THE SCOTTISH SOCIETY OF ANAESTHETISTS

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Editorial

Welcome to the 2013 edition of the Annals.

Following very good feedback on last years format change (especially the increased font sized - there must be much presbyopia out there) I have plumped for the same size and layout. Among other things, the efficiency of this layout lets us have more colour pages

It's been a busy year for everyone in the executive keeping up with this years president, Charlie Allison. Our second Spring meeting in Crieff was again a great success with good attendance. It was the first one organised wholly by this executive and I'm glad to say it went off without any great disasters. I may be confident enough this coming year to go with only one back up projector. The meeting itself was very good with excellent speakers and a great social program. It was preceded of course by the Trainees Meeting on the Friday which as usual had a great, mixed educational program and another huge entry for the poster competition. We've got a new pair of trainees reps now on council in John Allan and Sabah Munshi. All the best to them and a huge thanks to Vishal and Sarah for all their hard work over the past three years. They did an excellent job.

As I said last year, I'll minimise my editorialising as I feel anything I may wish to say is probably said better by others.

Next Year is a big year for the Society. I better go start on the next Annals now.

Cheers & enjoy.

Brian Stickle

Presidents Message

Dr C W Allison

It's a real pleasure & privilege to be your President, at a time (like my predecessors) when I am reflecting back on a career in anaesthesia. May I therefore start by wishing all my fellow 2012 retirees well, indeed all those going this year too. I attended events for both Harry Macfarlane in Aberdeen and Gordon Smith in Kirkcaldy, as well as seeing a lot of old friends at my own personal jubilee in June. The Dalai Lama was in the building but sadly too busy to drop in!

I can look back on a year of great merit for the Society. The trainees' meeting at Crieff was well attended with an excellent programme and, as a judge, I can attest to both the numbers & quality of poster submissions. The Saturday meeting was well received too and I must thank all those involved. The move from Peebles after 20 years was a big decision taken by the Glasgow executive. Crieff Hydro has been rated the best family venue in Scotland and hopefully gives quality at a fair price for our members. It was often said by Edinburgh colleagues that Peebles was too near for them to stay for a weekend and we were all ready for a fresh start.

The Society strives to maintain our role as a social focus for Scottish anaesthetists as well as presenting good science of clinical relevance in this CPD age. Many of us return year after year to the annual Spring meeting as friendships formed between our wives & children, as much as between ourselves. The date of the meeting (at exam time) may not be optimal and we may consider a change in 2014. It would appear that not as many younger consultants attend compared with times past. The rise of specialist Societies, some based here, might have taken some of our audience. Your Council is pleased about combining the Trainees Meeting and we'll continue to tweak the programming until we get the right formula. We would always value members' input into our deliberations.

On 1st June I was asked to an RSM event in London organised by Crawford Reid, President of their Anaesthetic Section. A lively good-hearted debate was won by "anesthesiology" over "anaesthesia" by the one vote of a prize-winning student - personally I would have taken his cheque back for voting that way! Later Elspeth & I dined on a Thames cruiser in the company of the College & Association Presidents. I hadn't intended to speak but was asked to clarify the position of Scots post independence. They feigned disappointment when I told them we're not all wanting to break away!

Our golf day at Newburgh was well attended - the West Coast lads had been up for a Thursday game at Cruden Bay and dinner at the Udny Arms, where we were joined by John Mackenzie, looking back to his best after his spell of serious ill-health. The often-in-the-hunt Alex Macleod won to earn the right to organise the 2013 event.

The two day Scientific Meeting in Dundee, held jointly with the Royal College, had a very full & varied programme. I particularly enjoyed Sue Black's talk on criminal anthropology and Robert Sneyd's thoughtful Gillies Lecture on student selection. The social evening at Verdant Works, with excellent curries and ample refreshments, seemed well received. I must thank Fiona Cameron for staying an extra year on Council to lead a fine organising team.

The Society now looks forward to its Centenary in February 2014 with Neil Mackenzie at the helm and we are trying to organise a worthy scientific, social & exhibition programme. I am also pleased that the following President in that centenary year will be Ian Johnston from Inverness. Both Neil and Ian have played major roles in our speciality at Scottish & UK levels and the honour is worthy recognition of their sterling work on our behalf.

I must also thank all the SSA council - particularly our star Secretary Gordon Byers, Andrea Harvey 'on the money' and Brian Stickle for his continued good care of the Annals! Regions should now be thinking of "bidding" a team of three for these executive positions for 2015. Aberdeen, Glasgow & Ayrshire as the most recent should rest meantime. Council would be happy to receive notes of interest and bring the successful group on board a year ahead to shadow & learn.

Tony Wildsmith told me when you retire all you can legitimately lecture on is history. Well I am currently touring Probus Clubs & the like with The Gasman Cometh (not the SSA version - just the 'job talk') Everyone finds our work fascinating and at one recent talk I received three nuggets in return, regarding ethylene & trilene industrial accidents and non-vapourising chloroform failing to dispatch some kittens!

I hope we can meet up sometime during the year. Do try to come to Crieff in May, particularly as there's no meeting in November - instead please note Edinburgh, 20th-21st February 2014 on your advance calendar.

Dr Charlie Allison

Presidential Address

The Gasman Cometh

12th May 2012 Crieff Hydro

Dr Charles W Allison

It is a great honour to be elected President of this Society and to see so many Past Presidents here today. I will endeavour to match my predecessors, though I've decided not to learn to play the bagpipes! However I did take a few soundings and the first piece of advice came from John May who insisted there must be music today!

My title is The Gasman Cometh and Ninewells artist Maureen Sneddon drew the cartoon (right) back in the 70s. I have used this for various 'job talks' to Rotary clubs & the like, where I'm invariably introduced as one who hopefully won't send them all off to sleep! I fondly remember the Stobswell Women's Guild where my mother-in-law was speaker secretary. Joyce, never known for fulsome praise of her son-in-law, reported my talk had gone 'quite well', apart from two ladies who'd got the wrong tack and had come along to query their gas bills! At scientific meetings I delighted in showing Stracathro being near all the 'great Scottish seats of learning' (Carnoustie, St Andrews & Gleneagles!) and that the 'mansion house' was our junior doctors residence! Perhaps there's been a hospital there for 2000 years as there was a Stracathro Roman camp to which casualties were taken after the Battle of Mons Graupius

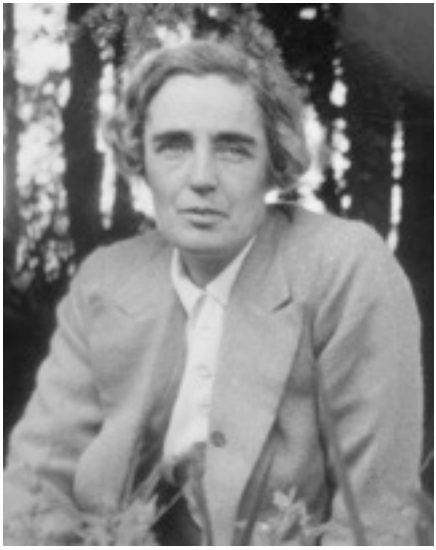
in AD84. And our motto -Ye May Gang Faur an Fare Waur - was borrowed from a transport cafe nearby!

We have all heard a great diversity of marvellous talks over the years - on subjects many & various, personal to the Presidents concerned. I have chosen two suitable topics today (one musical) but will first follow a well-tried template by spending ten minutes going over biographical details and paying tribute to my mentors.

I was born in Newport-on-Tay, which makes me a 'Fifer', though my Angus friends think I'm a Dundonian. I was brought up in the village of Gauldry, where my family lived in a former manse with a 60 foot windmill in the garden. I attended the village school and Madras College in St Andrews, then went 'over the water' to study medicine in Dundee - a city known for 'the three Js' - Jute, Jam & Journalism. Anyone coming to our Scientific meeting in November will be able to visit the Verdant Works, a former jute mill, for our social evening (and sample food from the Indian subcontinent). Dundee was the city where Mrs Keiller made up a recipe for marmalade and its wide range of journalism includes Desperate Dan, whose statue is an iconic meeting place in the City. My personal trio are Dundee United, Dundee pies (these two often go together!) and sailmaking. My father was the fourth generation running a ship-chandlers business in Dock Street and I spent many happy summers putting up marquees for various agricultural shows or society weddings. My mother meantime came from generations of farming folk in the East Neuk of Fife.

I graduated in 1975, then had a great houseman year up at Stracathro, chosen earlier for student attachments & locums as my girlfriend was a student dietitian up in Aberdeen. Elspeth & I have now been married for 36 years. I returned to 'The City of Discovery' (Capt. Scott's ship) to train in anaesthesia, where I had a historic connection. My Great-Aunt Jeannette Manzie gave anaesthetics in DRI during WW1 and was taken on Arthur Mills' staff in 1919. She married the professor of medicine's son (Dr J M Stalker) and they went into general practice in the town. Jeannette had undoubtedly been one of the first female anaesthetists in Scotland.

I had many great teachers at Ninewells - my composite photo (over) was assembled at a department dinner. Bill



Dr Jeannette Manzie

Bisset was probably the best tutor for new starts and some of his ingrained habits still remain with me to this day. Mel Milne was the obstetric anaesthetist and I never did a spinal tap after he taught me epidurals (though I did do one on day two of my career with someone who remarked that he was 'surrounded by idiots!') As you moved up the ladder you got to meet Stuart McGowan & Sandy Forrest, both Past Presidents of this Society (as indeed were the next four Dundee consultants I'll mention). Stuart, a hard-working anaesthetist who did a lot of Neuro, looked after the busy Tuesday Urology list which, after a short spell in the hands of Gordon Smith (who went to Kirkcaldy), I have done weekly since 1980. I always regarded Sandy as 'the Rolls Royce of Anaesthetists', because he used curare! I once had a case in Main Suite and asked for an ECG machine, but was told I couldn't have one "because Dr Forrest is doing a thyroid!" Changed days in monitoring - we'd never start anything now without it!

The three Intensivists Alfie Shearer, Farquhar Hamilton & Iain Gray have all

been very important influences. Alf was meticulous in his pre-op assessments and many an anaesthetist has been very grateful when subsequently looking after one of his patients. Farquhar had a most ordered mind and there were many times I forced myself to 'think like Farquhar' to solve some clinical problem. Iain was a great mentor who encouraged me to follow him to Toronto for a Fellowship at Sick Kids - a marvellous experience. I particularly enjoyed working (and golfing) with the legendary Dundonian scoliosis surgeon Bob Gillespie. We also travelled to Bermuda very cheaply, went free to see Frank Sinatra and I played football against Sir Stanley Matthews! (65, but he still ran rings round me!)

Back in Dundee Ian Lawson and I didn't always see eye to eye. On one occasion I had to have a tooth out with a GA given by my dentist and 'the boss' took a dim view of this. I was idly doing the rota one afternoon when a call came from A&E for someone to see a patient who'd collapsed after a dental anaesthetic. Ian immediately jumped up and instructed me to go with him "so you can see the error of your ways". On arrival in Casualty the senior Sister said "Oh good it's you, Dr. Lawson. It's one of your patients from the Dental Hospital this morning who's fainted in Boots". I can still see him throwing his head back & laughing loudly at the irony of the situation - this certainly broke the ice! I told this story to his wife Grace & daughter Joanna when they endowed the Lawson prize at NESSA.

I was encouraged by my other main mentor Ion Grove-White to come over from Canada to be interviewed for a consultant post at Stracathro and was appointed to start after I'd completed my

Top - Alfie Shearer, Sandy Forrest, Mel Milne, Farquhar Hamilton
Bottom - Ian Lawson, Ian Gray, Stuart McGowan, Bill Bisset

year in Toronto. Ion was highly regarded as an anaesthetist, particularly for children in ENT with dodgy airways. He was a great boss to work for, and indeed my other Stracathro colleagues were also pretty special. Alban Houghton is a Peter Pan (or Benjamin Button?) who is apparently getting younger all the time. Annie Donald used to summon her orthopaedic surgeons with a honking horn and Jan Beveridge brings a touch of class to our department. Despite recurring uncertainties Stracathro has had excellent staff at all levels and is a very happy place to work. When the Health Board periodically threatened to close the hospital, the local public manned the barricades for us!

I got great mileage out of working with Aberdeen orthopod Douglas Wardlaw, who injected chymopapain into discs to relieve sciatica, a painful procedure also fraught with an incidence of anaphylaxis. I presented my anaesthetic technique at various international meetings and was also asked to contribute a book chapter.

In 2000 I was encouraged to be Editor of the Scottish Society Annals and spent four happy years taking it down-market, writing about Para Handy's puffer converted into a day surgery centre and commissioning magazine articles of interest. I was ably supported by Donnie Ross (who painted the cover illustrations), my four Presidents and two fellow Dundonians - Secretary Neil Mackenzie (who I'm delighted will follow me as Centenary President) & Treasurer/ Conference Supremo Jon Bannister.

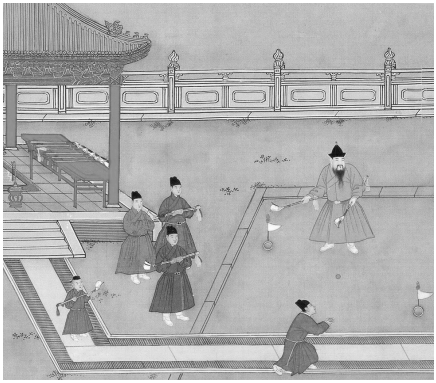
Lastly I have been to three World Congresses (Sydney, Cape Town & Buenos Aires) and would recommend these great gatherings to younger anaesthetists to attend in the future.

Now it is helpful to my voice not to have to speak continuously for an hour. I hope you will enjoy three short musical interludes by Procol Harum, a band I have followed since A Whiter Shade of Pale in 1967, which sold 10m copies and is seen here from Top of the Pops. I will later show performances from two concerts I attended - "Quite Rightly So" from Union Chapel, London (2003) and Grand Hotel at Ledrebourg Palace in Denmark (2006), the latter event with a symphony orchestra & chorus which played to 10,000 people on each of two consecutive days. My slides will show a number of facts about the band & their music.

Now a quiz question. Which country gave Anaesthesia to the world? Alex Salmond knows the answer - "It's Scotland, Miss!" Our Alex obviously knows about chloroform being used by Simpson - but perhaps not about his coach being stoned by presbyterian hard-liners as he arrived at the Royal Infirmary or how Simpson & his friends were 'stoned' at various social gatherings or 'ether frolics'. Of course we know about the prior claims of Wells & Morton with other agents and how anaesthesia first came to Dumfries from the New World in December 1846.

Now a different question - Which country gave Golf to the world? Alex has his hand up again - "its us again, Miss!" On this occasion I think he may be right and I aim to explore the argument that it was indeed Scotland who gave the game to the world. I will look first at the origins of golf in Scotland (and elsewhere), then look at ancient records to see the influence of our church & royalty, the formation of the first clubs, then later the dawn of the professional game and its spread (by Scots) to all corners of the globe. Finally I will take a light-hearted look at parallels between golf and anaesthesia. I have a personal golf book collection of some 250-300 volumes (which Elspeth would rather put in a skip!) and I probably know more about golf than anaesthesia. ("that wouldn't be hard" I hear my colleagues say!) I would just admit to being a conscientious duffer at both!

At the outset I would like to commend my four principal sources, in case I forget at the end. Malcolm Campbell, past-Editor of Golf Monthly (the great Scottish golf magazine which recently celebrated its centenary), Olive Geddes, Senior Archivist with the National Museum of Scotland and an authority of early Scottish sport and Glasgow surgeon & renowned golf historian David Hamilton, author of Golf - Scotland's Game. This is one of those rare occasions where we find a surgeon imparting great wisdom to an anaesthetist! Hamilton states "golf is a precise game, the ball is in the hole or it is not... but the history of the game lacks such precision and certainty." He reckons we should dump 'fanciful notions about shepherds & sticks' and follow up the many new 'source scraps' from the continent. According to golf historian, noted public speaker and my former obs & gynae colleague Professor David Purdie, there are two theories about the origin of golf - akin to the origin of the species - put forward by 'creationists' and 'evolutionists'. The former suggest golf sprang fully-formed from the linksland of Scotland, from a shepherd taking a break from idly tending his flock and doing what comes naturally to shepherds everywhere - casually hitting a pebble into a hole with his crook! (Incidentally the most famous golfing Shepard was Allan, who played golf on the moon!). The other theory is that the game evolved in a Darwinian-like manner from



Chuiwan

more primitive precursors in other parts of the world. Either way, no-one back then could have predicted the worldwide game it has become - with maybe 60 million players and a professional game worth fortunes to its gladiators.

From earliest times the human race played a great variety of stick & ball games - some developed into distinct sports we see today - cricket, hockey, hurling, shinty, even croquet. Some countries - the Low Countries of Holland & Belgium, now even China - have even claimed to have originated golf. To my ears the Chinese game Chuiwan sounds more like a bar of toffee! It has been stated that their games played to targets above ground, and it was the hole which Scotland gave to golf. I have however seen an ancient Flemish picture depicting kneeling men hitting a ball into a hole

The Flemish game of Coff

(below). But undoubtedly it was our Scottish game which has survived & thrived to reach world-wide popularity and that game was golf (or 'goff', as it was often called at the time).

Golf was not the preserve of the rich, but was also a game played by the masses. Hamilton reckons there were possibly two games - a short one and a long one. The 'short game' was a street or churchyard game, similar to colf played in the low countries. The nobility & well-off people played a 'long game' on estates with more sophisticated clubs & balls and it's this game which would be closer to today's golf. Over the years golf has been seen here as a game for everyman, played over city parks like Perth Inch & Glasgow Green, but chiefly on the linksland.

The links are rough grasslands just above the beach on land which is moderately fertile but not commonly used for agriculture. The sandy base means the linksland drains well in times of high rainfall. Sand blown over from the beach piles up as 'dunes' and marram grasses growing there help stabilise the sand. If the links are to be used for golf courses, natural fescue & bent grasses are sown on the greens and fairways. These are long-rooted and survive the seasons well, being resistant to heat, frost & the salt air. They are very durable and so tolerate the hacking efforts of golfers! However in the modern era we have over-fertilised & changed the grasses for greener golf courses. They look superficially great when all is well, but fragile grasses die off in times of climatic problems - drought, heat or frost - and are chewed up more by us too! Fortunately enlightened agronomy is winning the debate and we are now returning to traditional greenkeeping with indigenous links grasses. Gorse, broom & various wildflowers, some imported, also make the scenery attractive. The sandhill ridges are often incorporated into course design with dog legs, diagonal or over-the-top carries. Greens & tees are placed up in the dunes for shelter or for dramatic downhill drives. The dunes are great vantage points especially during tournaments with large galleries like the Open Championship. Next month we will see fantastic dunes at Cruden Bay & Newburgh for the Scottish Society golf and the new Donald Trump course nearby has evidently taken this to a new level. Some courses have had ancient glacial activities leading to a 'raised beach', which gives them two levels to add to their appeal. Royal Dornoch is a historic two-level course and a fantastic new one has been created recently at Castle Stuart near Inverness. Some courses are under threat from coastal erosion - Montrose is at risk and enhanced seawall defences and some re-design has taken place, with tees & fairways moved away from the edge. Rising sea levels particularly affect the Brancaster course in Norfolk - you reach it by causeway at certain specified tide times and the course may be lost entirely in the future.

The links usually belonged to a town for the recreation - 'the common good' - of the inhabitants. At St Andrews the links was expanded by the purchase of neighbouring land from local lairds. It was used for other pursuits, including dog walking and horse racing a few times a year - this survives only at Musselburgh. There was some military use for marching & exercising and Turnberry was requisitioned as a WW2 airfield and Barry Buddon is still an army training camp. Women used the links for drying clothes, there were bleachfields, and travelling fairs were held - at Brechin the Taranty Fair still closes the first fairway for a few days every June. Somewhat gruesomely, some links were used in time of epidemics as burial grounds. There was some grazing of sheep & cattle (still seen at Brora and a few other highland courses, where they reduce the need for fairway mowing!) Rabbits were essential inhabitants of the

links - one still wonders if the original golf hole was a rabbit hole and whether a network of them became the first bunkers? Inland golf was often established near rivers - on Inches or Greens. These parks or heaths should not really be called links but this term is commonly used abroad. Only a small proportion of the world's courses are true links and the highest number is here in Scotland - great for our tourist industry, as golfers flock here to experience those traditional features.

In her book A Swing through Time Olive Geddes lays out the Museum of Scotland archive on the 'dark ages' of the game, between its first record in King James II's 1457 proclamation banning golf to the formulation of the first rules by the Hon. Company of Edinburgh Golfers in 1744.

Geddes tells of 15th century Scotland suffering from feuds amongst the nobility and the young kings struggling to assert authority. They felt they had to be able to muster an army to repel any threat of invasion from their powerful English neighbours. To this end there was concern that men must practise their archery skills and golf & football were therefore banned at certain times. Archery practice in kirk-yards was mandatory and every male over 12 years had to shoot at least six shots on targets set up there. Failure meant a fine of two pennies, the money raised to be spent on drink for those who had complied with the Act!

Item it is ordanyt and decretyt that Wapinschawing be haldin be ye lordis an baronys spirituale an temporale four tymes in ye yeir. And (th)at ye fut bawe and ye golf be uterly cryt done and not usyt and at ye bowe markes be maid at all parochkirkes apair of buttes and shuting be usyt ilk Sunday... And touch and ye futebaw an ye golf We ordaine tit to be punyst be ye baronys unlaw. And if he tak it not to be tain be ye kings officars. (Act of Parliament, 6 March 1457)

There was a reminder in a further Act in 1471

It is thocht expedient (th)at ye futebal and golf be abusit in tym cumyng and ye buttes maid up and schot usit efter ye tenor of ye act of parlyament.

In 1491 (under James IV) golf & football were called "unprofitable" and much more severe penalties were defined.

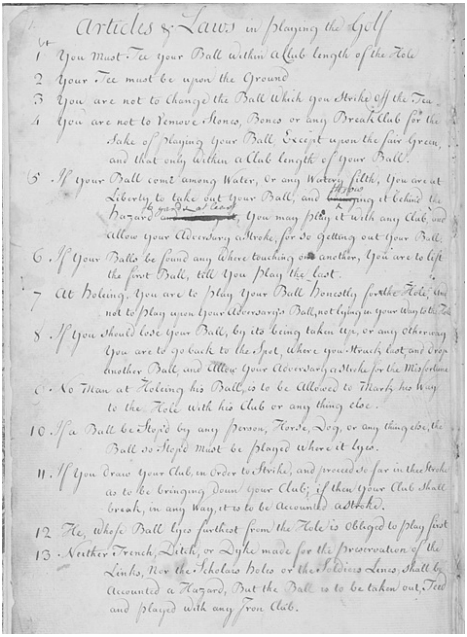
Item it is Statut and ordanit that in na place of the realme be usit fut bawis, gouff or uther sic unprofitable sportes bot fur common guid and defence of the realme be hantit bowis schuting and markis ... under ye pane of xl sh (forty shillings) to be raised by the shref an bailzies forsaid.

Golf did in fact enjoy the patronage of royalty - James IV has sometimes been called our Golfing King. Evidence from his Lord High Treasurer's accounts shows the King paid three French crowns in losing a golf match to the Earl of Bothwell in February 1503 and purchased clubs & balls in Perth & Edinburgh in 1503 & 1506 - one shilling for each club and three balls for a shilling. Mary Queen of Scots played golf at St Andrews in 1562 and was then alleged to have failed to behave like a Royal widow, indulging in a game of golf at Seton Palace with Bothwell a few days after the murder of her husband Darnley

Mary Queen of Scots at St Andrews

in 1567. Her son James VI & I also took an interest in golf and possibly learned to play on the North Inch at Perth. He exported the game to England when the Scottish court moved there in 1603 and is believed to have been associated with the founding of Royal Blackheath GC in 1608. It claims be the oldest club in the world, though an 18th century fire destroyed its early records (and several Scottish clubs like to claim precedence). Charles I had a difficult time with the 1745 covenanter rebellion and the English Civil War. He fled to France, was captured on his return, then executed in 1649. Nevertheless, like all of us, he had quieter days when there was time for golf. There's a picture, engraved later on a silver trophy, of him being interrupted on Leith Links to receive news of the Irish Rebellion of 1641. One speculates his response might have been it would cause difficulties ... in getting a good pint of Guinness!

In recent times golf continued to receive Royal patronage. Edward VIII was a keen golfer and his brother George VI and the current Duke of York were both Captains of the R&A. The Queen Mother played a little golf and a rare photograph shows Prince William with a golf club on the sands of St Andrews during his time there as a student.



Articles & Laws in playing the Golf

1 You Must Tee your Ball within a Club length of the Hole
2 Your Tee must be upon the Ground
3 You are not to change the Ball which you Strike off the Tee
4 You are not to Remove Stones, Bones or any Break Club for the Sake of playing your Ball Except upon the fair Green, and that only within a Club length of your Ball.
5 If your Ball come among Water, or any Watery filth, You are at Liberty to take out your Ball, and [illegible] it behind the Hazard [illegible] You may play it with any Club and allow your Adversary a Stroke for so getting out your Ball.
6 If your Balls be found any where touching one another, You are to lift the first Ball, till You play the last.
7 At Holing, You are to play your Ball honestly for the Hole, and not to play upon your Adversary's Ball, not lying in your Way to the Hole.
8 If You should lose your Ball, by its being taken up, or any otherwise You are to go back to the Spot, where you Struck last, and Drop another Ball and allow your Adversary a Stroke for the Misfortune
9 No Man at Holing his Ball, is to be Allowed to Measure his Way to the Hole with his Club or any thing else.
10 If a Ball be Stop'd by any Person, Horse, Dog, or any thing else, the Ball so Stop'd must be played where it lyes.
11 If You Draw your Club in order to Strike, and proceed so far in the Stroke as to be bringing down your Club; if then your Club Shall break, in any Way, it is to be Accounted a Stroke.
12 He, whose Ball lyes farthest from the Hole is Obliged to play first
13 Neither Trench, Ditch, or Dyke made for the Preservation of the Links, Nor the Scholars Holes or the Soldiers Lines Shall be Accounted a Hazard, But the Ball is to be taken out, Teed and played with any Iron Club.

The First Rules of Golf

A famous painting The Sabbath Breakers depicts the forebears of Messrs. Dougall & Wilson being 'caught in the act' by stern disciplinarians from the local parish! I'm sure they would have paid their penance and gone out golfing again as soon as they could! There were also clergy who played golf and one developed an overwhelming guilt about it. The Bishop of Galloway saw a vision of two men attacking him while playing on Leith Links in 1619. Taking this to be an indication of his wrong-doing after accepting the office of Bishop, he's said to have put down his clubs, taken to his bed & died! A bit extreme, methinks.

Golf also came to the attention of the Scots judiciary. I was fascinated to learn the first homicide with a golf club was in 1508 in my adopted home cathedral city of Brechin, where John Thowless

committed the slaughter of Alexander Meill by the stroke of a golf club. Later in 1632 William Hangetsyde, an indweller in Kelso, and his son Robert were accused of the death of Thomas Chatto ane onlooker at ane bonspill within the kirk yaird of Kelso, by:

geving him ane deidlie straik with ane golf ball under his left lug upon the vene organe thairof.

The National Archive contains many testimonies to the development of the game in Scotland. Robert Gordon, who founded the school & now university bearing his own name, wrote in 1636 eulogising the course at Dornoch as The fairest & lairgest links.... fit for archerie, goffing, ryding & all other exercise. They do surpasse the feilds off Montrois or Saint Andrews.

The stout Edinburgh nobleman Sir John Fowlis of Ravelston kept meticulous household accounts which reveal that over the winter of 1685-86 he gave 14 shillings to golf professional Malcolme for a new head for his lead scraper club & repairing his play club, 5 shillings for balls and 4 shillings for carrying his clubs. More interesting for us modern-day social golfers was his payment for eight winter golf outings with his cronies - for equipment, wagers, coach hire and food & drink - a total of £21 10shillings. Obviously a good time was had by all and this maybe goes some way to explaining a picture of Sir John being carried around in a sedan chair by two straining servants!

In 1687 Thomas Kincaid, an Edinburgh medical student, became the first person to write about the theory of the golf swing - you must turn the body as far about to the left before swingeing of the clubb.
Golf found a place in Scots poetry too. Glotta eulogised a golf game on Glasgow Green (1721)

The timber curve to leathern orbs apply Compact, elastic to pervade the sky
These to the distant hole direct their drive They claim the stakes who thither first arrive .....
The impelling blow to strike with greater force And shape the motive orb's projectile course.

And in 1743 The Goff described golf on Leith Links (said to be North of Edina eight furlongs or more lies that famed field on Fortha's sounding shore)

Goff and the man, I sing, who em'lous plies The jointed club; whose balls invade the skies
O Thou Golfiana, Goddess of these plains Great Patroness of Goff, indulge my strains.
Round the green the flying ball you chase Or make your bed in some hot sandy face.

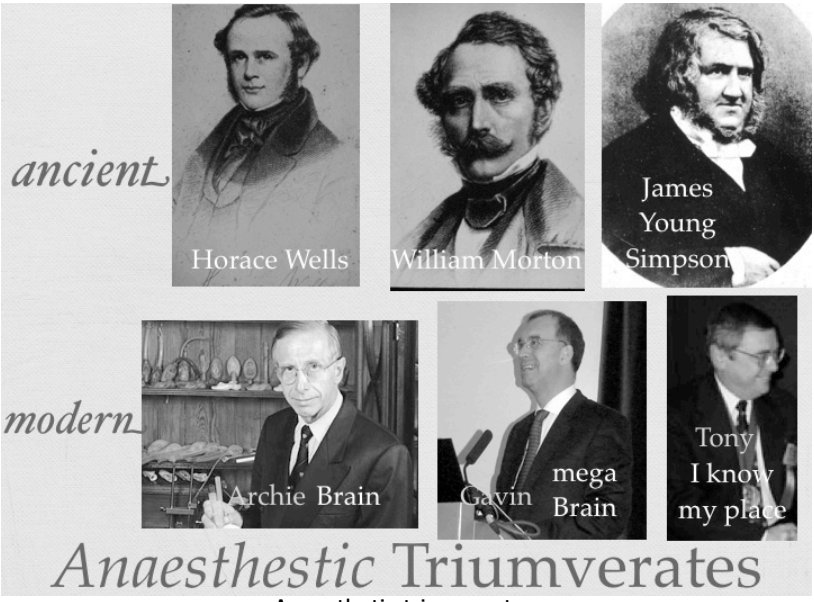
Two of the great golf centres in Scotland, perhaps jousting for pre-eminence, were Leith & St Andrews. Although the Royal & Ancient Golf Club of St Andrews is the governing body today, the first rules of the game were formulated by the Gentlemen Golfers of Edinburgh in 1744. Unlike the complexities of today, thanks to two centuries of revision & legal challenge, these first 13 rules were simply laid out on one sheet of paper. Would that we could still use them today! Edinburgh Council gave this Hon Company a silver club for competition and this was paraded annually prior to their Spring competition.

Golf had been played at St. Andrews for three centuries or more before this. The 1574 diary of James Melville, a student from Montrose, records his paternal gratitude for providing him with bow, arrose, glub an bals for archerie and goff, sic was my father wesom for my weill. Later in 1691 Professor (of Philosophy) Alexander Monro arranged for his legal

friend John Mackenzie to have ane Sett of Golfe-Clubs from this place, the Metropolis of Golfing, dispatched to him along with ane dozen of golfe balls.

Old photographs show the Union Parlour clubhouse (forerunner of the R&A), Hell Bunker and the Swilken Bridge looking exactly as they do today. In what I might suggest was an early example of stereo-isomerism, (the only bit of science in this talk!) the Old was played as both a left & right-handed course after Tom Morris widened the links and expanded it to 18 holes in the mid 19th century.

That period brought the dawn of anaesthesia, and was also the start of the professional game of golf. The greatest player of the day was club & ball maker Allan Robertson of St Andrews, reputedly never beaten in a money-match. Sadly he died in 1859, a year before the first Open Championship, contested by eight golfers over the ancient links at Prestwick and won by Wille Park of Musselburgh. The Morris family from St Andrews were then to dominate the game over the next 15 years, winning eight championships. Old Tom was Keeper of the Green at both Prestwick then St Andrews - his golf shop is still on the links to this day. Old Tom died tragically in his late 80s when he opened the wrong door from the bar in the New Club and fell down a flight of stairs into the cellar. Young Tom Morris, the Rory McIlory of his time, competed in his early teens and won three times to claim the Championship Belt outright, then won the first playing for the Claret Jug. He passed away tragically aged just 24 “from a broken heart”, soon after his beloved wife had died in childbirth. St. Andrews regaled all the heroes of golf over the ages from war-hero Freddie Tait & American Bobby Jones to Arnold Palmer (whose caddy Tip Anderson was a St Andrews man) & Seve Ballesteros.



Anaesthetic triumverates:
Wells Morton & Simpson
Brain, Kenny & Wildsmith

The Royal & Ancient Golf Club was founded in 1754. This members club is full of tradition with two particular ceremonies - the new Captain plays himself into office to the sound of cannon fire (& a host of caddies jousting to retrieve his ball for a gold sovereign reward); and at their first Dinner new members must kiss the Captains balls! The commercial arm of the R&A reviews the rules, including adjudicating on irregular equipment and also promotes the game worldwide, both in terms of instruction, agronomy and competitions like the Walker Cup and the Amateur & Open Championships.

Scotland's greatest golf designer James Braid, a fifer from Earlsferry, was responsible for hundreds of courses and in his era was one of a 'Great Triumvirate' of championship winning professionals (along with Englishmen Harry Vardon & J H Taylor). In later years we had 'The Big Three' of Nicklaus, Palmer & Player and maybe for us a Scots group of Lyle, Lawrie & Montgomerie. In anaesthesia we of course had an ancient triumvirate in Wells, Morton & Simpson and maybe a latter day trio in the pioneers of LMAs, TIVA and regional analgesia - Archie, Gavin & Tony (or Brain, mega-Brain and "I know my place!")

Perhaps an analogy of anaesthetists as accompanists is not worth expanding on, but golf has its caddies, a colourful group who add much to the gaiety of the nation and indeed had to be regulated for their behaviour & sobriety! There were many lovable eccentrics with interesting nicknames - Pint-size, Lang Willie, Donal Blue & Trapdoor (who cheated with a hidden ball compartment!) Golfers & caddies both work symbiotically as a team sharing credit in success, but apportioning blame when things went wrong - "we won the match pretty easily" or "he hit it in the water at 17....useless bugger" This 'mutual respect' is much the same as we share with surgeons - "things were going really well until that moron cut the femoral vein!"

When one turns to the World of Golf it is easy to describe the role Scotland played in the international dissemination of the game. I have already mentioned James VI taking his court South to Blackheath. Other early English clubs like Royal North Devon, Wimbledon & Royal St Georges all had Scots as founding fathers or designers. Scots in the British Empire, particularly doctors & engineers, were key to the setting-up of clubs in India, Canada & Australia and the influx of hundreds of Scots professionals taught the game in the U.S.A. Dunfermline's John Reid is regarded as 'the Father of American Golf' in setting up the St. Andrews Club in Yonkers (or The Apple Tree Gang), Carnoustie pro Stewart Maiden taught the great Bobby Jones and Dornoch's Donald Ross designed many great American courses. Sadly the kilted patriot Dr Alister MacKenzie, who laid out both Augusta & Cypress Point, was actually born in Leeds. It interested me that one of his partners was Charles Alison, whose best work was in South Africa & Japan, where big bunkers are still called "Arisons!"

Scottish courses can be described as links, heathland or parkland and with Ireland we have the vast majority of the links courses in the world. Many overseas golfer come here to play the ancient championship venues (Carnoustie, Turnberry, Troon & St Andrews) as well as some newer challenges (Castle Stuart, Kingsbarns & Trump) and lesser known "hidden gems" (too many to mention!) Scotland also exports golfing treasures - art & antiques - and many clubs worldwide have cabinets of hickory clubs, featherie balls, trophies & memorabilia bought from these shores. One can trace the explosion of golf through the celebrities who play the game (Frank Sinatra, Glen Campbell, Alice Cooper & Chris Evans) and the diverse new countries where golf

is developing - like the Emirates, Argentina, Bulgaria & China, which has the largest complex in the world (Mission Hills with 16 x 18holes!) Some courses pose unique natural challenges, including interfacing with local wildlife like alligators, snakes or elephants! One club in South Africa has an extra hole whose tee is reached by helicopter and offers a $1m dollar challenge to hole out on an Africa-shaped green 2000 feet below! It only costs $200 to have a go but it would have to be a once in a lifetime shot, like this one of Rory McIlroy hitting the bell at the Belfry! (if you believe what you see!)

Gary Player, accused of being lucky by a spectator when he holed a difficult bunker shot, famously retorted "the more I practice, the luckier I get!" Anaesthetists & other medics now use skills labs & simulators to hone their skills. There are other similarities between anaesthesia & golf - both have expensive new kit with extravagant advertising claims in the journals, both have a huge instructional literature ("paralysis by analysis") & complex scoring/assessment systems and both enjoyed royal patronage at key points in their development. It's fair to say that in both disciplines Americans do it differently (but not necessarily better!) and ladies have their own particular place (though we in anaesthesia have absolute equality, with no "ladies tees", as brute strength is not an issue!)

The last word goes to celebrated American writer Grantland Rice (1880-1954) who wrote that

Golf is in part a game, but only in part

It is also in part a religion, a fever, a vice, a mirage,

a frenzy, a fear, an abscess, a joy, a thrill, a pest,

a disease, an uplift, a brooding melancholy.

a dream of yesterday, a disappointing today and a hope for tomorrow.

I feel the exact same words could equally be used to describe anaesthesia and surely, after examining the central part our country has played in exporting golf, we can confidently tell Mr Salmond that even though its origins may have come in part from Europe, golf is indeed a game which Scotland gave to the world.

It only remains for me to ask the piper to tune up and toast the Scottish Society of Anaesthetists!

Charles Allison, Crieff 2012

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REGIONAL REPORTS

News and updates from around the country

News reports from around the regions. Check out how your friends (or otherwise !!) are getting on.

Aberdeen

What's the critical mass of an anaesthetic department? Is a certain size attained beyond which it cannot expand? At the end of 2011 there were 60 consultants, 5 Associate Specialist/Staff Grade and 48 trainees attached to NHS Grampian. This did not include FY1s and cross-specialty ICU trainees, Now fast approaching the end of the 2012, our numbers stand at 61 consultants, 4 AS and 40 trainees (not including FY1s, and ICU). So consultant numbers may be much the same but trainee numbers have declined, although we are assured they will not decrease further!

During 2012 we have welcomed the appointment of five consultants – Andrew Bayliss (neuroanaesthesia), Kay Davies (paediatrics), Anoop Kumar (regional) Michelle Lamont (education) and Anne Wake (remote and rural) each bring their own sub-specialty interest. Clearly our numbers have stayed static partially due to retirals of distinguished colleagues. Harry McFarlane, Margery Macnab and Ann Robertson jointly provided many decades of support of the department. We wish each of them an enjoyable and well-deserved retirement.

As the trainee numbers go down and the others stay stable it is inevitable that something will change and that is the reduced numbers of lists accompanied by trainees. Reduced trainee numbers are a national 'problem', which is driving us towards a truly consultant delivered care system. All our out of hours duty systems are under pressure, with the mooted loss of a tier of on call at weekends. The plus side from this is that there is an increased drive to get work done in 'office hours', leading to pressure on theatre efficiency and implementation of 7 day a week trauma sessions. As our theatre efficiency currently runs high, a plan for the main theatre suite expansion is gathering pace.

As training opportunities are reduced it is notable that clinical and teaching time are protected to allow trainees as much exposure during their specialty attachments. We now run a regional analgesia and a pain fellowship, with the possibility of other specialty attachments in the pipeline.

Admittedly things have got busier, and are set to continue that way. The Emergency Care Centre (i.e. new Grampian Acute Hospital) is only weeks away from opening, at time of writing. Although not providing any new surgical facilities, it is linked to a brand new Emergency Department, has a Medical HDU, and lots of new imaging nooks and crannies where we might find ourselves dragged to!

We still manage to find time to do other worthy work. Dr Kathleen Fergusson was elected to the council of the AAGBI, and has taken on the role of lead for Patient Safety.

Graham Wilson

Borders General Hospital

We are all very pleased that Cath Livingstone returned home safely from her second tour in Afghanistan. She has recently been promoted to the worthy ranks of lieutenant colonel. However, it is her animal husbandry, sausage making skills, and as a small holder that she really excels.

Fortunately for the chronic pain service, Rob Forbes decided to return from his sabbatical in New Zealand - if he intended on escaping from pain clinics for a while, the smart Antipodeans had other ideas and exploited his gift in this area and put his talents to good use. Despite this, Rob can now be seen sporting a new lease of life (lycra is definitely the way to go) as he runs round Melrose in training for his next triathlon.

Due to an expansion of elective workload, we have been able to welcome two new consultants to our team - Simon McAree (with a keen interest in ITU) and Jonathon Antrobus (who has proposed to and since married his ultrasound machine).

Lynne Prophet is now running out of boys names, after the safe delivery of a fourth son, Jamie - we look forward to her return in spring next year.

We have benefitted from the input to our department from various locums who have joined us in the past year who have plugged gaps in our rota mainly due to maternity leave, military service and the increase in elective work - Kitty Duncan has taken a break from her usual pursuits of transport and mountain medicine, whilst Heather Matthews is licking the pre-assessment clinic into shape with her Liverpudlian charm. Simon and Jonathon also held locum positions before taking up their substantive posts.

The trainees continue to contribute valuable work to our department and seem to enjoy their time with us - some even request to come back for a second stint! We have heard guarded reports that trainees will become a rare resource and so we will have to watch this space…

Shona Smith

Caithness

Not much to report from the wilds of Caithness. The department is going through an unusual period of stability, with no staff changes for some 3 years now. The usual challenges remain, with a slow decline in surgical activity year on year , and a concomitant decrease in surgical complexity: this creates challenges for consultants who wish to maintain their anaesthetics skills. We do endeavour to visit other departments, but the 1:3 rota with prospective cover makes this difficult.

Dr Macleod has recently been appointed to the Clinical lead post for the Hospital, and continues to provide leadership and the greater part of the medical input to the Highland -wide chronic pain service, based in Raigmore, leaving his two colleagues to do the actual work.

John MacLeod

Crosshouse

Such was the stature of our latest retiree that when John Hildebrand left in the

summer, he was replaced by not one but three young consultants. John's presence and humour will be sadly missed, especially in the maternity unit and at departmental meetings where he was want to cut through the waffle and make his views felt in no uncertain terms. In a masterpiece of planning, John's old office space has been taken by a fellow Irishman, Tim Geary. It's remarkable that they found someone with the same barbed wit, although Tim is not, as yet, as slick at crosswords. His fellow 'newbies ' are Aileen Clyde and Catherine Eckersley. All three have been here before as trainees yet they still saw the benefits of working in Ayrshire. It's a pleasure to have them at Crosshouse where they are already settling in and making a huge contribution to the department.

It has been an interesting year with many changes to working practices. Some of my colleagues have so missed being first on call that they have been working evening sessions as the junior anaesthetist. This is in response to a shortage of junior staff to cover rotas. The more sensible approach of merging clinical services across Ayrshire and having one acute hospital site would solve this problem, but for some reason is politically not acceptable. The more cynical colleagues may feel it is easier option than being 'second on' with a trainee, but at what cost to the public purse?

Talk of the public purse reminds your author of the inappropriately named BMA 'day of action' earlier this year. I was working as normal in day surgery when one of the nurses approached me and pressed 50p in my hand saying "Here you are son, something for your pension fund." Rarely have I been so embarrassed to be a BMA member. I promised to return the 50p with interest when I retire.

On a cheerier note, Janie Collie and Martin Watson made the trip to the Scottish Health Awards ceremony in Edinburgh in the company of the rest of the Orthopaedic Enhanced Recovery team to accept the '2012 Top Team' award. This is a well deserved award reflecting the immense amount of work put in by all staff concerned. The physicians can now block the empty orthopaedic beds with their patients instead.

Finally, I must not forget our backroom gals, Sylvia, Fiona and Margaret who are beavering away sending letters to patients to remind them that they can sue the NHS if they have to wait too long for their ops at the same time as reappointing them to clinics they have failed to attend. When not engaged in such Kafkaesque activities, they even find time to show the old codgers how to work the digital dictation system and fancy photocopiers, for which we are ever grateful. Thank you again ladies for all your support.

Chris Hawksworth

Dumfries and Galloway

Here on the Scottish Riviera we are all getting excited about plans for a new hospital, with all that entails. There are all sorts of "workstream planning solutions", so thanks to Wayne Wrathall, Dewi Williams, David Macnair and Willis Peel for getting stuck into this.
Meanwhile, work goes on, the ill and the injured are always with us. Viv Edwards does a great job getting the rota to work. Vince Perkins sorts the Preassessment Clinic out, John Muthiah and Harinda Goonesekera man the Pain Clinics. James

Neil sorts the Blood Transfusion Committee out, Ron Meek and John Carruthers help with sessions and Libor Verner divides his time between here and Czech Republic. Our Clinical Director, Wayne, has done a lot of work on recruitment and we hope to have a tier of Staff Grades to join David Ballingall and Khuram Shazad.

As for Critical Care, we contribute to the Scottish Intensive Care Society. Dewi is on the audit team, Willis is on the Council and Paul Jefferson was on the research team before he moved to Warwick.

We have a stream of Glasgow trainees every 6 months, they are a good bunch. Willis is our College Tutor, he keeps them sorted. Jacqueline Harkins won second prize at GAT for her audit on hyperoxia after cardiac arrest and Andrew Clarke won first prize at this Society's meeting for his "Pushing and Twisting" survey on breathing system disconnection. Roger Foye, David Falzon and Graeme Brannan have all presented at the Scottish Airway Group Meeting and Ally Maddock at GAT. We have teamed up with NHS Lanarkshire for our "Emergency Tracheal Access Course" and have an established airway training programme for all new starts, including our Rachel Darling.

Out in the West, an era ends with the retirement of Hamish Stewart, with Ranald Spicer holding the fort.

David Ball

Elgin

The past year has seen more changes in the anaesthetic department here in Elgin. I am pleased to report that we now have an acute pain nurse appointed after a long wait.

Sadly, Dr Phillipa Armstrong who had Chronic Pain as an interest has left and now works south of the border in York. She moved reluctantly because her husband is now flying for Jet2.com from Leeds Bradford Airport etc.

Happily, we have recruited an excellent replacement in Dr Chris Smith who originally hails from Buckie. Our new Head of Service is Dr Judith Kendell who is doing an excellent job of keeping the ship steady!

At present, there is an ongoing Review of Paediatric Services in the North of Scotland and it seems almost inevitable that our paediatric service will change! Time will tell!

Many of my contemporaries in Aberdeen have or are about to retire and it seems that so will I in the not too distant future.

George Duthie

Fife

After many years of discussion and planning, the new wing at Victoria Hospital opened for business in January 2012. All appropriate services were transferred across smoothly. Most important, our Obstetric services are now on the acute site. Forth Park Hospital, the site of our isolated Obstetric unit, is now closed and up for sale, while Queen Margaret Hospital is being developed as a day case facility.

It is a pleasure to work in the new wing. The theatres are spacious and well equipped, although the swipe card security system can be troublesome if, like me, you are forever leaving your ID badge on the bench in the anaesthetic room. The new wing has also allowed us to gel as a department. When we were working across three sites, it was

possible to go for weeks before you met up with some of your colleagues. Unfortunately, we have lost our common room (converted into office space).

The Treatment time Guarantee will undoubtedly represent our principal challenge for the year ahead. Alongside the ongoing uncertainty around trainee numbers, this will inevitably lead to changes in the pattern of service delivery.

Meanwhile, there is increasing pressure on inpatient beds in Kirkcaldy. Consequently, there are moves to introduce 23 hour stay facilities at Queen Margaret Hospital, supported by the appointment of RMOs.

Gordon Smith has stepped down as Clinical Lead to be followed by yours truly. Poacher turned gamekeeper indeed! I have found the role stimulating and challenging with a fairly steep learning curve. I must take this opportunity to thank the department for their support over the last year. Their hard work and flexibility has allowed the department to maintain the service in spite of increasing demands from our surgeons. They also deserve great credit for tolerating the ranting from the short aggressive weegie!

We have had some changes in personnel. Megan Dale joined the department in October after training in Tayside. Bridget Podmore, from Lothian, joins the department in January 2013. Bodil Robertson left the department in June. Bo married an orthopod from Newcastle and has relocated to Tyneside. She departs with our best wishes.

Finally, a special mention to Gordon Smith who retired in November. Gordon joined the department as a Consultant in 1980. He has spent almost 33 years at the coal face in Fife, including 11 years leading the department. We wish him a long and happy retirement.

John Donnelly

Glasgow Royal Infirmary

Two years worth of news to catch up on this time from Glasgow Royal Infirmary; here goes!

They say the only constant is change and the NHS is going out of its way to prove it- the last two years has seen some momentous changes here at Glasgow Royal Infirmary. Stobhill Hospital now exists as the Ambulatory Care Hospital, with no inpatient beds. We have lost our Urology and Vascular services: Urology to the Southern and Gartnaval in August 2011, and Vascular to the Western at the end of October 2011. Various personnel who previously considered themselves Royal Infirmary staff wander Glasgow, syringe in hand- flexible sessions have never been quite so flexible. There are now no inpatient beds for either service on site at GRI, so it is to be hoped patients are not so unaccommodating as to have more that one thing wrong with them at a time. There is thought to be no truth in the rumour that Management are looking at an expanded interhospital form of the laboratory pod system, adapted for patients instead of blood samples. Apparently nothing could be done about the percentage which vanished without trace.

Things are looking good in the Intensive Care Unit- we now have West and East wings; the previously existing unit being West and the newly built, East. My favourite bit is definitely the magic glass in the cubicles- one flick of a switch from transparent to opaque! (Dr Geddes did

point out she could have had a couple of trainees for the magic glass budget, however). The expanded space has allowed Stobhill's ICU beds to move down, with space for some HDU beds.

The Princess Royal Maternity Hospital is busy as ever- the caesarian section rate goes up and up, and the birth rate has had the cheek not to fall as expected either. In terms of personnel we have to congratulate Drs Shree and Evans, both of whom took up their consultant posts in Forth Valley in 2011. The Western Infirmary in Glasgow was fortunate to get Dr Malcolm Sim, and Crosshouse won Dr Colin Pow. They have all been fantastic colleagues and we'll miss them greatly. Treat them well or we'll take them back.

We have also been fortunate enough to welcome a number of new consultant colleagues in the last year- Drs Rachel Kearns, Hanlie DuPlessis, Rosie Snaith, Andrew Harvey, Mairi Mackinnon, Elizabeth Marshall and Brenda Daly have been appointed and we look forward to welcoming Taz Burwaiss in February 2013. Our most recent consultant colleagues are working a rota which includes a resident on call component, which seems to be working well so far. More on that topic next year...

Geraldine Gallagher

Golden Jubilee National Hospital

My colleagues in the orthopaedic department continue to impress me. Firstly because of their sheer genius of being on an on-call rota that doesn't involve them rolling on the floor weeping and wailing piteously "Why me God? Why?"

Secondly and more importantly their enthusiasm for carrying out a huge amount of lower limb joint work with efficiency that Honda would marvel at, as well as maintaining the highest standards of care. I only fear what might happen when the orthopaedic surgeons here realise that there are two other bone-containing limbs called arms….

It's been nearly 5 years since the birth of the West of Scotland Heart and Lung centre and it's been a rollercoaster of a ride so far. However an aura of calm seems to be settling over us (well relative calm…this is a cardiothoracic unit after all!).

The cardiothoracic workload remains varied but arduous; more complex cases have led to Consultants arriving with kit that would put a Himalayan Sherpa to shame. It's no longer enough to turn up with a tea bag and a mangled chocolate bar found buried in the depths of your bag. Now small one-man tents (we have to let the trainees go by 6pm), picnic hampers and urinal devices (for both men and women) are de rigour!

Mechanical circulatory support in the form of IABP's, VAD's and ECMO are old hat – nearly all of us know what the letters stand for now!

The relationship between cardiothoracic surgeon and anaesthetist is usually akin to the one between kidnapper and hostage, but in the last couple of months, the concept of revalidation has entered the arena and we have noticed a change in the atmosphere. Shy smiles and glances full of hope are exchanged between surgeon and anaesthetist as requests for MSF forms are sent through cyberspace. It is unlikely that this ceasefire will last forever but whilst it

does a little ray of sunshine peeks from behind the storm clouds

Cardiology continues to give us a significant number of patients; do folk truly only have their cardiological emergencies out of hours, on weekends and public holidays or does it just seem that way? The only time I don't wince when I see a blue light racing into the GJNH is when I'm racing in the opposite direction. Like a cat bringing in a mangled bird, the interventional cardiologists proudly pass their sickest patients over to you with the immortal words "we have achieved complete angiographic success".

So to other news: During the past 12 months there have been some major staffing changes.

Dr Nick Sutcliffe has left the cardiothoracic rota for the orthopaedic/ general rota and Dr Mike Higgins has been elevated 2 flights of stairs into the new Medical Director of the hospital. The interview process just took slightly longer than the time needed to appoint the last pope.

Dr Nick Scott has left Glasgow for the vitamin D rich country of Qatar where he will be the Associate Professor of Anaesthesia at the University. Apparently Qatar is marketing itself internationally as a "peaceful, neutral world power" – so we've sent the right guy! Nick was a dynamic force within the hospital and made a huge contribution to the service and we wish him all the best in his future career.

Dr Andrew Sinclair who was our previous cardiothoracic anaesthetic fellow was appointed to a substantive post in August 2012 and joins the ITU rota. Although after a few weeks of catastrophically busy on-call, he has lost his fresh-faced looks, a stone in weight and stopped speaking in sentences, we still think he's happy to be with us! We are certainly delighted that he has joined the department.

In the summer, we were joined by Dr Simon Patullo, a Consultant anaesthetist from the Gold Coast. Blasé from working in an environment that boasts warm weather and good working conditions, he came back to his spiritual home for a 6 month sabbatical in cardiothoracic anaesthesia. We doubted his Scottish ancestry however; teeth that white have never been seen beyond Hadrian's Wall before. He has been a much liked and valued colleague during his time here and we were sorry to see him go. However there are a whole host of individuals who are only too happy to fly to Brisbane and give some refresher courses if needed, when the cardiothoracic unit in his hospital is finally completed.

Dr Karim Elkasrawy, our advanced cardiothoracic fellow, will be leaving us at the end of January. He has been an important member of the team and we wish him well in his future career in cardiothoracic anaesthesia.
We are also very fortunate with the calibre of trainees rotating through the West of Scotland and Tayside deaneries. They throw themselves into life at the "Jube" with a mix of enthusiasm and naivety and it has been a pleasure to work with all of them.

Isma Quasim

Institute for Neurological Sciences

Another busy year at the Institute. Following an external review of Paediatric

Neurosurgery, we finally waved off the children, to their new home at Yorkhill, at the beginning of the year. Ward 66 held a big party to see them on their way. Drs Colin Goutcher and Simon Young have settled into Yorkhill and although not entirely smooth, the move does seem to be a successful one.

Theatres are currently undergoing a review to improve services – with an external assessor appointed by the Health Board. As many of the problems lie with facilities and lack of staff, we are hopeful that this will result in an investment in these areas (although the way the health service is at the moment, no-one's holding their breath!)

In ITU we are all coming to grips with the advance of technology which is Carevue (some easier than others it has to be said!) We had our "Go Live "date in September and so far everything seems to be going well with no major hiccups. Chris Hawthorne is undertaking a research project, working towards his MD. This is looking at possible non-invasive measurement of intracranial pressure and we look forward to welcoming him as Clinical Fellow early in the new year.

In staffing, after successful years undertaking Higher neuroanaesthetic training, Drs Andy Rae and Nithin Roy have joined the department as consultants. Dr Robbie Thorpe has also joined us as locum consultant. Hopefully these appointments will help deal with the reduction of junior numbers – which has become so bad of late that you may be more likely to see the Queen in the INS, than an anaesthetic trainee!! Dr Connie Werstler has stepped down as Lead Clinician following a successful 3 years in post, with the baton being passed to Dr Urmila Ratnasabapathy. Dr Linda Stewart has similarly demitted office as college tutor, with Dr Kavin Fitzpatrick as her successor.

Linda Stewart

Inverclyde

Another year and the assembled faces show the passage of time, the effects of working into the small hours and most of all, the strain of Revalidation. The injuries caused by carrying the vast tomes required in the name of Enhanced Appraisal, the tears,the sighs. Still that's progress for you.

From a staffing point of view we have seen off Everard lee who departed for New Zealand with wife and small baby to take up a training post in Auckland. The envious glances as he left spoke volumes. The gap left in the rota exposes what is felt across the country, too few people to fill the gaps and too few locums around. Medical workforce planning at its finest.

We had a cameo role from a Dr from Eastern Europe who was intended to fill Dr Lee's shoes. Unfortunately, the demands of the West of Scotland lingo left him baffled and incapable of providing the cover expected. Caveat Emptor!

Hatches, Matches and Despatches: nil else to report. We remain a distant outpost of the Glasgow arena watching with interest as the New Southern Behemoth arises and with it the competing interests of Specialties and individual departments. You can almost hear David Attenborough's hushed tones as he describes the posturing, the calls and breast beating, all to grasp the best and largest territory.

Duncan Thomson

Inverness

We have had a fairly quiet year up here in the Highlands. We are delighted to have welcomed Dev Srivastava to Inverness. His enthusiasm for teaching and expertise in all things pain makes him an excellent addition to the team. We have also been fortunate enough to recruit Kristina High to a locum consultant post.

The reason for the locum post is the happy news that Lisa Handcock has given birth to a beautiful baby girl. Kristina has big shoes to fill in Lisa's absence as Lisa has done a sterling job of keeping the unruly boys in our department under control. Speaking as the recipient of many a (deserved) chastisement I am sure that Lisa will make an excellent parent.

On a departmental level things have not changed as much as some had hoped at this time last year. Our bid to move into the 20th century by having a dedicated intensive care consultant on call rota was thwarted at the final hurdle when the finances were not forthcoming for the required increase in workforce. Perhaps next year...

Ross Clarke

Ninewells, Dundee

The year started with the freezing of valuable departmental assets – not a reference to the cycle commute to work but the departmental coffee fund which fell victim to draconian regulation regarding the use of specific departmental finances. I'm pleased to report this was rapidly resolved by our industrious secretary, Lezley Cassidy, and caffeine consumption has once again rocketed, resting tachycardia and moderate anxiety levels restored the department marched on into the year.....

The BMA strike passed with a whimper rather than a roar – some minor personnel changes aside, the day itself functioned like almost any other. Surely (in retrospect) a missed opportunity to have argued more specifically for reducing the age of retirement rather than financial parity in terms of contributions across the public sector elite? It was however amusing to read that senior judges were, somewhat disingenuously, planning legal action over increases in their contributions!

A number of modernisation initiatives are bringing the department rapidly up to date. The pre-assessment facility is now fully established and departmental HQ is currently under threat to turn it into a DOSA facility, such has been the PAC success and drive to admit the majority of patients on the day of surgery. At the time of writing the sword of Damocles is hanging over our premises – ironically it looks as though it's too small for purpose!

Our rota has finally gone electronic, so if you want to locate any member of the department you now need to have a minimum of a smart phone, broadband connection and fifteen minutes to spare. There was hope that the knock-on reduction in stress levels and workload would ease the pressure on those brave souls involved in this complex process; early signs were promising and in November, Fergus Millar reported remarkable hair re-growth, this was however above his upper lip rather than his shiny pate. Fergus, in typically understated style, chose to dye his fetching moustache pink which massively increased charitable donations and post-

operative confusion amongst colleagues and patients alike.

The University department continues to promote the specialty at national and international level – you may even have seen Professor Hales on a recent BBC documentary, displaying his expert knowledge of opiate receptor systems – he really would make a great anaesthetist. Graeme McLeod won the AAGBI anaesthesia innovation award ward with a novel transducer design that may hopefully make the lives of ultrasound users a little easier. The impressive academic/clinical track continues and Stephen Humble returns to clinical work after completing his PhD, swapping places with him is Fiona King who embarks on her 3 year (PhD) program.

We had two notable retirements in 2012 – Iain Levack and Charlie Allison. Iain, who enjoyed a peripatetic consultant lifestyle, retired after 13 years in Tayside and distinguished himself with service in Iraq, Kosovo and Afghanistan with the TA. Arguably more valiant, although I suspect not as exciting, was his time spent in the highest echelons of hospital management as Clinical lead for Critical Care in Tayside.
Charlie Allison has been a feature of anaesthesia in Tayside for the past four decades and retires after 30 years in his consultant post. Charlie was clinical lead at Stracathro hospital, a facility that he leaves in revitalised condition going forward with a significant recent expansion in services and resources. Charlie is also our outgoing SSA president, a duty that he has fulfilled with his usual charisma, effortless ability and enviable golf handicap. Charlie's successor will be Neil Mackenzie and we wish him well in this important role during the Society's centenary year, we are in safe hands.

Other outgoings – Megan Dale has joined our colleagues in Fife and Siva Raghaven departed for Melbourne in a fellowship role with a view to remaining there, best of luck to both. And, finally, we are delighted to be joined by Simon Crawley and Sharon Christie, both of whom trained in Tayside, in substantive Consultant posts.

Calum Grant

Orkney

2012 in Balfour Hospital has been an interesting and challenging year, and now we can have great expectations of 2013- and beyond! A 2- bed HDU is now in existence, with nurse training underway to enable availability of appropriate staffing in each 24hours.

Aberdeen Anaesthetic Department have agreed to provide a limited number of Consultant exchanges with us in the coming year. Our thanks go to Brian Stickle and Anne Wake for initiating and supporting this collaborative development.

On the anaesthetic nursing assistance side 2 additional staff members have embarked on core competency training. Also recruitment of additional 4 theatre nurses is being actively pursued. Aneta Sowinska is progressing training and documentation for an Acute Pain team, while Marek Wolanski continues to juggle a daunting portfolio of committee memberships alongside his clinical activities. Having been unsuccessful in 2008, Colin Borland intends to re-visit reduction of his departmental commitments to 0.5 WTE in 2013 in search of that ever- elusive personal free

time. But also in order to pursue training as an appraiser for NHS Orkney.

A site in Kirkwall having been decided, management inform us that the expected gestation period for the new Balfour Hospital is 2 years. However, a CT scanning facility is being planned for as soon in 2013 as is feasible.

Investment has been made into extending our ultrasound machine availability and its useful functions. Sadly it does not incorporate any 'crystal ball' facility which would allow us to see into 2013 when we look for a Consultant Anaesthetist in order to secure a permanent establishment of 3.5 WTE Consultants.

Colin Borland

Perth Royal infirmary

We have had some significant "goodbyes", and welcome "hellos" this year. Mike Bell retired in July, to spend more time with his cameras. After a first Consultant job in Dumfries, he spent 17 busy years in PRI. He was an intensivist before they really existed, and remained the person to turn to for sound ITU advice. He served as College Tutor, rotameister, Clinical Leader and Chairman of the hospital Medical Staff Committee. In the midst of a stressful Acute Services Review he fought his corner effectively, but had too much honesty and decency to be really comfortable in health board politics. Good luck for a long, healthy and well deserved retirement.

We also said goodbye to John Bonner and Dora Paal. John started as a trainee in PRI, and finished as a locum Consultant with us, before moving to Guernsey. He leaves us with many happy memories (along with the fridge he donated to our coffee room). Dora has moved to a Consultant post in Fort William. She had been a Specialty Doctor with us since 2010. Her diligence and expertise with sick patients became highly valued throughout the hospital, as was her cheerful smile. Both John and Dora were extra special to us and we are rightly proud of their achievements. Rhona Younger and Stephanie Sim have joined us as Consultants.

Rumours that the ongoing feminisation (or is it modernisation?) of the department would require investment in scatter cushions for the coffee area have proved groundless, thus far. We look forward to them making their marks in Perth. We also welcomed Jo Doughty back from maternity leave.

The department has moved back into our "original" offices, with the completion of a new endoscopy unit above us. We are glad to be back close to theatres and the ITU, but miss the space of our temporary offices in the old labour suite. The refurbishment of the department made no provision for temperature control or natural light. (Indeed, there seems have been little provision for air for us to breathe.) Snagging issues, we hope.

Duncan Forbes continues tirelessly as Clinical Leader and Chair of the LNC. Great flurries of management activity bombard him. Reorganisations take the place of progress, with jelly babies lasting longer than many managers. The latest drive seems to be for patients to have their operations before they have realised they have anything wrong with them. Waiting list initiatives and new computerised theatre and rota management systems are seen as the answer. And, while the hospital gets

busier, the latest threat emerges- to general surgery this time. One day it will all prove fatal. Or maybe not.

Michael Forster continues as rota-meister, with the more enjoyable role of circulating the trainees' gossip. May Mok is College Tutor, and has taken up the post of Lead Consultant in the University Clinical Skills Unit.

Bikes remain the commonest mode of transport, lycra the fabric of choice. Running, sailing and Gore-tex are close behind. We loved the Olympics, with several savouring the London atmosphere at first hand. Peter Coe's wife, Susan, was a judge at the Paralympics swimming, and Ewan Ritchie now has a very lovely Jessica Ennis poster looking down on us all. It all adds up to PRI continuing as a great place to work.

Michael Forster

Royal Alexandra Hospital, Paisley

After a year of multiple retirements last year, nobody else has left this year – we were beginning to get a bit paranoid. However, the appointment of all those young people to replace our retired colleagues has had the inevitable consequence – we have had some anaesthetic babies! Jenny Edwards gave birth to Chloe Louise and is currently on maternity leave, and Ahmed Almaki is proud dad to baby Olivia Sara – a third girl, so he's seriously outnumbered at home.

We have made an additional consultant appointment - Alistair May, whom we know well as a trainee, is joining us early in 2013. His post will contain some resident first on call work – although other departments in Scotland have gone down that line before, it's a new thing for us in Paisley, and we will be watching how this develops. This is part of the solution to the great big rota gaps that in common with many departments, we will be experiencing in the next few months. Our stopgap solution at present is consultants getting well paid to volunteer for shifts, but that's not a tenable long-term solution for either the finances or the volunteers. There is no easy answer to this, and we are not alone, so nationwide there will no doubt be interesting and innovative solutions proposed.

We have had a period of service change, with the eviction of ophthalmology from main theatre (to accommodate more orthopaedics – how we cheered when we heard this!), and eye surgery is now conducted in the day unit, with a few other things shoved out altogether. This has been a difficult process, with lots of people feeling hard done by. For once in anaesthetics we have been standing by waiting for the dust to settle, which it just about has now.

We are still squatting in what was the old CCU at Paisley, and we've been here fifteen years, so we think we probably have legal status now. The only problem is, there hasn't been a serious tidy up for fifteen years. This came to our attention when Michael Brett, one of our new consultants, pointed out that he thinks some of the shoes in the trainee room had been there since he was an SHO. Your correspondent has taken responsibility for sorting out the trainee bench books, and the oldest book I've found so far is dated 1959… I'm sure we'll find a trainee that we mislaid in 1999 asleep under a pile of papers any day now.

Like most anaesthetic departments, we have a significant cohort of MAMILs (middle aged men in lycra), but this year we extended our sporting prowess into distance running. In May our department had four teams in for the Edinburgh marathon relay event. One of our trainee teams was 5th overall (out of over 700 teams), and the first mixed team home, so well done the Gas Girls – Lizzie Stuart, Katerina Tober, Graeme Brown, and Iain Thomson. The ITU consultants' team came in a very creditable 18th, which may be even more impressive as it included former couch potato and no spring chicken John Dickson as well as the young lads. Our other two teams also finished under the four hour mark, so overall a pretty good effort. Anaesthetists are a competitive lot, and if any other departments out there want to put up a team for the 2013 event, bring it on!

As further evidence of our competitive spirit, we have also held our second bake-off event, which this year was won by Susan Halliday with her patriotic Jubilee-themed cake, and she received the highly-coveted anaesthetic bake-off pinny. We are waiting to see if a career in anaesthetics is of interest to the Glasgow medical student who was in this year's TV series, as we feel we can offer a "best fit" training experience.

In the midst of all this activity, we have also managed to give quite a lot of anaesthetics, while training our few remaining trainees, bracing ourselves for enhanced appraisal, and trying not to be too grumpy about the surgeons. Plus ca change…

Hilary Aitken

Royal Hospital for Sick Children, Edinburgh

2012 brought more big changes in our department. Dr Dave Simpson retired and with him took over 25 years experience in PICU and paediatric anaesthesia in Edinburgh. Dave was greatly respected both in the Sick Kids and nationally for all his work especially in regard to the organisation of critical care services for children. He was always willing to help and offer advice to many colleagues and will be greatly missed by us all. He heads off to enjoy time as a grandad, lowering his handicap, and I'm sure he will find other ways to avoid getting under Margaret's feet including enjoying a pint or two with the great and good of Edinburgh's anaesthesia fraternity in the Cask and Barrel.

With Dave leaving, we have appointed 3 new consultants, Dr Pamela Winton joined the anaesthetic department from Southampton, and Dr Catherine MacDougal took up post as a consultant in PICU. The paediatric retrieval service also increase our consultant representation with the appointment of Dr Omair Malik, from Northern Ireland, as a consultant with interest in retrieval and paediatric anaesthesia.

Our latest consultant appointment was Dr Suzanne Boyle, who having finally completed the most tortuous route into the specialist registrar (Article 14), decided to start a family. After allowing herself 6 months maternity leave with her new daughter, Suzanne will finally be joining us, as a fixed term appointment for 2 years, in February. We welcome all these new consultants into the fold and look forward to maintaining the pace of progress we have embarked on in developing many areas of paediatric anaesthesia and critical care.

Dr Boyle was not the only mother in the department. Dr Emma Dickson added a beautiful baby sister for Hamish. Congrats to both on their happy events.
With maternity leave and retirements, we have been able to offer locum appointments to Dr David Peat from Tayside and Dr Louise Aldridge, returning from retiring last year to work on the Mercy Ships, to help out over the winter.
With so much change it is good to see that our department is still impacting on a national basis with David Rowney taking up the post of paediatric education coordinator with the Scottish Simulator Centre. this will enable him to continue the great work he started with the retrieval feedback sessions, initially using the skills bus, on a more permanent basis.

So what of our new hospital, well after stalling for a couple of months waiting for agreement over the leasing of the land and funding, plans are taking shape. Latest date is 2017, but lets not carried away!

Alistair Baxter

Shetland

2012 in Shetland has been a peaceful year with some good early summer weather which unfortunately proved short lived. All three of us headed to the sun with Catriona sailing in Croatia, Brodyn going to South Africa and Jacek camping in Southern France. Back in Shetland we have enlarged our surgical team again with a third consultant coming to us from South Tees. Beatrix Weber will be doing general surgery but has an interest in laparoscopic colorectal surgery and is settling in well.

Areas of interest for the department in CPD this year have been Advanced Life support in Poland for Jacek, Obstetric and ITU for Catriona (thanks to colleagues at ARI and AMH for that), and an Etape in Northumberland involving some serious cycling Acute pain for Brodyn.

Our lot has been improved this year by the Board agreeing to some locum cover which means that another person's holiday does not mean one in two drudgery for their colleagues. Six weekends of locum cover this year has led to us entering the Winter season slightly less exhausted than in previous years. Managing our workload sustainably is going to be an important theme for all of us as we head inexorably towards our fifth decades. We have to have some time and energy left to take on revalidation after all!

Catriona Barr

Stobhill

Stobhill General Hospital (1904-2011) has now closed. The old building still stands tall, too expensive to demolish due to asbestos. However the New (award winning!) Stobhill Hospital (2009 onwards) is alive and well, even if it doesn't actually have an anaesthetic department. The merger with Glasgow Royal Infirmary has gone well, north and east united against common foes. Dev Sewnauth and Roger Hughes retired but Roger has been seen more in theatres than ever due to generous locum rates. Our secretary Susan Hemmens followed us down the hill to GRI, and delayed her retirement until we'd settled in.

We wish them all well. The new six theatre unit is pushing the boundaries of what's possible with just 12 overnight beds but there's a fantastic coffee shop, and we've been able to discover new

experiences at GRI, 12hr weekend trauma shifts for example! So farewell from Stobhill, hello brave new world.

Barry Evans

St John's, Livingstone

The waters have been a bit choppy for the good ship St John's this year. NHS Lothian has had some minor difficulties with waiting lists, requiring some weekend working and a new Chief Executive. As we go to press it would seem that some other Health Boards have had trouble with their numbers – oops. St John's has also been at the sharp end of the issues with Paediatric staffing in the UK, as our paediatric ward closed overnight for a month in the summer. The Health Board, Deanery and politicians thankfully have good lines of communication but there is no easy fix.

We are fortunate that the Dept has been guided through these challenges by Captain Mike Brockway and 1st Officer Jeremy Thomas. Their advice around revalidation was especially helpful. Mike Fried has been being buying helicopters and fixed wing aircraft in his role with the Scottish Ambulance Service. Bridget Podmore has been appointed as a Consultant in Fife after doing an excellent job as a locum Consultant for us. Heather McAllister is starting a postgraduate Masters in Law.

Claire Caesar and Angus Wragg have produced offspring of the female and male variety respectively. All are doing well. Donald Galloway wins this year's prize for novel use of a bicycle inner tube. Having broken his clavicle (bicycle + pothole + carrying a takeaway curry) he decided that his NHS sling was no use and manufactured a very supportive sling from an old inner tube. Apparently it was better from an infection control perspective. Top man.

Duncan Henderson

Stracathro Hospital

It now falls to me to write about Stracathro following the retirement of Charlie Allison at the end of June 2012. All the theatre staff were very sad to see him go but Charlie was delighted as he now has time for all his numerous other activities and Interests -- his family, golf, photography, writing, public speaking and many more. We had at least three very jolly farewell dinners/tea parties and he has left the hospital at a time when it is in good heart and busy.

As well as Michal Bohm and Wojciech Borowski our two Resident Medical Officers/Consultant Anaesthetists we have been joined on a regular basis by Sharon Christie, Simon Crawley, Lois Fell and Praveen Manthri (Charlie was a hard act to follow!) and guest appearances from other Ninewells anaesthetists. Their commitment to Stracathro, their enthusiasm and, dare I say, new ideas are much appreciated by all the anaesthetic staff.

We are still doing one Orthopaedic list a week for Grampian and one for Fife and have also taken on Plastic lists for Fife. These are staffed by their own surgeons all of whom (I think) enjoy their day out in the country although as I write this the snow is falling heavily and it has been difficult to get to Stracathro.

We are very happy still to be hosting the meetings of NESSA and had three successful and interesting events in 2012 including Eddie Wilson's excellent Presidential Address in November on his

namesake Dr Edward Wilson the famous polar explorer.

Jan Beveridge

Victoria Infirmary, Glasgow

There is a bit more technicolor in the sepia toned Victoria these days. Angela Baker has introduced the Great Victorian Sponge, a competitive baking event held along with the departmental meeting. Not only is there a veritable cornucopia of preprepared culinary delights to savour, but it also shifts the mind away from the Machievellian scheming necessary to secure the assistance of the only anaesthetic trainee in the hospital for your list the next day.

There has also been an influx of new talent across the South. In the not so distant past, if you wanted to see the world you were advised to join the navy (or the RAF like Gavin McCallum). Now the world comes to us with new consultants Victor Tregubov from Siberia (is the weather really better in Glasgow?), Oliver Licari from Malta, and Elia DelRosario from Valencia. Welcome also to locals Cathy McDowall and Tom Pettigrew, and to Rami Rifai who joins us from the far flung reaches of the Southern General.

Adding to the continental flavour, we have external locums from the Baltic states, Australia and the Indian subcontinent. Not so long ago, colleagues from north of the river were considered exotic!

Congratulations to trainees who left us to be appointed as consultants elsewhere;Matt Freer(Forth Valley), Tim Geary(Ayrshire), Andy Rae (INS), Aileen Clyde (Ayrshire) and Vishal Gupta (Gartnavel).

Work on our new home at the Southern site continues apace with the many rumours that the massive concrete towers were slowly sinking into the sandy foundations proving untrue. When completed, this will be a state of the art flagship providing modern services to patients in Glasgow and beyond. Somehow, though, the Great New South Glasgow Hospital sponge doesn't have the same ring to it.

Neil Smart

Western & Gartnavel

In contrast to previous years, life at the Western and Gartnavel has moved decisively into a new phase. Several factors are relevant. The decision of the Scottish Government to reduce trainee numbers in the West of Scotland in advance of the move into the new South Hospital has destabilised rotas across Glasgow. The ongoing push for shorter waiting times has aggravated the situation. The Western's role as the Vascular centre for most of Europe has left the Consultant General rota bearing the brunt of many thousands of ruptured aneurysm operations annually. This period of intense activity will cease in 2015, when the new South opens and the Western closes. Gartnavel's role after 2015 is very uncertain.

As ever, there have been many personnel changes. Emily Walker was appointed as a consultant here; many other senior trainees moved elsewhere. Julia Robertson was appointed to a post in Hairmyres, Judith Ramsey to Ayr, Wesley Edwards to Vancouver Island, Shebeen Hamza to Darlington and Kenny O'Connor to Reading. Nithin Roy and Robbie Thorpe have taken up locum posts in the Institute; Kathie Howie did likewise in Forth Valley. In the last few months, GG+C has appointed new

consultants to bolster its unstable overnight rotas and so Shubh Gupta, Aravind Basavaraju and Vishal Gupta will join us shortly.

Among the department's less young group, Alex Macleod and Neil Storey have stepped down from roles as WoS TPD and rota consultant respectively, after years of sterling service. Their replacements are Neil O'Donnell and Jonathan McGhie; we wish them both well.

The department Christmas party (and sketches) beckon as I write. As ever, that event will promote warm feelings of affection and enthusiasm which will support us through our current and future difficulties.

Colin Runcie

Western General Hospital, Edinburgh

We have had number of changes on the staffing front. Claire Baldie and Matt Royds have taken up posts in the main department. Mike Fried has given up his sessions in intensive care to go back full time at St John's. Rosie Macfadyen and Murray Blackstock have filled his shoes in intensive care. They are also doing some anaesthetic sessions. Colin Baird is currently doing a locum consultant post in chronic pain and will take up a substantive post early in the new year.

The reduction in numbers of junior staff has seen changes to rotas. In intensive care many shifts are now covered by advanced nurse practitioners. In anaesthesia we have one physician assistant who fulfils a useful role. We don't have consultants doing resident on call overnight as in other parts of the city.

The neuro theatre suite had a facelift at the end of 2011 to bring it up to scratch for any HEI inspections. This required the theatres to move out into temporary accommodation. A lasting legacy of this time has been the introduction of the preoperative surgical briefing which has resulted in better team working and communication. Unfortunately, it has been more of a struggle to get other groups of surgeons to embrace it.

Our colorectal and urology colleagues are keeping the main theatre suite as busy as ever. The 12 week waiting target and the bowel screening programme mean that capacity is a challenge. Weekends are busy times with often four additional lists being performed.

The beautiful new Royal Victoria building for medicine for the elderly opened in the summer months. Only a few months later some wards down at the closed Royal Victoria Hospital had to reopen to cope with winter bed pressures. Not much news on the re-provision of neurosciences on the Royal Infirmary Site. I think 2017 is the date. Watch this space.

Sue Midgley

Royal Hospital for Sick Children, Yorkhill.

This year has seen some significant events within the hospital, not least of which was the formal transfer of paediatric neurosurgery services to the Yorkhill campus in March of this year. Despite much angst this long anticipated event occurred relatively smoothly. As expected there have been some equipment issues and the occasional communication hiccup but there can be little doubt that our children are better served in a fully resourced paediatric hospital. To my knowledge no

neurosurgeons were harmed in the making of this service. An occasional toy may have taken a flighty trip from the pram however. From the perspective of the anaesthetic department it has caused an increase in pressure on theatres and out of hours workload, perhaps more than we anticipated.

Lack of funding has been a perpetual issue throughout the year. Nursing shortages and ward closures have meant a steady stream of bed shortages and resultant elective surgical cancellations. At its worst there were 16 patients on one particular day queuing in A and E awaiting ward beds. We are told a ward is being refurbished and will open early in the New Year. This should ease the pressure a little.

Bed pressures have also meant that there has been a mixing of medical and surgical patients on some wards which logic would dictate is not sensible. A recent spate of post tonsillectomy bleeds had halted the elective tonsillectomy service for a short time. It was postulated although not proven that intercurrent infection may be responsible and by extension mixed medical and surgical wards could have been a contributing factor. One would expect that in this climate of strict infection control that the infection control police would have been on this like an orthopod in the tool aisle in B&Q. However it appears they are only really interested in ensuring compliance with the 'no ties or wristwatches, and laminating all the case notes so they're wipeable' malarkey.

The powers that shouldn't be, in their infinite lack of wisdom and it being Christmas decided that it would be a nice idea to invite a few reindeer accompanied by a suitably attired Santa to visit the hospital. As one of the reindeer was devoid of tie or wristwatch it was invited into the orthopaedic ward to s*** in the cubicle of a patient who had allegedly just undergone a major hip reconstruction. It duly obliged. Unbelievable!

It is rumoured however that the laminated documents were a great help in scraping the droppings from the floor.

All the above does not bode well for our future in the new build on the Southern General campus. There has been little mention of this over the last year but anxiety remains high with regard to it not being fit for purpose. Quite clearly it will not provide the capacity we need but those that should be listening are likely to be intoxicated by the aroma of reindeer dung for sometime to come.

Within our department itself there have been some significant changes. After a long and exemplary career we finally said a very fond farewell to John Currie. His sense of humour and wisdom will be sorely missed. The department welcomed Ewan Wallace to a substantive appointment and also Colin Lang who has returned to us one day a week from Forth Valley as part of our outreach service.

The department also welcomed the arrival of Rob Ghent's son Callum and my daughter Emily who were both born at the end of the summer.

Ross Fairgrieve

Meetings

In case you missed them, here's a summary of the major meetings of the society this year.

Trainees Meeting

11th May 2012

There was a good attendance at the second trainees meeting in Crieff, possibly attracted by the varied program. Barbara Miles gave an overview of the current hot topic of enhanced recovery after surgery (ERAS) with a very well presented mixture of general overview including background research and local applications. She also broke down the ERAS process into it's component parts, highlighting the contributions anaesthesia can make. Sarah Thompson provided a comprehensive overview of the pathophysiology and management of major obstetric haemorrhage with emphasis of the role of TEG. There was palpable joy in the room when she promised to help us all understand clotting without reference to cascades!

Alan McNarry's lecture "Every anesthetist is an airway expert" was approached as a question and Alan explored the factors which contribute to being an airway expert. Alan Macfarlane, a new consultant at GRI presented the case for regional anaesthesia, it's benefits and the practicalities of using regional anaesthesia in normal clinical practice. Alan also gave a very useful account of how to get a training in regional anaesthesia with details of his own experience in Canada.

Three Speakers were concerned with largely non-clinical topics. Firstly Willie Frame delivered his "Tales from the dugout" which, despite including a lament for his beloved, sunken, Rangers, was nothing to do with sport. Rather he provided a humorous but insightful description of the good and bad of medical management. Michael Murray then gave a tour of the do's and don'ts of getting a consultant job. From selecting the post you want, how to present a CV and how to present yourself at interview.

The day was closed by Arnie Arnstein speaking about green anaesthesia. Arnie provided a highly informative and persuasive account of the changes occurring in the world caused by our activity. Healthcare might be an absolute necessity but there are clearly choices in how we deliver it. For those of you sceptical about the use of disposable versions of absolutely everything in the current health service there were some interesting facts. The aluminium in 200 disposable laryngoscopes alone accounts for 0.6 tonnes of CO_2 to be released into the atmosphere.

In the middle of all this there was a trainees election and, from a competitive field, Sabah Munshi and John Allan were elected to carry the torch for the next three years. Good luck to them.

Spring Meeting & AGM

12th May 2012

This was the second time the Spring Meeting and AGM of the society has been held in Crieff and those of us who'd been here a year ago were certainly happy to be back. Paul Wilson chaired the AGM which included the election of new reps for Tayside, grampian and the West. Step forward Calum Grant, Graham Wilson and Laura McGarrity. There was support for continuing the relationship with Crieff. The Centenary year of 2014 will be a busy one with a special Centenary Meeting in February

as well as the usual Spring meeting and WSM.

Catriona Connelly from Dundee gave the Keynote lecture this year. Scotland has had a relationship with Malawi through the United Nation's Millennium Project since 2005. Catriona has been a member of the Scotland Malawi Anaesthesia project which has the goal of sustainably improving the provision of anaesthesia in Malawi. She described the work which has been done and the large number of volunteers involved to try to improve Malawi's anaesthetic services. There are 32 Anaesthetists involved from Scotland. It may sound like a large number but they've done a lot. The aim has been to make a lasting difference so as well as delivering adapted versions of familiar courses, local faculty have been identified. There have been repeated visits with reducing numbers of visiting staff as local anaesthetists are able to pick up some of the educational roles. All those involved have been volunteers and give their own time and often money to this project. Catriona and her colleagues should be very proud of their efforts.

The Trainee competition was up to it's usual high standard with the top 5 ranked entries getting to present. The winner was Dr Anne-Marie Doherty with her paper on reducing blood transfusion requirements with an enhanced recovery program. All the papers presented are represented here in the Annals.

There was another very useful and well received "open forum" session with Drs John Colvin and Alistair Michie representing the RCoA and the AAGBI respectively. It provided the usual very useful insight into the more political aspects of Scottish Anaesthesia.

Following lunch the presidential chain was formally passed from Dr Paul Wilson to Dr Charlie Allison. As is traditional the new president then gave us his inaugural presidential address. Charlie's loves (besides his family) are anaesthesia, golf and the band Procol Harum. His address was devoted evenly to the three of them. It is reproduced (without the music!) earlier in these annals. It was a wonderful, varied and entertaining lecture and worth every bit of the obviously enormous amount of work Charlie had put in to it.

The next and final lecture of the day was, in terms of IT input the total opposite. Professor Phil Hanlon of Glasgow University spoke about the Afternow project (www.afternow.co.uk). He did so using only a flipchart and his considerable powers of communication. In essence, the initial plan for NHS envisaged an initial high cost then a decline as everyone got healthier. As we all now know that didn't happen. And as medicine developed and evolved costs just escalated in the NHS model with unlimited availability and with no direct costs to the consumer. Interestingly, as recently as the 70's, increasing longevity was mainly due to improved social circumstances, but subsequently is more due to the availability of better medicines and treatments. Prof Hanlon also pointed out the tension between management, professionals, patients and the market, and the problems with each of these. Professionals have hierarchies and don't distribute resources fairly for instance and markets distort priorities in the direction of profit instead of societal wellbeing. What a mess. There is no easy solution to all this but there is great hope that we, as a (worldwide) society can think our way out of these problems.

Meetings Section Continues after Gallery

Gallery

Charlie Allison presents the Campbell Quaich to Dr Anne-Marie Docherty for her prize winning presentation on reduced transfusion requirements in an Enhanced Recovery Program

Two past presidents, Jim Dougal and John May Pipe in the current president.

Dr's Falzon (1st and left) and Dr Hannah (2nd) collect their prizes in the Poster presentation competition from Paul Wilson.

Fiona Cameron and Calum Grant, The organisers, at the Winter Scientific Meeting.

Fiona was obviously unable to stand for the picture. She was probably just exhausted.

Thanks for an excellent meeting.

Prof Hanlon delivers the Guest Lecture "old school" with no visual aids except a flipchart. The chart shows the quartet of patients, professions market and management with the resultant chaos at the centre!

Hopefully not allergic to flowers, Sarah Cross and Vishal Uppal, the outgoing trainee reps receive the thanks of the executive for an excellent three years..

Winner of the individual competition at the annual golf outing: Alex MacLeod is congratulated by President Charlie and name-sake Donald MacLeod, the event organiser.

Dr Andrew Longmate (left) the National Patient Safety Lead , Mr Derek Feely (centre) the Director General of NHS Scotland and Dr Dilip Nathwani (right) all contributed to an excellent session on quality and safety at the WSM in Dundee.

Winter Scientific Meeting, Dundee

November 15th & 16th 2012

It was Dundee's turn to host and jointly organise the SSA WSM with the RCoA. They produced a packed program over two days with absolutely excellent educational content. With 21 speakers and topics there simply isn't space here to give even a brief account of all the lectures. The full two day program is available on the societies website.

The meeting began with a session covering kidney disease from two perspectives, transplantation and the military approach to major hemorrhage control. It had a wide variety of speakers, a nephrologist, an anaesthetist, an intensivist and a Navy Doctor. Many CME boxes were ticked!

This was followed by Prof Sue Black, a forensic anthropologist who fed our inner ghoul. I for one will never forget the fact (or the slide demonstrating) that a semi-decomposed seals flipper looks just like a severed hand! Further lectures covered recent developments in Ultrasound technology and the epidemiology of chronic pain. Interestingly it seems our susceptibility to chronic pain is another thing to blame our parents for.

The Gillies Lecture was delivered by Professor Rob Sneyd of the Peninsula medical school in Plymouth. Prof Sneyd gave an excellent overview of the issues surrounding the selection and training of our future medical workforce. The lecture is reproduced below.

The following day began with some rather more fundamental science relating to clinical practice. The Institute for Academic Anaesthesia in Dundee was showcased in this section with some excellent speakers including last years Keynote lecturer from Crieff, Prof Tim Hales speaking about ion channels and the potential for regional anaesthetic techniques to reduce cancer recurrence rates.

The afternoon session saw a shift of emphasis to quality and safety. There was much reporting of the successes of the initiatives of the SPSP which were the topic of last years Gillies lecture. There is now good evidence that a lot of the work of the past few years in this regard seems to be producing real and very substantial improvements. One of these areas, namely sepsis was highlighted and the methodical approach to implementing improvements in sepsis management reviewed. The punchline from this session is that these national strategies introduced under the SPSP banner seem to work individually and collectively. Very good news.

The final session looked at the interface between the anaesthetic and ICU services we supply with other areas, namely A&E and Obstetrics. In A&E Dundee's code red system is aimed at a coordinated response to major trauma . One of the other major causes of concern is difficult airway management in A&E as highlighted in NAP4. The obstetric patient in ICU is a complex and difficult problem which was well tackled with a case presentation format which still handily covered a good deal of relevant pathophysiology and the clinical conundrums which can arise with these patients.

Thanks and congratulations to Fiona Cameron and Calum Grant, the organisers of this excellent meeting.

The Gillies Lecture

What kind of doctor, what kind of health service?

Professor Robert Sneyd.

Plymouth University Peninsula Schools of Medicine and Dentistry

Dundee, 15th November 2012

Gillies was a clinician and leader who would have recognised the importance of choosing the right people, training them properly and supporting them of course with the right equipment.(1)

If we are to train doctors we must first identify the essence of what a doctor is. All healthcare workers are expected to have the proper skills and knowledge for their roles, to be good communicators and generally professional. However, all of these are generic characteristics and certainly not exclusive to doctors. What are the other "must have" characteristics of a doctor? Arguably diagnosis, the ability to manage uncertainty and clinical evidence, communication with patients, development of treatment plans and general leadership are all seen to some degree in other healthcare workers especially with the recent emergence of Nurse Consultants, Advanced Practitioners etc. However, these are uniquely concentrated in doctors with a special emphasis on taking ultimate responsibility for difficult decisions in situations of clinical complexity and certainty.(2)

How should we choose medical students? Currently UK medical schools rely on actual or predicted examination grades (typically) the UK Clinical Aptitude Test (www.ukcat.ac.uk). UKCAT measures reasoning, logic and personality traits. This is supported by an interview which should be structured and explore motivation and commitment to study medicine, insight into a medical career, team skills, problem solving, reflection and a general understanding of one's own limitations etc. There is evidence base to support this process and the value of strong prior academic achievement, especially in Chemistry and a high interview score as predictors of successful test performance.(3)

Registration of final medical undergraduates with the GMC from 2013 offers the opportunity to link scores and characteristics determined during selection not only to performance at medical school but subsequently to Deanery evaluations, performance in College, Primary and final examinations etc.

What should we teach the students? The learning outcomes for an undergraduate medical programme are defined by the GMC.(4) The programme at Plymouth University Peninsula Schools of Medicine and Dentistry is patient centred, delivered in partnership by scientists and clinicians from the University and the NHS. Encouraging students to undertaken real tasks and participate in meaningful work-based learning makes the programme authentic and contextual. Research-informed teaching from scientists and clinician scientists, physician's medicine as a scientific discipline in a clinical context.

Clinical scandals, enquiries and public expectations have rightly pushed professionalism up the agenda. Today's medical schools must teach it, expect it, respond when it is missing and finally assess it. Whereas knowledge can be robustly tested using multiple choice delivered by computer, assessing professionalism is less exact. Nevertheless, you "know it when you see it". Generalizability theory(5) supports the use of multiple assessors and we encourage every healthcare professional to whom a student is attached to make a Professionalism Judgement on them. Although initially resistant we can remind clinicians that they confidentially make clinical decisions at short notice on incomplete information and deciding whether someone has or has not behaved professionally is really no different.

Expansion of UK undergraduate medical programmes has put pressure on spaces in the foundation programme which has recently threatened by legal action from Ms Kapenova, a Czech medical student seeking a UK Foundation Programme place. Had she been successful the UK FP would have been open to medical graduates from 16 other European countries. However, in November 2012 she lost her case preserving most of the capacity of the foundation programme for UK graduates. The Situational Judgement Test, SJT(6) assessors the attitudes and decision making we look for in a newly qualified doctor using scenarios in clinical settings supplemented by proposed causes of action which the student must prioritise. Students from UK schools with substantial NHS exposure should find this assessment manageable.

How good a job are we doing? Regular published surveys at 1 year after qualifying ask doctors whether their experience in medical school prepared them well for jobs. In 2003, the graduates of 1999 and 2000 answered yes to this 75% of the time from one medical school down to as low as 25% from another.(7) Clearly success at producing work placed ready graduates was very variable between UK schools. By 2012 the graduates of 2008 and 2009 the situation had improved nationally with 82% of PU PSMD graduates feeling well prepared however performance across medical schools remains very variable with the worst performer still scoring less than 30% on this evaluation.(Goldacre 2013, Postgraduate Medical Journal, in press)

Once foundation training is completed, specialty selection must be transparent, fair and efficient. In anaesthesia a national selection process using evidence based assessment centre methods(8) combine structured approach to interview, portfolio and presentation. This has been efficient for staff time and highly rated by applicants.

How should we structure training? The report “Aspiring to Excellence” proposed reducing Foundation Training to a single year followed by “Core Specialty Training”.(9) This has not been adopted although Acute Core Common Stem combining anaesthesia, critical care and emergency medicine has been popular. The 2012 “Shape of Training review” (www.shapeoftraining.co.uk) is reconsidering the nature of specialist training amidst concerns that a “consolidation phase” may consign trainees to a limbo of sub-consultant service from which only a minority will be selected for final training and a true consultant role. Rather than abandon our trainees to this we should consider revision of the 2003 consultant contract which is ill-fitted to 7 day working, residential on-call and contemporary practice. In return trainees would likely consider a longer incremental scale possibly a lower starting salary and other changes as long as they can achieve the desired “Consultant” appellation.

Financial challenges frame our service delivery. In England the “Nicholson Challenge” demands unprecedented savings of £5 billion a year for four consecutive years (something never attempted or achieved in any western economy). Interestingly the bank bail-out found approximately £800 billion at short notice to prop up the financial services sector. Recently the evidence base for this frugal approach to the NHS has been challenged. The 2010 National Audit Office report(10) much cited by politicians claimed “since 2000 . . . productivity in hospitals fell by around 1.4% per year” subsequent critical analysis showed this accusation to be false with sustained reduction in mortality and improvements in a wide range of health outcome and productivity measures across the period 2000-2009.(11) Further, the Kings Fund(12) noted that one-off savings have started to slow and a majority of NHS finance director surveyed felt that there was a very high or high risk failure against the Nicolson challenge.

Can the work be shifted to primary care? The 2001 “Shifting the balance of power within the NHS” report called for new ways of working and a shift towards primary care.(13) The reality has been in the opposite direction. NHS emergency department attendances and admissions tend to increase rapidly with huge pressures on hospitals at the same time as beds are being cut. Further pressure arises from private finance initiative, PFI schemes causing unmanageable deficits.

Can generalists save the day? A key question for Scotland, this is also recognised as a problem in England were the Royal College of Physicians report “Hospitals on the Edge” describe soaring clinical demand from ever frailer (often demented) elderly patients with Consultants under pressure, Registrars reporting unmanageable workloads and difficulty recruiting into emergency medicine and general medicine.(14) These trends combined with aggressive initiatives to restrain or cut pay and reductions in SPA time and abolition of clinical excellence awards in Scotland risk compromising aspirations to excellence and may consider exceptional clinicians and future leaders to consider working overseas.

Variability and care. Governments and the public are rightly intolerant of inexplicable variations in care. Huge variations in preoperative medical assessment of surgical patients(15) are hard to defend and lead one observer to comment “we can either wait for payers and governments to define appropriate versus inappropriate variation or anaesthesiologists can take a leadership role and perform the research necessary to establish clinically meaningful process-of-care measures”.(16) (reference Anaesthesiology).

Outcomes from major surgery vary widely across Europe (reference EUSOS) despite adjustment for confounding variables. Poor outcomes are not only found in Eastern Europe, with Ireland a significant outlier in the EUSOS study.(17) UK initiatives to reduce their ability and improve quality of care in hip fracture are starting to work(17) and the awarding of the Emergency Laparotomy Audit for England to the Royal College of Anaesthetists with the Royal College of Surgeons as a sub-contractor is very welcome. Hopefully Scotland and Ireland will find ways to join this important process for quality assurance of perioperative care.

In conclusion these are difficult times to choose and train doctors to practice as a consultant. Nevertheless, public expectation and pressure from Government are at an all-time high. As professionals we must stand up for excellence, professionalism and proper resourcing.

J Robert Sneyd

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Annual Trainees Competition

Crieff 2012
The Donald Campbell Quaich

The following are the 5 papers which were presented at the Annual Spring Meeting at Crieff on the 12th May 2012. They are ordered here in their ranking in the competition. Papers 4&5 were ranked equally.

Winner

The effect on allogenic blood transfusion requirements for total hip replacement, following the introduction of an Enhanced Recovery Programme (ERP) in a District General Hospital.

Anne-Marie Docherty, Jonathan Antrobus, Heather Matthews
All of the Department of Anaesthesia, Borders General Hospital, Melrose, Scotland

Introduction

We introduced an Enhanced Recovery Programme in our District General Hospital. During this, we developed a blood conservation strategy. This included pre-operative optimization of Hb, a restrictive intravenous fluid regimen, peri-operative tranexamic acid and well defined transfusion triggers.

Methods

To assess the effect on rates of blood transfusion we surveyed all patients who underwent total hip and knee replacements in the Borders General Hospital After obtaining ethics approval we measured pre-operative haemoglobin concentration (Hb), intra-operative blood loss, intra-operative fluid volume, Hb on post-operative day 1, and units of packed red cells transfused over six month periods both before and after implementation of the ERP.

Results

Total Hip Replacements:	Pre-ERAS	Post-ERAS
Number	56	94
Pre-operative Hb mean (range)	13.2g/dl (10.7-16.2)	13.3g/dl (11.1-17.9)
Intra-operative blood loss mean (range)	532ml (min-1000)	403ml (100-900)
Intra-operative fluids mean (range)	2137ml (1000-3500)	727ml (400-1500)
Post-operative Hb mean (range)	10.0g/dl (6.5-13.2)	10.8g/dl (7.8-13.6)
Patients transfused	24 (42%)	4 (4.3%)

Total Knee Replacements	Pre-ERAS
Number	37
Pre-operative Hb mean (range)	13.2g/dl (11.1-16.0)
Intra-operative blood loss	minimal
Intra-operative fluids mean (range)	1981ml (1000-2500)
Post-operative Hb mean (range)	11.0 (8.3-13.4)
Patients transfused	3 (8.1%)*

*two further patients were transfused after day 8.

Discussion
Allogenic blood transfusion carries significant risks to the patient, and is a scarce and expensive resource [2]. Post-operative anaemia is associated with poor rehabilitation, and post-operative complications [3].
With the introduction of a multi-modal Enhanced Recovery After Surgery programme, we have significantly reduced the transfusion rate by 90% in patients undergoing total hip replacement in our hospital.

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2nd place

Fascia-iliacus Blocks in Children Undergoing Elective Orthopaedic Hip Surgery- A Retrospective Re-Audit of Pain Scores and Length of Stay

JM Currie, C Hawthorn, **OM Tanner,** CNS M McCulloch, A Rae.
Royal Hospital for Sick Children (Yorkhill), Glasgow, UK

Introduction
Following a change in anaesthetic technique by the principle investigator (PI), there was a perception that fascia iliaca blocks (FIBs) were as efficacious as epidurals. The aim of this re-audit was to evaluate these perceptions.

Methods
Following ethics approval, cases over a one-year period were identified retrospectively using both the Departmental Pain database and the Orthopaedic Ward Admissions book. The study included all patients receiving a regional anaesthetic technique (epidural or FIBs) from the primary investigator and had undergone any of the following orthopaedic procedures: osteotomy, shelf procedure, acetabuloplasty or open hip reduction. A retrospective audit of patient case notes was performed using a standardised proforma. Data collected included pain scores (0-3), length of hospital stay (in days) and additional breakthrough analgesia requirements over a 48 hour period. A re-audit was conducted a year later.

Results

	Epidural Group (n=28)	**Fascia Iliaca Group (n=28)**	**Re-audit (n=15)**
Days stay - range (average)	2 - 9 (2.8)	1 - 8 (3.2)	1 – 5 (2.0)
Pain Score > 5	6	0	0
Pain Score < 5	21	28	15

Re-audit:
Fifteen patients underwent hip surgery in total. All received FIBs. The mean duration of their hospital stay was two days (range 1-5). Only forty percent remained after 48 hours. One patient required additional breakthrough analgesia (codeine) following a shelf procedure and required the longest admission (5days).

Conclusion
Our findings suggest that single shot FIBs performed by the PI are as efficacious as epidurals in these cases. Although patient numbers are low, several benefits are apparent. FIBs provide reliable analgesia with a potentially improved safety profile. Post operative monitoring and nursing demands are less and they facilitate earlier discharge. Although a single case, we recommend that the provision of analgesic for patients undergoing shelf procedures is reviewed.

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3rd place

An Analgesia Bundle to Facilitate Patient Mobilisation after Fractured Neck of Femur Surgery

K. Mcilmoyle, I. Seater and E. Jack
All of the Anaesthetic Department, Forth Valley Royal Hospital, Larbert, UK.

Introduction
Pain in the peri-operative period continues to be a major contributing factor towards morbidity and mortality in patients who have fractured neck of femur (NOF) surgery.

Aim
To improve post-operative pain control, and increase the percentage of patients mobilised on day one and two post surgery.

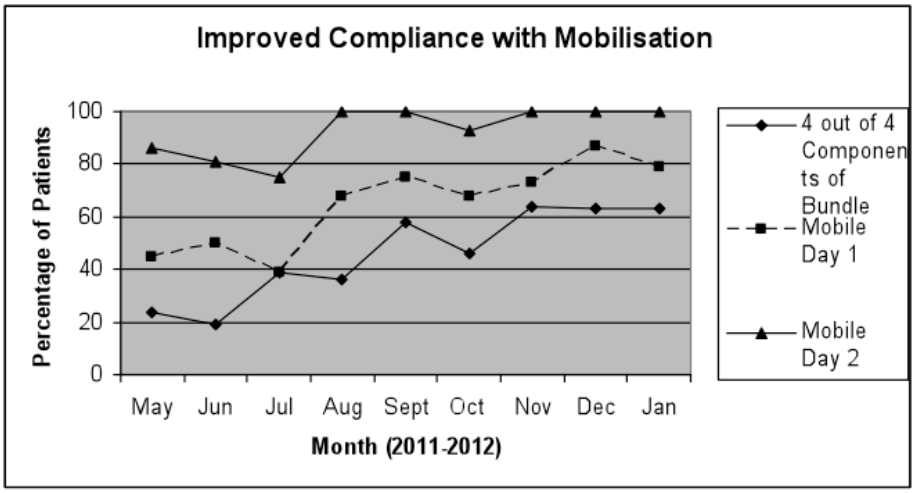
Method
By performing audit to improve compliance with a four stage analgesia bundle:
1. regional anaesthetic technique during hip fracture surgery (axial or peripheral)
2. regular paracetamol prescribed post-operatively
3. regular dihydrocodeine prescribed post-operatively
4. PRN dihydrocodeine prescribed post-operatively

Audit is ongoing and records data monthly.

Results
This audit has been running for nine months (May 2011 - January 2012). From the inception of this audit, the number of patients having regional anaesthesia has increased by 19%, and the percentage of patients receiving regular paracetamol has remained between 96-100%. Those receiving regular weak opiates and breakthrough analgesia have increased by 31% and 15%, respectively. Overall the percentage of patients complying with all four steps of the analgesic ladder has risen by 39%. Maximum pain score in the first 24 hours and time to mobilisation have also improved. The percentage of patients mobilised on day one post-operatively has risen by 42%, to 87% of patients. Additionally, 79% of patients now report nil or mild pain, in comparison to 45% prior to implementation of the bundle.

Conclusion
This high risk patient group is known to have a mortality of approximately 5-10% at one month [1]. Extended length of immobility contributes to this. Implementation of this analgesic bundle has improved pain scores and dramatically shortened duration of immobility. Data collection continues and we now also measure delirium within this patient group and its correlation with improved pain control.

Table 1: Correlation of bundle compliance with percentage of patients mobilised on day one or two.



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Equal 4th/5th place

Emergency Laparotomies: The West of Scotland Experience

Dr Robert Docking for ATARSN (Anaesthetic Trainee Audit and Research Support Network) University Section of Anaesthesia, Pain and Critical Care Medicine

Introduction
We live in an ageing world, a fact seen on a daily basis in hospitals across the land. Emergency major abdominal operations carry with them some of the highest mortality rates for all surgery, second only to ruptured aortic aneurysms, and this is seen across all age ranges. In England an attempt has been made to try and capture ongoing work and drive quality of care upwards through the Emergency Laparotomy Network (ELN). In this snapshot we aimed to mirror their work in the West of Scotland.

Seven hospitals were approached, and a trainee under the supervision of a Consultant applied the ELN's data collection form to a recent cohort of patients treated in emergency theatres. The inclusion criteria included laparotomies, for non-gynaecological surgery excluding simple appendicectomies but including reoperations. Data was sought from laboratory services, casenotes, theatre logs and critical care. The study was registered with relevant audit services.

Results
139 patients were captured in this snapshot, with a mean age of 60.5 (SD 19.8). 52.5% were male with 89.3% being admitted under the care of the General Surgeons. There were a wide range of operation types, with colonic surgery accounting for 33%. There was an overall mortality rate of 15.1%, with significant variation between units. Mortality varied markedly between age groups, from 5% in the <50yr old cohort to 28.6% in the >80yr group. Consultant Surgeons were present in 78% of cases, compared to Consultant Anaesthetists who were present in 63%. Differences in postoperative levels of care were seen between Units.

Conclusion
In summary, outcomes from emergency laparotomy are analogous to those demonstrated by the ELN with marked rises in mortality seen in the elderly. Proposed changes such as the use of goal directed therapy were not seen in this cohort, but invasive monitoring and critical care were well utilised.

Noise levels in the operating theatre

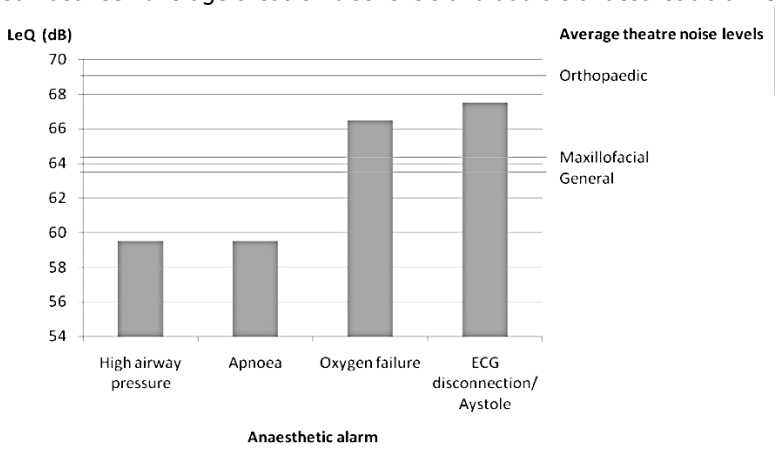
L. Robertson[1], G. Scott [2], M. Sik [3] and J. Chestnut [4]
1, 2, 4 Dept of Anaesthesia and 3 Dept of Medical Physics, Crosshouse Hospital, Kilmarnock, UK

Introduction
In the operating theatre high noise levels can increase patient risk; by reducing effective communication, impairing surgical performance and increasing error rates [1]. For the anaesthetist, extraneous noise is a barrier to delivering quality patient care [2] and may interfere with detection of subtle clinical abnormalities or audible alarms.

Methods
We used an audiometer to recorded continuous noise levels during elective theatre lists in orthopaedic, general and maxillofacial surgery. The audiometer was positioned on the anaesthetic machine as a surrogate for the mostly likely position of the anaesthetist. Ethical approval was not required as the study was observational and did not involve changes to anaesthetic or patient surgical care.

Results
Noise level recordings were analysed for 11 elective operating lists. Average, peak and trough levels were calculated for surgical lists in each speciality. Orthopaedic theatres had the highest noise levels throughout. Average noise levels in all theatres approximated that of normal spoken voice (66.2dB) and exceeded the level of audible anaesthetic machine alarms indicating high airway pressure and apnoea. In orthopaedic theatres, they also exceeded alarms indicating oxygen supply failure and ECG disconnection/asystole.

Figure
Comparison between average theatre noise levels and audible anaesthetic alarms



Discussion

Accurate verbal communication is important in theatre. For >90% of wo ɔe heard, they must be spoken 10-15dB(A) louder than the average noise in a]. In our environment this would require voices to be raised above 80dB al communication may therefore be difficult in normally operating theatres and significantly impaired at times of excess noise. Furthermore some commonly employed anaesthetic alarms were lower than average theatre noise levels. Safe anaesthesia is aided by appropriate use of audible alarms and the ability to hear and respond to these is imperative. Anaesthetists must remain vigilant for audible alarms regardless of background noise levels.

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Poster Prize Competition
The James Macgregor Imray Salver

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

Winner

The effect of the introduction of a Procedural Sedation and Analgesia registry on documented guideline compliance in a district general hospital Emergency Department

Falzon,D[1]. Stevenson,A[2]
1 CT2, Anaesthetics Department, Gartnavel General Hospital, Glasgow, UK
2 Consultant, Emergency Department, Ayr Hospital, Ayr, UK

Introduction
Procedural sedation and analgesia (PSA) is potentially associated with complications which can include cardio-respiratory arrest and unexpected ICU admission [1, 2]. Studies have shown that PSA guidelines outside anaesthetic remit are not always followed [2]. Previous evidence suggests a PSA proforma improves documentation [3]. This study examines whether introduction of an Emergency Department (ED) PSA registry, guideline and proforma improves documented guideline compliance during ED PSA.

Methods
No changes were made to patient management, so ethical approval was not required.
Using ED patient tracking software, data was collected for patients aged over 16 years undergoing ED PSA (April to October 2009.) This suggested suboptimal documentation according to recognised standards [2]. Therefore an ED PSA registry, guideline and pro-forma were developed and introduced, in addition to formalising criteria for discharge post-sedation and patient discharge information. The effects of this were then re-examined (February to June 2010.)

Results
26 patients underwent ED PSA in the initial period and 32 in the second. The sedation registry increased accuracy in identification of patients undergoing ED PSA by identifying seven who were not identified using the departmental software ie. an average of 1.6 procedures per week vs. 0.89. Sedation level was documented in 25(78%) patients in the second period but never documented before the registry pro-forma was introduced. In addition there was improved documentation of: staff present 26(81%) vs. 14(54%) (p=0.036,) appropriate equipment present 30(94%) vs. 18(69%) (p=0.016) and consent 24(77%) vs. 10(38%) (p=0.006.) Overall amount of

sedative drugs given, use of reversal drugs, documentation of advice given on discharge and complication rates were similar in both groups.

Conclusions
Introducing an ED PSA guideline and pro-forma registry document improves detection of patients undergoing ED PSA, improves procedural documentation and increases documented adherence to intercollegiate guidelines, potentially leading to improved practice, governance and patient safety.

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2nd Place

Feasibility of an aggressive postoperative haemoglobin monitoring policy to reduce un-recognised anaemia in postoperative hip fracture patients.

Dr Miriam Stephens ST3 Royal Alexandra Hospital, Paisley UK, Dr Stuart Hannah CT2 Glasgow Royal Infirmary UK, Dr David Griffith SpR Edinburgh Royal Infirmary UK, Dr Susan Geddes Consultant, Glasgow Royal Infirmary UK

Introduction
This audit included the introduction of an aggressive haemoglobin monitoring policy to improve detection and treatment of postoperative anaemia.

Methods:
We performed two data collections each containing around fifty patients. We reviewed the timings of the pre and post-operative haemoglobin values and then introduced an aggressive haemoglobin monitoring policy to detect and treat anaemia earlier in postoperative patients. The new policy included bed side haemoglobin measurements in recovery and a formal measurement six hours post-operatively.

Results:
The proportion of patients having a laboratory haemoglobin measured on the day of surgery was 24% and this increased to 83% after the introduction of the new policy. In addition, 10% of patients at the first data collection had their first post-operative

haemoglobin measurement delayed to the second postoperative day. No patients experienced this delay after the introduction of the new policy.

In the first data collection there were fourteen patients with a haemoglobin of less than 9g/dL with a median time from detection of anaemia to transfusion of 28 hours. In the second data collection there were 6 patients with a haemoglobin value of <9g/dL and the median time from detection of anaemia to transfusion was 2 hours.

Compliance with the policy was good with 70% of patients undergoing bed side measurement in recovery and 56% of patients had a formal sample within 4-6 hours of surgery.

Discussion
We successfully introduced an aggressive haemoglobin monitoring policy, with high compliance and a clinically and statistically significant improvement of haemoglobin monitoring within the first twelve hours of surgery. The introduction of the policy reduced the median time from detection of anaemia to blood transfusion by twenty six hours.
We have demonstrated a system that not only significantly improves detection of post-operative anaemia, but is easy to integrate into our current clinical practice.

3rd Place

Knowledge of Local Anaesthetic Toxicity, Management amongst Midwives. Audit conducted at PRMU

A-Dr Sabah Munshi -Trainee ST5 Anaesthetics West of Scotland Rotation
B-Dr Ravi Agaram -Consultant Anaesthetist PRMU Glasgow UK

Local Anaesthetics are used by midwives to top up epidurals for labour and for repair of perineal tears. Toxicity although rare can be fatal if maximum dose is exceeded or if injected intravenously.

Methods:
Aim of the audit was to check the level of knowledge amongst the midwives .Standard was that all midwives administering the drug should be aware of doses, recognition of toxicity and management.42 midwives completed the audit questionnaire in January 2012.

Results
Four (nine and a half %) knew the toxic dose in mg per kg of lignocaine (three mg/kg) and levobupivacaine (two mg/kg). Thirty two (76%) were aware of central nervous toxicity which included ringing in the ears, unresponsive patient, convulsions. Fifteen (35%) were aware of cardiovascular toxicity which included arrhythmias, hypotension, cardiac arrest. Thirty seven (88%) did well on basic management which was stop giving the drug, call for help, CPR and ABC. Thirty four (80%) knew about Intralipid whereas twenty eight (66%) knew that Intralipid was located in the emergency trolley.

Change of practice seen was education for midwives .The audit also highlighted that the unit was using old Association of Anaesthetists of Great Britain and Ireland guidelines therefore the new 2010 guideline has been printed and attached with Intralipid on the emergency trolley and on the consultant office notice board. Teaching was delivered in the unit the following week in small groups. Reaudit done amongst 40 people showed a hundred percent awareness in all sections.

Discussion
The midwives giving local anaesthetics should be aware of its doses and management of toxicity. This audit highlighted the fact that there is a need for education and also that the department guidelines are now up to date with the 2010 version. Plan is to conduct more such education days.

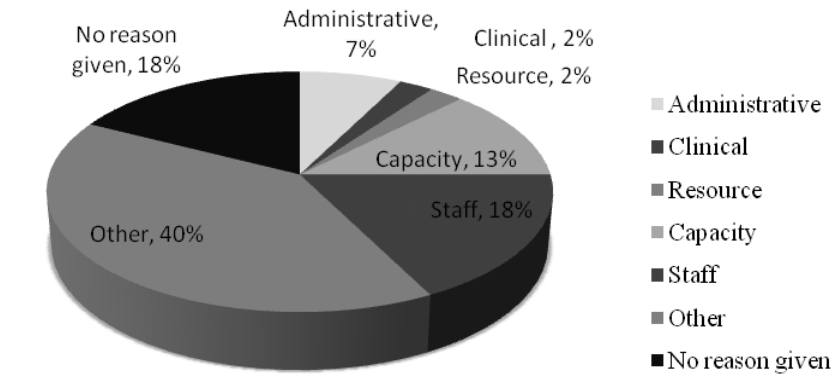
The following abstracts are the next most highly ranked, presented in order.

Audit of Delays in the Emergency Theatre of a Large Teaching Hospital
Dr J. Wilkinson, Dr K. Simpson and Dr I. Raju. Department of Anaesthesia, Glasgow Royal Infirmary, Glasgow, UK

Introduction
NCEPOD and AAGBI have published guidelines on provision of care. These include targets for maximum time to theatre in different surgical categories. Guidelines recommend a 24 hour dedicated emergency theatre with senior anaesthetic and surgical personnel [1-3]. Our institution provides a dedicated 24 hour emergency theatre covered by an anaesthetic consultant between the hours of 08:30–18:00, Monday to Friday. The aim of this being to get the majority of cases done during daytime hours. To facilitate this, unnecessary delays must be minimised. We audited our emergency theatres to assess the number and extent of delays in patients presenting for surgery.

Methods
We compiled a data collection sheet to be completed for every patient listed for the emergency theatre between the hours of 08:30-18:00, Monday to Friday. It included information on whether the case was discussed with an anaesthetist, surgical specialty, NCEPOD category, time patient sent, time patient arrived in theatre and reason for delay. A delay was defined as a period greater than 30 minutes from theatre being ready to the patient arriving.

Results
Over the audit period 85 forms were completed. 53/85(65%) of cases had been discussed with an anaesthetist. In 40/85(47%) there was a delay of >30 minutes from theatre being ready to patient arriving in theatre (range 32 to 320 minutes).
Figure: Breakdown of causes of delays in patients presenting to the emergency theatre



Discussion

The majority of "other" causes were due to miscommunication. Since auditing we have introduced an emergency white board and new booking form to improve communication. The relevant surgical and peri-operative directorates have received a copy of the audit results for dissemination. We plan to recommence our 2nd round within the next couple of months and hope to see an improvement in emergency theatre efficiency.

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Improving the efficacy of antimicrobial treatment through switching from intermittent to continuous Vancomycin administration

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Introduction

In Vancomycin treatment failure the relative contributions of sub-therapeutic plasma levels, failure of tissue penetration, and variability of minimum inhibitory concentrations are unknown [1]. However, it has been shown that an initial trough plasma concentration of less that 15mg/L is associated with treatment failure [2]. Although there is no data to suggest outcome benefit when using continuous infusion, Wysoski [3] demonstrated it to be more cost-effective with a trend towards improved attainment of target plasma levels.

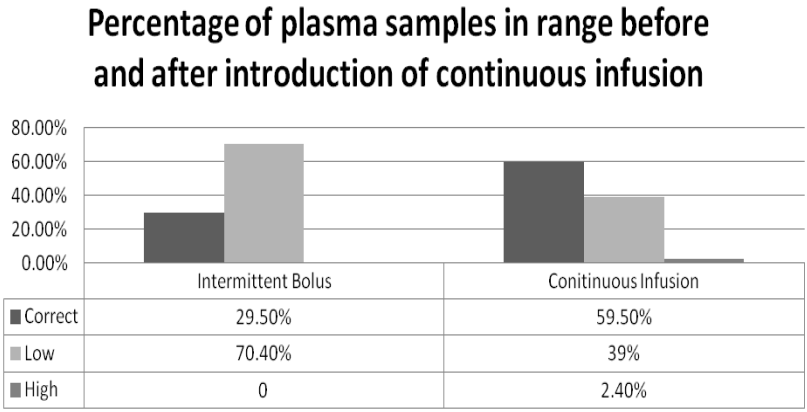
Methods

This was a clinical audit and ethics approval was deemed unnecessary; approval was granted by hospital audit and pharmacy departments. We retrospectively audited plasma Vancomycin levels over a six month period during which plasma concentrations

were targeted at 15-25mg/L. A continuous infusion regime was introduced in July 2011 using a template developed by the pharmacy team in the Glasgow Royal Infirmary. A computerised tool was developed to allow simple instructions for dose administration and levels analysed for the following six months.

Results

In the six months prior to introducing the continuous infusion regime there were 20 patients treated with Vancomycin, and 44 plasma levels performed. Only 13/44 (29.5%) of these were within the therapeutic range, the remaining 31/44 (70.5%) were sub-therapeutic. Following introduction of the Vancomycin continuous infusion regime and computerised tool, compliance was high with 12/16 patients being given the infusion in six months. The results presented are on an 'intention to treat' analysis. In the continuous infusion group, 24/41 (59.5%) of samples were within the therapeutic range with 16/41 (39%) sub-therapeutic and 1/41(2.4%) high. The highest level was 27.5mg/L.



Discussion

We have introduced a simple tool to allow Vancomycin to be administered in a safer manner to critically ill patients leading to a tangible improvement in therapeutic levels: a measure that has been shown to correlate with reduced treatment failure.

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Acknowledgements
We would like to thank Alison Thomson and the pharmacy department at the Glasgow Royal Infirmary for allowing us to use their Vancomycin template.

An audit of postoperative oxygen prescribing & administration of oxygen therapy

J. O'Donoghue, L. Chee, Anaesthetic Dept, Inverclyde Royal Hospital, Greenock.

Introduction
The application of postoperative oxygen therapy decreases the incidence of hypoxaemia. In practice however this is poorly done and may contribute to morbidity and mortality. British Thoracic Society (BTS) guidelines for the prescription of oxygen are well publicised and endorsed by the Royal College of Anaesthetists. This project was an audit of standardised oxygen prescribing and subsequent oxygen administration.

Methods
Data was collected from all patients undergoing general or regional anaesthesia in main theatres over five days, 52 patients in total. Data collection included oxygen prescription details on the anaesthetic chart and drug kardex. Patients were followed up on the ward to ascertain if oxygen was being administered as indicated. Medical, nursing staff and patients were unaware of the subject or purpose of data collection in order to prevent alteration in normal practice.

Results
Nine patients (17.3%) were prescribed supplementary oxygen on the anaesthetic chart to be continued on the ward. None of these patients had oxygen prescribed on the drug kardex. Four of the nine patients (44.4%) did not receive oxygen on the ward, including two septuagenarian ASA3 patients who had received intrathecal opioids, and a 36 year old ASA3 who had undergone a small bowel resection. One patient (11.1%) received the incorrect method of administration of oxygen as prescribed on the anaesthetic chart. Thus four patients (44.4%) received oxygen therapy as prescribed. Three of the 52 patients (5.8%) had an oxygen prescription on the anaesthetic chart in accordance with BTS guidelines.

Discussion
This study highlighted poor oxygen prescribing practice by anaesthetists when compared with BTS guidelines as the gold standard. Lack of prescription clarity on the anaesthetic chart, and omission of oxygen prescription on the drug kardex, resulted in patients not receiving postoperative oxygen therapy as intended. A local guideline would provide a consensus on oxygen prescribing.

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Does the use of High Fidelity Simulation alter Confidence Levels in Managing Critical incidents in Multi-professional Staff Members?

Harvey R, Edgar S, St Johns Hospital, Livingston, Scotland.

Introduction

Confidence per-se cannot be directly related to competence in clinical performance[1]. There is a definite relationship between confidence in ones ability to address and complete a task: confidence–enhanced performance, possibly mediated through familiarity and appropriate decision making[2]. Armed with this thesis, we attempted to understand what scale of intervention was necessary to increase confidence in unexpected clinical critical incidents experienced by multi-professional staff groups.

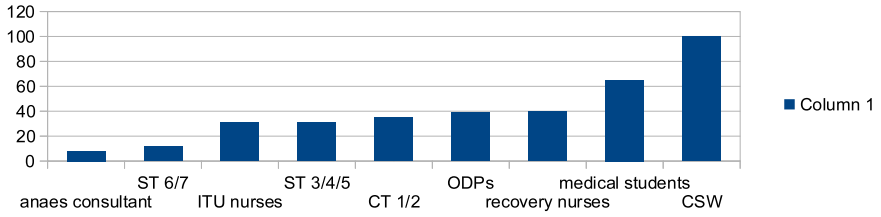
Methods

A high fidelity simulator exposed a multi-professional team to commonly occurring critical incidents in anaesthesia and intensive care, over 6 months. Scenarios were run in the clinical environment, using locally available equipment and drugs. Participants took part in debriefing conversations, including didactic teaching and completed a questionnaire rating confidence in real life critical incident management, before, and after each scenario. Percentage change in average confidence levels was analysed.

Results

77 participants completed the questionnaire (100% response rate). Clinical support workers had the highest increase in confidence levels of 100%. Medical students had a 65% increase, recovery nurses a 40% increase and ODPs a 39% increase. CT1-2 and ST3-5 anaesthesia trainees had 35% and 31% increases respectively. Intensive care nurses had a 31% increase. ST6-7 anaesthesia trainees and anaesthetic consultants had lower increases, 12% and 8% respectively.

Graph 1. Percentage increase in confidence levels of participants following simulated critical incident exposure.



Discussion
Although confidence is a subjective measure of competence[3], an increase in the former directly mirrors ability to address and complete a task. Seniority leads to a smaller increase in overall confidence post-intervention[2], a factor that may be related to a greater self-assessment of competence. We can predict that behavioural changes resulting from the intervention will benefit multidisciplinary team members, and improve patient safety. Future work could concentrate on measuring competence directly.

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Provision of focused airway training through informal drop in sessions can influence Technique and Confidence levels.

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Aberdeen Royal infirmary

Introduction
Airway training workshops have been suggested as being useful to improve and maintain the Airway skills by many experts [1, 2, 3]

Methods
We organized an informal drop in session for dealing with a Can't Intubate, Can't Ventilate (CICV) situation in which surgical cricothyrotomy and seldinger technique using the Melker kit was taught.
We surveyed anaesthetists, attending this teaching, regarding their technique of choice and confidence level in performing the chosen technique on a numeric scale of one to ten, with 10 being very confident. We then repeated the survey approximately 12 weeks later to see if the training had changed their technique of choice and confidence levels. No ethical approval was sought as the study did not involve any patient intervention.

Results
Forty-seven anaesthetists of various grades were surveyed. They included 16 consultants (34%), 15 (32%) senior trainees, five (11%) intermediate trainees and six (13%) junior trainees. There was a marked change in the quoted technique of choice pre and post training.

(Table1)

	Small Bore Cannula Cricothyrotomy	Large Bore Cannula Cricothyrotomy	Seldinger Cricothyrotomy	Surgical Cricothyrotomy	Other
Pre training	26	6	4	5	1
Post training	19	4	6	13	0

Confidence levels pre and post training showed a significant change in the junior and intermediate trainee group. With the median score increasing from 2 to 5 (ranges 1-7 pre-training) (4-7 post training).

Discussion

A 2009 survey suggested 42% of departments conducted regular airway training workshops [4]. Our survey shows that an informal focused drop in session can impact on confidence levels and influence technique choices for emergency airway management. We recommend running these sessions on a regular basis. These can be easily organized in most anaesthetic departments with minimal or no costs involved and can have far reaching consequences in management of CICV situations thus improving patient safety.

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Intrathecal morphine and peripheral nerve block for postoperative analgesia and there side effects after primary total knee and hip arthroplasty - An audit

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Introduction:

THA and TKA are generally associated with moderate to severe postoperative pain, more so with TKA and on mobilisation [1]. Several methods are available for postoperative pain management like opioids administered intrathecally or by patient controlled analgesia (PCA) and PNB. In our hospital general anaesthesia (GA) is usually combined with PNB and spinal anaesthesia (SA) with ITM (0.1-0.2mg). The aim of this audit was to compare the efficacy of PNB and ITM by measuring morphine consumption and their side effects.

Methods:
This retrospective audit was conducted by reviewing the pain management database for the year 2010. Patients were divided in to GA+PNB and SA+ITM groups. Both group received PCA morphine for additional analgesia and monitoring. The mean morphine consumption and side effects of the two techniques were compared using t test.

Results:
Two hundred and seven patients were included in the audit. There was no significant difference in the age between the groups. The results are shown in table 1

(Table 1)

Technique	Procedure	Number of patients	Age (Years) (mean)	PCA Morphine(mg) Mean(95% CI)	p
GA+PNB	THR	34	68.2	27.19 (17.8- 36.5)	0.46 Not significant
SA+ITM	THR	57	66.21	31.4 (24.3-38.5)	
GA+PNB	TKR	59	67.6	33.7 (28.1-39.5)	0.82 Not significant
SA+ITM	TKR	57	69.9	34.9 (26.1- 43.7)	

There was no incidence of respiratory depression in either group. Twenty four (17.9%) patients in the GA+PNB group and 44(31.8%) patients in the SA+ITM group suffered from nausea & vomiting. Six (4.34%) and 3 (2.23%) patients complained of itch in SA +ITM and GA+PNB group respectively. None of the above side effects was statistically significant between the groups.

Discussion:
ITM is simple to administer but can be associated with respiratory depression and purities [2]. Peripheral nerve blocks can lead to motor block and rarely associated with nerve damage. Our audit demonstrated that in our patient population ITM and PNB resulted in a similar degree of post operative analgesia. Either technique can be used as a method of postoperative analgesia depending on patient's preference and clinical judgement.

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Feasibility of an aggressive postoperative haemoglobin monitoring policy to reduce unrecognised anaemia in postoperative hip fracture patients.

Dr Miriam Stephens ST3 Royal Alexandra Hospital, Paisley UK, Dr Stuart Hannah CT2 Glasgow Royal Infirmary UK, Dr David Griffith SpR Edinburgh Royal Infirmary UK, Dr Susan Geddes Consultant, Glasgow Royal Infirmary UK

Introduction

This audit included the introduction of an aggressive haemoglobin monitoring policy to improve detection and treatment of postoperative anaemia.

Methods:

We performed two data collections each containing around fifty patients. We reviewed the timings of the pre and post-operative haemoglobin values and then introduced an aggressive haemoglobin monitoring policy to detect and treat anaemia earlier in postoperative patients. The new policy included bed side haemoglobin measurements in recovery and a formal measurement six hours post-operatively.

Results:

The proportion of patients having a laboratory haemoglobin measured on the day of surgery was 24% and this increased to 83% after the introduction of the new policy. In addition, 10% of patients at the first data collection had their first post-operative haemoglobin measurement delayed to the second postoperative day. No patients experienced this delay after the introduction of the new policy.

In the first data collection there were fourteen patients with a haemoglobin of less than 9g/dL with a median time from detection of anaemia to transfusion of 28 hours. In the second data collection there were 6 patients with a haemoglobin value of <9g/dL and the median time from detection of anaemia to transfusion was 2 hours.

Compliance with the policy was good with 70% of patients undergoing bed side measurement in recovery and 56% of patients had a formal sample within 4-6 hours of surgery.

Discussion

We successfully introduced an aggressive haemoglobin monitoring policy, with high compliance and a clinically and statistically significant improvement of haemoglobin monitoring within the first twelve hours of surgery. The introduction of the policy reduced the median time from detection of anaemia to blood transfusion by twenty six hours.

We have demonstrated a system that not only significantly improves detection of post-operative anaemia, but is easy to integrate into our current clinical practice.

Cost implications of wasted emergency drugs.

Yvonne Bramma, Carol Gray, David Alcorn.
Department of Anaesthetics, Royal Alexandra Hospital, Paisley, UK.

Introduction

Drug wastage is a potentially controllable cost in anaesthesia. Emergency drugs are commonly drawn up at the start of a list. Most of these drugs are not used, representing a waste of resources at considerable cost. Our aim was to quantify the magnitude and cost of wasted drugs to our department.

Methods

Over two weeks, we audited emergency drugs across in-patient theatres. Data collected included: drugs drawn up at start of day, drugs discarded at end of day, and grade of anaesthetist. Cost of individual drugs was obtained from pharmacy. A wasted drug was defined as a drug drawn up from the ampoule but not used. The quantity and cost of wasted drugs was calculated and extrapolated over 12 months.

Results

The quantity and costs of wasted drugs are shown in Table 1. Trainees drew up the majority of drugs.

Table 1

Table 1 – Quantity and Costs of Wasted Drugs

Drug (Cost per amp)	Drawn up (2 weeks)	Discarded (2 weeks)	Money wasted (2 weeks)	Money wasted (12 months)
Glycopyrolate (£1.48)	40	32 (80%)	£47.36	£1231.36
Atropine (£0.11)	21	17 (81%)	£1.87	£48.62
Ephedrine (£0.14)	45	33 (73%)	£4.62	£120.12
Metaraminol (£1.82)	62	29 (47%)	£52.78	£1372.38
Suxamethonium (£0.70)	58	58 (100%)	£40.60	£1055.60

Discussion

Our department potentially wastes £3800 pa on emergency drugs. There are a number of options to reduce this cost. Suxamethonium is used so infrequently that use of pre-filled syringes in emergencies could lead to significant savings. For other drugs, pre-filled syringes are substantially more expensive. The most viable way for us to reduce costs without impacting upon patient safety is to draw up drugs as they are required, not routinely at the start of a list. Pre-filled syringes should be available in theatre for occasions when there is not sufficient time to do this, but not for routine use.

What ASA Grade? Factors influencing ASA Grading amongst Anaesthetists in Scotland

S J Smith, P Jefferson and D R Ball. Dept of Anaesthesia, Glasgow Royal Infirmary, Dept of Anaesthesia, Dumfries and Galloway Royal Infirmary.

Introduction

The ASA grade is used to guide assessment for anaesthetic training, but is open to subjective interpretation and hence inconsistent classification [1,2]. This study aimed to determine the factors considered important amongst anaesthetists in Scotland.

Methods

Ten hypothetical patient histories were constructed, focusing on BMI, Age, Diabetes Mellitus, difficult airway or mental health. An email invited 498 Consultant Anaesthetists in Scotland to participate in an online questionnaire and ASA grade each patient. They were also asked to identify factors considered worthy of ASA 2 grade in an otherwise fit patient

Results

There were 113 responses (22.5%)

Table 1. ASA Grade assigned to patient histories, number of responses (% responses)

Case Summary	ASA1	ASA2	ASA3	ASA4	ASA5	ASA6
Difficult Airway	104 (92%)	7 (6%)	1 (1%)	-	1 (1%)	-
Diabetes & Hypertension	-	110 (97%)	2 (2%)	-	1 (1%)	-
Systemic inflammatory response. Appendicectomy	50 (44%)	43 (38%)	16 (14%)	3 (3%)	1 (1%)	-
91yo.Road traffic accident. Shocked. Laparotomy.	16 (14%)	29 (26%)	19 (17%)	41 (36%)	7 (6%)	1 (1%)
16yo.Road traffic accident. Shocked. Laparotomy	51 (45%)	6 (5%)	16 (14%)	33 (29%)	6% (5%)	1% (1%)
Body Mass Index 38. Appenidicectomy	22 (19%)	79 (70%)	10 (9%)	1 (1%)	1 (1%)	-
Asthma, Previous ICU stay	-	63 (56%)	48 (42%)	1 (1%)	1 (1%)	-
44yo, organ retrieval	2 (2%)	-	-	1 (1%)	15 (13%)	95 (84%)
78yo, Osteoarthritis. Total Hip Replacement	32 (28%)	64 (57%)	16 (14%)	-	1 (1%)	-
Depression. ECT list	29 (26%)	74 (65%)	9 (8%)	1 (1%)	-	-

Eighty nine percent of consultants would classify an otherwise ASA 1 with type II diabetes as ASA 2. The figures for obesity, heavy smoking and age over 80 were 78%, 44% and 30% respectively.

Discussion

There is inconsistency in ASA grading among Consultant Anaesthetists in Scotland. Obesity, age, heavy smoking and depression are frequently regarded as systemic diseases. There was a discrepancy in the ASA classification of a fit young patient with acute physiological disturbance, the majority considered this patient an ASA 1 but many graded the case ASA 4. The ASA classification was originally constructed to quantify systemic health prior to surgery but is perhaps considered an assessment of operative risk. ASA grade is used to guide consultants in suitability for day surgery and indirect supervision of trainees. Further clarification is required to ensure patient safety.

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Step down Analgesia in Colorectal Patients – a Prospective Audit

A. Davey, J. McCollum, L. Rhodes, C. Wright and G. Bathgate. Dept of Anaesthesia, Raigmore Hospital, Inverness, UK

Introduction

Postoperative analgesia is an important aspect of perioperative care and there is a large body of evidence on the use of regional and systemic techniques for managing immediate postoperative pain [1]. However, management of postoperative pain when primary analgesia is discontinued requires significant attention [2]. This project aimed to assess step down analgesia failure following colorectal surgery.

Methods

The audit team carried out case note review of analgesia prescription and pain scores in 30 colorectal surgical patients during November 2011. Audit standards were defined as all patients should have adequate analgesia at review following step down, and analgesia failure should be managed effectively. Analgesia failure was defined as pain score equal to or more than four (on 0-10 numerical scale).

Results

Cases included a range of laparoscopic and open surgical procedures carried out on an elective or emergency basis. Most patients, 26 (86%) had adequate analgesia at review. However, a significant proportion, 18 patients (60%) had had one or more episode of severe breakthrough pain. Of this group, the response to analgesia failure was satisfactory in only 10 patients (55%). In patients with failure of step down

analgesia there was a significant incidence of patient-chart disagreement, 11 (61%). The predominant step down prescription was that of weak opioids.

Discussion

Optimisation of post-operative analgesia after withdrawal of primary analgesia has received little attention in spite of its importance in outcomes and the current climate of enhanced recovery pathways. Analgesic regime in this audit was varied and although most patients were comfortable at review, there was a significant incidence of step down analgesia failure and subsequent unsatisfactory response. The incidence of patient-chart disagreement suggests that under detection of patients' pain may be a significant factor. Furthermore, analgesia failure may be attributable to prescription of weak opioids as step down analgesia.

References

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Introducing an Undergraduate Teaching Course in Critical Care and Perioperative Medicine

R. Junkin and H. Neill. Department of Anaesthesia, Crosshouse Hospital, Kilmarnock

Introduction

Many new medical graduates feel that they lack confidence in their ability to manage acute clinical conditions [1]. The necessity to incorporate critical care into the undergraduate curriculum is now well recognised [2]. Our aim was to increase the role of our department in undergraduate education with the introduction of an anaesthetic teaching programme developed at Ayr Hospital.

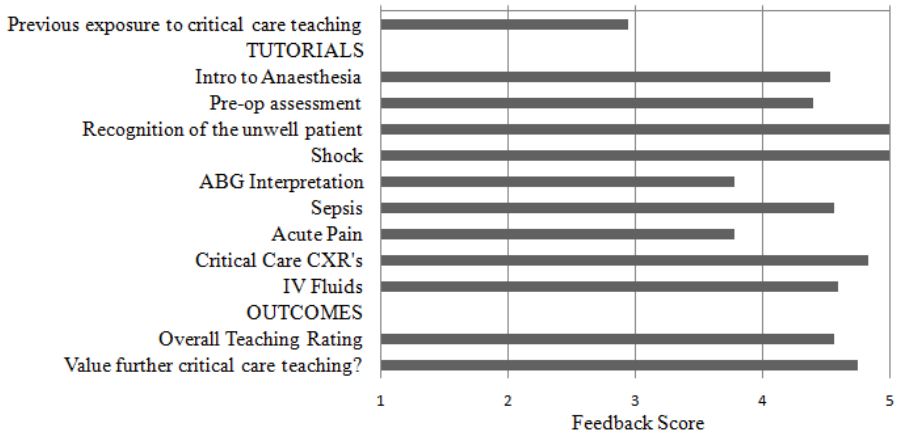
Methods

We enrolled fourth and fifth year medical students rotating to our hospital for their five week core general surgery block. We delivered two supplementary four hour sessions of anaesthetic teaching. The format was small group interactive tutorials led by an anaesthetist. We also asked the students to elect relevant topics to be covered during the second session. We moulded a curriculum based on relevant perioperative and critical care topics. We asked the students for feedback on their pre-existing knowledge and then quality of anaesthetic teaching delivered using a five-level scale.

Results

We ran the course three times to 16 medical students. Each student received eight hours of small group tutorial-based teaching led by a consultant or experienced trainee anaesthetist (≥ST3). The most commonly requested elective topics were interpretation of arterial blood gases and critical care chest x-rays. Across the board the feedback was very good for the individual topics and we also demonstrated that the students would value further teaching (see fig.1).

Fig.1 – Student feedback scores (1=poor, 3=average, 5=excellent) following teaching in anaesthesia and critical care



Discussion

Medical students value supplementary teaching in critical care. In addition, the formal sessions are a good opportunity for anaesthetic trainees to gain workplace-based assessment in medical education and for consultants to provide formal evidence of teaching for appraisal. Our plan would be to increase the number of sessions for future students and include other formats of teaching such as simulation and mannequin-based procedural skills.

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Dr Mike Tunstall

The first of an occasional series reflecting on the lives and careers of some of the "Greats" of Scottish Anaesthesia. With the editorship currently based in Aberdeen, where better to start with than with Dr Mike Tunstall (1928-2011), who spent most of his working life in the North East and contributed massively to the development of safe and effective anaesthesia.

There is a subconscious tendency, when one sets out on a career or even joins a new department, to assume that everything is as it has always been, that things were ever thus. Even those in the middle third of our anaesthetic lives might feel that we have seen only a little change in our working practices – a novel airway device here, a new volatile or muscle relaxant there, the steady expansion of monitoring into each and every physiological nook and crannie.

But of course anaesthesia made tremendous strides throughout the 20th century in terms of the quality and safety of the service we deliver, although as historians say such progress is by no means inevitable. Sometimes it takes the contribution of a single remarkable individual to lead the way forward. Mike Tunstall was such an individual, advancing anaesthetic practice in a number of ways and also helping lay some of the foundations for many of our apparently "modern" assumptions of how we should best go about our work.

His three major innovations are well known – he created Entonox, safely

premixing Oxygen and Nitrous Oxide and flying in the face of many assumptions of the time. He pioneered the Isolated Forearm Technique, providing astonishing insight into the risks of awareness during general anaesthesia for Caesarean delivery. Thirdly he publicised, for the first time, a Failed Intubation Drill.

Entonox

Why did Entonox happen? In his own words at the time Mike certainly wanted "safer and more satisfactory analgesia" for labouring women and could clearly see the benefits of portability, safety and ease of use of the gases in an a pre-mixed cylinder. However the conventional wisdom, formulated in the Nuffield Department in Oxford (where he rotated briefly during the latter part of his training), was that a pre-prepared 50:50 O2 & N2O mixture couldn't be used safely due to the risks of separation pespecially on cooling. Mike, though, persuaded the British Oxygen Company (BOC) to give him some pre-mixed research cylinders and with the assistance of a local ice cream producer in Aberdeen who stored the cylinders down to -25C and in 1963 he showed rather elegantly that even after cooling with appropriate measures the mixture was safe1.

Countless labouring women have had the benefit ever since to say nothing of innumerable fracture victims in the back of bumpy ambulances. BOC reaped the financial rewards of patent ownership - it is a telling insight that the thought of monetary gain from Entonox didn't even occur at the time - and Mike continued to experiment with gas mixtures for pain relief for the next 50 years.

Isolated Forearm

The development of the isolated forearm technique, at a time when the use of muscle relaxants was becoming more widespread, confirmed concerns about light anaesthesia and allowed the detection of inadvertent awareness. In the 1970s general anaesthesia remained the technique of choice for Caesarean Section, using techniques that most Obstetric Anaesthetists today would consider unacceptable, with low concentrations of Nitrous Oxide supplemented, possibly, by tiny fractional concentrations of volatile agent. Unsurprisingly the reported incidence of awareness was considerable.

Mike developed a technique where a BP cuff was inflated to tourniquet pressure prior to the administration of suxamethonium, and the patient asked to obey simple commands. The astonishing results, reported first in the shortest of BMJ short reports2 showed that despite the use of conventional techniques all but one woman in twelve were moving, and four in twelve were consistently obeying commands despite "anaesthesia". This landmark work led to Mike's advocacy for the use of increased concentrations of anaesthetic agent, unpopular at the time, and he went to publish further work confirming successful reductions in wakefulness using this technique.

As he also reflected, these studies were the first to hint at different levels and types of awareness, partly depending on recall, and his insights into depth of anaesthesia are the precursor of much of the modern work in this area. A further legacy of his work, at least in Aberdeen, is a habit several colleagues share of talking to and reassuring our GA section mums during the procedure, disconcerting though this may be for obstetricians, trainees and newer members of the theatre staff…

Failed Intubation

The third major Tunstall innovation was the failed intubation drill. This followed a maternal death in Aberdeen where the anaesthetist concerned had been unable

to intubate and had no alternative plan. It is very likely that it fell to Mike, as the senior man, to pick up the pieces. His attitude to trainees was one of "if you are already beating yourself up, I won't join in" and it is no surprise that out of this particular incident came the drill, a way to learn from and prevent the horror of a maternal "airway" death. Published in 1973, it is the original and direct ancestor of very many of the drills, algorithms and protocols we use today to protect our patients, and as such is possibly the most profound and long lasting of his contributions to modern anaesthesia. It is worth reprinting the original summary, presented at the OAA's Annual Scientific Meeting in Nottingham on 26th Match 1976:

"Maintain cricoid pressure, put the patient head down and on the left side (ask surgeon and sister to 'unscrub' and help), Oxygenate by I.P.P.V.; it may be difficult – try different positions and sizes of guedel airway – get someone else to squeeze the bag if necessary and aspirate pharynx as required.

If obstruction persists, try effect of releasing cricoid pressure. The patient must be in the lateral position before this is done.

If ventilation and oxygenation easy, ventilate with N_2O, O_2 and either ether or methoxyflurane and establish surgical anaesthesia with spontaneous ventilation using face mask, pass wide bore stomach tube through mouth, aspirate, instil 15 ml mag. trisil., withdraw tube and clear pharynx and level the table and place in lateral tilt position. Allow operation to proceed using inhalational anaesthesia with a face mask.

If oxygenation difficult, allow suxamethonium to wear off and let patient wake up, empty stomach, undertake and inhalational induction and continue with spontaneous inhalation anaesthesia.

Consider local or regional anaesthesia as an alternative to the above techniques."

Recognition

These three hugely significant contributions to scientific invention, technical innovation and the development of safer ways of working thus come together in a man whose achievements went relatively unrecognised until late in his career and late in his lifetime. He received the Gold Medal of the Obstetric Anaesthetists Association just prior to his retirement and a belated Honorary Degree from the University of Aberdeen in 2006. Both of these honours delighted him, but it is

reasonable to speculate that had he been less humble, and perhaps more of a "committee" man, he might have received far greater recognition and reward during his working life.

Nonetheless from his beginning in anaesthetics in the mid-50's until his "retirement" in 1992 (he was still experimenting with gas mixtures 10 years later) he had an enthusiasm for life and an enjoyment of his job which allowed him, in his own words, "the freedom and privilege of getting on with it" for half a century in the specialty.

What can we learn?

If there is a single common experience for those who trained under Dr Tunstall, it is that he was a hugely inspiring figure – a singularly powerful positive role model. It is no accident that many of those who he trained have themselves gone on to be significant figures in anaesthesia, in Aberdeen, Scotland and well beyond. Some of this effect can perhaps be captured by considering what impression he made on consultant colleagues, trainees and theatre staff.

The most consistent single word used by those asked their recollections is "kind". Kind to patients, kind to trainees, kind to anyone who he might have perceived as vulnerable. An early pioneer of a "no blame" approach when things had gone wrong his first instinct was to establish what could be learnt, understanding that those involved had likely beaten themselves up more than was necessary in any case.

He was a doctor of his time, of course, and understood that the medical professional was in charge. However his approach, as with those of his finest peers, was doctor led but never doctor centred. Indeed, the golden thread running through all of his innovation is a powerful desire to make things better for his patients. As we have seen, this was not just about equipment, clinical techniques or ways of working – rather it imbued an entire approach to clinical anaesthesia. He placed his patients at the centre of everything, and when he realised that some aspect of patient care could be improved, he took firm hold of the problem and wouldn't let go until he had worked out a better way.

Sometimes, of course, this better way did not suit everyone. Change never does. Confrontation was never his style, though, and colleagues recall a master of the art of persuasion and, if necessary, manipulation, to achieve his ends. His work often challenged perceived wisdom and this was rarely to his benefit, and perhaps sometimes to his detriment. Although he essentially invented Entonox, he was content for BOC to hold the patents and didn't seek to benefit financially from his efforts. Whereas today it is normal to lecture and dine out on achievements for years afterwards, he simply moved on to the next problem to be solved.

When his findings challenged accepted practice, for example his isolated forearm work which revealed uncomfortably high rates of awareness, he understood that despite a lack of appreciation from some at the "summit" of the profession he had to continue his research to its conclusions. Undoubtedly he realised that there is less oxygen at the summit and thinking can become muddled. In any case, spinal anaesthesia made an early return to anaesthetic practice in Aberdeen under his influence.

He is best known as a ground-breaking Obstetric Anaesthetist, but also made significant contributions to the development of Paediatric and Neonatal services in Aberdeen. Specifically, he worked with colleagues to establish one of the first Neonatal Intensive Care Units in the country, spending very many nights sleeping in the hospital in an era when

the phrase “resident consultant” would have been considered an oxymoron.

Modern Legacy

Much of the language that we use today to describe what we do to provide safe and effective care would have been gobbledygook to anaesthetists in the 60s and 70s. The basic concepts would not. Mike Tunstall and others were practising Patient Safety before it had a name, but surely the inventor of the failed intubation drill would have recognised and embraced the objectives of the movement.

We have a tendency to raise our eyebrows skywards whenever new rules and regulations attempt to further instruct us in the safe care of our patients, ourselves or our colleagues – infection control, lean process, moving and handling etc, but perhaps we can learn from a man who was building scavenging systems to protect pregnant theatre nurses at a time when few cared about such apparently minor stuff.

Trying to do things better for patients has been jargonised as Clinical Practice Improvement. Getting the kit to perform better can seem lost in Health Technology Assessments. Yet perhaps those who are immersed in these processes and buried in that jargon are simply trying to achieve, in our modern and highly constrained environment, what a man whose world sometimes seemed held together by zinc oxide tape was trying to do to. We may not always know someone in the hospital basement who can turn us a new connector on their lathe, but inasmuch as we all yearn for simpler times there is perhaps a broader lesson from the career and character of a man like Mike Tunstall.

Being Great in 2013

Reflecting on a career so rich in its contribution to patient care, it is easy to forget that many of the attributes that made Mike Tunstall an “Anaesthetic Great” are to be found in anaesthetists working today – kindness, patient-centredness, original thinking, problem solving. He also had a very modern understanding of the importance of a work-life balance, with the kind of rich hinterland of family and activities that would appeal to most us today, though it takes a particular kind of man to teach himself wind surfing in his 50s.

In a world where so much of what we do seems about survival – keep on top of the inbox, get the appraisal folder done, worry about the pension etc etc it is good for the anaesthetic soul to look up for a moment and consider that even in our vastly different world, we can, if we wish, encourage each other to keep in touch with the inner anaesthetic “great”.

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My thanks to a number of former colleagues of Mike Tunstall for their insights, particularly Dr Fiona Knox. Any errors are mine and views expressed are mine alone. Those who are interested in more details of his career can find more information on the OAA website.

GOLF REPORT by A Wee Divot

The Society's annual golf day was held in June at Newburgh-on-Ythan Golf Club in Aberdeenshire. The original 9 hole links dates from 1888 and a further nine of different character was added up on the headland in 1995. You can see there are well-placed walls, outstanding views of the Sands of Foveran and a hole with a name worthy of our Society's President ! (see below)

18 members met for a fine morning's Stableford, expertly organised by Donald Macleod. It was a good day for the clan, as Alex MacLeod proved to be a worthy winner. It was particularly good to see John Mackenzie back to his best after an episode of serious illness. The weather deteriorated somewhat in the afternoon, but the scramble format meant fun for everybody.

The Glasgow & Ayrshire lads also played on the Thursday at Cruden Bay and dined royally at the Udny Arms.

This years golf has been arranged by Alex MacLoed at Pitlochry, an alpine experience not to be missed! Hope you are able to join us. Details are on the website & back page.