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ANNALS- SCOTTISH SOCIETY OF ANAESTHETISTS

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THE ANNALS OF THE SCOTTISH SOCIETY OF ANAESTHETISTS

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Scottish Society of Anaesthetists

Council for 1998 - 1999

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Programme for 1999

Registrars Prize: Entries to be submitted to the Hon.Secretary by 28th February 1999.
Annual General Meeting: Peebles Hydro Hotel 23 - 25th April 1999
Trainee's Meeting: Stirling Conference Centre 17-18th June 1999
Scientific Meeting and Gillies Memorial Lecture: Kelvin Conference Centre, Glasgow
Friday 12th November 1999
Golf Outing: Ladybank Golf Club Thursday 3rd June 1999

PRESIDENT'S ADDRESS
John Thorburn

I was both flattered and delighted to be invited to be President of the Scottish Society of Anaesthetists, but it was with some foreboding that I accepted. There is a cost there are disadvantages to accepting this prestigious honour. I was conscious of so many illustrious predecessors who had so successfully filled the role with dignity, commitment and effect. There is, in addition the presidential address to be delivered. I had considerable misgivings as the goals of such address of entertainment, education and enjoyment appeared to be unattainable. I was, however, heartened when discussing these problems with Douglas McLaren, by his considered opinion that previous Presidents, had, on occasion, merely shown their holiday slides. Well, I had plenty of those.

As a schoolboy I was torn between going to sea (as a ship's officer, presumably) or becoming a doctor. I had always been attracted to the sea, I was keen on sailing, water sports such as swimming and my grandfather and uncle had been in the merchant navy. The former had regaled me with fascinating stories of calms and storms and life at sea in sailing ships. Despite the lure of the sea I opted for medicine, a decision which I have never regretted. In making this decision, I was able to pursue both careers. At the time I went to University, National Service was ending and so I felt that I had time to indulge in a little enjoyment before settling into general practice, which had been during my time at university my career choice. Another factor, which weighed with me, was that when I had almost completed my residencies I succumbed to some unknown disorder, which led to me becoming a relatively long-term inmate of Killearn Hospital, in the neurosurgical unit. At the time of my discharge, I could only walk a short distance, but Mr Sloan Robertson was of the opinion that a spell at sea would be of significant benefit to me. He had no knowledge of the sea or just how busy one could become looking after the 2 to 3 thousand people on a ship.

Off I went with the strength of almost two residencies behind me and various nerve palsies. My initial appointment as Assistant Surgeon to P&O Orient Lines, as they were known then, was to dock staff where one attended to the needs of the crew of the P&O cargo ships as they docked in the London. They did not carry a doctor and I was quite unused to seeing Chinese, Indians, Pakistanis and Goanese who did not speak any English, although the Serang (Bos'n) was very helpful. Hospital treatment (and a fair bit was required) was provided by the aptly named and very helpful, Greenwich Dreadnought Seaman's Hospital. After a couple of months of this I was then appointed to Orion, a 23 000 ton Orient Line ship built in Barrow-on-Furnace in 1935, (two years older than me). Orion was on the Australia run and was filled by British Migrants setting off to a new beginning in Australia. This was famous or infamous £10 assisted passage scheme, where for £10 per person a family could sail across the world. In my view, P&O looked after the passengers well, although the old ship was not air-conditioned nor stabilised and she could certainly achieve a 45(roll without any difficulty to the general instability of the passengers.

The medical staff consisted of two doctors, two nursing sisters, a dispensing pharmacist and a hospital attendant. This team had to meet all the health challenges that came our way. The challenges which befell us were those which would occur in any community of that number whose ages ranged from 6/12 to 90 years. There were approximately 700 children on board and on my first voyage a measles epidemic broke out. We did not have the staff to look after all the children who were ill and some of them were very ill with respiratory and middle ear infections but, fortunately, none died. Passengers were rather dismissive of the medical staff on board; the young one (me) was too young to know anything and the older one was at sea to escape from something. Ships' doctors had unenviable if well earned reputations for heavy drinking, although both surgeons I sailed with were virtually teetotal, this was very unusual. The other frequent problem was mental breakdowns among the passengers and the crew, I will return to that.

The voyage to Sydney took ten weeks as the old ship could barely be persuaded to do more than 14 knots. It is only when you go to sea that you realise just what miserable climate the UK, particularly Scotland has. A couple of days steaming south and the weather cleared and it was sunshine virtually to Australia. I learned a number of things aboard, one was how to dance on a shifting surface as the ship rolled and heaved its way across the ocean I also learned to undertake post-mortems, I had no idea just how common fatal coronary artery disease was. On the outward voyage Orion called at Piraeus to embark about 400 Macedonian Greeks. The frequently unaccompanied females carried a photograph of the person who was to marry them in Australia, usually someone that they had never met previously.

Many of them had never seen the sea before and were absolutely terrified as they climbed up the gangway, taking to their bunk and refusing to get up, even for food. Looking after them was difficult, a translator travelled with us, and he was a splendid chap, but he could only speak Greek and English, often we required two translators one translating the Macedonian Greek into Greek and then the second from Greek into English. Diagnosis required the skills of paediatricians and vets.

A fully equipped operating theatre was available, complete with anaesthetic machine, endotracheal tubes etc. Fortunately, we did not have to operate on any one, though I did correctly diagnose and appendix to my dismay and horror. It was a young steward, and he gave the classic history. I examined him; sure enough, tenderness and guarding in the RIF, classic. I had to go outside to wipe my brow as I thought we would have to operate on him. The surgeon had an FRCS, and I knew he liked surgery but I had never administered a general anaesthetic before. I confirmed the clinical examination and went looking for the surgeon. At this stage we were in the Red Sea, and when I told the surgeon he said put him on a drip and suction and antibiotics, we'll be in Aden to morrow and the RAF Hospital can look after him. And that was what happened, to my great relief. A second patient was admitted to the RAF Hospital as she thought she had swallowed her false teeth, and we decided not to take the risk of carrying her to Australia.

Ship's officers had special privileges, among them was permission to go on the various tours available at the various ports of call. This enabled me to visit various parts of the world such a Kandy in Sri Lanka , the Pyramids and to explore the Australian cities. This was before tourism was on a large scale, as can be seen from the accompanying photographs.

Although we were busy outward bound, homeward was different. As the ship was old and not air-conditioned, aircraft did not at this time dominate the travel scene as they do now. Orion was the cheapest (and slowest) way of visiting Blighty, so we used to fill up with young Australians who were going to 'do' Europe, and did they enjoy themselves on the ship.

They were not all young. One of the most difficult moments in my medical experience to date (and since) occurred with an older man as we were leaving Adelaide. He came into the surgery in the afternoon, in a state of some agitation looking tense and angry and said he was being pursued by the New South Wales Police by Mental Nephlepathy I looked grave (scared, Glasgow University Medical School had not prepared me for this) thought, and in an inspired moment asked what range did the police have. Four hundred and fifty miles he told me so I reassured him, we would be out of range to morrow as Orion could cover abut that distance in 24 hours and I gave him 1000mg of largactil. He returned the next day and said that the Police had brought up more powerful transmitters, but by this time the largactil was beginning to have an effect, I gave him another 1000mg and had no more trouble just kept him going on largactil until we got to England.

Life on the Orion continued, idyllic homeward bound in general, rolling gently over the sunlight oceans, as she was the oldest ship in the fleet the usual P&O codes were relaxed, the passengers were in general young and fit and few problems. I was on the Orion for her last voyage. This is always touching; all the ships in the harbour blow their whistles when she leaves, flying her paying off pennant, farewell to a grand old lady. On the last voyage when passing another P&O ship it would sail much closer than usual and salute. Normally, ships that were approaching each other at something over 40 knots would steer well clear of each other. Orion had been a troop ship during the war carrying 7000 soldiers. We used to run out of drinking water during the longest part of the voyage between Sri Lanka and Freemantle as only 6 tons/day could be made; what they did for the soldiers I cannot imagine. Orion was the last ship out of Hong Kong before the Japanese invasion, so she had a chequered and interesting career.

I was sorry to leave her as I had thoroughly enjoyed the leisurely sea voyages, but I was transferred to the Canberra, at that time the latest and grandest of the 28 strong P&O fleet. This was a much larger ship, 45000 tons, faster, 29 knots and carried more passengers and crew. She was a two-class ship, and never should the two classes meet. Discipline and arrogance had pride of place, quite different from the Orion. Canberra was at the dawn of her career, as I was and I recently had a cruise on her which was her second last, when we were both old and finished our careers, I had just retired.

Canberra attracted a much older age group of passenger, although she still carried some migrants to Australia. The increase in age brought new challenges with it, one of them being more frequent post-mortems. It was customary, when a passenger died to undertake the statutory post-mortem as soon as possible and burial at sea, in my view, a sensitive and touching ceremony, although perhaps slightly remote from the victim's home and relatives. Burial was most frequently performed at 6 p.m. ship's time. The surgeon phoned me to tell me that an elderly passenger had died on 'A' deck and could I prepare for a post-mortem while he was brought down to the Hospital deck. This I did and when he was placed on the table I started the PM. I was somewhat taken aback when I, after I had opened his chest, to find how warm he was. My immediate thought was that he was not dead, as I had not examined him. My first thought was immediately followed by the second which was that the patient was certainly dead now.

The whole ship was run on a much more formal basis than Orion and it took some getting used to. Proper uniform had to worn at al times. Again, psychiatric problems were common. Remember we had no police

on board, no psychiatric hospital or others whom you could call on for help. I have given paraldehyde intra-trouserly with a disposable syringe; you have to be quick. Making the diagnosis could be difficult. One such case was a Goanese steward who suffered an intermittent low-grade fever, and was obviously not well. We had an X-ray machine on board but it was really incapable of doing chests, the exposure was too long and the vibration of the ship caused 'camera shake'. Similarly we could do WBC counts on board, but those of you who remember doing them will recall that the count was performed on a suspension under the microscope. Thus a WBC could not be done as again the vibration of the ship rendered attempts useless. A stained H&E blood film suggested to us amateurs that there was a leucopenia.

When we arrived at Colombo, the port –health medical officer saw the patient and immediately diagnosed typhoid. This was not a disease that we were familiar with, but the port health doctor exuded confidence. We were not sure how infective typhoid was or how dangerous and infectious it was in a closed community like a ship. We had no idea how we should manage the passengers and crew. Neither was the shipping company when we radioed the report home. The captain placed the survival of the ship in our hands. We had 3000 capsules of chloramphenicol on board, (the recommended treatment) this was quite a lot of drug, but it represented only one capsule each. In the best-honoured tradition we decided to do nothing and waited for other patients to attend surgeries complaining of the symptoms of typhoid. Needless to say we did not announce that we had had a patient on board who had been diagnosed as suffering from typhoid. We left Colombo, and a couple of days out we received a radio message from the Hospital in Colombo that the Goanese patient had basal pneumonia and was making good progress. Another cure.

Compared to hospital medicine I was living a hedonistic life with a steward to look after me needs, food that was in comparison to hospital food, out of this world. But all good things have to come to an end. So before I became too used to it I resigned and undertook an obstetric house job in the Rankine Hospital in Greenock, where, for that time I was self- taught. The seeds of bitterness, which I remember so well, had been laid by the appointment of a non-consultant grade the SHMO. When there was a problem the SHMO would say send for the consultant, I'm not a consultant, and the consultant appointed to Greenock worked in Paisley, George Barr. No one I ever met worked harder or longer hours than George or was more devoted to patient care. I have a profound respect for him, nothing was too much trouble, although he was always reluctant to phone the Greenock anaesthetists. They were of the opinion that the indication for Caesarean section at that time was pregnancy at the 38th week, although in reality the section rate was about 7%.

This was followed by a period in General practice in Helensburgh. My prescribing costs were very low, as I had been used to using the P & O formulary, i.e. Tincture of this and that, no expensive proprietary medicines; even antibiotics were to be prescribed with caution. Helensburgh was an idyllic place to work in GP, it had its own cottage hospital, consultants came from Glasgow and the Vale, many lived there and were helpful and interested. The debit side was the wet weather. I felt too young to settle down and decided to train in anaesthetics, and Glasgow Royal offered me a training post. After 2 years or so I thought that combining General Practice and anaesthesia in Canada would be attractive. So with one daughter and a pregnant wife off we went to Sarnia in south-western Ontario for 4 years.

I was surprised to observe the effect of fee per item of service as it led to over investigation and frequent and in some cases too many procedures being performed. Obstetrics I found completely different, no midwives, the medical staff delivered all patients. An anaesthetist had to attend all deliveries, principally to resuscitate the child but also to anaesthetise the mother if she showed any signs of delay which would result in keeping the obstetrician from getting back to bed or the office. Anaesthesia in these case was a magill circuit with penthrane and mask semi-consciousness and a quick forceps delivery. General anaesthesia for caesarean section required the patient to be prepped and draped, anaesthesia induced and as soon as the pentothal was in and before the scoline drip had its effect surgery started! This was not quite what I had been taught. I was not a certified (specialist) anaesthetist and I could see that specialisation was becoming more common, although at that time in Sarnia, only two of the 14 anaesthetists were actually certified as specialists.

So back to school, return to the UK and was interviewed by the late Dr James Crawford at Glasgow's Western Infirmary and who had no hesitation in exhibiting his complete confidence in me with the words, "I'll take anything in trousers". The rest some of you at least will be familiar with.

The more perceptive among you may have noticed that I entitled my talk 'Aspirations in Anaesthesia'. This can be defined as a desire to achieve something or the sucking of fluid into the air passages, this latter being one of the greatest maternal killers at the time of my appointment in anaesthesia. The former could be applied to the tortuous career that I pursued before my final medical appointment. But it has been of interest to me to attempt to improve the safety of anaesthesia particularly in obstetrics and to reflect on what guides 'good' practice in a medical specialty. There is no doubt that among the most important influences is the education, training and experience of the embryonic anaesthetist, but what maintains the quality.

I would like to look at some aspects of the specialty that may influence quality with which I have been involved.

Common sense would suggest that scrutiny of 'things that go wrong' would be a good place to start. Critical incident reporting has been in vogue for some time, but a literature search was disappointing. Apart from the work of Runciman in Australia, there are very few reports of a successful system, perhaps because anaesthetists are afraid that it might reflect on their practice, particularly if not everyone reports similar incidents.

Runciman's work is fascinating, he found that 80% of the critical incidents were the result of human error. In an analysis of 14000 admissions to 28 Australian Hospitals, 16% were associated with an 'adverse event' and of those 51% were considered preventable. It is not yet clear if Runciman's work has influenced the practice of anaesthesia. But it underlines the need for improvement.

If we turn to audit, which has been a favourite topic for some years now and the subject of huge investments in both time and effort in the NHS. Some audits with which I have been involved have been in existence for a long time. The Confidential Enquiry into Maternal Deaths is one of the longest running clinical audits and has influenced practice. The frequency of deaths from acid aspiration was highlighted for years until it also became clear that deaths were still occurring despite attempts to alkalinise the gastric contents. This has had a profound effect on both antacid therapy and also the avoidance of general anaesthesia. But not all audits are so rewarding.

In-house audits are important, but the influence on practice is less clear. Audit committees are always seeking for ways to close the loop, but an audit is merely a measure of activity, not of clinical effectiveness which requires even more resources. Does audit shape our practice? The Scottish Audit of Surgical Mortality has been running for some time now. In 1994 the then Chairman, the late Mr Hugh Forrest in his preface to the Report was of the opinion that of the 4484 deaths reviewed, only a very small proportion might have benefited by an alteration of practice. The views of various senior figures were sought and included in the publication, the NHS Chief Executive declared that as a response a Common Core Work Programme would be developed I am not sure what that means. The President of the Royal College of Physicians of Edinburgh stated that it demonstrated a need to improve in-hospital documentation. The President of the Royal College of Physicians and Surgeons of Glasgow took the view that it was a classic example of how audit should be carried out. I would ask has it altered anyone's practice or resulted in the drive for improved facilities?

The final aspect of medical practice that I have been involved in and would like to touch on briefly, is medico-legal work. I have been associated with over 60 cases, of which, so far, only two have come to court. But does the threat of lawyers watching our steps alter medical practice? It has been suggested that we might practice defensive medicine, but I have not been aware of it. It is interesting to look at anaesthesia for caesarean section. In the late 1960's the incidence of awareness and unpleasant dreams was highlighted following the administration of unsupplemented general anaesthesia for caesarean section. In 1972 Donald Moir published his seminal paper on the effective elimination of awareness when 0.5% halothane was added to the gas mixture without endangering the safety of both the mother or of the baby. Hitherto it had been thought of as too dangerous as volatile agents cause uterine relaxation which leads to haemorrhage, it had been argued. However, unsupplemented gas mixtures continued to be administered, although over the next few years there was increasing numbers given with the addition of a volatile agent. Mothers continued to be aware, but it was not until the mid 1980's that mothers sued successfully on the grounds of awareness. By that time very few anaesthetists were administering unsupplemented gas mixtures, so it was not the threat of the law that had caused the change, but it is not at all clear why it took so long before the use of supplemental agents became widespread.

It is my view that the law plays little part in shaping medical practice. In my experience negligence is not primarily based on one act, but either a series of actions which may have been based on one wrong or mistaken act, or the continuation of an act which should have been avoided or picked up earlier.

If it were clear what established good medical practice then the mechanism would have been put in place years ago. It is not clearly based on the introduction of the latest tool as I have outlined. Looking back, I am of the opinion that the price of clinical freedom is eternal vigilance.

EDITORIAL

The death of Bruce Scott has cast a shadow over Anaesthesia and this Society in particular. Bruce was a Past President of our Society, a great thinker and protagonist for our Specialty but above all a friend. Tony Wildsmith has written a fitting tribute to him in this years Annals but I am sure I speak for all members in extending our condolences to Joan and his family.

Well it has arrived: the 5 year SpR Training Programme. On the whole this has been warmly welcomed to most trainees I have spoken to. The sting in the tail is that it appears that the opportunity for current SpRs to opt for 5 years will only be open to those in years 1 and 2 of the current 4 year programme. Those in years 3 and 4 are unlikely to be offered this option. Council of our College were faced with a number of difficult problems; there were calls from the NHS Executive for a reduction in the output of trained Anaesthetists by upto 20%, calls from trainees and trainers for a longer training programme and concerns by many that a reduction in trainee numbers would have a serious impact on the ability of many Departments to deliver a service. To give them credit, our College has come up with what is a rather neat solution by extending the training programme to 5 years. At a stroke, this reduces the output by 20%, satisfies trainees and trainers whilst at the same time maintaining current trainee numbers. The losers you may consider to be the trainees currently in years 3 and 4. The reasons for excluding them are obvious and little to do with training - to offer them this would inevitably lead to a dramatic fall in output of trained Anaesthetists for at least one year. Manpower planning was never easy and Calman hasn't made it any easier. Still, we have now returned to a two year Registrar period during which trainees must attain FRCA before progressing to the 3 year Senior Registrar post, of which at least two years must be spent in a recognised training post and one year may be taken as an option. One achievement of all this upheaval has at least been to introduce a seamless training programme without the need for competitive interview, relying on internal assessment and satisfactory progression. Indeed one could make an argument for taking this to its logical conclusion and making the entire training programme from SHO to Consultant seamless. Anaesthesia, unlike Medicine, has remarkably few individuals who drop out from the specialty once appointed to an SHO post. I have no figures to back this argument up but it would be worthy of study.

In the beginning, we had clinical audit then quality of care and now clinical governance.

The 'fall out' from events in Bristol have still to be felt in full and Charlie Alison from Stracathro has given us an insight into the devastating effects such events can have on Departments and Hospitals in his 'news update'. A recent article in 'Hospital Doctor', in my opinion the prime purveyor of medical 'doom and gloom', highlighted the number of Consultants suspended pending enquiries, the assumption of 'guilty until proven innocent' and the inordinate time the whole process takes. Given the total number of Consultant Anaesthetists, remarkably few featured in the specialty league table. However that should not lead us into an air on complacency. We are just at much at risk and need to be seen to be putting our house in order, even allowing for the almost certain introduction of some form of reaccreditation as outlined by the GMC. The College's Guide to Good Practice and outlines for CME requirements are positive steps in showing that the profession takes the issue of the need to maintain standards seriously. However, once appointed to a Consultant post it is remarkable how infrequently we are observed or observe a fellow Consultant administering an anaesthetic. On the few occasions it does happen it can be a very useful learning or reminding exercise (and at times entertaining!). That it not to say we should all be travelling the country 3 days a year with two Consultants administering an anaesthetic (a recipe for sure disaster!), but to remind us, including the current years 3 and 4 trainees, that learning does not stop on appointment to Consultant, and I write as someone who has had to learn several new techniques as a Consultant from colleagues. There is never any shame in asking for help.

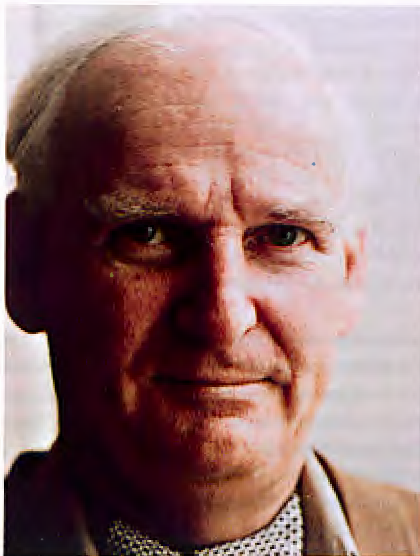
The other issue which is likely to have a major impact on the medical profession in Scotland including Anaesthesia, is the Scottish Parliament. Whatever your viewpoint on its inception, the reality is it will be here later this year. With 'Health' as one of the biggest budgets it will have to administer and 129 MSP's you can be sure that in the current climate towards the medical profession we will be put even further under the microscope. The possible implications for Anaesthesia in Scotland and the Society have been outlined in an article in this years Annals by Iain Davidson, a Past President.

Despite these clouds on the horizon, the Society continues to thrive. Lindsay Donaldson from Dundee was elected at this years Trainees Meeting in Stirling as the second trainee representative on Council and joins Pam Cupples who is currently away 'down under'.Their contributions to Council's deliberations are invaluable and much appreciated. Our overseas visitor Dr.Was, has written expressing her gratitude for the efforts made by members, some named (others not!), to make her stay educational and enjoyable. Her letter is reproduced here.

The entries for the Registrars Prize continue to be of an exceptional standard. Colin McCurdle's winning paper and Andrew Longmate's runner's up paper are reproduced in full. Our thanks once again go to Ohmeda who have kindly continued to sponsor this prize. On the Intensive Care Medicine side, we should acknowledge that 2 of the current 5 holders of the new Diploma in Intensive Care Medicine in the UK are members of the Society and from Scotland; Keith Kelly (Edinburgh) and Barbara Philips (Edinburgh, soon to be of St.Georges, London). This pool of talent is not confined to our trainees members but extends to full members with the discovery of hitherto unknown musical talent at the AGM. Perhaps most extraordinary of all, fish were caught at last year's AGM.

This is my last year as Editor. It is with a touch of regret that I hand over the Editorship but also some relief as someone else can relentlessly chase up much promised articles and put something together when they fail to materialise. My thanks must however go to all members who have contributed and made my life easy with articles on disk. I wish my successor well and I am sure he or she will ably take the Annals into the next millennium.

DONALD BRUCE SCOTT, MD FRCA FRCPEd
1925 - 1998



The sudden death of Bruce Scott has taken from us one of Scotland's world authorities in our specialty, because for nearly forty years no meeting on regional anaesthesia could have been considered truly international if he was not involved in it in some way or another. However, he was also very active on the local scene and no former President of this Society has been a greater supporter of the importance of its social aspects to the development of the specialty as was shown by his inauguration of the annual Society golf competition.

Donald Bruce Scott was born in Sydney, Australia on the 16th December, 1925 and moved to Britain at the age of three years. His family settled in Sussex and he attended Hove Grammer School before going to Edinburgh University Medical School, from which he graduated in 1948. He then spent a year as a junior hospital doctor in Sussex before spending four years in the Colonial Medical Service rather than undertake National Service in the Armed Forces (never a man to be regimented!). He spent this time in the Gold Coast (now Ghana), where his older brother lived, and then pursued his anaesthetic training back in Edinburgh, being appointed a consultant anaesthetist at the Royal Infirmary of Edinburgh and Senior Lecturer in the University in 1959. These posts he held until his retirement from clinical work in 1986, leaving the Department as consultant in administrative charge.

His interest in regional anaesthesia began early and he produced his MD thesis on epidural blockade while still a trainee. With the general antipathy to regional methods in the UK at that time, this may seem surprising, but the head of the Edinburgh Department at that time, John Gillies, had been involved with HWC Griffiths in the development of high spinal anaesthesia for induced hypotension, and he provided firm encouragement. Most of Bruce's clinical work as a consultant was with the specialty of obstetrics and gynaecology and his work was supported by the then Professor, Robert Kelly. Shortly after his appointment as a consultant, he spent another year in Africa at Ibadan in Nigeria, where he helped develop an academic and clinical service.

ON his return to Edinburgh, Bruce took up his other major research interest, the study of cardiovascular dynamics, particularly the changes associated with pregnancy. Perhaps almost as important as the demonstration of the occlusion of the vena cava by the gravid uterus was the fact that the work was performed by a truly multi-disciplinary research group (long before this was fashionable) that included obstetricians and physicians. Their work had a significant impact on the management of the supine hypotensive syndrome, particularly during operative delivery under general or regional anaesthesia. He was also involved in studies of the ant-arrhythmic actions of local anaesthetic drugs, this being one aspect of his work that led to his election as a Fellow of the Royal College of Physicians of Edinburgh in 1980.

All of this was accompanied by a prodigious output of publications and significant contributions to the organisation of the specialty. As well as being President of this Society, he was President of the Obstetric Anaesthetist's Association and founder President of the European Society of Regional Anaesthesia which has done so much to foster the development of regional anaesthesia in Europe. However, perhaps his most important work in promoting regional anaesthesia was performed within established organisations. He served for many years on the Editorial Board of the British Journal of Anaesthesia, insisting that studies involving regional anaesthesia should meet the same standards as any other, notably the employment of randomised and double-blind methodologies. He also served a full term on the Board of the Faculty (now Royal College) of Anaesthetists and was instrumental in ensuring that all UK anaesthetists received training in regional techniques.

For many years his interest in local anaesthetic drugs and techniques had involved collaboration with the Pain Control of Astra Pharmaceuticals, and two outcomes of this association are notable. Firstly, he persuaded the company to endow an annual Clinical Research Fellowship for an anaesthetic trainee, a position that

produced many benefits for the individuals appointed, as well as for the study of regional anaesthesia. Secondly, his association with the company was one of the key factors that led to the establishment in Edinburgh of the Astra Clinical Research Unit, of which he was Deputy Director for six years after his retirement from clinical practice. Even retirement from that post did not stop him. He continued to teach, to travel and to write, notably with his great friend the late Ben Covino.

Such a record of achievement, marked by many awards, would have been enough for many men, but there was much more to him than this. He had a great love of music, a sociable personality and a unique sense of humour with an inexhaustible fund of stories to go with it. He was a fine sportsman who gained a University Blue at soccer and who was always a formidable competitor on the golf course, seeming to me to specialise in three ball matches for which he had his own scoring system with one inevitable winner! Invitations to play with him on a Sunday morning equally inevitably meant an early start, not only because he was an early riser, but also because he had to be home in time to cook the family's lunch! He was a talented chef who had a great appreciation, and knowledge, of malt whisky and fine wine. A lovely man of many talents.
At the heart of all this lay his family: his wife Joan, their six children and ultimately many grandchildren. He was proud of them, and they of him and I am sure all Members of the Society share their loss. Bruce was a superb clinician whose robust approach to the practice of anaesthesia fuelled rather than impeded his pursuit of research and development. His views were summed up in the final paragraph of his Presidential Address;

"The whole of medicine, be it clinical practice or academic endeavour, if it is to be well done, depends upon having a balanced view of the evidence such as it is. Many things will try to distort this balance: fashion, spurious results of investigations, exaggeration of minutiae. Not least in importance, if we are to assess all the evidence properly, is the ability to rethink our beliefs and very occasionally to throw them overboard."

J.A.W.Wildsmith

GILLIIES MEMORIAL LECTURE

Professor Alan Aitkenhead
University of Nottingham Department of Anaesthesia

The 1998 John Gillies Memorial Lecture was delivered by Professor Alan Aitkenhead at the Annual Scientific Meeting of the Society on the 30th October at the Royal College of Physicians in Edinburgh.

In line with the theme of this lecture, Professor Aitkenhead addressed the issue of safety in Anaesthesia. However, he took a very radical and topical approach, namely that from a legal point of view. After several discussions between your editor and Professor Aitkenhead, we elected not to reproduce this lecture in print. Suffice it to say, members were dissuaded from shooting themselves and the President, very kindly, offered counselling.

TRAINEES MEETING
STIRLING 11-12th JUNE 1998

The Scottish Society of Anaesthetists Trainees Meeting was again held at Stirling Royal Infirmary Postgraduate Centre for the second year in its new format over two days from 11-12th June.

The Postgraduate Centre at Stirling Royal Infirmary is conveniently close to the Scottish Clinical Stimulation Centre *(on the grounds it in fact!)*. This allowed an opening session which included a live video link to the simulator with the enactment of a typical simulator scenario. This was both informative and entertaining. We all managed to get a closer look at the simulator during the coffee breaks throughout the meeting. The afternoon of the first day was concluded with an appropriate talk from the President of our College, Professor Leo Strunin, on the subject of eating and drinking prior to anaesthesia (receiving it not giving it, that is!).

On the social side, we were once again able to enjoy the stunning surroundings of Stirling Castle as we ate, drank and made merry.

The second day of the meeting started appropriately at 9.30. The first session provided an interesting insight to vascular disease from three points of view; the physician's *(the artist - edit)*, the surgeon's *(the stamp collector- edit)* and the anaesthetist's *(the connoisseur - edit)*.

Colin McCartney from Aberdeen Royal Infirmary went on to present his Scottish Society Registrar Prize winning paper on 'Pain and Disability Following Amputation' and this was followed by talks on the mechanism behind nerve injury and pain, and the molecular basis of anaesthesia by Professor Lambert.

The final session of the meeting centred around the controversial topic of thromboprophylaxis and regional anaesthesia, new left-handed local anaesthetic drugs *(not for me - I'm definitely right handed - edit)*, and the benefits of thoracic anaesthesia *(are there any? I presume epidural - edit)*.

The President of the Society, Dr.John Thorburn, brought the meeting to a close with a few well chosen remarks.

Aside from the educational and social aspects to the meeting, the trainees present elected Dr.Lindsay Donaldson, SpR in Dundee, as a trainee representative on the Council of the Society.

In order to try and assess the enthusiasm for continuing an annual two day meeting, we circulated a questionnaire. The responses from this highlighted several areas of difficulty which included study leave budgets being limited, clashes with other meetings and a clash with the final part of the FRCA exam being in close. However, the response to our questionnaire would indicate that the majority of trainees were in favour of continuing with the two-day format of the meeting.

Despite the drop in numbers attending this year's meeting for reasons already alluded to, this was a remarkably successful and enjoyable meeting, which will hopefully continue. We are extremely grateful to the Society and Simms Portex for their continued support of this meeting.

Lindsay Donaldson, Dundee.

REGISTRARS PRIZE
Sponsored by OHMEDA

Colin McCartney
Aberdeen Royal Infirmary

PAIN AND DISABILITY FOLLOWING LOWER LIMB AMPUTATION .

Introduction

Chronic pain affects a significant number of individuals after surgery. This problem has particular relevance for anaesthetists because the anaesthetic technique and method of pain management in the peri-operative period may have an important influence on the genesis of chronic pain. Chronic pain after lower limb amputation is especially common [1,2]. There are approximately seven hundred primary lower limb amputations in Scotland each year [3]. Post-amputation pain can be persistent and difficult to treat. In a study of 5000 American amputees less than 1% of respondents with phantom pain had found any beneficial therapy [1]. Recent studies have shown that pain is a significant factor in poor rehabilitation and quality of life after amputation [4,5].

A study was designed to evaluate the frequency and natural history of phantom limb sensation, phantom limb pain and stump pain and to assess their effect on the quality of life of lower limb amputees. This included an assessment of pain-related disability. The degree of pain-related disability may give an indication of the severity of pain after amputation [6].

Methods

The study design was a historical cohort based on all individuals who had undergone lower limb amputation between 1989 and 1995 in the North East of Scotland. This included all patients who had undergone lower limb amputation in Aberdeen Royal Infirmary, Royal Aberdeen Children's Hospital, Woodend Hospital, Aberdeen and Dr. Gray's Hospital, Elgin. The study was approved by the Joint Ethical Committee and by the General Practice sub-committee of the Area Medical Committee and included permission to tape interviews.

Patients were identified in the Scottish Morbidity Records system (SMR1) using the OPCS operation codes. This method identified 299 lower limb amputations in 280 patients including 95 above knee and 204 below knee procedures. The 280 patients identified consisted of 167 men and 113 women. The current vital status at the beginning of 1996 of the 280 patients was sought using the Community Health Index.

Of those patients who underwent lower limb amputation between January 1989 and December 1995 only 82 (27.5%) were alive at the commencement of the study. The General Practitioners of each of the survivors was approached and asked about the suitability of their patient to participate in the study. Questionnaires were sent by post to all those considered to be suitable. Patients were asked to complete and return the questionnaire in a stamped, addressed envelope. A reminder was sent to non-responders after a two-week interval. The reminder included another copy of the questionnaire. Patients who were unwilling to take part in the study were asked to return the questionnaire in the pre- paid envelope.

A self-administered questionnaire was used. The questionnaire was piloted on a number of in-patients in the Vascular Surgery ward at Aberdeen Royal Infirmary. Clear instructions on completion of the questionnaire were given on the front cover and inside the questionnaire. The questionnaire contained requests for demographic details, questions on general health status and detailed questions on phantom limb sensation, phantom limb pain and stump pain. The Von Korff Chronic Pain Questionnaire was included to assess the effects of post-amputation pain on quality of life. This questionnaire includes seven questions which are each scored and the total gives an ordinal figure which places the respondent in one of four groups and gives an estimation of pain related disability. The questionnaire also contained an opportunity for amputees to make comments about pain experiences following their amputation. In addition all respondents who completed and returned the questionnaire were asked if they would consent to interview in order to collect qualitative data on post-amputation pain.

Patients, resident in Aberdeen, who completed the questionnaire and stated their willingness to participate, were selected for interview. All patients selected for interview had experienced phantom pain. The interviews were all conducted by the same interviewer based on a semi-structured format to ascertain qualitative insights about the patients' pain experiences and the impact on their quality of life. The interview format was based on questionnaire responses and on the results of the pilot study. The interviews were taped with the permission of

the patients and were transcribed for analysis of themes. A total of ten interviews were performed (6 males and 4 females) and lasted approximately 30-40 minutes.

Data analysis was performed using the statistical software SPSS for Windows version7.5. Frequency analysis, chi-squared tests or independent t-tests were used to assess any relationship between the variables. Significance was calculated using Fisher's exact test. Survival analysis was performed using the Kaplan-Meier survival test. The relationship between type of amputation and frequency of pain was assessed using the Mann-Whitney-U test. Responses to the open comment question were analysed using conventional methods for textual data. The qualitative data obtained at interview was analysed using conventional methods for qualitative data.

Results

The 280 patients identified as having had a lower limb amputation consisted of 167 (59.6%) men and 113 (40.4%) women. The mean age of the patients at amputation was 70.9 years. Of the 280 patients in the study, 47 died before being discharged from hospital and a further 151 had died by the end of 1995 leaving only 82 survivors. The mean survival time of the 198 deceased was 1086 days (SE=72; 95% CI=944-1227) and the median survival time was 678 days (SE=111; 95% CI=461-895).
Twenty-one patients were considered unsuitable for the study, 11 were considered unfit, 3 had left the area, and a further 5 had died subsequent to the check on vital status at the end of 1995. Questionnaires were sent to 61 patients and after reminders, responses were received from 47 (77%) however only 40 questionnaires were fully completed and suitable for analysis. The characteristics of the respondents were as follows, five had bilateral amputations.

	Men	Women
Sex	24	16
Mean age (years)	61.5 (SD 18.3)	64.9 (SD 14.5)
Median age (years)	67 (range 12-86)	64.5 (range 27-92)
Above knee amputation	8	4
Below knee amputation	16	12

Table I: Characteristics of Respondents

Twenty out of the 40 were homeowners, 16 lived in council housing and three lived in housing association accommodation. A total of 16 (40%) received home help services and 9 (23%) had additional nursing support. Five patients had both home help and nursing support. A total of 37 used an artificial limb and 29 had a wheelchair, 26 used both. Thirty-five percent reported having diabetes, 28% heart disease, 10% a stroke and 5% had lung disease.

(i) Phantom Sensation

A total of 31 (80%) reported experiencing phantom sensation at some time since their amputation, 8 with immediate onset, 11 with onset between a week and a month, and 12 after one month. Twenty-four out of the 31 still experienced phantom sensation at the time of the study while 7 no longer experienced pain sensation. Of these five stated that the sensation had gone on it's own and two had gained relief with treatment. Most reported that the intensity was variable and the frequency varied from continuous to less than once per month, 13 reported that they experienced phantom sensations at least once per day. There was no relationship between type of amputation and frequency of phantom sensation occurrence (p=0.96).

(ii) Phantom pain

A total of 31 (79.5%) reported experiencing phantom pain at some point following the amputation, 9 with immediate onset, 10 between one week and one month, and ten greater than one month. Of the 31 patients who had ever experienced phantom pain, 24 reported that they still experienced pain at the time of the study. Seven patients reported that they no longer had phantom pain. Of these five stated that the pain had gone away on it's own and two patients had gained relief with treatment. The intensity of phantom pain was variable and frequency varied from continuous pain to pain less than once per month. There was no relationship between type of amputation and frequency of phantom pain occurrence (p=0.85) and no difference between the age of patients who did and did not have phantom pain (p=0.707).

(iii) Stump Pain

Twenty-seven respondents had experienced stump pain at some time following their amputation, 7 with immediate onset, 8 between one week and one month and twelve greater than one month. Of the 27 respondents who had ever experienced stump pain since their amputation 21 (77.8%) stated that they currently experienced such pain. Five respondents reported that they no longer suffered from stump pain and that the pain had gone without treatment. The intensity of stump pain was variable and frequency varied from continuous pain to pain less than once per month. . There was no relationship between type of amputation and frequency of stump pain occurrence (p=0.67) and no difference between the age of patients with and without stump pain (p=0.546).

Data regarding onset and frequency of pain after amputation are as follows:

	Pain Sensation	Phantom Pain	Stump Pain
At any time	31	31	28
Immediate onset	8	9	7
A week to a month	11	10	8
More than a month	12	10	12
Still Present	24	24	21
Now stopped	7	7	5
At least daily	14	9	9
Variable	19	20	16

Table VII: Onset and frequency of pain sensation, phantom pain and stump pain

The relationship between phantom sensation and phantom pain is shown below:

Phantom Pain	Phantom Sensation		
	Present	Absent	
Present	25	6	31
Absent	6	3	9
	31	9	40

Table VIII: Relationship between phantom sensation and phantom pain:

There was no association of gender and amputation type with post-amputation pain.

Treatment of Pain

Of the 29 patients currently experiencing post-amputation pain only 16 (55%) currently used any therapy for the pain. Therapies included paracetamol, codydramol and coproxamol, MST, carbamazepine, amitryptiline, non-steroidal topical creams and transcutaneous electrical nerve stimulation (TENS). Only 6 patients were satisfied with their pain therapy. These included one patient using paracetamol, 1 MST, 1 coproxamol, 1 codydramol and 2 carbamazepine.

Disability in relation to post-amputation pain

All respondents currently experiencing phantom pain (n=24), stump pain (n=21) or both (n=16) were asked to complete the Von Korff Chronic Pain Questionnaire. The pain grade of the 29 patients are shown below:

Pain Grade	No.	(%)
Grade I (low disability-low pain intensity)	13	44.8
Grade II (low disability-high pain intensity)	7	24.1
Grade III (high disability-moderately limiting)	2	6.9
Grade IV (high disability-severely limiting)	2	6.9
Missing responses	5	17.2
Total	29	100

Table X: Pain grade of 29 patients with pain at the time of the study

Qualitative Findings

Twenty respondents gave comments on their experience of post-amputation sensation or pain.

Two respondents gave comments in relation to phantom sensation.

"I want to scratch my foot and I can move the toes on my amputated foot".

"I feel as if the amputated leg is still there when I lie down to sleep".

Seven respondents gave comments in relation to phantom pain.

"I have a pain in the foot which radiates to the stump, it is like an electric shock and makes the stump jump".

"I still feel the bad corn on the amputated toe"

"The pain itself (phantom and stump) is the most important thing and to be rid of it would be a great relief".

"The phantom pain and stump pain is worse at night. Some days it seems as though the pain is in the foot".

"Having endured intense pain before the amputation I didn't think it was possible to experience the same sort of pain one year later".

"The pain is similar to that I had before the amputation. It is like cramp at the bottom of the foot that won't go away."

"Exercise and walking help to reduce phantom pain".

Five respondents gave comments in relation to stump pain.

"I still have neuroma pain and difficulty having a limb fitted properly".

"Stump pain is only there when I use my prosthesis. If I do any activity for one day I have to rest the limb for three days. The stump is painful and weeping".

"I get pain from the prosthesis".

"I get pain related to stump bleeding".

"The pain in the stump has a nagging, tingling sensation".

Two respondents described phantom pain in relation to using a prosthesis.

"I get dull aching at the ankle, along the top of the foot and across the toes especially when wearing a prosthesis".

"The phantom pain stopped when I started using a prosthesis".

One respondent commented that they would like more information on available therapy.

Interviews

Twenty seven respondents who completed the questionnaire agreed to be interviewed.
As phantom pain experience was of particular interest only those patients who had experienced phantom pain were interviewed. Ten interviews were performed on subjects who lived within the city of Aberdeen.

Interview results:

Seven patients currently suffered from phantom pain. The pain varied in its description from "sharp, hot", "cramping" to "knife-like".
Two patients said that their phantom pain was worse at night.
Seven patients said that phantom pain occurrence followed no pattern. This is illustrated by one patient who stated that:
"the thing that I couldn't handle was not knowing when the (phantom) pain was going to come on. If I knew that at the end of the day it would start, I could have coped with that".

All of those interviewed had also experienced pain pre-operatively. Seven patients stated that the phantom pain they experienced following amputation was not the same type of pain as the pre-operative pain. Three patients stated that the phantom pain was similar to the pre-amputation pain. This is illustrated by the following quote:
"I had a 'hole' in the side of my foot which they were trying to cure before my amputation.....it was ulcerated. They used to put stuff in it to try to burn the ulcer. That is the kind of pain I get at the side of my ankle were the ulcer was".

All of those interviewed continued to experience stump pain. Two patients described the stump pain as being "dull and constant" and two patients described it as being "sharp and transient". Three patients described their stump pain as being like an "electric shock" which makes the stump shake and jump, over which they have no control.
When asked about aggravating or relieving factors one individual stated that phantom pain was aggravated by wearing the limb prosthesis. One individual felt phantom pain was relieved by wearing the prosthesis. Three patients said that their stump pain was aggravated by wearing of their artificial limb and/or mobilising. Stump pain was relieved by rubbing the stump in three cases.
Four individuals stated that pain was worse in cold weather.

In relation to the effect of pain on lifestyle five individuals felt that pain affected their sleeping pattern and three felt that pain experiences affected their mood. Two individuals were under retiral age and felt that pain was a significant factor in preventing them from being employed. Five of those interviewed stated that pain decreased their ability to mobilise.

Six of those interviewed had sought help for their pain (general practitioner, 2; limbs and appliances centre,5; pain clinic, 3 and complementary therapies,2). Four individuals had tried TENS machines and two had found these helpful. Two had been prescribed carbamazepine which gave some relief. One individual had tried acupuncture for phantom pain and found it to be of no help. One individual had been cured of phantom pain by using hypnotherapy:
"Under hypnosis he went into my subconcious and told my subconcious that my leg was no longer there. After two sessions the phantom pain had gone".

Of those individuals who had not sought help for their pain one said:
"I was feart to tell them aboot the pain in the leg that wasnae there in case they laughed at me".

Two individuals had surgical revisions of their stumps to remove painful neuromata. In both cases the pain returned.

When questioned about information received preoperatively on postamputation pain five individuals would have liked more information.

Discussion

The reason why acute pain should become chronic in a proportion of patients after surgery remains to be fully elucidated [7].

Chronic pain is common after lower limb amputation and preventing the onset is a challenge. To date no firm evidence has emerged regarding efficacy of preventative strategies but interest has centred on the pre-emptive analgesic effect of perioperative neural blockade [8]. Although initial studies showed promise recent results have been less convincing [9]. Pre-emptive analgesia has so far failed to live up to expectation [10] and the 'Holy Grail' of preventing chronic pain after surgery continues to be evasive. Combining analgesic therapy at a number of sites of action may be more beneficial [7]. In particular therapies involving the NMDA pathway continue to show promise [11,12].
Treating post-amputation pain is also difficult [13]. In one large study only 1% of patients with phantom limb pain had found any beneficial treatment [1].

We found that phantom sensation, phantom pain and stump pain are all common after lower limb amputation. These figures agree with other large retrospective studies and smaller prospective studies of pain after amputation [1,2,14].

Pain is common after amputation but none of the aforementioned studies attempted to identify patients with pain-related disability. Those patients with

disability in relation to pain may have pain of greater severity than those without disability [6]. In our study 4/40 (10%) individuals suffered pain that caused severe disability and was moderately to severely limiting to lifestyle. This group may benefit from aggressive management of the pain problem in order to improve their lifestyle. Of the four patients most disabled by pain in this study, none had been referred to a specialist in pain management. In addition only three out of ten patients interviewed with phantom pain had been referred to a pain clinic. In order to achieve a greater response to therapy it is important that patients are referred to centres with the skills and resources to deal with intractable pain. In addition of the ten patients that were interviewed five would have liked more information about the prospect of pain after amputation. Although all patients in this study received counselling about pain before and after amputation more intensive counselling may be required.

It is important to determine the natural history of pain after amputation to assist the design of any future interventional studies. In addition to measuring the frequency of pain in a population it is also important to assess pain severity. This can be carried out using quantitative and qualitative methods. This study is the first to use an objective questionnaire that specifically assesses pain-related disability. These techniques could be used preoperatively and again in the postoperative period both to determine if an intervention has reduced the number of patients with pain and more importantly the number of patients with pain-related disability. Most pain management clinicians would regard successful interventions as those that reduce pain but also those that decrease disability and improve lifestyle even if pain remains constant.

Pain after lower limb amputation is common. However only 10% of individuals have pain that has a moderately to severely limiting effect on lifestyle. Future research should be aimed at determining if interventions such as pre-emptive analgesia reduce not only the frequency and severity of chronic pain after amputation but also the degree of pain-related disability.

Those patients with the greatest disability in relation to pain should be located and assessed to determine if access to pain clinics and rehabilitation services can reduce pain and disability and therefore improve quality of life.

Prolonged acute pain may predispose patients to chronic pain [15] and it is the responsibility of anaesthetists to provide the best peri-operative analgesic techniques so that the risk of developing chronic pain is minimised.

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The Scottish Society of Anaesthetists and The Scottish Parliament

During the summer of 1997 your Council recognised that the coming of the Scottish Parliament was likely to have significant implications for the medical profession in Scotland as a whole and Anaesthesia in particular. This served as a stimulus to carry out a wide ranging review of the Society's functions.

To appreciate the background to your Council's deliberations, it is necessary to look at the probable effects of the coming of the Scottish Parliament.

The Parliament will have 129 members, of whom 73 will be elected from existing Westminster constituencies on a 'first past the post' basis. The remaining seats will be elected from a party 'slate' based upon the regional system used in the European elections. Candidates in this later section will be elected taking into account the votes cast for each party's 'slate' and the number of successful members from that party already in place. The effects of this system are that all major parties are likely to have at least one seat in each region and that any one party is most unlikely to gain an overall majority. This has at least two important consequences; independence is not likely to be high on the agenda as only the SNP favours it and that there will be a tendency towards consensus politics.

The Parliament is set to operate in a different mode from Westminster, with much of the business being conducted in committees. These committees will be able to initiate legislation and will be obliged to consult. Of the subjects devolved to the new Parliament, Health will have the largest budget and, given that it is also the top doorstep issue for politicians, it is likely that a significant number of the new Members of the Scottish Parliament will take a major interest in it.

It was obvious to your Council that as a professional group we will need to learn to relate to politicians rather than as at present, to departmental officials. Furthermore, we will need to learn to take the initiative and become proactive. There is a clear need for the profession to establish issues to which politicians can espouse.

There has already been an indication that, given the poor level of health within Scotland, the emphasis in the new Parliament will be on Public Health and Prevention. We are already seeing organisational changes which reflect this and affect the standing of the Acute Trusts.

Anaesthesia is represented by some 13% of the Consultant body within Scotland. The Scottish Royal Colleges, by virtue of their history and physical presence, have considerable standing within Scotland and by comparison, Anaesthesia is at a significant disadvantage.

Against this background, in November 1997 your Council set up four working groups with remits to review;

- The implications of devolution for the Society and the links with our Royal College.
- The Society's finances and Educational activities.
- The responsibilities of Regional Representatives.
- Trainee representation on Council.

The reports from these working groups were considered in March 1998 and a number of issues addressed which would help point the way forward for the Society. These were;

- The importance of maintaining a unified body of Anaesthetists within Scotland, whilst recognising the differing interests and responsibilities of other organisations to which Anaesthetists belong.
- Strengthening the links with our Royal College and the BMA and SCHMS.
- Ensuring our financial base is sound.
- Recognition that a significant part of our income is derived from the 'trade'.
- Recognition of the need to explore other sources of income, including the possibility of further meetings.
- Recognition that if the Society is to become pro-active, additional expenditure will be inevitable.
- The need to review and consider the structure of Council, including the representation of trainees and co-option from the Scottish Standing Committee of the Royal College of Anaesthetists and other specialist Societies, both U.K. and Scotland based, in which Anaesthesia has a strong representation.
- The importance of ensuring that our system of election to Council and appointment of Office Bearers, is patently democratic, whilst maintaining our regional representation.
- The need to review the position whereby all those Office Bearers are present in one Region and how this may disadvantage other Regions.
- The need to review the term of Office of President in light of any changes in the direction and function of the Society.

A summary of these deliberations was reported to the AGM in April 1998 and members of the Society were asked to discuss these locally. Council will continue to debate these issues over the current year and will make a report, with recommendations, to the AGM in April 1999.

Iain A.Davidson
Immediate Past President
Scottish Society of Anaesthetists.

VISITING FELLOW Dr. Malgorzata Was

Dr.Malgorzata Was was invited by the Society as this year's visiting fellow. Malgorzata hails from the Silesian Medical Academy in Katowice, Poland. As always, I have published her letter to the Society in an unedited form.Unfortunately we do not have a photograph.

Dear Members of the Scottish Society of Anaesthetists

It was a great honour and pleasure to be your guest. I was really lucky to have this opportunity. During three weeks in Scotland I met many very friendly people and I was impressed with your hospitality and commitment. I felt very well being in your company.

I should like to stress that everything I saw in your hospitals is of great value for me as it enriched my experience and I believe it will help me much in my professional career. The list of hospitals I visited is long and in every single one I received a warm welcome and helpful professional assistance.

Please be assured that I passed on to my principals and fellow doctors all the information on everything interesting I saw and heard during my short stay in your hospitable country.

Here I must admit that all of them were impressed by the organisation of your medical service, which in a matter of fact is something that we really envy you.

May I also in this way express my gratitude to all the people who helped me to move around your hospitals. I would like to send special thanks to Dr. C. J. Sinclair, Dr. A. Lee, Dr. S. Mckenzie, Dr. C. Jung, Dr. Simpson, Dr. McGrady, Dr. Runcie, Dr. Kinsella, Dr. Frane, Dr. Binning, Dr. E. Wilson, Dr. J. Colvin, Dr. G. Hutchison, Dr. P. Lacoux and Sister Ch. Yuill.

Finally I would like to say a nice thank you to Professor John Thorburn, Dr. Iain Davidson, Dr. Colin J. Sinclair, Dr. David Scott and Dr. Edward Wilson. These people took care of me after office hours and invited me to their homes, where they showed such hospitality that I gained a few kilos.

I remain
Yours faithfully

Malgorzata Was

REGISTRARS PRIZE
SECOND PRIZE
Sponsored by OHMEDA

Dr.Andrew Longmate
Edinburgh

Anaesthesia in South Africa

The large district general hospital where I worked for over 6 months is situated in the township about 2 hours from Durban by road. It serves its own catchment area and also takes referrals from the many smaller rural hospitals in the region.

The New South Africa is in a state of flux. Massive political change has swept the country and the health service is being remodelled. The old "white" hospital in the nearby "white" town that the township served is soon to be amalgamated with the "black hospital". Soon everyone will be treated at the same institution. Everyone who is poor that is; if you have money, or insurance, you can be treated at a number of private institutions with state of the art technology and knowledge. Money is non-discriminatory.

But back at the township hospital we are truly in the third world.

Patients are poor. There is tuberculosis, malnutrition, dehydration, malaria and ignorance. The switchboard is barely functional, communication by telephone almost impossible. On the paediatric ward there are not enough cots. Dying babies lie side by side on a long wooden table top. Comatose patients are intubated and left alone to breathe spontaneously on the wards or in the ambulance for their transfer elsewhere.

There are not enough doctors or nurses.

Lack of basic supplies prompt improvisation: Drinking straws are cut from intravenous drip tubing, spacer devices for asthmatics from plastic bottles.
Pharmacy and supplies are poorly organised. Supplies run out from time to time. It may be intravenous fluids one week, drugs the next. The 11 year old boy with rabies is shown to his dirty isolation room on the adult ward. The windows are broken - not a problem in summer but winter is cold. The hospital is dirty. Large rats roam the compound at night. Community health is woefully undersupported. Tuberculosis drug compliance and follow-up are disorganised.

We walk past the burns ward - it's usually busy reflecting the reliance of local people on fire for heating, cooking and sometimes assaulting. Two children covered in bandages lie playing on the floor. They shout and laugh with you. They are coming to the end of their treatment of multiple skin grafts. The weekly burns list has many children and the odd challenging airway to manage.

As you turn the corner a chilled soft drinks machine looks enticing. It's well over 30oC with humidity in the 90's. One of the doctors has organised it as a sideline earner. Doctors and one or two patients are slipping their Rand into the slot. You enter theatre; suddenly it is cool. The air conditioning is working well today. In the doctor's rest room the cable TV sport is only interrupted by the screaming coming through the walls from labour ward next door.

Theatre is well equipped. There is a brand new video-endoscope, and a nice image intensifier. A "Bair Hugger" warming blanket is on trial with a view to purchase. We have a fibreoptic bronchoscope. The sound of a helicopter drones overhead. A premature neonate with respiratory distress is to be sent for ventilation to Durban. CT scans can and are arranged during daytime hours at a local private institution at no small cost. Our hospital has a CT scanner of it's own, still in boxes somewhere.

There are 6 theatres at the hospital and over 10,000 operations performed per year. The main specialities are orthopaedics, obstetrics and gynaecology and general surgery. Most anaesthetists have had little or no formal training but have learnt in a hand me down sort of way, sometimes spending as little as 2 or 3 months in the specialty. There are two consultant anaesthetists but their time present can be limited.

Each theatre has a standard Boyle's machine with piped gases. We have halothane on all machines, plus one isoflurane and enflurane vaporiser to share within the suite. We've a good selection of drugs and disposables. Only the double lumen tubes are red rubber. There are ventilators and recently arrived Datex monitoring. We are already on the second set of pulse oximetry probes. The breathing system is that omnipresent Natal phenomenon the Humphrey ADE, easy to use and relatively efficient as non rebreathing circuits go. I would like to see them more frequently used in the UK. There are ancient circle systems attached to one or two of the machines. They haven't been serviced for ages and I'm not keen to get the more junior people using them.

Cleanliness of breathing systems is a moot point. The incidence of tuberculosis and HIV infection is high in this community. Although there are plenty of reps visiting and offering microbe filters, the use of an expensive disposable for each and every patient seems out of our budget. I've discussed the importance of infection control with the nursing staff and we have agreed that the breathing tubes should be washed daily and if obviously contaminated.

That's the best we can do at present and at least we are cutting down potential exposees and exposures. Current theatre policy is to wash and reuse yankeur suckers and orophayngeal airways.

It seems ingrained here to place a Guedel airway routinely after every intubation. It hasn't been my routine practice in the past and I don't bother; that is until I've had 2 or 3 tricky biting situations at the time of emergence. I wonder if my technique is getting sloppy until another British anaesthetist recently arrived comments on the number of patients biting down and obstructing their airways at conclusion of anaesthesia. Is there a racial difference in airway reflexes ?

Ketamine is popular with the other anaesthetists, it is easy to use and almost foolproof. I'm not totally convinced by the talk of its analgesic effects in an acute clinical situation. Recovery is sometimes full of children, severely agitated, in pain and discomfort and hallucinating wildly. It resolves quickly with morphine though quiet hallucinating continues.

We have a couple of the green, single-use paediatric breathing systems; one "borrowed" from a local private hospital, one scrounged from a company representative with promise of orders to follow. Needless to say they are re-used time and again. The black rubber facemasks are perishing and need replacing though we do have a good supply of recently acquired laryngeal masks.

Disposable gloves and needles are not a problem - though once we had only 25 guage in stock for several weeks.

The 6 bedded intensive care unit has American ventilators and basic monitoring. It's run by a Rumanian doctor and managed separately from theatres. The case load is interesting, with many young patients and trauma sufferers. Patients with trauma often wait many hours before aggressive intervention and surgery. Its not surprising then that sepsis and ARDS are particularly common. In recent months there have been increasing numbers of children being managed on the ITU with the help of a British paediatrician. The nurses are finding the transition difficult and there are frequently problems with blocked endotracheal tubes.

In the outpatient theatre there is a daily list for minor septic cases such as abscesses. Patients are given propofol and alfentanil with nitrous oxide, oxygen and halothane before being discharged home. There simply aren't enough beds to admit these patients. Most will be seen later at a local clinic for a change of dressing. There is an additional septic theatre running in the main theatre block for more complex cases. A common problem is the obese, type II diabetic with uncontrolled hyperglycaemia and infection. Invariably they've spent many days at home before presenting to hospital. Severe cellulitis and necrotising fasciitis are seen frequently. The patients are semi-comatose, metabolically deranged and requiring extensive debridement. There is nearly always heavy bleeding.

Doctors at the hospital include many South Africans, plus a smattering of other nationalities including British, Dutch, German, Nigerian, Kenyan, Rumanian and Indian. Partly because of lack of doctors and intensity of work first year pre-registration doctors often work alone and unsupervised and though this sometimes works well, this system contributes to a general lack of discipline amongst the medical practitioners.

The interns generally have more practical experience than their British counterparts, for example most perform Caesarean section and intercostal drainage as routine. However, levels of competence are varied. Basic medical knowledge and understanding is sometimes patchy. History taking and examination are particularly poor and this means that a careful re-assessment is necessary before considering anaesthesia. To be fair, history taking via a translator can be difficult and time consuming task. The combination of disinterested doctor and nurse sometimes relegates us to a veterinary level of practice. I think that a level somewhere between British and South African models would be good for junior doctors.

Private medicine is big in South Africa and it is not essential to have specialist training or qualifications in order to offer one's services. Newly qualified doctors can start up as general practitioners immediately after attaining full registration. These conditions have adverse effects on the quality of care offered plus some interesting knock on politics. One consultant anaesthetist is discouraged from teaching certain juniors whom he feels are undercutting him in the private market. It also means that the junior doctors are keen to learn almost any practical procedure (it may earn them money later).The patient may sometimes inappropriately provide the practice. In a recent survey of the hospital's training for pre-registration doctors there were requests for more surgical experience in procedures such as circumcision, tonsillectomy and laparotomy. Absenteeism does occur and it is not unknown for doctors to spend time AWOL from the hospital while earning handsome private fees assisting at operation in some local institution or other.

New rules are being introduced to bring in a compulsory three year training programme for new doctors, similar in some respects to vocational training for GP's in this country. It is being resisted by junior doctor groups.

There is sometimes more than a whiff of racism and cruelty towards patients. Procedures are continued where it is quite clear that there is severe pain but such is the lowly status of the patient, they are obliged to endure it. A commonly heard phrase in the doctor's room is " these Zulus are tough and can take pain". I wonder if it's all an excuse and simply reflects the power/control relationship between white doctor and black patient with an apartheid hangover.

Some of the doctors have real missionary zeal. New laws have been passed in South Africa to make termination of pregnancy legal. There is a hospital meeting a week after the new legislation is passed. Key members of staff are strongly opposed to the idea and determine that this procedure should not be offered at our hospital despite the willingness of pro-choicers to help.

Patients speak Zulu; most cannot speak English. Nurses (almost exclusively Zulu) translate from Zulu to English although Afrikaans is the first language of many doctors. A bright and interested helper can make a world of difference. Most doctors speak little or none of the local language and make little effort to try. I've worked in this region before and am quite proud of my ability to communicate and understand. I'm brought down to earth as I learn that the phrase I was using to ask "what time is it?" actually means "I am menstruating now". I'd thought that the giggles had been a reflection of charm and a Bolton intonation.

Nursing is a good job for the local people affording prestige and a reasonable income and thus popular with school leavers along with teaching. This sometimes means that not all members of the profession have the same calling or interest that would be seen here.

Many nurses live under conditions of poverty often supporting several relatives with their wages. They are always immaculately turned out.

The standard of nursing can be lower than we have come to be acquainted with in the United Kingdom. For example, paraplegia means severe bedsores, urinary tract infections and an early death, different to the situation now in the western world. Young paraplegics are quite common on the wards, they make regular appearances on lists for debridement of horrendous bedsores. The orthopaedic surgeon has been operating on the patients with no anaesthesia for years. I watch as they remove a femoral head that is protruding from a gaping sore.

Occasional wards have the benefit of a pulse oximeter for post-operative monitoring, but today there is a struggle to convince the nursing staff to put it on a patient with fat embolus syndrome rather than one of their relatives.

Other nurses are excellent and would hold there own anywhere in the world. In particular there are some great scrub and anaesthetic nurses. They are a good bunch and we hold a weekly anaesthetic theatre meeting and tutorial. It's a chance to clear the air and discuss problems and solutions. There is keen interest in the subjects and a noticeable improvement in the level of assistance with time. We talk about how much air to put in an endotracheal cuff, how to place cricoid pressure. A patient last week aspirated at induction of anaesthesia and died 5 days later in the Intensive Care Unit. There were several preventable aspects that may have avoided the disaster. We talk it over and discuss management of regurgitation under anaesthesia and what we should do. There is a real improvement in the drill when the problem occurs a week later on an elective list.
Obstetrics is a busy specialty with about 7000 deliveries per year. The maternal mortality rate is nearly 11 per 10,000 with anaesthesia ranking as the second most common cause at 20%. [1]

Most medical officers preferentially use general rather that spinal anaesthesia for Caesarean section. It seems to be what they have been taught. Or do they prefer general anaesthesia for speed? Paul Fenton in Malawi argues strongly against spinals[2]. The nurses also seem edgy about them. They remember frightening complications, poor anaesthesia and deaths. Our recently arrived 60 year old community medicine Professor remembers killing an obstetric patient with a spinal. What is the best form of anaesthesia to use for Caesarean Section when the anaesthetist is inexperienced?

There seems to be a higher spread of local anaesthetic in this population. Most doctors are using 1.75 mls of heavy bupivacaine for Caesarean Section. A chap up the road uses 1.5mls. We have 25 g Quincke needles. There are also differences with the practice of obstetrics, including late engagement and descent of the head as compared to western populations.

Major obstetric complications are seen. Pre-eclampsia and eclampsia are common and present nightmarish situations. The local regime for general anaesthetic induction is alfentanil and etomidate followed by 2 grammes of magnesium sulphate before the suxamethonium. It seems to work quite well. Voluminous haemorrhage is seen frequently, no more so than that at delivery of live extra-uterine pregnancies. There have been 4 in a year. Hysterectomy and internal iliac ligation for bleeding is performed all too regularly.

Epidural disposable packs are available but lack of adequate anaesthetic staffing and no midwife training means that a labour ward epidural service is not undertaken, though epidurals are occasionally used in selected cases.

HIV is common affecting about 20-25% of child bearing women. Many patients die on the ward of AIDS. Sometimes staff members are afflicted.

The medical wards can be quite depressing. The more immediate and obvious nature of many surgical conditions coupled with a sense of hopelessness about things medical means that there is a real surgical bias in this hospital.

Many patients have insurance burial policies to pay for costs in event of death. Insurance companies often refuse to pay burial costs if the patient has died from an HIV related illness.

Usually this has not been made clear to the family at purchase of the scheme. Pressure from nursing staff and the family means that doctors often don't write the true diagnosis on the death certificate so that the family can claim the money. This may contribute to an under reporting of HIV and AIDS.

Trauma is an everyday part of life here, both from inter-personal violence and the roads. Over 400 gunshot injuries present to the hospital each year.
1000 people died on the roads in South Africa during the Christmas period alone. In this small town there are 2-3 murders reported weekly in the local newspaper. We are advised not to stray after dark. Security staff at the hospital and in shops carry shotguns. It's frightening.

Orthopaedic lists are composed of mainly trauma with little elective work. Injuries to the extremities and a handy corridor beside theatre means that nerve blocks are used frequently and effectively as the source of anaesthesia. I get quite good at supraclavicular blocks. A packed recovery room, and poor post-operative observation on the wards make regional anaesthesia attractive.

Christmas eve brings three heart stabbings. Two patients survive and one returns to theatre for bilateral femoral nailing a few days later. The reality and proximity of the violence is brought home when one of the consultant surgeons is murdered during a car-jacking. He is Scottish and a well-liked member of staff and local preacher. There is great sadness in the local and wider community. A protest march is arranged after his death.

Many trauma victims are HIV positive. They are tested before tibial nailing for prognostic reasons. Its quite discerning as bony shafts are reamed in theatre when patients carry the virus. On New Year's Day the orthopedic surgeon stabs himself with a K-wire from an HIV positive patient. He's not done something like that for over a year. I take the blood from him at the end of the procedure and ponder the risks he runs. I'm not sure I'd like to take them myself.

Beyond all the misery, there is somehow a glimpse of optimism, humour, hope and new life. We are in Africa. The nurses singing at prayer time is mystifying and fills one with emotion as the melodies wash through the wards.

The hospital takes referrals from many smaller district hospitals in the region. These hospitals run with a handful of doctors who deal with most work including anaesthetising and operating. It is rare for there to be anyone with specialist anaesthetic training at these hospitals. There is a varied skill amongst the doctors. Staff at most of these hospitals perform Caesarean section, tubal ligation, the odd simple laparotomy (e.g. for ectopic pregnancy) and a variety of other minor procedures but not much in the way of elective or major work.(e.g. gunshot abdomen, hysterectomies or thoracotomies.)

Patients with conditions outwith the scope of the peripheral hospitals are sent down many miles of dirt road in the back of an "ambulance" (essentially a transit van with benches) with drip and analgesia (or not). On arrival at our hospital they may face a further wait of several hours waiting for operation, especially at the weekend; as the trauma queues up.

I arrange for a couple of doctors working in the periphery to come and get some anaesthetic experience at the hospital. One is British. The other is a Cuban doctor. In Cuba there is such an excess of doctors that their role can sometimes be similar to that of a district nurse (including the bicycle). A fair number have been brought across by the government to boost flagging numbers in the peripheral hospitals. These doctors are expected to give anaesthesia for Caesarean section, unsupported in the bush.

I arrange to visit a bush hospital, tucked away on the Mozambique Border entering the sub-tropical region. They are experts at malaria treatment here. We arrive early, before the start of the list, which has a couple of tubal ligations and an elective Caesarean Section. There has been a power cut and we don't have lights or suction. The patient for delivery had started labour during the night and has already been operated on. After a couple of hours the power is back and the first patient called for. Checking the patient into theatre follows the same laborious routine as here. They usually do this operation here under spinal with a 22 gauge needle, but we decide to practice a general anaesthetic with intubation; as this is done infrequently but can sometimes be required for Caesarean section. The medical officer isn't so confident at intubation so its a good chance to practice. It's all a bit of a disaster. He struggles initially to intubate. Recovery is stormy. Better now I suppose than on his own alone at night.

We are on holiday in the Okavango Delta, deep in Botswana. My wife has an abscess on the back of her thigh after a spider bite. She is barely able to manage the short flight to Victoria Falls. We find ourselves a long way from anywhere with a long international flight looming in two days and she is unable to sit or even walk very far. The local GP on call agrees to see us and perform incision and drainage. We meet the anaesthetic nurse, a pleasant man who agrees to let me perform the anaesthetic. The ancient Magill circuit leaks, and there are only 22 gauge spinal needles. She is in the second trimester of her pregnancy. I try a nerve block but it doesn't work and so opt for a general anaesthetic. I'm pretty nervous; I wouldn't like to say how she feels. It's over onto the side and old fashioned gas, oxygen and halothane. Things go smoothly and she awakes. I've never been so relieved. We go back to the hotel in a taxi. As day case anaesthesia goes it's been OK. She's a bit queasy but a view of The Falls and some light food cure that. We make the flight and get to our destination in comfort.

It is the last day of work, I visit the nurses at lunchtime with doughnuts, cake and cola to say goodbye. They break spontaneously into song, haunting, melodic and spiritual. There is a lump in my throat and tears in my eyes.

Go well.
Stay well. I mumble.

They will need all the luck and hope that they can get.

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The Scottish Clinical Simulation Centre - the first year

Ronnie Glavin & Nikki Maran

The first anaesthetic simulator, Sim 1, appeared in the 1960's (1) but didn't last long! Major interest in simulation grew in late 1980's when Gaba in Stanford and Good in Sarasota began to publish work using simulators to assess responses of anaesthetists to simulated critical incidents (2,3). In Europe, groups in Leiden & Copenhagen began to develop their own simulators (3,4). By the mid 1990's, two full scale simulators were commercially available in US and use of simulators in training in medicine is growing exponentially.

The birth of the Scottish project followed a rare meeting of the four heads of University departments of anaesthesia who were (even more amazingly) in agreement that the concept of using simulation in anaesthetic training was sound. The Scottish Council for Postgraduate Medical and Dental Education were eager to support a project which centralised one aspect of anaesthetic training across the country and which potentially would involve other specialities including A&E and acute medicine. Stirling Royal Infirmary were willing and able to provide space for development of the simulator facility within the old main operating theatre suite which is adjacent to their excellent education and conference centre. Funding for purchase of the simulator and audiovisual equipment was made possible with a grant from the Wolfson Foundation.

Having secured overwhelming enthusiasm and the necessary funding, the management board then set about the task of appointing the 'workers'. Ronnie and Nikki agreed to share the post with Ronnie getting the bigger half' and both returning to their 'real' jobs for the rest of the week. The next task was to choose between the two commercially available simulators. Unfortunately, this meant several days of arduous wining and dining for Professors Spence and Kenny in San Diego. The METI (Medical Education Technologies Inc.) simulator arrived at Glasgow airport in December 1997 but was quickly secreted into storage away from prying eyes and hands until the building work was complete.

In February, the work was finally (almost!) complete and the mannequin installed. Of the three large crates, which had arrived in December, one contained the mannequin, one the operating 'stack' and the other a box of dog combs and condoms rather than a pentium computer! However, two days later, the replacement computer arrived from the US and we were in business! We were very lucky to have had Bosseau Murray, Associate Professor of Anesthesiology at the University of Pennsylvania (ex Durban, via Glasgow!) helping us out for our first week of action. Bosseau is one of the leading simulator experts in the US and his expertise helped save many hours poring over the manual!

Through March and April, we trained 60 consultant anaesthetists who had offered to become instructors, using their ideas to develop many of the scenarios which would later be used for training. These days provided well earned CME for our colleagues who had to exercise their knowledge of physiology and pharmacology as well as exchanging views with colleagues from other hospitals as to the best ways of dealing with the clinical problems we were inventing!

The following month was spent fine tuning many of the scenarios which we had written and test running them on willing volunteers!– Prof Wildsmith demonstrating that he can even cancel simulated patients on simulated operating lists!)

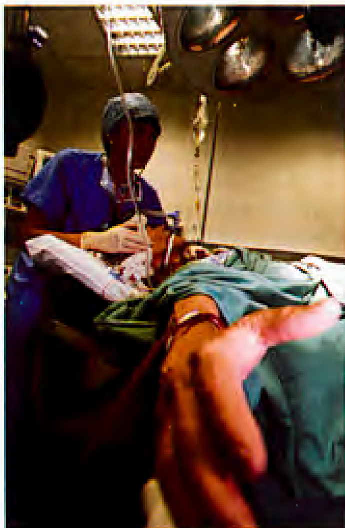
The first Scottish anaesthetic trainees to try out the simulator arrived on 13th May 1998. The initial trickle became a steady flow and to date 111 anaesthetists have sat in the 'hot seat'. The length of experience in Anaesthesia and the areas from which they came are shown in Tables 1 & 2. By September our dummy had been worked so hard that he was threatening to buy added years and take early retirement. Fortunately his wish was granted and he was replaced by an upgrade with even more features to challenge the anaesthetic community. The upgrade was part of the initial purchase deal and has been put through a demanding schedule which he seems to have taken in his stride.

YEARS	<1	1-2	2-3	3-4	4-5	5-6	6-7	>7
NUMBER	20	15	17	18	11	6	6	18

TABLE 1: ANAESTHETIC EXPERIENCE OF TRAINEES ATTENDING SIMULATOR

REGION	**NUMBER**
GRAMPIAN	11
SOUTH EAST SCOTLAND	42
TAYSIDE	10
WEST of SCOTLAND	46
ELSEWHERE	2
TOTAL	111

TABLE 2: GEOGRAPHICAL DISTRIBUTION OF TRAINEES ATTENDING THE SIMULATOR



Evaluations of the courses from the trainees are listed in Tables 3 and 4. The average scores are very high for most features and it is gratifying to see that trainees have enjoyed themselves while learning and gaining confidence to tackle challenging clinical situations. Most trainees have commented on the fact that the simulator was much less threatening than they had anticipated! Scores for Table 3 were awarded immediately after debriefing while the experience of the scenario is still fresh so consultants please take note that the it is not threatening as you think it might be. Although many expect that they will only benefit from a scenario in which they have taken the 'hot seat', the evaluations show high marks for non-hot seated scenarios in terms of learning opportunities.

QUESTION	**AVERAGE SCORE HS**	**AVERAGE SCORE O**
The scenario seemed realistic	8.3	8.2
I now feel more able to deal with the clinical situation portrayed in the scenario	8.5	8.0
The debriefing was helpful	8.9	8.6
There was adequate time for discussion	9.3	9.2
The material was relevant to my learning needs	9.2	8.9
I found the scenario threatening (10 most threatening, 1 least)	4.5	1.8

TABLE 3: TRAINEES EVALUATIONS OF SCENARIOS

Scores 1-10 (1 = least applicable or worst; 10 = most applicable or best)

QUESTION	**AVERAGE SCORE**
I learned new facts	8.1
I now understand concepts better than I understood them before	8.1
The day was enjoyable	9.1

TABLE 4: TRAINEES EVALUATION OF WHOLE DAY

Scores 1-10 (1 = least applicable or worst; 10 = most applicable or best)

Throughout the period of running these introductory courses, around 40 of the original cohort of instructors have been back to 'hone' their skills at running simulations, and indeed, 14 have been back more than once making them veritable experts!

Other 'events' through our first year have included visits to the simulator during the Scottish Society trainees meeting in June. Sir David Carter officially opened the Simulation Centre on 22nd June resulting in much television and press interest and the failure of all working parts which inevitably follows! On July 5th, to mark the 50th Anniversary of the NHS, Stirling Royal Infirmary had an 'Open Day' and the simulator was top attraction with over 200 visiting through the day and many hundreds more having to be turned away. Thanks to the generosity of Glaxo Wellcome, Zeneca and Alaris Medical, we had an open night for Scottish consultants and staff grades. This was a most enjoyable evening with over 80 in attendance marred only by the slow bus from Aberdeen being so aptly named that it didn't even make it to the pickup point! We hope that by the time of publication our Northern friends will have paid us a private visit!

Research opportunities with the simulator are many and fascinating. Apart from studies to evaluate the educational impact of the simulator, we are also working closely with the department of Psychology in Aberdeen to look at the role of experience in managing challenging circumstances.

Plans for the Centre in the year ahead include courses for Consultants as well as trainees covering areas such as 'Unusual Conditions', obstetric anaesthesia, difficult airway management and Advanced Cardiac Resuscitation for Anaesthetists. Preliminary discussions with a wide range of health care professionals suggest we shall seeing not only anaesthetists in 1999.

We hope to see many of you at the Simulation Centre in the coming year.

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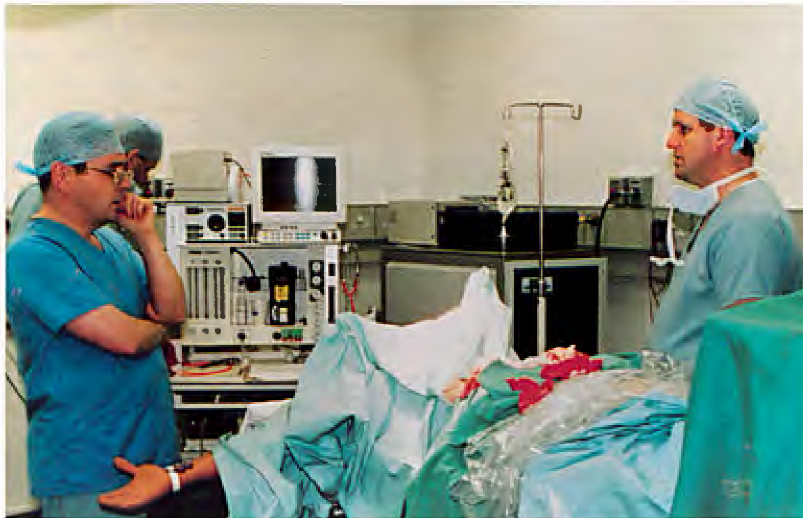


ANNUAL SCIENTIFIC MEETING
30th October 1998

This year's Annual Scientific Meeting of the Society was held at the Royal College of Physicians in Edinburgh on Friday the 30th October. Despite the 9.00 a.m. start and its associated difficulties of travel, there was an excellent turnout from the start.

***'Combined brains the size of a planet and we can't find the lights** - Gordon Drummond and Charles Reilly'*

The morning session was devoted to the management of problem patients, although to some of us present all patients present a problem, the trick is spotting it! The problem of impaired respiratory function was addressed by Dr.Gordon Drummond, not just a local but international expert in the field. He eloquently outlined the changes which occur in respiratory function during anaesthesia, leaving one with the impression of the obvious and not so obvious staring you in the face. Professor Charles Reilly of the University of Sheffield then went on, in similar style, to discuss the anaesthetic management of patients with high risk factors of cardiac disease.

Following a break for coffee and time to catch up with colleagues, the meeting was then presented by Dr.Alistair Lee from Edinburgh, with the many manifestations of liver disease and an instructive talk on the management of these patients.

***'Look, I didn't say you were geriatric** - Charles Riley and Chris Dodds'*

Dr.Chris Dodds from South Cleveland addressed the subject of the management of the geriatric patient. Despite the intermittent meteor showers which seemed to cross his computer generated visual aids, I am pleased to report that no member of the audience had a grand mal seizure! Nevertheless he highlighted a number of very important areas which tend to get overlooked in the peri- and postoperative management of the 'years impaired' patient. He skillfully avoided any definition of 'geriatric', much to the relief of some in the audience. The morning was concluded by Colin McCartney from Aberdeen as he presented his Scottish Society of Anaesthetists Registrars Prize winning paper on 'Pain and Disability Following Lower Limb Amputation'. This paper is reproduced in full elsewhere within the Annals.

***'The Ascent of Hypoxic Man - Michael!** From left to right, Alister Lee, Mike Fried and Niki Maran'*

Lunch included some 'in depth' discussion surrounding the construction of the pillars within the main hall of the College. Following this, Dr.Michael Fried from St.John's Hospital, Livingstone enthralled us with some spectacular scenery of the Himalayas taken during one of his many expeditions, alongside hard data, as he outlined the problems of oxygenation at altitude, whilst deftly operating a dual projection system. Dr.Niki Maran from Edinburgh (or is it Stirling?) and co-director of the Scottish Clinical Simulation Centre, closed this session with a talk on the experience of the centre to date. A fuller paper by both herself and her other half (not her other other half!), Ronnie Glavin, is reproduced in this years Annals.

'Picking things over. Lauchie Morrison reflects on his organisation of the meeting'

The meeting concluded with the Gillies Memorial Lecture delivered by Professor Alan Aitkenhead of Nottingham University. Mention of this is made elsewhere.

All in all, this was a highly educational and successful meeting appreciated by the large turnout of members. As always, the success of any meeting is not just down to the high calibre of the speakers, but as importantly, to the organisers. We must thank Drs. Lachlinn Morrison (Livingstone) and Alistair Lee (Edinburgh) for this organisation.

Professor Aitkenhead receiving the rose bowl after delivering the Gillies Lecture.

Dr's Alistair Lee and Chris Dodds

Annual General Meeting
Peebles 24 - 25th April 1998

The Annual General Meeting of the Society took place on the Saturday morning with Iain Davidson in the Chair. The meeting proceeded remarkably smoothly with no resort to verbal abuse. The Treasurer presented the Society Accounts in his usual precise fashion which left members in their usual perplexed state. However they had been audited and were passed by the meeting. Members elected John Thorburn to President and Iain Gray to Vice-President. The minutes of this meeting will be sent separately to members by the Secretary.

'The President waits to start his address'

The afternoon commenced with the newly elected President, John Thorburn delivering his Presidential Address.

'Colin McCartney receiving his prize from David Walker of OHMEDA'

'Andrew Longmate receives the runners up prize'

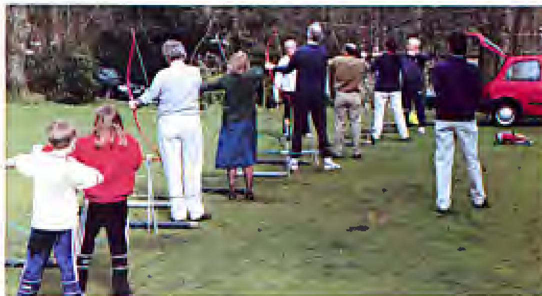
Following this David Walker of Ohmeda Scotland, presented the Ohmeda Registrars Prize to Colin McCartney of Aberdeen and the runners up prize to Andrew Longmate of Edinburgh. Colin then went on to give a short presentation on his paper entitled 'Pain and disability following lower limb amputation'.

'Prof Foex delivers his Guest Lecture'

The afternoon concluded with Professor Pierre Foeux of Oxford delivering the Guest Lecture on Cardiac Disease and Function. This held the audience captivated by the apparent simplicity with which Pierre put over a very complex subject.

'I hiv always wanted one of these'

Whilst members (at least most!) were attending the afternoon session, families were taking full advantage of the social programme laid on for them including trying to avoid killing each other with a bow and arrow.



'Imagine they are Council Members'

The meeting, as always, culminated with the Dinner and Ball in the evening. It was during this that the Society unexpectedly discovered the musical talents of some of its members, namely Duncan Ferguson, Val Wilson, Bill Duthie, Lorna Wilson, Jenny Wilson and Jane Freshwater. Rumour has it the Secretary has invited a representative of EMI next year.

***'Newly discovered talent.** From left to right; Duncan Ferguson, Val Wilson, Bill Duthie, Lorna Wilson, Jenny Wilson and Jane Freshwater*

'It his bin a lonng day'
Leslie Baird, Prof. Mrs Foex

'The three Muskateers'

THE ONES THAT DIDN'T GET AWAY!
(or, is 13 really that unlucky?)

Members will be aware that the Annals has for many years not carried a report on the fishing outing which precedes the Annual General Meeting. There is a simple reason - they always got away!

However this year, after extensive enquiries at surrounding fish merchants, we can confirm that a record 13 trout were caught by Drs. David Scott, Donald Millar and Alistair Cameron
The prize catch was by our Treasurer, David Scott.

'David Scott with his Prize Winning Catch

Scottish Society of Anaesthetists
Golf Outing
Downfield Golf Club, Dundee

From our golfing correspondent Eddie Wilson

A healthy turn-out of 20 keen members assembled at the Downfield Golf Club on the 28th of May for our annual golf outing. The weather, although not matching Glenbervie's blistering heat, was certainly acceptable and allowed a splendid day's competition.

The morning Stableford was won by Tom Moores who scored an impressive 40 points, including 5 straight pars to finish. Alex MacLeod (35points) and Bill Kerr (35 points) were also on the podium. Such West Coast domination seemed to point the way to a West victory over the East in the afternoon fourball. Alas, golf is never so predictable! The East duly upset the form book with a crushing victory by four matches to one.

The editor has heard from reliable sources that certain members of council are opening a book on this year's outcome.

The 'Thistle' Reports.

Once again the 'Thistle' has been out and about gathering news from the Anaesthetic Departments of Scotland. Elgin ' Town in Grampian Region, Scotland, on the Lossie. There are saw mills and whisky distilleries.(Pop.1994, 17,050)': Hutchison 20th Century Encyclopedia. Rumour has it there is an Anaesthetic Department. But for the rest, the Editor is considering running a competition for the newly formed Trust with the longest name.

Royal Infirmary of Edinburgh

We are all saddened by the death of Bruce Scott this year. A tribute to his life and career is cited elsewhere in this year's Annals.

The retirements of Alastair Spence and Iain Davidson, both past presidents of this society, were celebrated with great ceremony and enjoyment earlier this year. We all congratulate and envy them on their retirement and hope that Maureen and Moira can cope! *(the question is can we? idle hands and all that - thistle)*

With the closure of the Eastern General Hospital, we welcome Janet Jenkins, Dave Beamish, David MacCallum and Christine Robison to the Department. Janet and David, in addition to their duties at the RIE and PMR, continue to support the routine workload at Roodlands Hospital (Haddington). Roodlands, which far from winding down, seems to be becoming the mainstay of Lothian Health's Waiting List Initiative *(with a 'waiting list' of attending Consultant Anaesthetists - thistle).*

New Consultant appointments to the hospital include Julian Wang (a refugee of Liverpool) and John Donnelly(displaced person from Glasgow) who swell the numbers in Cardiothoracic *(no comment - thistle).* Carl Moores, home grown and late of academia *(but still growing we are informed-thistle)* joins the main department as a fully fledged Consultant. Tim Walsh has been appointed to an ICU/Liver position *(supine/prone or erect not specified - thistle)* and David Semple takes up a post with a major interest in Orthopaedics come April.

Congratulations also go to our trainees who achieved Consultant status elsewhere in 1998, Frank McAuley and Steve Digby (Gateshead), Jeremy Rushmer and John Laurenson (Ashington), Mike Shaw, Elaine Watson, Jeremy Thomas (St John's, Livingston), David Love (Borders General Hospital), Brian Cook (Hairmyres) and Susan Russell (Victoria, Kirkcaldy). .

At 'junior' level there have been a nursery-full of babies born to department staff. Fortunately or unfortunately, depending on your position *(? - thistle),* none have training numbers.

There have been changes within both the University and NHS Anaesthetic worlds. The former, as a result of a reorganisation within the University of Edinburgh, is now a part of the Department of Clinical and Surgical Sciences! Gordon Drummond is acting Head of Department and will fight the good fight *(applications invited - thistle).* Within the latter, Susan Nimmo has taken over from David Ray as head 'gofor', David Ray moves to Clinical Director, replacing Dermot McKeown who, in turn, has become Head of Service *(lucky at cards...... - thistle).* David Littlewood has stepped aside to allow David Brown to enjoy the conflicts of Administrative Consultant, but taken on the role of head photographer for the Department as he struggles to maintain an upto date 'who's who' on the Departmental notice board. Alistair Lee, as well as finding the time to organise the SSA scientific meeting in October with Lachlan Morrison, shoulders the ICU burden as well as becoming Chairman of the Area Division of Anaesthesia. Simon McKenzie takes over as Secretary.

The New Royal Infirmary is beginning to rise at Little France. However, the latest target relocation date is tentatively put at 2002. The 14,000 sq metre medical school will complement both the 869 bed hospital and new medical research institute. Let's hope the roof doesn't leak! The migration plans are already being discussed but I hope we all fly south smoothly *(dream on... - thistle).* First one to find a parking space wins. NHS Management 'speak' does not improve and the latest neologism 'clinical governance' will be on everyone's lips.

David Watson

Victoria Hospital, Kirkcaldy

We work under a cloud of uncertainty regarding the future configuration of services in Fife following the impending merger of the current two acute hospital trusts. There has been detailed discussion about the concept of one 'hot' site (either Kirkcaldy or Dunfermline) but there seem to be more question marks than there are workable answers. In anticipation of some form of integration, the Fife Division of Anaesthesia has been reformed *(tell me! - thistle).*

Some of the cottage hospitals, we are told, must close and Forth Park Maternity Hospital will move to a district hospital site. Meanwhile, the diagnostic capabilities of the Victoria Hospital have been extended following the opening of an MRI scanner.

We sadly have to report the death of Margaret Inglis following a long illness. Garry, as she was known, had worked in hospitals in Fife, based on this department, for 25 years. On a happier note Elizabeth Lovie is the envy of her consultant colleagues, having taken early retirement. We wish her well.

In the current year we welcome Susan Russell and Mary

McKenzie to Consultant posts. The mean age of the Consultant staff has moved in a favourable direction. We look forward to their particular talents enriching the department.

Arthur Davis

Borders General Hospital, Melrose

Not much news here *(no gossip at all? - thistle).* Our small department is now a little larger. A new consultant post has been created and we are delighted to welcome David Love to the department. We also now have places for four trainees at SHO and registrar level on the South East of Scotland rotation.

Janet Braidwood

Western General Hospital, Edinburgh

There have been a number of changes and one for your diary is that Jim Jenkinson retires in February 1999. Assuming you receive the Annals before they make the speeches (big assumption! - Ed.) you can find further information by phoning 0131 537 1652. There have been two new Consultant appointments Rob Sutherland and recently Talat Aziz (last seen looking at Megane Scenics). We warmly welcome their individual talents.

Ivor Davie has finally retired and we offer our best wishes. Brian Slawson acknowledges his retirement whilst still working *(definitely going for the title of most retired Consultant in Scotland - thistle)!*

As a result of the Eastern General Hospital move there have been staff changes. Jane Freshwater, Glenys Jones, Farrukh Iqbal and Pat Brooks will boost the department. Carol McMillan, Clinical Neuroscience Research Fellow, has returned to Tayside. Margaret Cullen is rewarded by becoming an RCA College tutor. Ian Levack is on the move again and this time it is to Dundee *(the most travelled Consultant in Scotland - thistle).*

There have been alterations within the Directorates. Anaesthesia/ICU/Theatres and Surgery have been merged as the Clinical Directorate of Surgical Services. Dr Gordon becomes the Deputy Clinical Director. There is to be a new Acute Trust for Edinburgh and this hospital is to be combined, managerially speaking, with the Royal Infirmary and Royal Hospital for Sick Children. The opportunities for cross-boundary collaboration will be stimulating.

Work has started on a major project to replace the Anaesthesia Department, the Main and Out-Patient Operating Theatre Suites, HDU, Day-case and many other in-patient wards. For those who remember the Nurses Home, it is no more, having been demolished to locate the new facilities beside the Alexander Donald Building. The old A&E entrance is now a Minor Injuries Unit and Acute Medical Receiving Unit.

Nick Gordon

Queen Margaret Hospital, Dunfermline

In the past year the eight consultants have continued getting older and hopefully wiser. A ninth consultant post has been unfrozen and an appointment is expected in November *(alas we know not whom - thistle).*

Our Intensive Care Unit has been granted provisional approval for training by the Intercollegiate Committee and we are delighted that a specialist registrar attachment on the South East of Scotland Training Rotation has now started. On the service side of things, our Acute Pain Service is progressing and we are hopeful of appointing a clinical nurse specialist.

Queen Margaret Hospital at Dunfermline and The Victoria Hospital at Kirkcaldy are planned to amalgamate to a single Acute Services Trust for Fife in April 1999 and we await with interest what, if any, changes will occur *(as do many others in Scotland! - thistle).* Vascular surgery continues as a Fife wide service at based at Queen Margaret and there are plans to integrate it within a regional vascular service as recommended in the Acute Services Review.

As the year turns we are viewing the future, as ever, optimistically and positively.

Paul Nicholas

Royal Hospital for Sick Children, Edinburgh

Our locum consultant Justin Reed will have left for Australia by the time this is read. We valued his help and wish him well. We are delighted to announce the appointment of Mary Rose, originally from Dundee, who is presently in Seattle learning many new things and no doubt enjoying her time abroad. She will take up her post in June 1999.

David Rowney SpR has moved to work at the Children's Hospital in Toronto. We know he will flourish and look forward to his return.

David Simpson

St John's Hospital, Livingston

Colin Small has retired and we will all miss him, especially his interesting stories. An Australian, Mike Shaw, fills his shoes *(same size I trust - thistle)* and has shown an increasing interest in obstetric practice. Two other appointments, Jeremy Thomas and Elaine Watson swell the numbers as a result of the move of maxillofacial surgery from the City Hospital in Edinburgh. To ensure adequate space to accommodate this venture a new obstetric theatre is being built on to the labour suite. I can now report that the anaesthetic department is now twice the size when I first arrived!

There have been a number of marriages and we wish Donald Galloway and Mike Brockway and their respective spouses every good wish. Mike Fried, now secretary to EESSA has moved into his castle retreat. His subterranean wine-cellar is so deep that you have to come up slowly to avoid decompression sickness *(is that just due to the depth? - thistle).*

The changes in acute services will become visible in 1999 and we look forward to closer collaboration with all NHS groups.

Lachlan Morrison

Glasgow Royal Infirmary

At long last the contract has been signed and work is due to start on the replacement Glasgow Royal Maternity and Canniesburn Hospitals and the new A&E department at GRI.

We are due to merge, or maybe we have already but no one has noticed *(didn't they tell you - thistle),* with the old enemy the Western Infirmary. We will combine under the grand title of North Clyde Acute University Hospitals NHS Trust, I think, a name which slips easily off the tongue *(NCAUHNHST anagram for?, suggestions to Ed. - thistle),* and I am sure we will all be proud to use it. The Chief Executive of the new trust will be Mrs Maggie Boyle, and Dr Bill Anderson has been appointed Medical Director.

New consultant appointments are Drs Fiona Bryden, who has moved from a consultant post in Vale of Leven Hospital, and Dr Steven Young, one of the GRI SpRs; both will undertake sessions at GRMH, to accommodate increased workload following closure of Rutherglen Maternity Hospital. Sadly, later in the year Dr Bill Fitch will be retiring, and he will be sadly missed.

Liz McGrady

Royal Alexandra Hospital, Paisley

Business at the RAH in Paisley continues at an ever-increasing rate and in an endeavour to match staffing to workload we have made 2 additional Consultant appointments over the past year. Dr Guy Fletcher has joined us from the Western Infirmary Glasgow as Consultant with an interest in Intensive Care. We are also delighted to welcome from the depths of the South the evergreen Hilary Aitken to help boost the female complement of the Department. Hilary's and Guy's appointments should increase the flexibility within the Department.

Developments within the Department have included a move towards more nurse pre-assessment, increasing daycases and the appointment of Specialist Breast and Colorectal Surgeons. This will probably be the last report from the RAH itself as from 1 April 1999 we shall become part of the Argyll & Clyde Acute Trust along with Inverclyde, Vale of Leven and Lorne & the Islands Hospital *(another interesting title - thistle).* It remains to be seen how this amalgamation will affect the speciality of anaesthesia in the different sites *(larger note paper for a start! - thistle).*

Barbara Scorgie

Royal Hospital for Sick Children, Yorkhill, Glasgow

The major excitement for the department this year was the move to our brand new non PFI *(not properly funded initially? -thistle)* theatre and day surgery suite.

This building now provides a day surgery / same day admission unit, a large recovery area and six state of the art operating theatres with a seventh yet to be commissioned.

We also have one of the first purpose built anaesthetic departments in Glasgow. This provides us with an office for every two consultants, separate accommodation for the Director, Service manager, Pain service and secretarial assistance. In addition we have a registrars room, a common room and a tutorial room linked by the in house two way video links to theatres and in the future elsewhere in the world. All we need now are the people to work it *(Yorkhill live on the Internet! - thistle)*!

On the personnel side of things, Dr Anne Goldie has been appointed as consultant in Anaesthesia and Intensive care, Dr Neil Morton has been appointed Senior Lecturer in the University of Glasgow Department of Anaesthesia and assistant editor of the journal Paediatric Anaesthesia and Dr David Hallworth is the President of the Paediatric Intensive Care Society of the UK. Dr Douglas Arthur is President Elect of the Association of Paediatric Anaesthetists of Great Britain and Ireland and becomes President in March 1999 *(all you need now is someone to work! - thistle)*

Our new specialist paediatric SpR is Dr Graham Bell who replaces Dr Girish Dhond who has returned to the South with a years paediatric experience and a private pilots licence.

Douglas Arthur

Southern General Hospital, Glasgow

This past year has very much been one for marking time and waiting to see what the Government's plans are for acute hospitals *(you could be in for a long wait - thistle).* The picture in south Glasgow now seems a little clearer with the establishment of one trust encompassing the Southern General Hospital and the Victoria Infirmary. It seems that the new trust will trade under the title of South

Glasgow University Hospitals NHS Trust *(SGUHNHST - thistle)*. There have been a number of meetings with our colleagues from the Victoria with a view to planning the future shape and siting of services. These have generally been amicable and there seems to be a consensus as to where we want to be in a few years time *(you don't say where or are you being politic - thistle)*.

Within our own department there have been a few changes in staffing. Jim Fitzpatrick retired in August and he will be greatly missed. Rosemary Cochrane our staff grade decided that anaesthesia was not her chosen career and has commenced training in obstetrics and gynaecology. We still see quite a lot of her, but at the other end of the table. Morag Hume who was one of the last of the senior registrars is joining us shortly to take up a new consultant post and we will appoint a replacement for Jim Fitzpatrick's post in the near future.

On the trainee side, there have been a number of changes with people moving on to posts elsewhere. There has also been an increase in the number of specialist registrars at the Southern thanks to the recommendations of the Royal College of Anaesthetists assessment of the West of Scotland School of Anaesthesia. We have also benefited *(as have the trainees we hope! - thistle)* as a result of the Victoria Infirmary sending their trainees to us for obstetric experience following the closure of Rutherglen Maternity Hospital in August.

Janet Pollock and I were among the first anaesthetic trainees into Rutherglen when it opened at the end of 1978. Things were very quiet in the beginning and as I remember, it was almost a month before I had a night time call-out, happy days indeed! It did become busier as the years went by. The keen young obstetric anaesthetic consultants at that time were Nancy Rennie, Helen Howie and Brian Stuart. Sadly the building is now being demolished after barely 20 years *(an early example of a PFI perhaps - thistle)*.

Allan Brown whose consultant post is based at the Victoria has also come across to continue his interest in obstetric analgesia and his contribution is much appreciated. Last month's delivery figures were significantly up on those for the same period last year and it looks at the moment as if Rutherglen patients will add at least 1,000 deliveries to our figures

Bill Kerr

Victoria Infirmary, Glasgow

One of the major themes which has run through the last year in the Victoria Infirmary's Anaesthetic Department has been the proposed unification with the Southern General Hospital into one Trust and, more importantly, a series of meetings to discuss reconfiguration of services across the southside of the city *(amicable we hear! - thistle)*. Any reconfiguration will obviously have a major impact on the two Departments. To some extent, anaesthetic collaboration has already been ushered in by the closure of Rutherglen Maternity which has catalysed a greater integration of the anaesthetic training opportunities across the two hospitals.

Our anaesthetic consultant establishment will be increased to seventeen when Dr.Gordon McGinn takes up his appointment in February. Gordon's special interest is in the management of pain.

Finally, we welcomed the appointment of Dr. Brian Cowan as the Hospital's Medical Director, a position he will perform on a part-time basis while maintaining his clinical involvement in both anaesthesia and intensive care *(on the usual part-time basis? - thistle. Unjust statement - Ed.)*

Camie Howie

Western Infirmary, Glasgow

The pace of change at the Western Infirmary has been as electrifying as ever in the last year. The Wallace/ McLaren tandem (clinical director and chairman respectively) has made way for the Algie/ Dougall combo though the relevance of both these positions once GRI becomes the principal acute hospital north of the river is unclear. A high-dependency unit has opened at GGH allowing pleasing improvements in the quality of postop care there.

Dr David Proctor has recently retired and will be sadly missed while Dr Lynn Anderson, one of our own SpR's, has been appointed as a Consultant Cardiac Anaesthetist to facilitate an enormous increase in cardiac surgical services.

Several trainees have moved on to consultant jobs elsewhere as already detailed. They have been followed by Drs Fiona Munro, Shiona Stott and Chris Hawksworth who have gone to Inverclyde, Stobhill and Crosshouse respectively.

Colin Runcie

Vale of Leven, Lomond NHS Trust

The Department continues to thrive! On the clinical side HDU and ICU activity present an ever increasing workload. On the management side we are looking forward to the challenge of the new Argyle and Clyde Acute Services Trust.

We have appointed Robert Brennan as a Trust Anaesthetist. Dr.Stuart Grant has left us as a research fellow for pastures new in the USA, whilst Dr.Craig Carr, who was due to join us has found the appeal of 'Transplantation' too much and moved to Edinburgh. On the Acute Pain Service we have appointed Karen Handcock to lead the Nursing side of this.

Bill Easy

Inverclyde Royal NHS Trust

We have recently had a few major changes. The first is recognition of the hospital in terms of oncology management. This has a major influence on the nature of the workload our Department is asked to undertake. Secondly we have appointed a new consultant who has a major role in the HDU/ICU. She has 'hit he ground running' and in a short space of time organised new monitoring and ventilators for the unit. Like most hospitals, the 1st April brings uncertainty but the pay-off at the moment does seem to be more money around *(tell us how you did it - thistle).* We still have consultant vacancies, but look forward to a an even more lively Department when these are filled. The view from the coffee room in Theatre is still great *(the envy of many - thistle)!*

Dumfries and Galloway Royal Infirmary

The Garrick Hospital in Stranraer has 42 beds and the Clenoch Maternity Unit 12 beds. There is one full time and one part-time Consultant Anaesthetist.

Dunfries and Galloway Royal Infirmary with its 352 beds and the Cresswell Maternity Hospital with its 35 beds and 10 cots, continues to thrive on 9 full-time Consultants, 2 staff grades, 1 Clinical Assistant and 4 SHO's. The management are currently considering a proposal to build a Day Case and Maternity Unit on the site of the Royal Infirmary and we are hoping to increase our Consultant complement to 12 with three additional post *(Dumfries clearly wants to maintain a low profile this year, although I hear Dewi Williams has joined them from Dundee - thistle).*

Annon *(well known Anaesthetist in DGRI)*

The Ayr Hospital, Ayr

The last two years has seen great changes for the South Ayrshire 'Gassers'. The Consultant complement has risen from 5 to 8 along with the arrival of new 'young blood' and we have celebrated the retiral of our elder statesman, W.H.Duthie on at least three occassions *(but is he still working to rival Brian Slawson? - thistle)!*

We service 5 in-patient and 3 day-case theatres and have been beset by similar pressures to colleagues all over Scotland with focus management on waiting list numbers and theatre throughput. One part of our response to these pressures was to upgrade the HDU to an ICU and also to form a new 4 bedded HDU from the former theatre reception area.

This has, in the main, been highly successful and resulted in a great improvement in the numbers of theatre cancellations *(up or down, depends on your viewpoint - thistle)* due to absence of a suitable postoperative bed. The new ICU was put through the process of Health Services Accreditation for Intensive Care Services and became the first ICU in Scotland to achieve this and the first newly formed ICU in the UK to use HSA as a template for its formation.

On the down-side, the square yardage of office space per consultant Anaesthetist remains outrageously low.

Challenges for the near future are mostly linked with the merging of the two Ayrshire Trusts and the remitting of the two directories which have been sundered for some 6 years.

We live in interesting times!

Iain Taylor

Crosshouse Hospital, Ayr

The Department at Crosshouse Hospital continues to flourish. Dr.Chris Hawsworth joined the Department as Consultant in mid December. He joins 5 others in ICU.

With the appointment of Val Sinclair as a Nursing Sister, we can now boast an Acute Pain Service!

Rodger White enthusiastic as ever, is now running more ALS and ATLS Courses than ever before in Ayrshire. Most importantly, we must congratulate Lyndsey Campbell and Judith Todd, two of our SHO's, on passing the Primary FRCA this year.

Ninewells Hospital, Dundee

The transfer of services from Dundee Royal Infirmary to Ninewells Hospital is finally complete. Parking has become increasingly problematic (and expensive) but may improve marginally on completion of the new multi-storey car park. Our next major local change will be the development of a single Tayside Acute Services Trust as outlined in the White Paper.

There has been a brisk turnover of senior trainees with four leaving for pastures new:- Simon Kennedy to Carlisle, Dewi Williams to Dumfries, Mary Mackenzie to Kirkcaldy and Mary Rose to Paediatric Anaesthesia in Edinburgh via Seattle. We wish them all well. New consultant appointments in Dundee are Matthew Checketts, Frank Mackay and Ian Levack who continues his own personal journey of exploration in East Coast anaesthesia. Mathew's replacement as Lecturer will be appointed by the end of 1998.

We are all delighted by Iain Gray's new role as Vice President of the Scottish Society and look forward greatly to his forthcoming year as President.

On the university front, definitive accommodation has

arrived and Professor Wildsmith has made his fourth (and hopefully last!) office move *(rumour has it ... - thistle)*. The purpose built suite of rooms includes some laboratory accommodation and, to the envy of the NHS department, windows *(planning mistake - thistle)*! Both the university and NHS staff are increasing their input to undergraduate teaching in medicine and dentistry with emphasis on pre- and post-operative care. Research activity continues to grow and includes major grants from the Scottish Office (Quality of Life After Intensive Care - Janice Rattray), the British Journal of Anaesthesia (Mechanisms of Anaesthetic Action - Cameron Weir) and Astra Pharmaceuticals (Clinical Studies of Regional Anaesthesia - Judith Kendell). The department is also a partner in the study of anaesthetic simulation based at Stirling.

Professor Wildsmith continues as a Member of the College Council, chairing both the Scottish Standing Committee and the Dental Anaesthesia Committee.

Eddie Wilson

Stracathro Hospital, Stacathro

Best regards from Angus to Anaesthetists everywhere, particularly those in hospitals door-stepped by the media. The suspension of two of our three general surgeons might seem a mite cateless, but their cases were wholly different. One, given the ludicrous sobriquet 'Dr.Blunder' by the tabloids, was subsequently restored subject to a sabbatical. The other's fate remains with an enquiry team who scrupulously sought anaesthesia input.

However, assimilation into the Tayside wide Trust should be cinch as we've all enjoyed city sessions for years and have consequently felt well integrated with Dundee. Their Clinical Director of Surgery and Professor of Orthopaedic Surgery have given terrific on-site support during the crisis and brought hope with promises of expanded cold operating, though the fate of emergency surgery remains undecided. Further periods of doubt and uncertainty are anticipated as other colleagues change jobs (flee?) or retire.

In the midst of such unbridled joy, I thought I'd give everyone a name check. Ian Grove-White is off on a month long antipodean adventure to an Aukland Meeting. Alban Houghton has become a grandfather. Annie Donald holidayed in Mauritius and I found a fine bolt hole in the Lake District. Donald Thomas regularly escapes to the wild blue yonder while Jan Beveridge will keenly follow the fortunes of her daughter during a gap-year in China. We welcome Willie McClymont ('all the nurses love big Willie') to alternate with Fergus Millar who, as Ninewells 'Maitre' de Vin, organises a most academic 'Mixed Case Presentation' each Christmas.

We live in unhappy times and, from our experience here, anticipate a growing culture of defensive medical practice. The management and local politicos say we have nothing to worry about - how reassuring!

Charles Allison

Perth Royal Infirmary

The Department of Anaesthesia at Perth Royal Infirmary has expanded again this year. We now have ten consultants, on staff grade and five trainees. Two of the consultants left and one new post was created, allowing us to appoint three new consultants *(with talk like that, no wonder you convinced management! - thistle)*.

After twelve years of loyal service to Perth and Kinross, Andy Kutarski left to face new challenges as a consultant at Lincoln County Hospital. Dil Kapur moved away to another consultant post in Newcastle. We will miss them both as they were two of our more charasmatic and energetic members of staff.

The future looks bright however, as our new recruits seem more than capable of replacing those who have left. Dr.Michael Forster from Aberdeen will join us in December 1998 and Shelagh Winship will join us from Merseyside in January 1999.

Arthur Ratcliff

Aberdeen Royal Infirmary

The merger of acute services in Grampian into one trust will take place in April 1999 to form the Grampian University Hospitals Trust (Where is the Grampian university?) *(try Elgin, GUHNHST - thistle)*. This means that the orthopaedic services at Woodend Hospital now rejoin us, as well as Dr Gray's Hospital in Elgin. Dr Donnie Ross, the current Medical Director has been appointed Medical Director of the new trust.

Waiting list demands continue to increase our workload, with many members working extra hours and weekends. The recurring waiting list money has also funded an extra three consultant posts.

Approval to expand the ITU by 8 beds has now been received. These beds will all be equipped to ITU standard, with 4 staffed to ITU level and 4 to HDU. These should be open in 2001.

Plans are well under way for the new Children's Hospital as well as a new adult Outpatient department and Day Surgery Unit. Work should commence in summer 1999 and be complete by 2002. Watch this space.

1998 has seen several changes in personnel in our department. Dr Michael Crawford has given in to the attraction of better football and more use of his season

ticket for Parkhead and left at the end of November to take up a consultant post at Hairmyres Hospital. We wish him well, but can't comment on the football *(colleagues at NCAUHNHST may be able to - thistle).* Sandy Kidd has taken over Michael's sessions and joins us at the Children's Hospital.

Our last two remaining Senior Registrars have been successful in obtaining Consultant Posts, Euan Ritchie moves to Perth, and Nicola Thompson has been appointed to a post here in Aberdeen. Two of our SpR's have also obtained consultant posts; Mike Martin has crossed not one but two borders to take up a consultant post in Abergaveny, while Colin Reid will take up a position in Aberdeen in April 1999 following completion of a fellowship in Cardiothoracic Anaesthesia at the Brompton Hospital.

Sadly, Dr Ronald Milne, retired consultant anaesthetist (1967 - 1987) died on 14th November 1998 after a long illness. We extend our condolences to his wife and family.

Gordon Byres

Raigmore Hospital, Inverness

Congratulations should be due to Highland for managing to submit two reports in successive years *(they are and are given with enthusiasm Make it three - thistle).* There have been few staffing changes within the region since the last report but we are awaiting the effects of the changes in management structure following the amalgamation of the three Highland Acute Trusts.

From the far north Dr. Vinod Gadiyar has been joined by Drs.Abraham and Kumar in Caithness General Hospital and are finding the time and resources to help set up the new High Dependency Unit, Day Surgery Unit and Acute Pain Service. Good luck to them! Drs.James Mackay, Wagih Antonics and Charles Leeson-Payne continue to provide an excellent service at the Bedford Hospital and Mackinnon Memorial Hospital in Broadford and we wait to see the effects of the withdrawal of emergency services in Skye.

Raigmore saw the return of Dr.Sandy Hunter from his 'extended' Intensive Care attachment in Perth, Western Australia, although we are sure it would take little persuasion to entice him back there! Dr.John May completed his term of office as Convenor of the Department and Intensive Care Unit to be replaced by Nial Hennessay. Howard Spencely was appointed Co-ordinator of the Management Group, leaving his post as Convenor of Theatres which will be filled by myself, Ian Johnston. Dr.Jacqui Howes is busy developing our Acute Pain Service. Finally, we have one staff change with the departure of Paul Jennings who was last seen 'hitting the A9' in his Suzuki tourer. We all wish Paul a very happy and healthy retirement.
(now that's a report! - thistle)

Ian Johnston

SCOTTISH SOCIETY OF ANAESTHETISTS

REGISTRARS' PRIZE

The Society annually awards a prize of £250 for the best original paper or essay submitted by an anaesthetist in Scotland holding the grade of Senior Registrar or under. A second prize of £150 and a third of £75 may be awarded for other papers of particular merit at the discretion of the assessors. It is not necessary that the trainee be a member of the Society.

The conditions attached to the award are as follows:

1. The paper or essay must be original, i.e. it should not have been read previously at any meeting or published in any journal. The winning of the prize is in no way a bar to the subsequent publication in another Journal.

2. It is desirable that papers submitted show evidence of personal work, but papers consisting of surveys of the literature are eligible for consideration. The Council of the Society wishes to stress that intending competitors should not be discouraged through fear of there efforts being judged elementary. It is fully realised that junior anaesthetists in some peripheral hospitals may not have opportunities to deal with special types of cases or to employ advanced anaesthetic techniques.

3. Papers for adjudication (4 copies) **must** reach the Secretary by **28th February 1999**

The Secretary places all entries in the hands of the Awards Committee which consists of the President, Vice President and Past President. The members of the committee have expressed the desire to be able to adjudicate without knowing the name or hospital of the writer: **it is requested therefore that the name, address, etc. of the entrant be submitted on a separate covering page. This will be retained by the Secretary, but otherwise the essay itself should give no indication as to its source. Acknowledgement of colleagues etc. should not be included.**

4. The Prize will be presented at the Annual Meeting of the Society where the winner and partner will be guests of the Society. The winner will be required to present a digest of their paper at the Annual Meeting and the Society's Trainees Educational Meeting.

Dr C. J. Sinclair,
Honorary Secretary,
The Scottish Society of Anaesthetists,
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