in 1914) and its aims. A list of 'Here you will find:' includes details of meetings, business of the society, grant application information, history, and golf outings. The President's bio notes he worked in Ayrshire and Arran and is being succeeded by Charlie Allison. A second red-bordered box lists 'Upcoming Attractions / Dates for your diary', including 'The Four Professors' (Feb 3rd 2012), 'Royal Society of Medicine Regional Meeting in Glasgow' (in association with the SSA), 'Call for Abstracts for trainees meeting' (Deadline 24th February), 'Trainees Meeting and Annual Spring Meeting: 11th & 12th May 2012' (Crieff Programmes for the Trainees and Spring Meetings), and 'Annual Golf Outing: 15th June at Newburgh-on-Ythan Golf Club'.

2012 Programme of Events

May 11 th	Annual trainees Meeting	Crieff Hydro
May 12 th	Annual Spring Meeting	Crieff Hydro
June 15 th	Golf Outing	Newburgh-on-Ythan Golf Club
November 15 th & 16 th	Joint Annual Scientific Meeting with RCoA	Dundee