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The Annals of The Scottish Society of Anaesthetists 2009



Glasgow - a hospital on
every corner



2009 Programme of events

April 17th Trainees Meeting at Peebles Hydro
April 17th-19th Annual Spring Meeting at Peebles
June 12th Annual Golf Outing at Edzell, Angus
**November 20th Annual Scientific Meeting, Centre for Health
Science, Inverness**

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

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Vice President:

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Hon. Treasurer

Kerry Litchfield, Glasgow

Editor of the Annals

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	Sue Midgely
West	Lynn Newman
	Grant Haldane

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Editorial

As editor of the Annals of the Scottish Society I strive not to dwell on West of Scotland issues. This year however Glasgow has furnished a once in a lifetime event similar to the MMC extravaganza which so delighted us last year. At a time when every other conurbation in the world is rationalising hospitals, 2009 sees Glasgow heading vigorously in the opposite direction.

Two new ACAD's (Ambulatory Care and Diagnostic Centres) will soon open in the vicinity of Stobhill Hospital and the Victoria Infirmary. Both are enormous buildings, larger than some of Scotland's smaller hospitals. The Victoria will close when the new Southern General opens in 2014, as part of a medical campus bigger than some small countries. Stobhill will close in 2010 when its acute medical receiving can be accommodated in Glasgow Royal Infirmary. GRI's renal medicine and perhaps vascular surgery will move to the Western to free up beds. The Western therefore remains operational indefinitely, as does Gartnavel where the new Beatson Oncology Centre is sited. Yorkhill/ Queen Mum's remains open until a new Children's hospital is built in 2012 as part of the new Southern medical metropolis.

The breakup of Argyll and Clyde has brought the Royal Alexandra Hospital, Paisley into the Greater Glasgow and Clyde fold, which is now responsible for 20% of Scotland's health care. The final piece in the jigsaw is the centralisation of regional cardiothoracic services in the Golden Jubilee. In essence this brings to 11 the number of hospitals in the functional unit of Greater Glasgow, although the Jubilee has its own very special health board.

Without wishing to sound too neggers, Glasgow has always had too many hospitals. Of course, when I first started thinking that (about 15 years ago), it had half the number of hospitals it does now. I have a strong memory of listening to Lawrence Peterken, the former chief executive of Greater Glasgow Health Board, in the Western Infirmary lecture theatre when he indicated that Glasgow should have a maximum of 3 hospitals. One north and one south of the Clyde was optimal, he thought. That was early in 1993. For a few months there was a real sense of impending change but by November that year he was no longer in post.

On a different tack, readers will notice some small changes in this Annals. To increase the chances of Society members being mentioned in it or contributing to it, the News from the Regions section continues its organic growth and there are more trainee abstracts included than in the past. The Peebles coverage is expanded to include most of the poster abstracts and there is a section showcasing the winning contributions from the competitions of the three main regional societies.

The big set-piece articles (Presidential Address, Gillies and Keynote lectures) continue and I welcome input from readers about the balance of these contributions and others. I hope the remainder of the year goes well for you.



President's Message



I was extremely honoured to be asked to serve as your President for 2008-09.

My predecessor, Alf Shearer, had an excellent year as President; a very hard act to follow.

I am also immensely grateful to Liz McGrady, Kerry Litchfield and Colin Runcie who have surpassed all expectation in their first year as your Office Bearers and given me such support.

Peebles last year was again a great success and the changes to the format have met with general approval, though the early start to the AGM means an early start for those delegates attending for the day. I would encourage all to come and enjoy the full weekend.

I was personally delighted to see my entire family there, including our latest addition, grandson Finlay, who managed to sleep through my Presidential Address along with a few others, I imagine.

Council is considering further changes to the format of Peebles with further integration with the Trainees meeting, which will be put to the AGM in April 2009.

Our Society has now handed over the political reins to the Royal College of Anaesthetists Advisory Board for Scotland and the Scottish Standing Committee of the AAGBI but our Society still has a role in guiding these two bodies in their advice to the Scottish Government and the Specialty. When we meet at Peebles there is a unique opportunity to hear an annual report and thoughts for the future from the Chairs of these bodies and for them to hear us. The AGM is possibly not the place to give this justice and perhaps presentations from the Chairs of the Board and Standing Committee should be incorporated into the full Saturday Programme.

I enjoyed Peebles enormously and I am grateful to all those who contributed to making it such a success. Both Howard Fee and Dermot McKeown gave excellent lectures and the trainee presentations and posters were of very high quality. Congratulations to Anoop Kumar on winning the Donald Campbell Quaich and to the winner of the Trainees' Poster Competition, Genevieve Lowe. One of my earliest Scottish Society meetings was at Aviemore in 1980 when Donald Campbell was President and his friendliness and approachability had a lasting impression on me and epitomises the strength of our Society. This friendship amongst the Society's members leads to cooperation in our large specialty, which is unique in the medical profession and ensures our status and security in times of significant change. The Society is endeavouring to engage with trainees in the specialty as it is only through them that our status and security as a consultant based specialty will be preserved.

Many thanks to Sarah Hivey and Jenny Edwards, who produced both an informative and entertaining Programme for the Trainees Day at Peebles and Council wishes to encourage more trainees in Scotland to attend. An increasing number of trainees stayed for the whole weekend and it is hoped this trend will continue.

Our Winter Scientific meeting, a joint exercise with the Royal College again this year was in Aberdeen on 20th and 21st November and I am very grateful to Andrea Harvey for her excellent organisation on behalf of our Society. The speakers were excellent and I wish to thank them all, including Brian Cowan for his Gillies Memorial Lecture, "Things that go bump in the night", which maintained the high standard of this prestigious lecture.

The future is rosy as long as we remain united. We will see a massive increase in the number of trained anaesthetists in the next few years and we must preserve our status within the hospital specialties. John Gillies fought long and hard to ensure we achieved consultant status in 1948 and we must again resist any attempt to reduce the proportion of consultants in our specialty compared to other specialties, particularly those represented by the ancient Scottish Royal Colleges.

I wish John May, President-elect and our Honorary Piper, every success in 2009. The Society promises to provide a very special Piper to pipe him in to dinner. I encourage you and yours to come and join us at Peebles for rest, recreation, friendship and a little personal development.





Presidential Address

“From his mother’s womb
untimely ripped”

John McClure 2008

Macbeth

“The Scottish Play” was written by William Shakespeare between 1603 and 1606. As a schoolboy I was fascinated by the hero of the Scottish play, MacDuff, the Thane of Fife, who was “untimely ripped” from his mother’s womb.

It is held that Shakespeare’s Scottish play was a celebration of King James’ ancestry and the Stewart dynasty, which had ruled Scotland for 300 years. In 1603 King James VI of Scotland had

been crowned King James I of England, joining the crowns of Scotland and England after many years of conflict.

300 years previously Robert the Bruce had been crowned King of Scotland, the year after Wallace was executed and the Bruce reigned between 1306 and 1329. In 1314 Robert the Bruce sent Edward II homeward “tae think again” after the Battle of Bannockburn.

*“Double, double toil
and trouble”*

*“Fire burn, and
cauldron bubble.”*

“beware Macduff”



The three witches

*“none of woman born shall
harm Macbeth”*

*“never vanquish’d be until
Great Birnam Wood to
high Dunsinane Hill shall
come against him”.*



Robert the Bruce 1303



Princess Marjory 1316

The Battle of Bannockburn and the post-mortem operation, Caesarean section.

The Bruce's first child Marjory was not yet 18 at the time of the Battle of Bannockburn. One of the heroes of the Battle was her second cousin, Walter Stewart, the 6th Lord High Steward, four years her senior, whom she married in 1315.

Princess Marjory was reputed to be beautiful, a keen horsewoman and after her marriage to Walter Stewart she quickly became pregnant.

Whether through rashness, fearlessness or igno-

rance of the possible consequences, Princess Marjory went out riding between Paisley and Renfrew to the North, while heavily pregnant. The year was 1316.

Her horse, taking fright at something, reared up, and Marjory was thrown violently to the ground and dislocated her neck. She fell at the roadside in an area known as "the Knock", one mile north of Paisley Abbey at the junction of Dundonald Rd and Renfrew Rd, Paisley.



This "Cairn" marks the site



Near this spot, the Princess Marjory Bruce was fatally injured by falling from her horse. Her son, born posthumously, became Robert the Second, First of the Stewart Kings of Scotland



Robert II of Scotland (King Blearie)

As she was heavily pregnant with Walter's child and no skilled person was at hand, a country fellow boldly acted as surgeon. He succeeded in delivering the baby by Caesarean operation. During the operation, the baby boy's left eye was badly cut. This scar, in later life, gave the child Robert the nickname "Blearie eye".

When he later became the first Stewart King of Scots, as Robert II, he was dubbed "King Blearie". Princess Marjory had what is now known as a post-mortem Caesarean section and was buried in Paisley Abbey.

Robert II (1316-1390) reigned between 1371 and 1390 after the death of David, son of Robert the Bruce. He was the first Stewart king and the Royal House of Stewart ruled Scotland for the next 300 years.

In 1603 when the Scottish and English crowns were united under King James VI of Scotland (James I of England), Shakespeare writes the Scottish play with Macduff based on the legend of Robert II.

Caesarean section was only ever performed post-mortem in the interest of the unborn child in these early days.

Surgery and midwifery

Surgery and midwifery have always been uneasy bed-fellows. The art of surgery was a male preserve and was reserved for the dead or dying. Midwifery was a female preserve and was for the living, bringing new life into the world.

Genesis 2: Verses 21-22 refers to Anaesthesia & Surgery:

"And the Lord God caused a deep sleep to fall upon Adam, and he slept and he took one of his ribs, and closed up the flesh instead thereof. And the rib, which the Lord God had taken from man, made He a woman, and brought her unto the man".



Genesis 35: Verses 16-18 refers to Midwifery:

"And Rachel began to give birth, and had it hard in her childbearing.

And so it was, as she had a very hard time in her childbearing that the midwife was saying to her, "Don't be afraid, because this one also is a son for you."

As her soul departed - for she died - she named her son Ben-Oni. But his father named him Benjamin".

In the early 17th century the management of childbirth was firmly in the domain of untrained midwives (Shakespeare's era) but the "Tectonic plates" of the medical profession and midwifery were to begin to shift.

The "Accoucheurs"

Responsibilities evolved and the beginning of Obstetrics was heralded by the arrival of the "Accoucheurs". The first accoucheurs in England were a secretive family of French Huguenot refugees, the Chamberlens.

Peter Chamberlen was surgeon to the Queen and delivered the wives of James VI (I) and Charles I. The family guarded the secretive use of forceps for a century as delivery was performed under a sheet. Caesarean section was still reserved for cases of maternal demise.

In the 18th century the era of the Man-midwife arrives.

The Scottish doctor, William Smellie (1697-1763) has a profound impact on the practice of midwifery. He was born in Lanark and studied at Glasgow University. In 1752 he wrote "Treatise on the Theory and Practice of Midwifery" and was considered the "Master" of British midwifery. He added the pelvic curve to the Chamberlen forceps.

There was serious professional rivalry between him and the midwives. He was a man of humanity and common sense but was: "sadly lacking in the social graces and a poor conversationalist".

He says of midwives: "A midwife ought to void all reflections upon men practitioners; and when she finds herself difficulted, candidly have recourse to their assistance;...this confidence ought to be encouraged by the man, who, when called, instead of openly condemning her method of practice, (even though it should be erroneous) ought to make allowance for the weakness of the sex, and rectify what is amiss, without exposing her mistakes."

The William Smellie Memorial Hospital, which provided maternity services in Lanark closed in the early 1990s and was re-located to a unit at the Law Hospital in Carlisle. This was also closed re-



A Man Mid-wife



William Smellie

cently and maternity services moved to Wishaw General Hospital.

William Hunter (1718 –1783) went to London to join Smellie, who was 21 years his senior. Hunter was another Scot, who graduated from Glasgow University and then studied in Edinburgh. He was born in East Kilbride, the elder brother of John Hunter.

He was trained as an Anatomist and Physician but specialised in obstetrics. Hunter knew about forceps but he took pride in using them rarely and commented that his had rust on them.

He praised the virtues of conservative management. Nevertheless he was one of the first obstetricians to enter the field of normal labour, which had hitherto been the prerogative of female midwives, and this led inevitably to tension.

Hunter was made consultant to Queen Charlotte at the age of 44 and at 50 he was elected to the Royal Society. He was one of the new breed of 'male midwives' and attended Queen Charlotte, wife of George III, at the birth of her children.

When Queen Charlotte was delivered in 1762 of the future King George IV, the midwife, Mrs Draper, was inside the room and Hunter was kept outside in case of emergencies. Eventually he persuaded the Queen to be rid of Mrs Draper so that he himself could conduct the delivery.

George III and Queen Charlotte had 15 children, 13 of whom survived to adulthood. George III was pronounced insane, possibly secondary to porphyria in 1810 - they had been married for nearly 50 year. Queen Charlotte was the grandmother of Queen Victoria.

Queen Charlotte's Maternity Hospital, London has been in existence since 1739, making it the oldest maternity hospital in the United Kingdom. It was Queen Charlotte's son, the Duke of Sussex, who persuaded her to give her name to the hospital, which was a charitable institution at the time.

Caesarean section

The derivation of Caesarean section is often credited to Julius Caesar but he was not born by Caesarean section. His mother, Aurelia, had further children and she outlived him. Its origin is more likely to be from "Lex Caesare", the law of the Emperor; "if a woman dies when pregnant, her baby was to be delivered." Caedere is Latin "to cut".

The first "Caesarean" in which the mother survived is said to have happened in 1500 in Switzerland. Jacob Nufer, a pig gelder performed a Caesarean section on his wife after a prolonged labour. She is said to have had subsequent normal vaginal deliveries (vaginal birth after caesarean, VBAC) but many believe she had an extra-uterine pregnancy.



The first Caesareans with maternal survival in the British Isles were in the 18th century:

- Ireland 1738: Mary Donally
- England 1793: James Barlow

They were usually combined with hysterectomy.

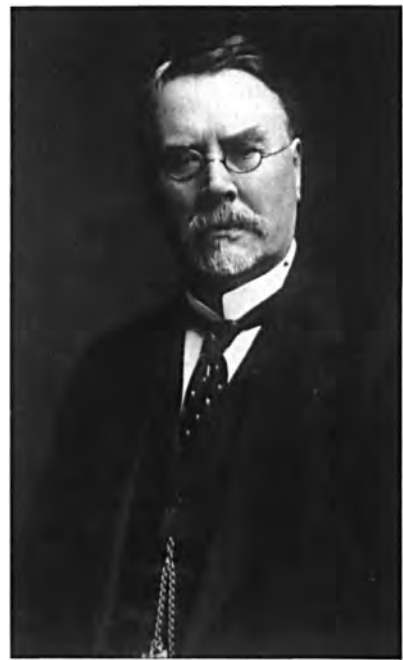
There were then major developments in the 19th century:

- ◆ Knowledge of anatomy: Robert Knox in 1826 ran a private anatomy school in Surgeon's Square, Edinburgh. He was to be supplied with bodies by Burke and Hare, the "Body snatchers".
- ◆ Anaesthesia: Morton's discovery of ether anaesthesia in 1846 led to James Young Simpson's discovery of chloroform anaesthesia at 52 Queen Street, Edinburgh on 4th November 1847. There is no record of Simpson, who was Professor of Midwifery at Edinburgh University, having ever performed a Caesarean section.
- ◆ Antisepsis: Semmelweis 1861, Lister 1867
- ◆ Uterine suturing: Sänger 1882.

In 1876, Eduardo Porro reported the first Caesarean hysterectomy in which both infant and mother survived. The mother was Julia Cavillini, a 25-year-old primigravid rachitic dwarf. This Italian success was followed by widespread publicity throughout the world

In Glasgow in the late 1880's rickets was endemic resulting in poor pelvic capacity and obstructed labours. Such labours resulted in dead babies and damaged or dead mothers. The developments between 1826 and 1882 gave Murdoch Cameron (1847-1930) the opportunity to consider Caesarean section as a delivery option.

The first Caesarean section at Glasgow Royal Maternity Hospital was performed by Cameron in 1888. In an improvised operating theatre crowded with doctors and undergraduates Murdoch Cameron carried out the first Caesarean section under modern antiseptic conditions. The mother, Catherine Colquhoun, was a rachitic dwarf incapable of natural birth.



Murdoch Cameron

"Do it yourself" Caesarean section

A Mexican woman, Inés Ramírez Pérez, born in 1960 is reputed to have performed a successful Caesarean section on herself on 5th March 2000. Her case was written up in the International Journal of Obstetrics and Gynecology (March 2004).

She assumed the traditional Zapotec birthing position, sitting up and leaning forward. She then used a large kitchen knife to cut open her abdomen in a total of three attempts. She severed the umbilical cord with a pair of scissors and became unconscious.

When she regained consciousness, she wrapped clothes around her bleeding abdomen and asked her 6-year-old son, Benito, to run for help.

Caesarean section in the present day

"Too many or too few"

The obstetricians' view is: "Damned if we do and damned if we don't".

There are major medico legal issues involving Caesarean section. In 2000, outstanding claims against the NHS were £3.9 billion with 70% of funds expended related to obstetrics and gynaecology - 80% for delay or failure to perform a caesarean section and 20% for complications.

The major risk of Caesarean section is major obstetric haemorrhage. It is no longer anaesthesia. Are we victims of our own success?

The risk of a first Caesarean section is negligible but what about the following one?

The prevalence of major haemorrhage in 2005 in Scotland is 4.4 per 1,000; the majority have had a previous Caesarean section. The prevalence of placenta accreta is rising in proportion to the rise in caesarean section rate.

Today Caesarean section is often performed to prevent intrapartum asphyxia. The substantial and steady fall in the rate of neonatal asphyxia-related mortality and morbidity suggests that a significant proportion of cases of intrapartum asphyxia may be prevented by early Caesarean section.

We therefore have a conflict of interest between mother and baby.

The schoolboy fascination with the hero MacDuff, Thane of Fife

My mother was a State Registered nurse and qualified midwife in Belfast during the Second World War. Then, over 50% of deliveries were at home and she used her bicycle to travel the streets of Belfast practicing her profession. Caesarean section rates were 2 to 3%.

My father served in the Royal Navy on a Hunt class Destroyer in the Mediterranean and after the war he was demobbed with an ill-fitting suit and tuberculosis. After a long time in a sanatorium and the miracle of streptomycin they married in 1947. In those days marriage meant that my mother had to stop work.

Two years later they were expecting their first child, me.



A summary of my mother's maternity record would read:

- Johnston House, Royal Maternity Hospital, Belfast
- 5' 2", Size 4 shoes
- SRM, 2 weeks premature
- Labour
- Failure to progress/ fetal distress
- Caesarean section

In 1949 after delivery in hospital, women remained in bed for 12 days and were then allowed up to toilet etc. for two days before discharge.

She had a general anaesthetic, details unknown but probably not intubated. Thiopentone, cyclopropane, nitrous oxide and trilene were available. Curare was also available but was unlikely to be used. There was no suxamethonium, no halothane and no syntocinon but ergometrine was available.

Spinal anaesthesia was used for Caesarean section in some centres but was controversial.

Hence, my fascination with MacDuff. Perhaps this also sparked my interest in medicine and obstetric anaesthesia.

There were other influences, of course. Those who teach you have a major impact on your life. Miss Jean Brodie in her prime quite rightly held: "Give me a girl at an impressionable age, and she is mine for life!"

There are many in this Society to whom I owe a great deal and there are four I would wish to acknowledge:

Keith Dodd, Consultant Anaesthetist to the Southern Group of Hospitals, Edinburgh.

Bruce Scott, Jimmy Wilson and Tony Wildsmith of the Royal Infirmary, Edinburgh and the Simpson Memorial Maternity Pavilion.

In conclusion Caesarean section has had a role in the destiny of Scotland and also in mine.

"When you hear the call to attend, without delay, for a 'stat' (category 1) Caesarean section think of the mother and babe who depend on your competence and skill."

Travelling Fellowships



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



Keynote lecture

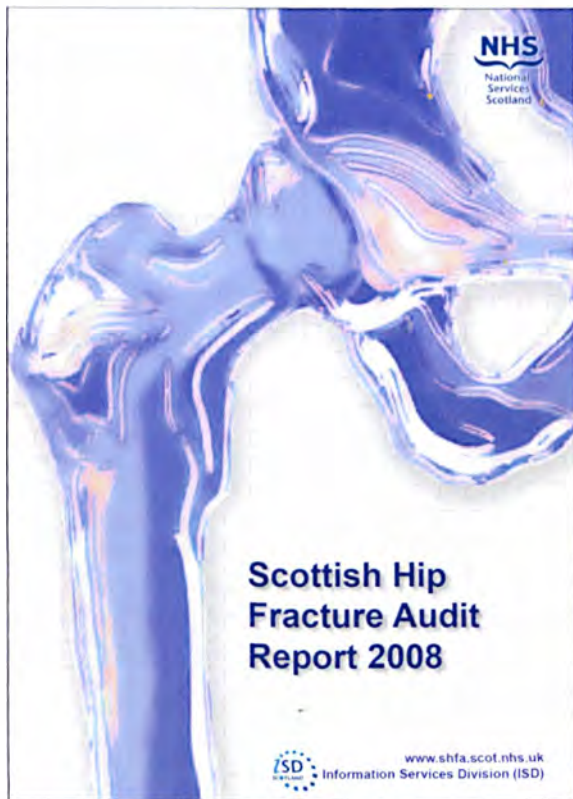
It is not necessary to change.

Dermot McKeown, Consultant in Anaesthesia and Intensive Care, Royal Infirmary of Edinburgh



It was indeed an honour to be asked to give the Keynote Lecture at the Annual General Meeting. Like many of those present, I had enjoyed this meeting, both socially and scientifically, over a period of enormous changes in medicine and our

specialty. My lecture reflected on aspects of change - but before summarising those thoughts, I would wish to sincerely thank all those more senior members of the society who have been influential throughout my anaesthesia career, and those more junior members who keep me on my toes!



I chose to consider some aspects of the management of patients with hip fractures. It is notable that several members of the SSA have made significant contributions to the literature [1-3] on hip fracture anaesthesia and general management from the early 1970s - yet there are many problems that remain. I hoped to discuss how good national data helps us understand variance in management of patients in Scotland and the UK, and whether we should, or could, take steps to reduce that variance.

Hip Fracture Audit

We are fortunate in Scotland to have the Scottish Hip Fracture Audit (SHFA)[4] which started in 1993 in four hospitals. It is a multidisciplinary audit, with anaesthesia representation from that original time.

Hospitals have joined and left the audit at various times, depending on funding, but with a gradually increasing proportion of patients being studied. Recent Governmental interest in the management

of this vulnerable group of patients resulted in extra funding, allowing 100% cover of all Scottish orthopaedic units from March 2007. The extra funding was used to ensure short turnaround 'real-time' information on hospital performance was made available to Trusts, to facilitate their management of a Government 'Target'.

Hip Fracture

Hip Fractures following falls in the elderly are a major cause of morbidity, and associated with a high hospital mortality. There are approximately 80,000 per year in the UK, with an estimated cost of £1 billion per year [5]. It is well recognised that this group have a high incidence of medical comorbidity, and that more comorbidities are associated with higher mortalities in all time epochs following surgery. It would be hoped that expert anaesthetic and perioperative care could go some way to reducing that mortality.

Delaying surgery to optimise preoperative status is an entirely appropriate response for elective surgery, and has been contributory to reduced perioperative mortality in elective surgery. This is particularly obvious to those of us who are involved in anaesthesia for elective joint replacement surgery. In emergency surgery, however, a balance frequently is necessary. Some conditions are associated with high perioperative mortality, and can be rapidly and effectively treated, but others may not be effectively treatable, and delay for investigation or attempted therapy might even add to development of other complications.

Does delay matter?

There are many publications on the association between delayed surgery and perioperative death [6,7]. Suffice to say that no unequivocal link has been demonstrated between delayed surgery and increased mortality, but non-medical delay is associated with less organised care, longer hospital stays, and increased 'minor' complications. There are several centres where hip fracture patients are allocated a high priority for early surgical treatment, yet that is by no means universal.

Does type of anaesthesia matter?

Enthusiastic proponents of regional anaesthesia can point to improved analgesia, and slightly reduced rates of pulmonary embolism and confusion, but the best evidence suggests [8,9] that there are no substantial differences between general and regional anaesthesia for fractured hip surgery. This is confirmed from our Scottish data, which shows no real differences, although in the very elderly ASA III patient there seems to be a slight improved survival in patients who received general anaesthesia - we will investigate this association, although of course no causation can be implied.

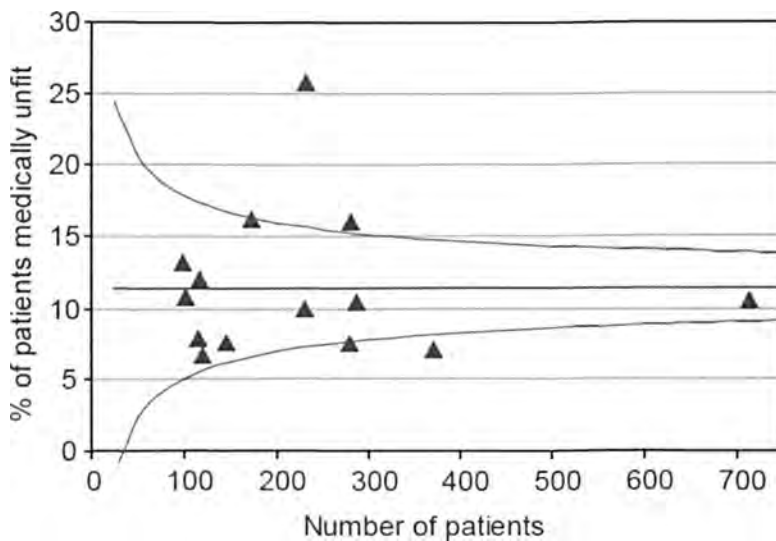
Anaesthesia type may be less important than integration of assessment, operation and postoperative care into a team care pathway.[10]

Statistical Process Control and Targets

The integration of quality control procedures, increased production, and efficiency in industry was pioneered during the Second World War. One individual whose name is inextricably linked with this was W Edwards Deming (1900-1993), a statistician, physicist and engineer who was involved in setting American war standards for production of armaments and munitions among other resources. I suspect there is a certain concentration of mind on quality control and safety if you are making high explosives.

He collaborated with others like Shewart to produce graphical ways of expressing data to show variance in both quantities and qualities of production. 'Run charts' and 'Funnel Plots' will be familiar to those who peruse the SHFA, SASM and SICS reports. [11]

A Scottish Governmental target was proposed for Hip Fracture specifying that all hip fracture patients should undergo surgery in the first 24 hours. Fortunately they discussed this proposal with a Delivery Team, who suggested that it would be more sensible to specify 24 safe hours operating (avoiding operating through the night and returning patients to less well staffed wards and recovery).



2006 Data showing proportion of patients delayed as 'unfit'

ery areas) and 'medically fit' for operation.

'Fitness for Anaesthesia?'

We are well aware that fitness for anaesthesia is not the problem - it is whether patients are fit for anaesthesia, surgery, recovery and rehabilitation. When we reviewed the timing of operation for patients throughout Scotland, it was evident that there were differences in practice, with rates of delay for medical reasons varying from 10-40% at first assessment.

There were clearly major variations in how different units manage their patients, that may in some cases be related to casemix, but on applying the sort of casemix adjustment for postcode and local health issues, there still seemed to be variance.

We undertook, with the assistance of many trauma orthopaedic anaesthetists throughout Scotland, an audit of findings in those patients whose surgery was postponed. It is difficult to find consensus on reasons for cancellation, so we collected data that allowed us to look at conditions which were shown retrospectively to be associated with complications following hip fracture surgery [12].

We discovered that common reasons for delay included:

- ◆ Lack of previous notes or investigations
- ◆ Uncorrected coagulation disturbances
- ◆ Pending cardiac investigations
- ◆ Abnormal investigations
- ◆ Concurrent medical conditions, particularly cardiac

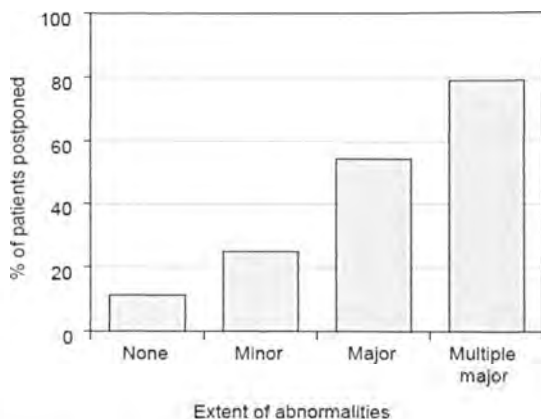
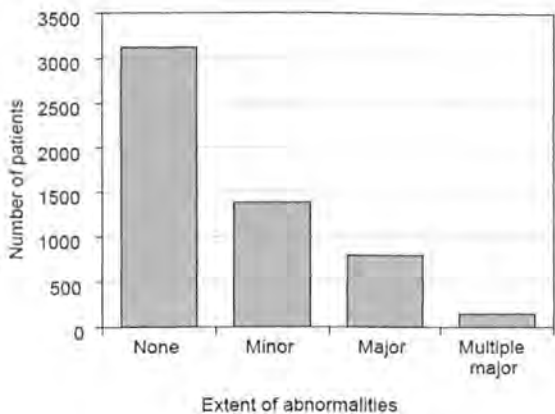
More major, and combinations of abnormalities were more likely to be associated with delay.

There were significant variations between hospitals on rates of initial delay, and use of additional investigations (such as variation of 0-15% for rate of echocardiographic assessment). This has again prompted review of practice.

The report "Clinical Decision Making: Is the patient Fit for Theatre" is available for download from the SHFA site.

Response to the Target

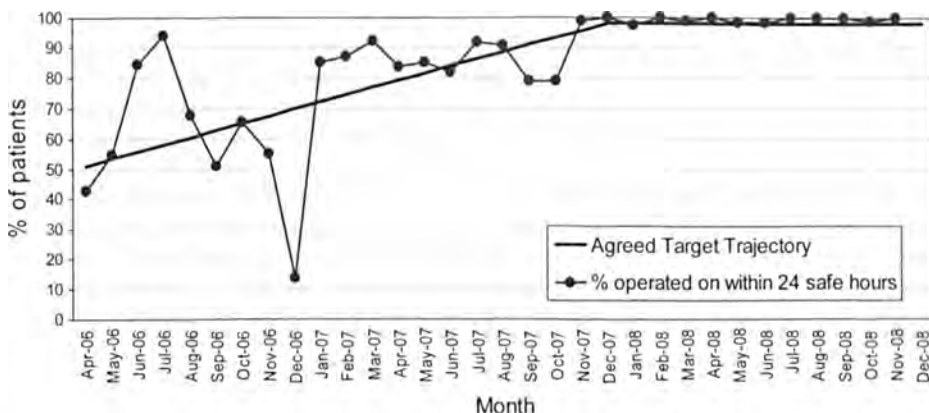
The views of the medical profession to 'top-down' target-driven control of activity are varied. Introduction of targets without adequate resource, or without consideration as to whether they are clinically relevant, provokes understandable resistance.



Extent of major/minor abnormalities and % patients delayed.

This target was modified to be clinically relevant following consultation with clinicians, and some resources were made available during the period of implementation. Many units critically re-evaluated their management of hip fracture patients during this period, and the target has been

broadly achieved. Speaking from the largest unit, which also had the largest problem, I'm glad to say that it has helped us get these vulnerable patients to theatre sooner, and to increase their profile in the hospital. Previously it is fair to say that their priority was lower than it should have been.



Excludes patients delayed by more than 24 safe operating hours who were recorded as medically unfit. Time is calculated from time of admission to orthopaedic ward (or time of departure from ED if time of admission to orthopaedic ward was unknown). If the patient was sent to theatre from a non-orthopaedic ward, time is calculated from the first orthopaedic consultation.

In 2007 88% of eligible RIE patients were operated on within 24 safe operating hours (n=812), compared to a national average of 95% in SHFA participating hospitals.

Conclusions:

- ◆ Hip fracture is a growing problem for orthopaedic surgery and anaesthesia
- ◆ There is considerable variance in our management of these patients which does not seem to be adequately explained by casemix
- ◆ We have an excellent audit system, with good anaesthesia input, of our management of these patients
- ◆ Introduction of a clinically relevant target, with commitment from all specialties and Trust management produced significant improvements. Real-time data displayed in understandable form assisted this considerably
- ◆ Nationally, waiting time to theatre was reduced for medically fit patients, with no adverse increase in waiting time for unfit patients
- ◆ There was no rise in definition of patients as unfit, or increase in mortality.

The data we have has prompted further investigation and change in practice. I believe that we have demonstrated as a specialty cohesion and willingness to co-operate, and hope that we can reach similar agreement nationally on

other topics. The Society and its members can be proud of this achievement, and should look forward to the next challenge!

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You can help!!

All out-of-date equipment that would usually be disposed of can be used in Malawi. Please collect out of date equipment from your theatres and ICU. These can be shipped out through a secure link from Glasgow city council. For further information please contact me.

If you are interested in teaching on a short refresher course any time in the future please contact me at your earliest convenience
c.connolly@doctors.org.uk.



Regional Society Prizewinners

This section showcases the winning trainee submissions for the research competitions of Scotland's 3 main regional societies. First is the submission which won the Nick Gordon Medal presented by the Edinburgh and East of Scotland Society of Anaesthetists.

Transversus Abdominis Plane (TAP) Blocks

Dr Adam M Paul SpR SESSA / Provisional Fellow, Middlemore Hospital, Auckland

Over a 4-month period we audited ultrasound (US) guided TAP blocks versus standard techniques for postoperative analgesia in elective caesarean sections (LSCS). Work was carried out at Middlemore Hospital, Auckland, NZ between August and November 2007.

What are TAP blocks?

The abdominal wall is innervated by the anterior divisions of spinal segmental nerves. These nerves run in the plane deep to internal oblique and superficial to transversus abdominis known as the transversus abdominis plane (TAP). One should remember that a lateral branch comes off the seg-

mental nerves just anterior to the mid axillary line. These spinal segmental nerves can be blocked by infiltrating this plane. It is worth noting that unlike most regional techniques the goal is not to locate a specific nerve but to locate the correct plane. This technique will provide abdominal wall analgesia from T8 to symphysis pubis (1).

The correct plane can be visualised using an ultrasound machine. The needle can be visualised entering the plane and the local anaesthetic can be visualised in real time being delivered to the correct plane.

What was happening prior to TAP blocks?

Standard practice for elective LSCS was CSE with postoperative pethidine PCEA - 15mg with 20-minute lockout. Postoperatively patients usually were discharged to a postnatal centre (on a separate site) once the epidural was down.

One of the main drivers for looking at TAP blocks in this patient group was the potential to avoid using epidurals for elective / scheduled LSCS. Standard practice was to discharge the patients after 24 hours to a postnatal care centre. This would be delayed if the epidural was still in situ. The epidural may still be in situ because of administration of dexane.

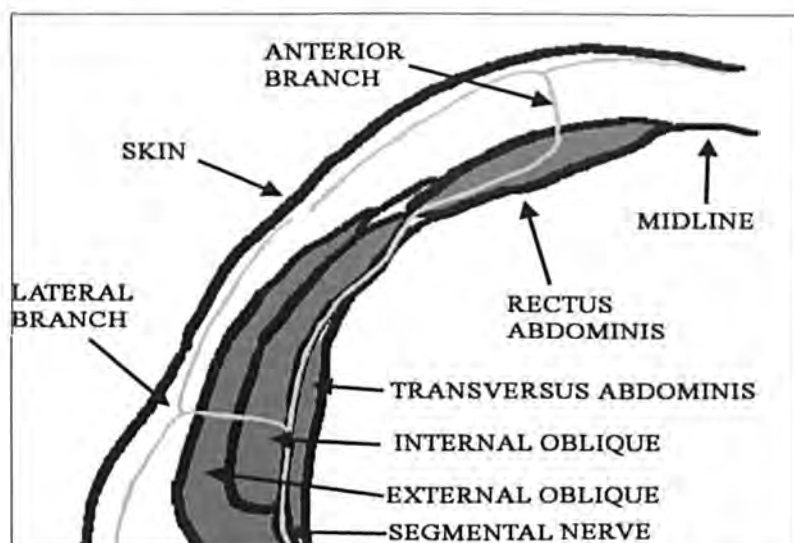


Figure 1: Innervation of the anterior abdominal wall, demonstrating anterior and lateral division of the segmental nerves. Courtesy of Dr Peter Hebbard, Melbourne

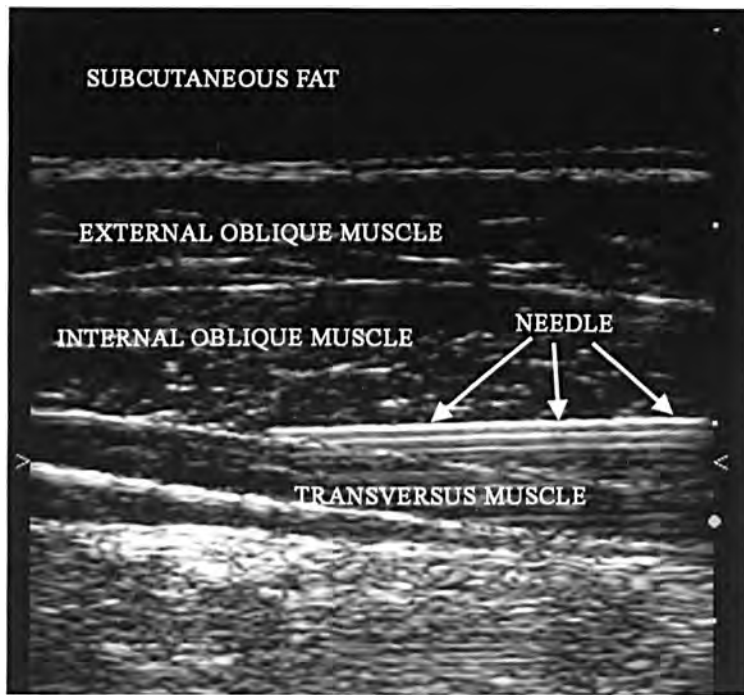


Figure 2: In plane ultrasound demonstrating needle placement between internal oblique and transversus muscles. Probe has been placed on lateral aspect of abdomen between inferior rib and iliac crest. Skin is at the top of this sonogram.

Intrathecal morphine was the alternative to placing epidurals but anaesthetists had been put off by respiratory depression on a couple of occasions.

What did we do?

24 LSCS patients having TAP block were followed and compared with an equivalent non-TAP group. All patients signed written anaesthetic consent forms as per New Zealand Medical Council guidelines. Ethics approval was not required as this technique was recognised and this was an audit of clinical practice.

The patients were assigned, by day of procedure, to a TAP (n=24) and non-TAP (n=26) group. Three anaesthetists performed the TAP block procedures. The anaesthetic technique was decided by the anaesthetist on the list.

Standard precautions were employed for all procedures. All procedures were carried out at the end of the case in theatre with full monitoring still in place. Using a Sonosite Micro MAXX, bilateral TAP blocks were placed in the TAP group. Patients weighing 50-70kg had 15mls 0.375% ropivacaine to each side. Those weighing 70-100 kgs had 20 mls 0.375% ropivacaine to each side

and greater than 100kg had 25mls 0.375% ropivacaine to each side. The weights were booking weights. All blocks had 1:200,000 adrenaline. Of note, one patient weighing 160kgs at booking had 30mls 0.375% ropivacaine to each side after a spinal anaesthetic as no epidural could be placed and with a BMI greater than 50 it was felt intrathecal morphine was contraindicated.

Patients did not receive long acting intrathecal or epidural opioids in theatre. Breakthrough morphine PCA was prescribed to all patients in the spinal group and pethidine PCEA was prescribed to the epidural group.

No TAP block complications were reported at the time of administration or thereafter. All patients were followed up at 24 hours using the data collection sheet we designed.

Results

All bar one patient were satisfied with the TAP block experience with an average score of 9.08 out of 10. There was a significant reduction in pethidine usage in the epidural group with a TAP block (Graph 1).

Despite a reduction in pethidine usage we did not find the same reduction in PCA morphine usage. There was no significant reduction between the 2 groups at 24 hours. Overall there was no significant difference in VAS for pain. There was also no significant difference in post-operative nausea and vomiting in the first 24 hours.

Discussion

It seemed initially confusing that there was such a significant change in the PCEA pethidine groups but not in the PCA morphine groups. Whilst we cannot explain this fully, it did become apparent that the vast majority of the TAP group had good analgesia and blocks immediately afterwards. However as the blocks wore off between 8 and 12 hrs there was a sudden increase in PCA usage. We feel a study looking at VAS for pain at 1, 6, 12 and 24 hours may be of use in determining this and having a regime for loading the patients with oral analgesia to stop the block switch-off problems. However we concede that this does not explain why it should be so different between the PCA and PCEA groups.

TAP blocks have yet to change practice within the department for obstetric anaesthesia. However I have had a series of general surgical patients who have benefited enormously from this technique. These include patients who were not fit for epidural, epidural failure, surgery more extensive than

planned for and severe pain after epidural removed at 3-5 days. It may therefore be more useful as a "rescue" technique.

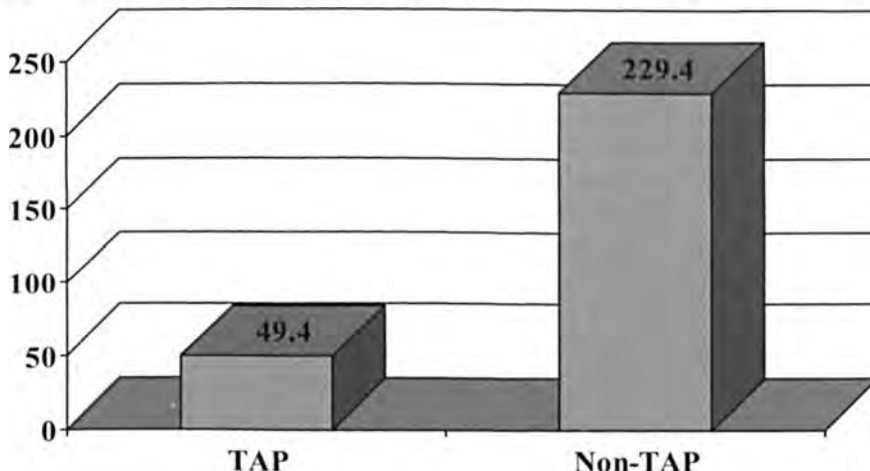
Certainly with the move away from epidural anaesthesia in Australia towards multi-modal analgesia this technique may prove a useful weapon in our armamentarium (2). In the UK, where epidurals still remain in favour, there is still a significant group of patients who cannot have an epidural for a number of reasons. Again TAP blocks would be useful here. In obstetrics, GA LSCS would also be an indication for US guided TAP blocks as the LA can be seen entering the correct space.

We have moved towards the next logical step, which is catheter insertion under US guidance. I feel that this again would improve the analgesia provided for those who cannot have an epidural.

Conclusion

US guided TAP blocks provide a safe adjunct to providing well-balanced analgesia for abdominal surgery. Whilst their routine use in elective LSCS has not been proved, there is increasing evidence for its use as a rescue technique when axial techniques have not been possible or have failed. This is likely to become more prevalent as US machines become more widely available, anaesthetist become more skilled in their use and catheter techniques take over from single shot approaches.

Graph 1. Average PCEA pethidine usage (mg) in the first 24 hours post elective LSCS.



Thanks to Dr Matt Taylor and Dr Craig Birch with whom the work was undertaken. Thanks to Dr Peter Hebbard, Melbourne for his advice and use of the pictures herein.

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Appendix A

Reply to letter in February 2008 *Anaesthesia* by Walter et al.

Walter et al describe the use of ultrasound for transversus abdominis plane (TAP) blocks. We have found that inserting catheters into the TAP is useful for prolongation of analgesia.

We also use ultrasound to assist correct needle and catheter placement. With the patient supine we place the ultrasound probe midway between the superior iliac spine and the subcostal margin in the mid axillary line. Three muscle layers are clearly visualised, namely external oblique, internal oblique and transversus abdominis. As one moves the probe posteriorly the posterior border of external oblique can be visualised. The 18G epidural Tuohy needle is inserted at the anterior end of the probe, in plane with the probe and thus visualised at all times. The needle tip is directed into the TAP, which is deep to the internal oblique muscle and superficial to transversus abdominis muscle. Local anaesthetic (20ml of 0.375% ropivacaine) is then injected which results in a "lensing" effect of the TAP on ultrasound. The catheter is threaded so that the tip extends 1-2 cm beyond the tip of the needle. The catheter position can be confirmed using ultrasound by visualising injection of a further 1 ml of local anaesthetic or saline. We then top up

the catheters every 8 to 12 hours or as required with 20 ml of dilute local anaesthetic solution into each catheter, e.g. ropivacaine 0.375%. Alternatively one could run an infusion of local anaesthetic solution.

This technique is especially useful for patients who have had surgery involving the lower abdominal wall, eg total abdominal hysterectomy. The catheters placed as described do not provide analgesia for the upper margins of the abdomen above the T8 dermatome. We have used catheters to rescue failed epidurals, or when an epidural is contraindicated. The TAP catheter provides good analgesia but does not provide the same degree of analgesia as an epidural as it does not block abdominal viscera. It does not cause the haemodynamic disturbance associated with an epidural. It offers a safe and effective means of providing continuous local anaesthesia to the anterior abdominal wall.

Next is the winner of the North East of Scotland Society of Anaesthetists Trainee Research prize.

Audit of Epidural Requests at Aberdeen Maternity Hospital

Dr E. Whyte & Dr M.A. Cruickshank.

Introduction

Aberdeen Maternity Hospital has a relatively low epidural rate (19.7%) compared with the rest of Britain (24%). Many reasons have been proposed for this including a stoic local population and a high rate of 'late' requests. However, alternative factors may be poor antenatal information and service provision. If either of the latter factors play a part then a proportion of women who would potentially benefit from epidural analgesia in labour are denied it.

Aims

This audit aimed to 1) quantify the proportions of labouring women who requested epidural analgesia and who received it, 2) to identify any reasons for the service being denied and 3) to identify the

factors involved in the decision made by the women who did not request epidural analgesia.

Results

65 women were surveyed on the postnatal wards. 37% had requested an epidural during labour but 33% of these requests had been denied. The most commonly given reasons for denial were that labour had progressed too far and that an anaesthetist was not available. 38% of the women surveyed felt they had inadequate information antenatally to make an informed decision regarding epidural analgesia during labour. The most commonly stated reasons for not requesting an epidural in labour were that it was felt unnecessary, the woman had a dislike of needles or a wish to avoid any 'numbness'.

Discussion

If epidurals are the gold standard for labour analgesia, we should be working to narrow the disparity between the number of epidurals requested and the number provided. The problems of distributing antenatal information regarding epidural analgesia must also be addressed.

Finally please find the winner of the Annual Research Competition held jointly by the Glasgow and West of Scotland Society of Anaesthetists and the Glasgow Anaesthetic Research Club.

Pre-operative dynamic cardiopulmonary exercise (CPX) testing in populations undergoing upper gastrointestinal surgery. A prospective cohort study.

Dr J Edwards, Dr R Carter, Mr R Carter, Mr M Forshaw, Prof. JK Kinsella, GRI

Comparison of post operative mortality figures are often compromised by differences in the background co-morbidity within populations. Standard tests for the preoperative evaluation of patients prior to surgery are poor at predicting actual risk. Objective preoperative cardiopulmonary exercise

testing (CPX) has been shown to provide an indication of individual risk. CPX has also been used to identify patients at high risk (with an anaerobic threshold <11ml/min/kg) who may benefit from enhanced postoperative monitoring in a critical care setting. Functional capacity can also be expressed as metabolic equivalents (METs). The aim of this study was to evaluate the use of formal pre-operative CPX assessment in a tertiary referral pancreatico-biliary and oesophago-gastric centre.

Methods:

Over a 6 months period, patients were recruited for formal preoperative CPX if they had a clinical diagnosis of pancreatic, biliary, oesophageal or gastric neoplasia deemed suitable for resection on clinical and radiological staging, were available on the testing days (2 days per week), and gave written formal consent. Oesophagectomy patients underwent CPX 4 weeks after completion of neoadjuvant chemotherapy.

Results:

35/39 patients recruited completed a pre-operative CPX. Median age 62 years (19-75); 21 male, 14 female. AT was unable to be measured in 4 patients; one due to significant ischaemic ECG changes and three due to abnormal breathing patterns. Median AT was 9.0 (5.0-14.3), 26 patients had AT<11 and 5 patients had AT>11. Functional capacity, as measure by peak VO₂ and converted into METs, gave median of 4.4 [2.1-7.5]; those with good functional capacity n=23 (MET>4) and those with poor functional capacity n=12 (MET<4). One patient was turned down for surgery on the basis of further cardiac evaluation. One patient had an elective post-operative admission to ITU, Thirty day mortality was 1/35, in-hospital mortality was 2/35.

Conclusion:

AT and MET scoring indicates a high level of background morbidity with associated high risk of perioperative morbidity in our population. If suggested guidelines were followed, >80% of patients should receive elective ITU admission. Given that current in-hospital mortality is 6%, further evidence proving ITU admission reduces mortality in such groups would be required before implementing a policy with significant resource implications.

Gillies Lecture

Things that go bump.....
the mistakes are out there
just waiting to be made

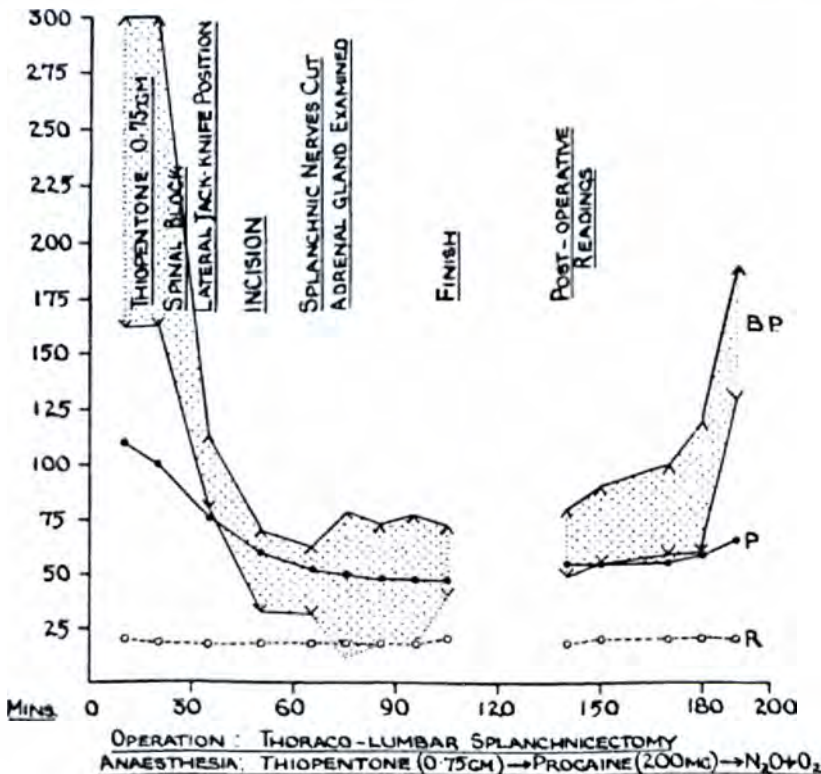
Brian Cowan 2008



The family of John Gillies endowed this lecture and the only stipulation is that it should be about an aspect of patient safety of interest to anaesthetists. John Gillies was one of the key individuals who in the forties and early fifties moved the clinical and academic standing of this specialty forward both through his role in the founding of the Faculty and in his work with the Association. He was the Simpson Reader in Edinburgh University

and his main clinical interest lay in induced hypotension using high spinal techniques.

He faced the challenge of providing clear operative fields for sympathetic surgery on patients with malignant hypertension whose outlook in that period was inevitable death from renal failure or a cardiovascular event. You can see in figure 1 one of his anaesthetics reproduced in a lecture from



1951 he entitled 'Physiological Trespass in Anaesthesia' ¹. He is using a high spinal to T2 and he brings the systolic blood pressure from 300mm to 70mm and restores the pressure uneventfully at the end after 90 minutes of profound hypotension. When you consider that his monitoring at best would be an oscillotonometer then his interest in patient safety becomes immediately understandable.

I intend to look in this lecture at the development of patient safety over the last 10 years and review the latest developments in Scotland in the light of our past experience.

The incidence of adverse events worldwide ranges in studies from 3.7% to 16.6% and this is a truly international phenomenon in healthcare. A recent study in Scotland from Williams and colleagues ² fits with this pattern but also illustrates an important point. Only 10% of the harmful events were identified by the hospital's standard incident reporting system. This is important if we are hoping to learn from past experience and has implications for many of our existing systems nearly all of which depend on voluntary incident reporting.

The first and most important entrant in what is now a crowded field was 'To Err is Human - Building a Safer Health System'. Produced by the prestigious Institute of Healthcare in 1999 this report had profound effects and is recognised as the start of patient safety as an issue for healthcare providers not just in the USA but also across the world. The report was media friendly and soon the statistic that 44-98,000 patients die each year in the USA as a result of medical misadventure, even more dramatically described as the equivalent of a jumbo jet crashing every day, not the last time that the airline analogy will be used in the patient safety debate, resounded round the media and government.

Yet the data was old. It had already been published in 1994 in JAMA by Lucian Leape and had disappeared, possibly because the editor by his own admission buried the paper in the Christmas edition fearing the backlash from the profession if the media picked it up ³.

However the report had much in it that appealed to the doctors. It emphasised the role of system rather than individual failure and called for remedies which focussed on analysing the problems in the light of improving the systems clinicians work in rather than blaming individuals. Unfortunately many of the public and media saw this as an abrogation of the clinician's responsibility for their actions and wanted to concentrate on removing bad doctors and nurses.

The report led to patient safety being debated nationally, Congress voted \$50M to research into safety improvement, and much effort was directed locally and nationally to patient safety improvement.

Five years on Berwick and Leape ⁴ reviewed the effects of all this activity and their conclusions were surprisingly low key. They welcomed the new emphasis on systems rather than individuals, but by 2004 all the money voted for safety research was going into the development of IT systems, a number of regulatory bodies had published a list of effective practices, there was legislation in many states to enforce more effective reporting, and trainee hours of work were now reduced. I will review the evidence that reducing hours of work improves safety later.

They also touched on another problem, the evidence that safety is improving or more accurately the lack of evidence. Attempts to measure improvement, for instance by use of insurance claims, had failed to demonstrate any change. They quoted a number of promising observational local studies of changes linked to benefits in safety but no Randomised Controlled Trials.

In the UK 2000 saw the publication of 'Organisation with a Memory' a major initiative with the personal stamp of the CMO Liam Donaldson. His analysis in what is an excellent and readable report is that the prevailing NHS culture did not encourage the reporting and analysis of incidents and near miss reporting was virtually non-existent. The service did not learn from previous errors and leadership from management was lacking with patient safety accorded little importance. His recommendations come down to a call

for better unified reporting systems, a national mechanism to disseminate learning quickly, better links between systems dealing with incidents and those dealing with poor performance, and leadership from senior management.

He returned to review progress in 'Safety First' in 2006. He concluded that things were moving too slowly, the NPSA had failed and that patient safety was still at one remove from Board agendas. He revised the system by changing the role of NICE and the NPSA and placed the responsibility for improving patient safety on Chief Executives and Board chairs. He wanted the service to develop champions and change the culture of their organisations. He revisited safety a year later but the resulting document is disappointing, it is a compendium of local projects with little in common, it fails to demonstrate measurable change in safety 7 years after a massive investment of time and resources. Indeed all England has achieved to the outside observer would appear to be a massive database of incidents, the NPSA and the 11 do not do's.

So what of progress in Scotland over the same period?

Scotland introduced the CNORIS scheme in April 2000. This was an insurance scheme to provide indemnity to clinical staff and protect Trusts from exposure to large claims by covering these from a national pool to which all contributed. The amount paid in by an individual Trust was assessed by analysing a large number of factors no doubt involving lengthy calculations but which to the uneducated seemed merely to relate to how many labour wards you had in your Trust. The new and interesting part was the attempt to link this to risk management and patient safety by developing a set of standards, which if met by the Trust could reduce the payment into the fund.

These related to the development of risk registers, good incident reporting arrangements and a Trust wide mechanism to disseminate any learning. There were a number of levels and most organisations had achieved level 1 by 2002. Level 2 was never implemented and risk management was absorbed into QIS in 2003. The assumption then

might be that little was achieved and indeed there was some box ticking rather than real change involved in the implementation, the usual departments progressed such as obstetrics and anaesthesia and others were less involved. But there is no doubt that for the first time there was a real management and clinical focus on setting up Trust wide incident reporting, clinical risk groups and risk registers, the first elements of a systematic approach to patient safety.

All of these approaches from England and Scotland have the same basic features and therefore the same problems. They rely on self-reporting and we have seen already that this approach can capture as little as 10% of the incidents of patient harm that a retrospective case note study will show. They are top down and despite an initial management focus that tended to be relatively short-lived the programme never became a regular meaningful part of the Board agenda. It proved difficult to ensure that any learning is universal and there was little feedback to staff. These initiatives did not change the culture of the organisations.

Another issue is that of evidence of improvement after a significant focus on safety since 2001.

Two measures commonly implemented to improve patient safety have been a reduction in trainee doctors' hours of work and the introduction of Rapid Response Teams. These seem to be intuitively sensible measures guaranteed to improve safety so is the evidence clear on these common improvements?

Libby Zion was an unfortunate young woman who died in 1984 as the result of an error committed by an exhausted resident who had been on duty continuously for over 80 hours. Her father was a journalist and the resulting coverage in the media led New York State to demand that hospitals reduce resident hours of work to below 80 hours per week. When the resulting post reduction period was examined it was found that complications had actually risen after the reduction⁵. A number of reasons were advanced for this seeming anomaly, such as increased handovers and decreased continuity of care, failure to implement the hours re-

duction reliably, or because the trainees did not dutifully spend their extra free time asleep in bed but did exactly what you would expect including clubbing, and locums in other hospitals!

There is much evidence from simulators that tasks such as laparoscopic surgery are performed worse after loss of sleep⁶ but practising good medicine is more than task performance. Has the effort and expense, which has brought the average working hours of trainees in my Board from over 80 in 2000 to less than 50 in 2008 likely to have led to an improvement in patient safety?

The only meta analysis⁷ looked at studies from 1966-2004 and cut over 1200 studies down to 7 felt to be reliable. Gottlieb⁸ found that following a reduction in hours that prescribing errors fell, this may again be the predicted effect on task orientated work, and Howard and colleagues⁹ demonstrated a reduction in mortality following a reduction in hours. Unfortunately the same fall in mortality occurred in units where hours had not been reduced. The conclusion of the meta analysis was that there was no demonstrable improvement in safety related issues following a reduction in working hours.

I am not suggesting that we should return to a long hours culture but here again it is difficult to demonstrate an improvement in safety. Some changes are a two edged sword, here balancing fresher doctors against an increase in handovers and reduction in continuity of care.

If there is an intervention that seems to be intuitively right it is the implementation of rapid response teams (RRT) to bring skilled clinicians to the bedside of deteriorating patients. This was one of the interventions championed by IHI in their 'Save 100000 lives' campaign and gained further momentum when the University Hospitals collaborative made it a compulsory standard of care; one author even suggested that to not have an effective RRT in your hospital was malpractice.

Yet the evidence is not clear-cut.

Up to 2007 there have been 10 studies looking at the impact of RRTs. There are 8 observational

studies and 2 RCTs. When subjected to a meta analysis by Winters et al¹⁰ they concluded that 5 of the former studies met their criteria. Of these two showed significant improvements in mortality and three studies showed significant falls in the number of cardiac arrests. One of the prospective RCTs showed a significant reduction in mortality but the largest study by Hillman (MERIT Study)¹¹ showed no significant changes in cardiac arrest rate, unplanned admission to ICU, or death after the introduction of RRTs. This latter study has been criticised¹² as underpowered according to its own criteria but the study did have over 125,000 patients from 23 centres. Inevitably there was variation in the implementation of protocols and centres with no RRTs still had their cardiac arrest teams acting as RRTs to some extent as over half the calls to the teams in these centres were pre-arrest.

Williams concluded that there was weak evidence that RRTs led to a reduction in mortality and cardiac arrest rates and that evidence from another large RCT was needed before RRTs could become a standard of care.

Again it is difficult to find good RCT evidence for a measure which intuitively makes sense. Berwick¹² has discussed whether RCTs should be the gold standard for research into patient safety or whether we need to expand the range of scientific tools utilized to measure and describe improvement in this specific area.

So our efforts over the last 9 years have had at best a modest impact and one that is difficult to measure – where to now?

A new era in patient safety in the UK began when in 2004 the Health Foundation identified 4 pilot sites including Ninewells in Scotland to work with the Institute for Healthcare Improvement (an American non profit making organisation with a track record in health improvement over the last 17 years) to use their methodology for quality improvement. This methodology is based on an industrial model originating in Japan in the 1950s and utilises PDSA cycles to test change, and the robust use of measurement, to implement processes proven to work clinically and to ensure these

are implemented reliably and reproducibly. There are strategies to spread the learning and a keen focus on leadership. Increasing the reliability of healthcare is an important issue; a study of nearly 7000 case records in the US showed only in 55% of cases was proven high quality healthcare implemented¹³.

Following the success of the pilots Scotland has embarked on a unique venture. It has formed a partnership with QIS, IHI, and the Health Service to establish the Scottish Patient Safety Alliance and implement the programme in every acute ward in Scotland. The programme does not extend yet to paediatrics or into the community but it is planned to do so over the next 2 years. This will be the first time IHI has attempted to introduce their methodology to an entire country and the challenge is made more interesting by the uneven sizes of our Health Boards.

The aims of the project are shown in table 1 and are very ambitious. Does our system have a standard of care at present which would allow an improvement in mortality of 15%?. There is a focus on highly acute areas – theatres and perioperative care and ITU. You will be familiar with care bundles and PDSA cycles in ITU and theatres but some of the other aspects of the programme will not be so familiar.

Work in the US has shown that leadership at the top of the organisation is vital to success¹⁴ so significant time has been spent motivating Chief Ex-

ecutives and Chief Operating Officers, there have been no previous initiatives where so much time and focus has been put into the leadership area since the introduction of targets. There is an emphasis on leadership walk rounds and senior management involvement in sorting problems at ward level. Boards will be looking at outcomes in public at board meetings and nothing can be more motivating to medical directors than that degree of accountability and scrutiny.

An attempt is made to look at the total amount of harm rather than simply reporting incidents utilizing a tool to review a selection of case notes every month and recording the number of instances of patient harm. The target is a drop of 30% but currently in our Board our instance of harm is low enough to give me concerns that a reduction of that magnitude may be impossible; this is one of many targets where starting low makes life difficult.

This work is going on elsewhere in the UK and there are some results emerging. Rowan and colleagues¹⁵ reported the results of a study in Wales looking at data from 2002 onwards from 10 units that had fully implemented the ITU bundles for 19 months, comparing with 51 months of pre-implementation data. However despite high levels of compliance with the bundle there was no significant change in mortality or length of stay over the study period. Rowan concluded that 19 months may be too early to detect an impact or that compliance with a bundle may not equal full delivery

Table 1. SPSA Outcome Aims

Mortality: 15% reduction

Adverse Events: 30% reduction

Ventilator Associated Pneumonia: 0 or 300 days between

Central Line Bloodstream Infection: 0 or 300 days between

Blood Sugars w/in Range (ITU/HDU): 80% or > w/in range

MRSA Bloodstream Infection: 30% reduction

Crash Calls: 30% reduction

Harm from Anti-coagulation: 50% reduction in ADEs

Surgical Site Infections: 50% reduction

of all the components, or that the evidence base for bundles is weak.

However, next month one Welsh ITU reported their experience over 2 years¹⁶ following the implementation of the ventilator and weaning bundles. Almost every parameter improved significantly including reductions in length of stay, pharmacy costs, tracheostomy rates, and a dramatic reduction in VAP rates. It is undoubtedly too early to draw conclusions and it is not surprising that seemingly conflicting results are emerging.

In my view this time we have a quality improvement system that engages both clinicians and senior management, both groups are enthusiastic or at least strongly motivated and that is a first. We have a unique opportunity here as well as a major challenge but whether this national effort can be translated into the same improvements as claimed elsewhere remains to be demonstrated.

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Peebles 2008

Peebles Hotel Hydro was, as per, the venue for the Society's Annual Spring Meeting. The merger with the Annual Trainees Meeting last year was held to be worth repeating; Jenny and Sarah provide fuller details elsewhere. As in 2007, trainees were offered a variety of heavily subsidised accommodation/ meeting/ food packages.

The weekend proper kicked off with a round at Peebles Golf Club on Friday afternoon. In wet and chilly conditions I played a round of colossal but controlled power allied to precision shotmaking and emerged with the trophy. Steven Lawrie collected the booby prize, maintaining Crosshouse's remarkable run of success in this area of the Society's endeavours. Only 1 Society member expressed interest in the fishing competition which was therefore cancelled, perhaps in perpetuity. Our now standard 5K run attracted 17 entrants, so many that they were not all included in the pre-run photo. Alex Patrick again took first prize; some form of handicapping for him may be introduced next year.

2008 saw changes to the more academic part of the meeting on Saturday to make it more family-friendly. In previous years, there has been little time for relaxation between the close of the educational meeting and the start of the reception and dance in the evening. The running order and timings were changed to allow a 3.15pm finish and thus some time with children or for a walk or swim or whatever. Hopefully the meeting will continue to evolve to meet the needs of as many members as possible while retaining the elements which have proved popular in the past. To that end the AGM started at 8.30am and saw the election of John May as Vice-President. Council changes included the replacement of Alex Macleod by Lynn

Newman in the west and of Alasdair McKenzie by Paul Nicholas in the east.

After coffee, Dermot McKeown gave the Keynote Lecture "It is not necessary to change" about the Scottish Hip Fracture Audit. His remarks and style were enjoyed by all. The Registrars' Prize presentations followed, maintaining the high standards of previous years. In the afternoon John McClure was installed as President and was called upon to give his Presidential Address "From his mother's womb untimely ripped". We were treated to insights which only his virtually unique position in UK obstetric anaesthesia can provide, delivered in his usual relaxed but compelling fashion.

The Guest Lecture followed - 'Something ventured, something gained' - by Professor Howard Fee. Professor Fee detailed his experiences in his commercial enterprises (designing and producing a more realistic airway and intubation simulator). To avoid problems with commercially sensitive information and seeming to advertise, there is no transcript in the Annals but Professor Fee's talk was a fascinating chat about an area few of us will ever know.

The meeting closed with John presenting the Registrars' prizes. Anoop Kumar won the Donald Campbell Quaich and James Limb and Natasha Hurley received runners-up cash prizes donated by GE Healthcare. Later in the day, the final prize of the meeting, won by Callum Patrick for the laser clay pigeon shooting, was presented at the President's Reception before the Annual Dinner Dance. The dance allowed members of the Society to socialise within the limits which dictate the behaviour of responsible professionals and a jolly time was had by all.



Runners



Swimmers.



Dancers





Alf, Dermot and the Scottish Society bag-for-life



James and Natasha receive prizes from GE Healthcare



John and Professor Howard Fee

Trainee presenters - James Limb, Catherine Eckersley, Anoop Kumar, Natasha Hurley and Sachin Valap.





Prizewinners



Sporrans

The Vice President and his wife



Donald Campbell Quaich

Declining use of nitrous oxide in general anaesthesia in a Scottish university hospital

Dr A.Kumar, Dr S. Parkin, Dr W. Brampton
Department of Anaesthetics, Aberdeen Royal Infirmary.

Following evidence published in 2007 that omitting N₂O during major surgery may be beneficial [1], we analysed prospectively collected audit data to measure if there had been any decline in N₂O use. The Research Ethics Committee were informed but did not require formal approval.

Every November from 2005-7 approximately 200 consecutive adult patients admitted following GA have detailed audit data collected. We compared N₂O use in each sample, subdivided *a priori* by grade anaesthetist and anaesthetic duration.



Our President presents the Quaich to Dr Kumar

Results

Year	2005	2006	2007
Patients in audit (n)	193	210	172
Proportion [95% CI] given N ₂ O	41% [48-34%]	28% [34-22%]*	13% [18-8%]*
Use of N₂O by grade of anaesthetist			
Proportion [95% CI] given N ₂ O by career grade	40% [48-33%]	32% [41-23%] NS	11% [16-6%]*
Proportion [95% CI] given N ₂ O by trainee anaesthetist	45% [62-28%]	20% [29-11%]*	20% [36-4%] NS
Use of N₂O by duration anaesthetic			
Proportion [95% CI] given N ₂ O for anaesthetic > 1hour	35% [44-26%]	22% [30-14%]*	7% [13-1%]* ‡
Proportion [95% CI] given N ₂ O for anaesthetic ≤1hour	48% [58-38%]	34% [43-25%] NS	20% [27-13%]*

*Proportion significantly different to previous year (p<0.05)

NS No significant difference from previous year

‡ Proportion significantly lower than anaesthetics ≤1hour [95% CI for diff 2.8 - 23%]. No significant difference in these proportions in 2005 or 06.

Discussion

Since 2005 N₂O use decreased each year. In 2006, before the publication of Myles' study, this was mainly due to a fall in use by trainees. In 2007 the career grades accounted for the decrease which was particularly marked for longer procedures as is in keeping with the published evidence.

References

1. Myles et al. *Anesthesiology* 2007; 107:221-31

Comparison of three methods of assessing glycaemic control in ITU patients

J. Limb, J. Duffly, L. Plenderleith. I.C.U., Western Infirmary, Glasgow

Tight glucose control has been shown to improve mortality in surgical ITU patients¹, and medical ITU patients admitted for more than three days². Many units have developed insulin protocols, aiming for tight glucose control. The infant Scottish Patient Safety Program (SPSP) also requires an assessment of glycaemic control as one outcome measure.

The group compared three means of assessing individual patients' daily glycaemic control for accuracy and practicality in clinical practice. All patients admitted to the intensive care unit in a three-month period were included. Data were extracted from the Carevue[®] patient record and analysed using Excel[®]. The assessment measures used were 7am laboratory glucose, median daily glucose, and a time-weighted measure of glycaemic control.

There was a strong correlation between the median daily glucose and the time-weighted daily glucose, and a lower correlation between each of these measures and the 7am glucose value. The complexity of calculating the time-weighted glucose means that in daily clinical practice, the median daily glucose value offers the best compromise as an individual patient's measure of glycaemic control.

Two means of assessing an Intensive Care Unit's compliance with glycaemic control were com-

pared. Cumulative graphs may be drawn of the proportion of patients falling within the target range, or a single numerical fraction of patients in range can be used, as required for the SPSP dataset. The single numerical fraction may lead to an inaccurate estimate, as it may be skewed by the increased frequency of sampling when glucose values are out of range.

References

1. Van den Berghe G. Wouters P. Weekers F. Verwaest C. Bruyninckx F. Schetz M. Vlasselaers D. Ferdinande P. Lauwers P. Bouillon R. Intensive insulin therapy in the critically ill patients. *New England Journal of Medicine*. 345(19):1359-67, 2001.

2. Van den Berghe G. Wilmer A. Hermans G. Meersseman W. Wouters PJ. Milants I. Van Wijngaerden E. Bobbaers H. Bouillon R. Intensive insulin therapy in the medical ICU. *New England Journal of Medicine*. 354(5):449-61, 2006.

An anaesthetist with one monitor knows what time it is, an anaesthetist with too many monitors is never quite sure! Time accuracy in clinical areas.

Dr Natasha Burley, FT2 Anaesthesia, Borders General Hospital, Melrose.

Background

Accurate time is essential in Anaesthesia for clinical decision making, physiological assessment, timing of interventions, and critical incident reporting.

Objective

To assess the accuracy of clocks and monitors in areas used by anaesthetic staff.

Method

This observational study was undertaken in the theatres, Intensive Care Unit, Day Case Unit, Emergency Department, Labour Ward, and all in-patient wards of Borders General Hospital. Time displayed on all clocks, anaesthetic and recovery monitors were assessed. Time difference was recorded in minutes. Standardised time was taken as

that displayed on my digital wristwatch (CASIO LA670WA-1UW). This was set at the beginning and end of each period of data collection against the "Speaking clock".[†]

Results

A total of 122 wall clocks and 42 monitors were compared with standard time. 28.6% of clocks and 14.28% of monitors were accurate. None of the theatre clocks and monitors showed uniformity or 100% accuracy. Average time discrepancy seen in clocks was 1.9min (range +8 to -20mins), and 5.5min (range +62 to -2mins) in monitors. The largest range of time discrepancies in minutes were seen in Theatre 3: +60, +2, -1, -1, -2; Theatre 5: +62, +1, -1, -4, and the ED resuscitation room +61 and +8. All timing devices in the labour suite were accurate due to the local decision to buy "radio controlled" wall clocks.

Conclusions

This study has shown that time keeping devices in important clinical areas are not uniform and often inaccurate. This has clinical and medico-legal implications. It places us at risk of time disorientation during patient care and production of non-contemporaneous notes.

References

1. Crow et al. Time is of the essence. *Archives of Disease in Childhood Fetal and Neonatal Edition*

2004;**89**:563-564.

2. Ferguson et al. Time out! Is Timepiece Variability a Factor in Critical Care? *American Journal of Critical Care* 2005;**14**:113-120.

3. Henderson and McCracken. Bare below the elbows: Clinical value of a wristwatch. *British Medical Journal* 2008; **336**:10.

4. Wong et al. As Time Goes By. *Scottish Medical Journal* 2002; **47**:138-139.

[†] "Speaking clock" Is the time sponsored by *Accurist*. Obtained by dialing 123 on your telephone.

Revisiting thromboprophylaxis after vaginal delivery and Caesarean section : is it getting any better?

C Eckersley (SpR), G Mathew (SpR), PA Stone (Consultant) Dept Anaesthesia, Queen Mother's Hospital Glasgow.

Thromboembolism remains the leading direct cause of maternal mortality in the UK ¹. The latest Confidential Enquiry into Maternal Mortality found that thromboembolic deaths after Caesarean section have fallen, but those after vaginal deliveries have not improved. This audit assessed risk categorisation, and provision of adequate thromboprophylaxis to moderate and high risk patients following vaginal or Caesarean delivery against local guidelines.

Results

	April 2005	July 2007
Total deliveries audited	271	171
Vaginal Deliveries	189 (70%)	101 (59%)
VTE Risk Assessment form used	68 (36.4%)	98 (97%)
Patients eligible for thromboprophylaxis	31(16.5%)	19 (18.8%)
Patients receiving enoxaparin	14 (45.1% of eligible patients)	12(63.2% of eligible patients)
Of patients receiving enoxaparin : timings as per guideline	NA	9 (75%)
Caesarean Sections	82 (30%)	70 (41%)
Patients receiving enoxaparin	79 (100%)	69 (100%)
1 st dose enoxaparin at 3 to 6 hours after delivery	47 (59.9%)	55 (80%)

Methods

We retrospectively audited the presence of risk factors and use of thromboprophylaxis on 171 patients selected randomly who delivered in July 2007. Compliance in filling in the local Venous Thromboembolism (VTE) Risk Assessment form was audited. The appropriate use of enoxaparin (dosage, timing and duration) was checked on prescriptions. Results were compared with a previous audit done in 2005.

Discussion

This audit shows that, despite some improvement since 2005, some moderate and high risk patients delivering vaginally received inadequate thromboprophylaxis, some receiving no enoxaparin. There was associated incorrect documentation on risk assessment forms. The local risk assessment forms need updating in the light of our findings. Greater diligence is needed in ensuring the appropriate administration of enoxaparin to improve quality of care.

References

Saving Mothers' Lives: CEMACH Report 2003-05.

Audit of anaesthetic records

S Valap, J Robertson, F Burns. Department of Anaesthesia, Royal Alexandra Hospital, Paisley

Objective

To assess whether anaesthetic records comply with RCoA recommendations.

Standards

Recommended data set published by the Royal College of Anaesthetists in 2002. We aimed to determine how current practice in our department complies with RCoA recommendations.

Audit Setting

Anaesthetic records of cases performed in a week were assessed (Jun 2006 & Oct 2007). Data were collected by recovery nurses. Anaesthetists were unaware of the audit.

Results

There were 97 responses in 2006 and 98 in 2007. The table shows the comparison of the data between the 2 years. Reaudit in 2007 showed an average improvement of 55 % in data documentation from previous year. Of the 98 responses - 45 were assessed as adequate, 51 as inadequate and 2 causes for concern according to the RCoA standards.

% Missing Data	2006	2007
Patient details	5	0
ASA	45	12
Name of operation	3	1
Dated	13	4
Signed	3	2
Supervision documented	43	27
Techniques & Risks	43	21
Postop instructions	4	4

Conclusions

This audit shows marked improvement in the standard of anaesthetic record keeping from the previous year. But there is still room for improvement especially in documenting supervision and techniques and risks. Only 45% of the records complied with all the RCoA recommendations

References

1. Good practice: a guide for departments of anaesthesia. Royal College of Anaesthetists and Association of Anaesthetists of Great Britain & Ireland.
2. NHS Quality Improvement Scotland. Care before, during and after anaesthesia. 2005

Editor's note. The 5 abstracts above competed for the Donald Campbell Quaich. The 3 below won prizes in the Trainees' Poster competition.

Educating patients about anaesthesia: Effect of a patient information leaflet on anxiety, perceived information gain, and patient satisfaction

Genevieve Lowe, FT2, Dinesh Parmar, FT3, N. Smart, Consultant, Department of Anaesthesia, Victoria Infirmary, Glasgow G42 9TY

Preoperative patient education aims to decrease patient anxiety (1) and increase knowledge for informed consent (2). If much of this information about the general process and risks of anaesthesia can be provided before the preoperative consultation, anaesthetists can then focus on the specific needs of the individual. The aim of this study was to investigate the effect of a patient information leaflet on patient anxiety, perceived information gain and patient satisfaction.

Methods

With informed consent, 107 patients were recruited in a one month period. After admission to the ward, baseline anxiety was measured on a 100mm visual analogue scale. Patients were then asked to read 'You and your anaesthetic', an information leaflet published jointly by the Association of Anaesthetists and the Royal College of Anaesthetists as part of the Information for Patients project (3). The VAS anxiety rating was repeated approximately 30 minutes after this, and patients were also asked to complete and return a piloted questionnaire which examined the following 3 domains using 5 point Likert scales: effect of the leaflet on anxiety, perceived information gain about risk and processes, and overall patient satisfaction with the information provided. Results were calculated as percentages and compared by Chi square analysis where appropriate ($p < 0.05$ significant).

Results

Complete data sets for 66 patients were obtained (response rate 62%), modal age group 21-40 years, of which 64% were female. Anxiety measured by VAS scores was not significantly different before and after reading the leaflet ($p < 0.05$) and this was supported by Likert scale data with over 78% of patients finding the leaflet 'neither helpful nor unhelpful' in reducing anxiety. In contrast, a majority of patients (68%) considered the anaesthetic consultation to be an effective intervention in reducing anxiety. With regard to information gain, 54 respondents (82%) indicated that the leaflet answered most or all of their questions, 58 (88%) believed that the leaflet contained enough information and that no more was required, and 51 (77%) found the information easy to understand. Overall, 49 (74%) respondents perceived the leaflet to be of value in educating them about the anaesthetic. Patient satisfaction is commonly used as an index of quality of care and 60 (91%) were 'quite or very satisfied' with the leaflet and the information provided therein.

Conclusions

Reducing patient anxiety has been defined as one of the main purposes of the preanaesthetic consultation (4). This study found no significant reduction in anxiety levels attributable to reading the patient information leaflet, although anxiety was reduced in the majority by talking with the anaesthetist. The main benefit from the information leaflet was an increased level of perceived knowledge about risks and the process of anaesthesia. As such, the information leaflet contributes to patient centred care, helping patients to make informed choices and strengthening the process of consent.

References

1. Capuzzo M, Gilli G, Paparella L et al. *Anesth Analg*

2007; 105: 435-442.

2. Thoms G, McHugh G, Lack J. *Br J Anaesth* 2002; 89: 917-9.

3. You and your anaesthetic. <http://www.rcoa.ac.uk/docs/section4-ifp.pdf> (accessed 29 02 08).

4. Klapka JM, Roizen MF. *Anesth Analg* 1996; 83: 1314-21

What's in a Name?

Dr A Bull & Dr S Cross. Western General Hospital Edinburgh

Patient identification is essential to administering drugs and transfusions but becomes even more important when a patient is under anaesthetic. We decided to audit current practice in 2 teaching hospitals within Lothian.

Methods

We selected 20 patients from each of the departments. Medical, Surgical, and Critical Care, Clinical Neuroscience at the Western General Hospital and Gynaecology/Maternity at the Royal Infirmary of Edinburgh. Information we collected included presence/absence of a nameband, details recorded on it, legibility and accuracy.

Results

The results of our audit at the Western General Hospital showed that 20% (16) of the patients had no nameband. 42% (27) had a CHI number and 71% (46) had a hospital number. 15.6% (10) of the namebands were illegible and all these were addressograph stickers. 4.6% (3) of the namebands displayed actual inaccuracies, all of which were handwritten.

At the Royal Infirmary of Edinburgh 15% (12) patients had no nameband on. 5.8% (4) patients had a CHI number and 54% (37) had hospital numbers. 7.3% (5) of the namebands were illegible and 4 of these were addressograph stickers. 5.8% (4) of the namebands were inaccurate with ward details.

Discussion

Namebands were often removed for cannulation or line insertion and not replaced. Addressograph labels quickly became illegible through wear but handwritten namebands had more potential for error. The NPSA Safer Practice Notice (July 2007) recommends that by July 2008 NHS organisations have wristbands that meet their guidelines.

An audit of medical vacuum suction device performance at the Royal Alexandra Hospital, Paisley, July 2007

A. Meikle, SpR, K Rooney, Consultant, Dept Anaesthetics, Royal Alexandra Hospital, Paisley

Obstruction to the airway of an unconscious patient is a potentially life-threatening event, and upper airway clearance of blood, vomitus, or other material is essential.¹ The effectiveness of certain medical vacuum suction devices was perceived to be poor in our department, and we sought to evaluate the performance of all suction devices.

Methods

We evaluated 38 medical vacuum suction devices: 12 in the theatre recovery area, 18 in the main theatre suite, 4 in the maternity unit, and 4 in the day-surgery unit. The following standards for the performance of each suction unit were set:

100% of vacuum suction units should attain a minimum occluded negative pressure of ≥ 53 kPa at 10 seconds.

100% of vacuum suction units should aspirate ≥ 100 mls of water through a Yankauer catheter within 5 seconds.

Results

5.3% of suction devices failed to meet the standard with regards minimum occluded negative pressure. Two devices in the main theatre suite (Dräger *Julian*) failed to meet the standard with a negative pressure generated of -30 kPa and -50 kPa.

23.7% of devices fell below the standard set for aspiration of water. The devices that failed were in the main theatre and recovery area (range 4.07-7.17 seconds). The two Dräger *Julian* devices that failed to attain the first target also failed to meet this standard (range 6.15-6.74 seconds).

Conclusion

The performance of medical vacuum suction devices was found to be sub-optimal (Dräger *Julian*) and in light of this two new devices were installed by medical physics.

References

Arnstein FE. A practical evaluation of four human-powered portable airway aspirators. *Anaesthesia* 1996; **51(1)**: 63-68.

Editor's note. The following abstracts are the remaining entrants for the 2008 Trainees' Poster competition excluding case-reports.

Monitoring of basic physiological parameters on maternity wards.

Judith Ramsey, Joyce Reid, Dept Anaesthesia, QMMH

The Confidential Enquiry into Maternal Deaths has recommended that a national modified obstetric early warning system (MEOWS) be introduced in maternity units to aid the more timely recognition of women with significant illness. The reporting system should involve 4 hourly recordings of blood pressure, heart rate, respiratory rate, temperature and oxygen saturation. We therefore aimed to assess the current monitoring standards in our maternity wards to establish whether the new MEOWS system can be introduced successfully.

Method

We identified patients who had an elective or emergency caesarean section from the labour suite records and reviewed their charts in the wards. We noted the recording of the parameters: - BP, HR, RR, O2 saturations and temperature and the interval at which they had been recorded during the first 24 hours post-operatively.

Discussion

Current monitoring standards are sub-optimal and it is therefore unlikely that the MEOWS system can be successfully implemented at the present time. A review of the number of midwifery staff available on the wards to carry out these observations is required. An education programme is also essential to emphasize the importance and significance of these recordings in picking up significant illness at an early stage and prompting medical treatment.

Reference

Confidential enquiry into maternal and child health. Saving mothers' lives: reviewing maternal deaths to make motherhood safer 2003-2005. London RCOG Press, December 2007.

General Anaesthesia Practice for Caesarean Section at the Queen Mother's Hospital, Glasgow.

Simon Martin, Brian McCreath, Joyce Reid, QMMH

Results - physiological parameters on maternity wards.

	% Of patients who had 4 hourly recordings of this parameter for the first 24 hours post-op	% Of patients who had recording of this parameter done 3 times or more in 24hour period
Blood pressure	0%	70%
Heart Rate	0%	76%
Respiratory Rate	0%	35%
Oxygen Saturation	0%	6%
Temperature	0%	70%

Type of Surgery	Lap.Sterilisation	Diagnostic Lap.	Other Lap.
Post-op Morphine	64%	43%	36%
Intra-op Parac.	65%	42%	50%
Post-op Parac.	21%	0%	0%
No Parac.	14%	58%	50%
No Post-op Morphine	36%	57%	64%
Intra-op Parac.	12.5%	44%	14%
Post-op Parac.	0%	6%	0%
No Parac.	87.5%	50%	86%

General anaesthesia (GA) for Caesarean section (CS) is associated with a 17-fold increased mortality compared to regional anaesthesia (RA). A retrospective audit of this high-risk patient population was carried out in our institution to investigate current practice.

Methods

All CS patients who had a GA during 2007 were identified from the theatre register. The case notes were reviewed and information pertaining to indication, airway management, documentation and pain control was collected.

Results

Of the 71 patients identified, the case notes of 56 (79%) were available for study. Foetal distress was the most common indication for GA, 19/56 (34%). Failure to establish RA was the second most common indication, 13/56 (23%). Trainees performed 41/56 (73%) and 37/56 (66%) occurred out of hours. 44/56 (81%) of patients had a Body Mass Index at booking of less than 30. The most difficult laryngoscopy recorded was Grade II in 4/56 (7%). There were no failed intubations. Omissions from the anaesthetic chart were common e.g. airway examination was not documented in 18/56 (32%). Postoperative pain required anaesthetic review in 20/56 (36%) and of these, 16/56 (29%) warranted intravenous morphine.

Conclusions

Disappointingly, failure to establish RA was a common indication for GA. This requires further investigation. Trainees frequently perform GA outwith normal working hours. The quality of documentation could be improved. Pain control in this patient population can be challenging.

Audit of Effect of Intra-operative IV Paracetamol on Post-operative Pain

Rhona Younger, Fiona Cameron, Ninewells Hospital.

The introduction of IV Paracetamol in the UK over the last few years has given anaesthetists another weapon in their multimodal analgesic armoury. The perceived benefit of better post-operative analgesia and the possibility of reduced opiate requirement is apparent to those of us who are enthusiasts of the drug. The Cmax of IV Paracetamol ("Perfalgan") is at 5-10 minutes. However by 60 minutes, and for the next 12 hours it is the same as the equivalent dose of oral Paracetamol. 61 day surgery gynaecological cases were audited to examine intra-operative/post-operative analgesia and determine whether the use of intra-operative IV Paracetamol affected the amount of analgesia required post-operatively.

Results. IV paracetamol

Conclusion

As opposed to the expected obvious analgesic benefits to those receiving intra-operative IV Paracetamol there appears to be little difference. However Paracetamol is still important in the multimodal approach to post-operative analgesia, but consider:

Cost of IV Paracetamol versus oral

Routine oral Paracetamol in paediatric practice

As a result of this audit there has been change in practice within our department, prescribing oral pre-operative Paracetamol where appropriate

References

1. Perfalgan Data Sheet, Medsafe, New Zealand Medicines and Medical Devices Safety Authority.
2. Randomised control trial duration of analgesia following IV or rectal Acetaminophen after adenotonsillectomy in children. BJA Vol. 100, No.2 Feb 2008, Capici et al
3. Paracetamol infusion use in Ninewells theatres 2007/2008, Ninewells Hospital Pharmacy.

Prospective audit of maternal bradycardia with phenylephrine infusion.

S Fraser, J Reid, B McCreath., QMMH

Phenylephrine infusion is now the technique of choice for maintaining maternal blood pressure during spinal anaesthesia for Caesarean section in our institution. However there are concerns that this practice has increased the incidence of maternal bradycardia (defined as heart rate < 60 bpm).

Aim

We conducted a prospective audit of women undergoing elective Caesarean section of a singleton pregnancy at term to review the incidence of maternal bradycardia and frequency of vagolytic use in our institution.

Method

A data form was collected for 46 patients charting preoperative heart rate, lowest heart rate and any treatment given.

Results

Lowest Heart Rate	50 – 59 bpm	60 – 69 bpm	>70 bpm
Treated	6	8	0
Untreated	4	15	13
Total	10/46 (22%)	23/46 (50%)	13/46 (28%)

Discussion

Maternal bradycardia in response to phenylephrine infusion is not uncommon and its treatment is inconsistent. Although one study suggests that even heart rates of less than 60 bpm for 10 minutes have no detrimental effects on fetal blood gas¹, there remains a paucity of research into the effect of maternal bradycardia on maternal and fetal well being.

Reference

1. Examining influence of maternal bradycardia. Brenk et al. *IJOA* July 2007 16(3):208-213.

Adequacy of Acute Pain Training at the University of Edinburgh

R Browning, M Broyde, J Cave, L Hummerstone, C McErlean, S Richardson, P Swann, B Heidemann, R Hignett, B Ulyatt, I Power. College of Medicine, University of Edinburgh; Dept of Anaesthesia, Royal Infirmary of Edinburgh

One of the most common difficulties facing a foundation doctor is treating patients in acute pain; therefore the capacity to manage this is a vital requirement for graduating medical students. It has been shown that acute pain management by foundation doctors is ineffective and knowledge amongst medical students upon graduation is deficient¹. We set out to investigate the confidence and knowledge in this area amongst 5th year medical students and foundation year doctors in Edinburgh.

Methodology

An internet questionnaire was sent out to all 5th year medical students and FY1 doctors. This asked the respondents to assess the quality and relevance of their undergraduate teaching.

Results

We received 40 and 139 returns from the 5th year medical students and FY1 doctors respectively. 39% of FY1s who studied in Edinburgh felt their training had not adequately prepared them for assessing a patient's pain and 41% found that their undergraduate training had not adequately prepared them for prescribing as junior doctors. While students felt confident in their abilities to assess and treat acute pain, as foundation doctors only 75% chose the correct dose of paracetamol.

Discussion

Our survey supports the published literature. We feel that the knowledge deficits are primarily due to insufficient support materials and teaching time in assessing and prescribing for a patient's acute pain. As a result of this study we are undertaking a project to produce a computer assisted learning programme to be used as a resource for teaching the basics of pain medicine.

References

1. Manpreet Singh, Sharmila Ahuja, Medha Mohta, Asha Tyagi. Undergraduate Medical Students Assessment of A Revised Curriculum- How Effective? *J Anaesth Clin Pharmacol* 2006; 22(4) : 399-402

The practice of neuromuscular function monitoring in a Scottish teaching hospital

A Kumar, N Kumar, R Casson. Dept Anaesthetics, Aberdeen Royal Infirmary, UK.

This anonymous survey done in November 2007 aimed to identify the current practice of the use and monitoring of non-

depolarising muscle relaxants in our department. The response rate was 61%.

Results

Atracurium is the most commonly used neuromuscular blocking agent. 79% of anaesthetists in the survey routinely used a peripheral nerve stimulator at the end of an operation to assess muscle power. 63% use clinical signs in addition. Only 53% of the anaesthetists who were surveyed would routinely reverse neuromuscular block.

Discussion

The findings of our survey are in agreement with those of a similar survey previously conducted by Grayling et al in England and West of Scotland (1). There was a wide variation in the practice of neuromuscular function monitoring. Current practice relies on a subjective assessment of TOF ratio and clinical assessment of muscle power. A need to raise awareness regarding the TOF ratio considered safe for extubation was also recognised.

Conclusion

The subjective assessment of TOF ratio and clinical assessment alone are poor markers of muscle power (2). A role for a device capable of more objective measurement of TOF ratio was identified, for use under special circumstances.

References

1. M.Grayling, B.P Sweeney. Recovery of neuromuscular blockade: a survey of practice. *Anaesthesia* 2007; 62: 806-809
2. Kopman A.F. Relationship of the TOF fade ratio to clinical signs and symptoms of residual paralysis in awake volunteers. *Anaesthesiology* 1997; 86:765-71

Information recorded on anaesthetic charts in a Glasgow teaching hospital.

A Puxty, Glasgow Royal Infirmary.

The Royal College of Anaesthetists (RCOA) have issued guidelines¹ on the information that should be recorded in the anaesthetic assessment form. In Glasgow Royal Infirmary we undertook an audit of which parameters were recorded on the anaesthetic forms, and whether those with headings on the form were better recorded than those without.

Methods

Over three days every anaesthetic chart in the main recovery room in theatres was audited for the information recorded on 9 parameters. Four of these were under headings included on the current forms and 5 were of parameters suggested to be included by the RCOA but not currently under headings in the chart.

Results

99 anaesthetic charts were reviewed. 15% of charts failed to mention either the agent, ET value or both. Only 9% of charts mentioned a machine check, 61% noted the patients exercise tolerance, 79% their laryngoscopy grade (in those intubated), 24% mentioned discussion of risks with the patient, 93% had information regarding previous anaesthetics and 95% had a date on them. 63% of charts had airway assessment recorded. Of the 15 charts with a trainee as the primary anaesthetist, only one identified the responsible consultant.

Conclusion

Certain areas of the chart are poorly filled out, risking medicolegal problems if they were ever scrutinised after a patient came to harm. Those parameters prompted on the chart were better filled in than those that were not.

Reasons for discontinuation of epidural treatment in the Surgical HDU of a hospital with an Enhanced Recovery Program.

Joanna Renee, Ninewells Hospital, Dundee.

Epidural analgesia is an effective treatment with many added benefits to surgical patients such as earlier mobilisation and reduced post operative complications. However it is an invasive procedure that is not without risk. Epidural insertion requires specialist training and is usually performed by a senior anaesthetist. Management of a patient with an epidural requires specially trained staff and increased levels of monitoring. Therefore, in most centres these patients are cared for in a Surgical High Dependency Unit. Ideally epidural analgesia will be discontinued when there is no need for further analgesia via this route. However it is not uncommon for premature discontinuation of treatment to take place. The Western General Hospital provides a range of surgical services to Edinburgh and the Lothians. The 10-bedded Surgical High Dependency Unit (HDU) is a busy ward with a team of specialist nursing staff. The hospital operates an Enhanced Recovery Program within this unit for general surgical patients including epidural analgesia, early mobilization and early participation in physiotherapy. This audit determined the causes for premature discontinuation of epidural treatment within the unit and in particular the rate of accidental removal.

Method

Retrospective analysis of data collected from the Acute Pain Record of all patients with an epidural admitted to the surgical HDU over a 9 month period (Sept 2006 - May 2007).

Results.

298 patients had epidurals. In 12% the reason for discontinuation could not be determined. 25.2% of epidurals were discontinued prematurely. Reasons were found to be ineffective analgesia (5.7%), HDU bed pressure (3%), hypotension (1%), surgeon's request (1%), patient request (1%) catheter disconnection (1%), swelling at site of insertion (1%) and most commonly accidental removal (13.8%).

Discussion.

The benefits of epidural analgesia include superior pain control, quicker recovery times and reduced complications. These benefits were lost for 1 in 4 patients with an epidural due to premature discontinuation of their treatment. The accidental removal rate was high which could be for many reasons. It may be due to insertion technique or consequent management of the epidural or the patient such as early mobilisation of the patient.

Conclusion.

Although the majority of epidural analgesia was managed as planned there were several important reasons identified for premature discontinuation of treatment. In particular there were a significant number of epidurals accidentally removed. Further investigation is required into the cause of accidental removal of epidural catheters and the relationship between pre- & post operative management.

A retrospective study looking at airway management during sinus surgery.

Jason Hardy, Ninewells Hospital, Dundee.

An increasing number of patients in our hospital having endoscopic nasal sinus surgery are being managed with a Laryngeal Mask Airway (LMA). We were keen to see if this had resulted

in an increased rate of complications (for example; coughing, bleeding, raised blood pressure).

Methods

We collected data on 86 patients. They were divided into two groups; 43 were managed with an endotracheal tube (ETT), and 43 were managed with a LMA. The data collected included; ASA, grade of anaesthetist, size and type of airway, reason (if any) for intubating the patient, pain and nausea scores.

Results

Of the 43 patients managed with an ETT, 20 were anaesthetised by consultants and 23 by trainees. Of the LMA group, 40 were anaesthetised by consultants and 3 by trainees. The ETT group contained more ASA 2 and 3 patients. Only one complication was noted in the LMA group whilst 10 were noted in the ETT group. Reasons for intubating the patient were not always clear but a variety of co-morbidities were documented on the anaesthetic chart. Trainees intubated more ASA 1 patients. There was no difference in the pain or nausea scores.

In our limited study we found that patients managed with a LMA had a lower level of complications than those managed with an ETT. Trainees tended to favour endotracheal intubation.

Variability of ASA Grading in the West of Scotland

Lesley Green, SpR, Western Infirmary, Glasgow.

The American Society of Anesthesiology (ASA) classification system has been used since 1941 [1]. Difficulties include lack of adjustment for: age, sex, pregnancy, nature of surgery and anaesthesia, skill of physicians, degree of pre-theatre preparation and facilities for post-operative care. This survey assessed the degree of correlation of ASA grading among West of Scotland anaesthetists.

Methods.

100 anaesthetists from 3 hospitals completed the questionnaire. They were asked to assign an ASA grade to 12 hypothetical patients. Differences between consultants and trainees were compared using a Chi-square test.

Results.

77% anaesthetists assign scores routinely. 23% do not assign scores. 66% find ASA scores useful, 28% do not find ASA scores useful and 6% find it useful sometimes. There was no patient where all participants agreed on a single ASA grade and only one patient where responses were limited to 2 grades. The median number of anaesthetists who agreed on the most popular grade was 64 (IQR 56.5-72 [range 37-88]). The median number of ASA grades assigned to the 12 patients was 4 (range 2-5). There was no difference between consultants and trainees (P=0.64).

Discussion.

Two-thirds of anaesthetists agreed on a single ASA grade with the remainder spread over another 3 grades. Trauma, pregnancy, obesity, extremes of age and cancer proved controversial. Acute physiological derangement also provided disparate results. Consistency of grading with education may be possible but ultimately there is inherent weakness in the grading system and a committee decision on ASA grades for certain disease states may be required.

References.

1. Saklad M. Grading of patients for surgical procedures. Anesthesiology 1941; 49: 281-284



What?

Who?

Where?

When?

- News from the Regions.....

Many thanks to those who have been willing to contribute. The Western General report, omitted twice due to the incompetence of successive editors, makes a welcome reappearance. Colin MacFarlane died shortly after submitting the report bearing his name. The Society sends its condolences.

Aberdeen - Andrea Harvey

Aberdeen is often referred to as "The Oil and Gas Capital of Europe". For those of you unaware of this, as well as our own Anaesthetic 'gas' industry there is also the North Sea 'gas' business. We do have some similarities with our 'namesakes': long hours spent away from home, close team working in a safety conscious working environment. Although the older specialty, we are however a much smaller and poorer relative. As a result of the large scale and wealth that accompanies the North Sea gas-side, our own specialty is not quite as noticeable. This certainly was not the case when over 130 anaesthetic 'gas' men and women arrived in Aberdeen last November for the 2 day joint Scottish Society of Anaesthetists and RCoA Winter meeting, held at Mercure Ardoe Country House and Spa. (See Annals for meeting review). As one of the local organisers, I would like to say a BIG THANK YOU to all who braved the heavy snow to attend this meeting and supported our Society.

Several major changes have taken place here in Aberdeen with regards to our work pattern in the past year, worthy of mentioning. These changes and the reasons for their introduction, I know, are not unique to our geographical location. A reduction in the number of, and the hours worked by trainees, has seen this workload shift over to the consultant work pool. From Monday to Thursday we have now lost a trainee tier from the out-of-hours general emergency rota. Government driven waiting-time targets have seen the lengthening of the standard working day until 8pm, with elective orthopaedics the first to set this up and more specialties to follow. This year also saw the first Grampian general surgeon appointed with his contracted all day elective list being allocated to a Saturday. Progress?

As our surgical colleagues' day and numbers expand, it goes hand in hand with a required growth of our own specialty. This year saw 4 new consultant colleagues join our general pool (Ruby Pratrapp, Vrinda Kathra, Norma Van der Horst and Roopa Devanahalli) and we welcomed back from Australia, Paul Holder as a consultant with a special interest in Intensive Care Medicine. At the time of writing we are also interviewing for a Paediatric consultant who will (hopefully) be in post by the time of print next year (2009).

Three of our trainees were successful in their applications for consultant posts outwith Aberdeen, and we wish Deepak Mathur now in Inverness, Mike MacMillan in Paisley and David McNair in Dumfries & Galloway every success and happiness in their new positions. There have been quite a few changes to our non-career specialist posts too since last year. Four of our long serving Staff Grades were successful in becoming Associate Specialists; congratulations to Helen London, Alison Ross, Mala Sathananthan and Joanna Szygula. Vicki Edwards joined us as a Staff Grade and Averell Bethelmy departed from this role as he and his wife headed south to work in London.

Onto other areas linked to Aberdeen Anaesthetic Department: Brian Cuthbertson was awarded a personal chair this year by the University of Aberdeen bringing our Anaesthetic tally of Professors up to three!

Rona Patey handed over at the end of her successful Presidency of North East of Scotland Society of Anaesthetists (NESSA) to Neil McKenzie from Dundee. As this Society approaches its 50th year anniversary, special celebrations including some exciting meetings will be planned. 'The' space to watch for further up-to-the-minute(ish) news will be NESSA's just launched web-

site at: <http://www.anesaesthesia.com>, set up and designed by our own Brian Stickle and Rona Patey...and they are hoping to ensnare willing victims, sorry, volunteers to provide additional help later. Continuing with the NESSA/ Aberdeen link, the NESSA Trainee Research prize was won by the Aberdeen entry from Moira Cruickshank & Emma Whyte, while Jolene Moore, just a FY2 at the time was awarded 2nd prize for her entry. Aberdeen trainees also performed well at this society's research forum with Anoop Kumar winning the 2008 SSA registrar's prize at Peebles.

Several happy deliveries occurred this year (we're thinking babies and not FRCA certificates here - although those too were plentiful here this year.). Girls certainly seemed to be winning (no surprise there!!) in the number stakes. Beautiful daughters were added to the families of Jamie Macdonald and his wife Louise (who was also a former Aberdeen anaesthetic trainee), Cynthia Szalai, Paul Holder, Garry Reilly and David Seath. Kara Halcrow welcomed a little boy to her family.

In conclusion, using 'North sea gas industry' language: "The Aberdeen Anaesthetic department is prospecting new frontiers through the drill bit. We already have molecules moving through our pipelines but ongoing concerns as to security of supply/demand on resources/customers, as usual, continues to be dependent on market forces to determine the sustainability of this producing asset" (Thanks to my gasman husband (non-medical type) for help with the above jargon !).

Ayr Hospital - Ruth Jackson

It's been another year of changes at the seaside - on the personnel side Ken MacKenzie decided it was finally time to take his golf even more seriously and retired in March, we had a great 'do' at the Western House Hotel which attracted many faces past and present. His were difficult shoes to fill - so we appointed three new consultants to fill the void. Kevin Walker, originally from Aberdeenshire via the Northern School arrived in February, closely followed by Rose McRobert from Glasgow in April, the third of the trio Thomasz Bialozynski joined us in July from Bangor in north Wales. They have all settled in well and seem to be enjoying the salt air.

Following the birth of her daughter Jillian Hewitt-Gray made the difficult decision to head back south and has just taken up post in Banbury. We will miss her ability to keep the rota running with minimal fuss and maximum efficiency. We continue to enjoy the constantly changing faces of our trainees during their brief visit to the south of the county - hopefully the ever changing

view of Arran from the car park helps to compensate for the band 1A and increased commuting time!

More changes in 2009, but I'll tell you about those next year.....

Balfour Hospital Orkney - Colin Borland

2008 has been an eventful year for the Anaesthetic Department at Balfour Hospital.

Malcolm Thompson has taken on roles for Nurse Anaesthetic Competencies Assessor and been offered training as EPALS instructor. During this time his OU language studies have progressed from Spanish through French into Ancient Greek.

In July Colin Borland retired '60 not out' with the intention of returning to work half-time. In August our half-time French colleague (Jean-Francois Enault) announced his intention to call it 'un jour' and will have left the Balfour team by the end of 2008.

Newly arrived from Poland, via Scarborough, is Marek Wolanski who is heading up establishment of a formal HDU facility. Surgical Consultants have also increased by 1 as Cesar Zawal (also Polish) has recently arrived from Faroe Isles.

Air ambulance transfers remain an infrequent but contentious liability. We're making progress with obtaining suitable transport equipment, and cannot help but fantasize about a future Adult Retrieval Service for the Northern Isles. Also featuring in our current 'Fantasy Island' hallucinations is the prospect of an entirely new hospital building.

As in last year's article we would wish to announce our intention to recruit an additional full-time Consultant Anaesthetist taking the establishment to 3.5 FTEs in 2009. Perhaps this will bring into reality Colin Borland's wish to reduce his working to part-time while allowing continuation of his input into Chronic Pain, Cardiology and out-of-hours cover in Kirkwall.

Borders District General, Melrose - Tom Cripps

We now have a complement of ten consultants, with Jonathan Aldridge and Imogen Hayward in post following Janet Braidwood's departure. Janet, although "retired", is still doing locums for us and others when not enjoying the Isle of Coll. Jane Montgomery is becoming further involved with Postgraduate Activities in Edinburgh. The whole department remains uncertain as to the full implications of the European working time directive and MMC.

News from the Far North Caithness - John MacLeod

I'm pleased to report a considerable lack of news from Caithness in the past year- No change of staff- no major dramas- we remain one of the busiest anaesthetic departments in Scotland, a feature we share with many of our rural brethren. Our senior colleague is fast approaching his 69th year and shows no signs of slowing down. The struggle to maintain skills and enthusiasm in our particular setting continues. These are particular challenges for remote and rural practitioners in any specialty. As yet I fear we have not met this challenge- a work in progress. There is the imminent possibility of a remote and rural anaesthetic trainee joining us- a cause of high excitement in a department of 3 anaesthetists, and a vital development in ensuring the survival of the remote and rural hospitals.

Those of you familiar with the details of the GRIPS report will know that our little bit of NHS Scotland is sadly lacking in the provision of chronic pain services- however in the past year we've expanded our service provision from Caithness to Inverness - (and here I must thank my anaesthetic colleagues at Raigmore Hospital for their support). Unfortunately there is a something of a budget crisis in Highland at the moment and the fledgling pain service may be a casualty.

On a lighter note, we eagerly anticipate the introduction of revalidation- these fine chaps from the GMC surely have the best interests of the profession at heart.

Crosshouse - Chris Hawksworth

It's been a hectic 12 months at Crosshouse since the last report. After several years of saying he only had a few months to go as Clinical Director, Alistair Michie has finally stood down as our beloved leader. While delighted to have passed on the responsibility of office to a younger man, Alistair has asked me to point out that his replacement, Phil Korsah, is only doing a fraction of the job he had to do. Management have finally realised that Ayr and Crosshouse hospitals have separate anaesthetic departments and thus deserve a CD each. Critical Care is also getting its own CD soon, so that's even less for Phil to worry about. One benefit of Alistair's move is that the cleaner can now see the carpet in his old office. Sadly, however, there is no wall space for his Aberdeen FC pendant in his new one. Apparently it's taking Alistair and Phil a while to settle into their new roles and workspaces. Sylvia and Margaret, our erstwhile secretaries, have to remind them where to go each morning. Sylvia is well practiced at this - she tells me where to go on a regular basis as well.

We welcomed Dr Collie back from maternity leave in October. Her return was timed to perfection as Chris

Johnstone had just about had enough of his role as acting lead obstetric anaesthetist. Mind you, I think Janie felt the same after her first week back. Also returning from maternity leave and starting as our new ITU colleague is Alison Speirs, one of the growing band of former trainees staffing our department. It doesn't seem like that many years ago that as a new consultant I was astounded by SHO Alison's enthusiasm and aptitude for ITU. Paul Wilson says this is a sure sign that I'm getting older. Does this mean I'll have to wear half - moon glasses too?

Phil Jacobs joined us last January and is setting new standards of sartorial elegance for the department. His laid back appearance fits well with the soporific breast list he's been lumbered with of a Monday. With two staff on maternity leave and one on sick leave, we've been helped out by a multi-tasking long term locum, David Clark, who has coped admirably with both the midwives and the feisty ITU staff. We are grateful for his input in ITU, especially his contribution to the ITU education programme. Having decided that the Highlands were too cold, staff grade Shiam Ravury has joined us from Inverness in the summer.

As for the trainees, I used to be able to keep track of their comings and goings as well, but now so many seem to be on rotation all the time, I've no idea if they've left or not. This must be what a teaching hospital feels like. Anyway, they seem to be doing well at the exams and deserve our congratulations for passing, often at the first attempt. Some have been moved to Glasgow such as Steven 'Commando' Wilson, while others have travelled further afield like Ryan Campbell (Liverpool) and Katrina Dick (Lincoln). We wish them well in their new posts.

At the time of writing, Nicola Willis is on sick leave. We all wish her a speedy and successful recovery. Hopefully she will be in fine fettle and back at work by the time this article is in print. Sadly, we are losing the services of Jillian Hewitt Gray who is taking up a post in Banbury. Finally, after much nagging of the management, and with departmental support, our senior colleagues Stan Zimmer and Sandy Morris have managed to get off the on call rotas. They both assure me that they are doing more daytime work to make up for it, but they're still smiling.

Dr. Gray's - Colin MacFarlane

This year we have appointed two new consultants, Dr Judith Kendell and Dr Philippa Armstrong, and now we are nine. We have a new Pre-assessment Clinic supported by Anaesthetic sessions, and an Acute Pain Nurse has at last been appointed to help us develop our Pain Service. As the rest of the hospital, our office has

now run out of space, and a takeover bid for the Doctors' Mess next door is required. The whole hospital has greatly developed and expanded over the last 12 years. Elgin is to get a Life-Science Centre, and we have a (non-anaesthetic) Professor of E-Health now in place! We have taken all our Anaesthetic Nurses through the new NES Portfolio and continue to train new Anaesthetic Assistants, now using the Napier University modules along with our newly-developed in-house training framework. So overall it has been a good year.

Greetings from the South West

Dumfries & Galloway and Stranraer - Willis Peel

Only one change this year from last. We are pleased to welcome Dr Pavel Motka who joins us from Whitehaven as a permanent replacement for John Carruthers.

Hugh and Ron are still helping us in their retirement. Thank you. Randal and Hamish hold the fort, out west, in Stranraer.

The trainees continue to come and go. At the moment we have Lia Paton (ST1), Alistair Ross (ST2), Chris Holmes (ST2), Anita Vinjirayer (ST4), Dorta Michalowicz (FTSTA2) and Sanjay Agarwall (FTSTA3). Alistair has fully passed his part one and Sanjay is sitting a final Viva as I type this note.

We, as ever, encourage the trainees to publish anything that moves (4 posters - 1 a prize winner - and several letters), and we continue involvement in 3 National trials (PACMAN, SIGNET and BALTI) and one international audit (SAFE TRIPS). We hope to gain approval for a Research Fellow early next year. So the publications will no doubt continue.

Fife - Gordon Smith

Whereas 2007 was a time of great change in our departmental staffing in Fife with 3 retirements and 4 new consultants taking up post, 2008 has been one of consolidation with only one colleague Maher Gergis "hanging up his boots" in December after 16 years in the kingdom. He will be sadly missed not least in our community dental unit and elective orthopaedic theatres for his friendliness, charm and excellent choice of after shave. His departure also gives me the dubious honour of being the oldest consultant anaesthetist in Fife - I am indebted to all my colleagues for not rubbing this fact in too much!

To more mundane matters. The large open space which will eventually house all the Acute Services in Fife remains an empty fenced off ex car park, though at least the tar has been removed. This has made parking a nightmare for patients and staff alike. The distance from the hospital means that we have devised a new test of our patient's fitness for anaesthesia - if they can walk to

the hospital assessment unit from the car park without severe shortness of breath they can withstand any anaesthetic! On the positive side of the project a lot of preparatory work has been carried out to the road infrastructure surrounding the hospital and the new building should start to take shape soon with a build time from the contractors of 150 weeks. My rudimentary maths makes this a completion date of early 2012, though last year, I remember, completion was estimated for 2010. We shall see in the fullness of time.

Meanwhile we have to struggle on staffing 3 acute hospital sites. As predicted in previous Annals this has meant more and more Consultant Anaesthetists having to do resident 1st on call which, despite a generous payment negotiated with NHS Fife, remains relatively unpopular. Fortunately so far everyone is just pitching in and helping out, but it is going to be a long 3 years before we see the end of it and we still have to take into account the further reduction in junior doctors' hours in August 2009. Perhaps by that time we will have developed a new breed of consultant who has this sort of work pattern factored into their job plans. Whether this takes the form of a junior consultant who will take a larger share of the overnight workload from their more senior colleagues or some other incarnation dreamed up by our masters in Edinburgh remains to be seen.

January 2009 sees the first of our Physician Assistants-Anaesthesia starting work in Fife after her 2 year training. We are confident that she will be a great help in covering some of the work previously done by our ever decreasing number of trainees especially in the area of pre-assessment. Another 5 are at present training in Fife and will come on stream in 2010/11 to further help the situation. If only they could do overnight on call duties!

In conclusion I would like to thank all my colleagues in Fife who make my job of Clinical Director a lot easier. I would like to single out John Donnelly our College Tutor who has put in a tremendous amount of work this year in ensuring that our rotas are covered in one way or another as well as all the Lead Clinicians in our specialist areas. I couldn't ask for a better group of colleagues and it is their professionalism and dedication that makes the Fife Anaesthetic service one of the best in Scotland (I would not be so presumptuous to say we are the best - why state the obvious!)

Forth Valley - Crawford Reid

We welcome Judith Wilson as a new consultant colleague in place of Bob Law and we wish Bob all the best in the future. Judith very kindly agreed to host the Christmas party! Prasaad Kasthala retired in October after 22 years in post, the last five as Associate Specialist - we wish him a long and happy retirement. We welcome

Neils Weidenhammer as his replacement. Congratulations go to Francois Taljard and Marian MacKinnon on their appointment as consultants in Monklands.

We have had a very high success rates in exams with our trainees. Congratulations to all – too many to mention by name. The department is presently awaiting the appointment of 2 PAA's with mixed feelings. It would be interesting to hear what others think on this issue.

We are still in limbo waiting for the new hospital in Larbert to open. It will be great to get onto a single site. Our chronic pain team is not going to be so lucky as they will still have to work on two sites.

Glasgow Royal Infirmary - Stewart Milne

The New Stobhill Hospital or Ambulatory Care Hospital (ACH) is due to open in 2009 and will result a major redistribution of work between the GRI and Stobhill sites. Most of the day case and 23 hour surgery will move to the ACH thus freeing up inpatient theatre space at GRI. I currently work on both sites but a lot more of us will be travelling up and down Springburn Road. The chronic pain service will move into the ACH when it opens. The council are planning to build a cycle path along the dual carriageway so it should make life much safer for those of us who choose to travel between the hospitals by bike.

Cardio-thoracic surgery moved from GRI to the Golden Jubilee Hospital. Some of the cardiac consultants retain sessions at GRI but Mike Higgins, Steven Moise, Derek Paul and Robyn Smith have all left us permanently. The 3 theatres left vacant when cardiac surgery moved are being used as spare theatre capacity while some of the other theatres are modernized.

ICI remains as busy as ever but there are plans to increase it in size in the near future.

The obstetric anaesthetists are bracing themselves to work even harder as patients are transferred from the Queen Mothers Hospital. This will make the Princess Royal one of the largest maternity hospitals in the UK with well over 6000 deliveries per year.

Andy Crockett joined us from Dundee and has theatre sessions at GRI and chronic pain sessions at the Southern General.

The Institute for Neurological Sciences - Linda Stewart

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

thetic trainees. We have established a difficult airway training module and a number of local SpRs have undertaken 6-month attachments to this end. Dr Cunningham runs regular Airway Training Days and an associated website – gaslab.co.uk. (Keep an eye on the website for upcoming courses!) 3 of our consultants take an active role in the RCA Airway workshops. This year has seen the retirement of Dr Dora Cossar after many years service. She has been replaced by Dr Simon Young, who hopes to forge ties with the University.

In ITU we are working closely with the University of Glasgow to develop a real time breath ethane monitor to detect oxidative stress. We have been trialing a portable bedside monitor, the results of which will be published shortly.

We have been working hard to improve our Non-Heart Beating Donation Service, and in collaboration with colleagues in Edinburgh will shortly produce a Scotland-wide Protocol to guide ITU clinicians in this field.

Glasgow Western & Gartnavel - Colin Runcie

Little has changed here at Gartnavel in the last year, save for 2 notable retirements – John Brown and John Asbury. The department wishes them well in the years ahead; their contributions to the Chronic Pain service and to academic anaesthesia were substantial.

In addition, there has been a pulsating miasma of changing responsibilities among senior consultants. Nick Pace and Sandy Binning have jointly moved into Cammy Howie's pan-Glasgow shoes. Cathie Brydon has replaced Neil O'Donnell as rota consultant and Graeme Hilditch and Brian McCreath have replaced Pauline Stone and Cathie as College Tutors. My own time as Chairman will soon draw to a close.

From our SpR group, Pam Doherty has obtained a consultant post with an ITU interest at the Victoria Infirmary. At ST and FTSTA level, August at the Western and GGH now brings change so marked that my aging brain struggles with the blizzard of names and abbreviations.

The other major change has been the departure of the WIG cardiothoracic service to the Golden Jubilee in February 2008. Some consultants chose not to transfer. Others jauntily moved part-time and some have since less jauntily returned. Alistair Macfie and Isma Quasim have plunged full-time into the maelstrom that is the West of Scotland Regional Heart and Lung Centre. Their contribution to the last decade of the old Western service was of extraordinary dimensions and is fondly remembered. Our collective ability over that period to anaesthetise a high volume of sick patients with good

outcomes and almost negligible use of resources seems almost incomprehensible in the current circumstances.

Back at GGH, the cardiothoracic move has drawn a line under years of Cardiac v. General rivalry and our aging accommodation is suffused with optimism and warm feelings of mutual support. More united and focussed than ever, we collectively embrace each other and the challenges which lie ahead.

Hairmyres - Grant Haldane

The main event of 2008 was the move of our Thoracic surgical unit from Hairmyres to The Golden Jubilee Hospital at Clydebank. 3 consultant anaesthetists at Hairmyres now have fixed sessional commitments to the Golden Jubilee which also incorporates SPA time spent at Clydebank. Although the move has apparently generally gone well it has left a considerable hole in Hairmyres which has yet to be completely filled. It appears however, that this will be filled with an increase in our orthopaedic workload & we hope that this will continue to allow us to develop our interests in peri-operative pain management & regional anaesthesia.

Dr Jane Burns has continued to climb the corporate ladder & was recently appointed as Associate Medical Director for the Surgical & Critical Care Services Division of NHS Lanarkshire.

MMC resulted in local difficulties in keeping junior rotas compliant due to problems with back filling but this was largely resolved much to the relief of the consultant staff!

We continue to be actively involved in the national programme to train Anaesthetic Physician Assistants with the first group due to graduate at the end of this year. In addition NHS Lanarkshire has also appointed Critical Care Practitioners across all three sites & 2 trainees started in Hairmyres in September.

Mid life crises have set in for many of the male members of the consultant body with a flurry of sports cars, cycling, marathon running & even triathlons. This has also spilled over & affected the trainees with head to head competitions in the last year. I am delighted to report that the consultants remain victorious but I am not sure if concerns about future career progression played a part in these outcomes!

Dr Allen has also cycled all over the Pyrenees to raise money for charity & came through unscathed. A further baby is expected in the new year & we hope this goes well.

Monklands Hospital - Roddy Chapman

The last year has seen an end to the uncertainty regarding the future of services at Monklands Hospital. The Picture of Health review would have seen acute care and major surgery being provided on two sites in Lanarkshire. However, following an independent review commissioned by the Scottish Parliament, it was decided that acute care should remain available on all three sites.

Amidst the political uncertainty the Anaesthetic Department continues to thrive and two new Consultants have taken up posts – Paul McMurray who was an Associate specialist in the department and Juan Escuder. Paul has made a significant contribution to the clinical service over the years and the Department were all pleased to see this recognised.

The last year has also seen the re-establishment of a chronic pain service at Monklands. Intensive care continues to run at full capacity for the majority of the time. As is the situation in most other units, our Intensivists have been kept even busier with the implementation of the SPSA care bundles. Monklands ITU is to receive two of the Advanced Practitioners in Critical Care and a number of us are involved in the provision of lectures and tutorials as part of their course. Another two trainee Physician Assistants in Anaesthesia (PAAs) have recently joined our department as part of their training, the first pair having recently sat their final exams.

I am sure in the future the PAAs will have an important role to play in maintaining theatre efficiency with the reduced trainee input to service provision.

On the subject of theatre efficiency a number of us were involved in the "LEAN" project which was facilitated by GE healthcare. LEAN has its origins in the motor industry and aims to eliminate "waste" from a process. All of us that were involved found it to be an extremely useful exercise although we Anaesthetists were slightly bemused at the proposition that having an anaesthetic was classed as a "non value added step" in the patient journey!

Tales from Tayside - The Ninewells News - Matthew Checketts

Well another year slips by and the world keeps turning despite the Credit Crunch. We are still just solvent at Ninewells and the patients keep coming. The staff also keep coming and going. I am finding it increasingly difficult to keep up with who everyone is! Yes, I hear you say, "he's losing his marbles" – maybe so, but you try memorizing the names of the glut of new faces who have appeared in the anaesthetic department in the past year. I've even bumped into a few folk and said "haven't seen you for ages" and they remind me that

they have been in Australia for a year! Oh well...only 15 years until I retire, or maybe less if the men in the white coats come and drag me off to the locked ward.

Here's a synopsis of personnel changes. Mel Thomson retired on 1st December to dedicate himself to his farm. We all miss his wise words and company. In August 2008, Judith Joss was appointed to Alf Shearer's post and Gail Gillespie came from Truro to join the pain team.

Antipodean Brain Drain

Hugh Rorrison left in June to take up consultant post in New Zealand starting in August and Paul Currant is taking up a consultant post in Christchurch in January 2009. Christina Beecroft left in February to spend a year in Adelaide.

Pauline O'Neil was appointed as consultant in Paisley and takes up post in February 2009. She will be closer to her beloved Celtic Park, but what about supporting the Buddies?

New trainees keep coming and going at a frightening rate - a few in February and quite a lot in August - too many to list. Our fly-boy Scott Farmery, left to take up a HEMS post in London in May. If you sprain your ankle during a visit to the Association don't be surprised if he appears out of a helicopter to deftly apply a tubigrip and pop a Brufen into your sweaty palm!

We now run orthopaedic lists at weekends to keep the waiting times down and plastics are also getting in on the act. The Scottish National Treatment Centre at Stracathro continues to struggle on under BMI/Netcare, although I think it's future is on a shoogly peg once the current contract runs out next year. Who knows what will happen after that...let me just text Mystic Meg for a heads up!

Best wishes to all.

Royal Alexandra Hospital, Paisley - Jackie Orr

Greater Glasgow and Clyde has arrived. We are no longer in transition. The management structure has changed but John Dickson remains the source of all knowledge. He is now Associate Medical Director (Board wide) and Liz James has become Lead clinician.

Fergal Burns is our new College tutor and has thrown himself into the role with enthusiasm. His predecessor, Malcolm Smith, served as College tutor for 6 years. He was a natural at encouraging trainees to success. A stickler for detail, he gave freely of his time and trainees at all stages appreciated this individual attention. He could also organise a good social outing! Malcolm is

now Deputy REA for the Western sector.

ICU consultants come and go. Mike Buttiegieg left in July to return to his native Malta as an intensivist there. We welcomed David Ure to the ICU team in May 2008 and Pauline O'Neill has been appointed to start in Feb 2009.

Annette Whalen retired in October 2008 after 20 years as the departmental secretary. She coped with the pressures of administering a busy department with calm and cheerful impartiality. Her popularity with the many trainees she had "fostered" was evident from the attendance at her retiral dinner.

Adrian Tully and Alastair Cameron have so far survived C Difficile and are still working between the Vale and RAH together with many RAH consultants.

Geoff Douglas retired last year and enjoys commuting to Florida.

Perth Royal Infirmary - Cliff Barthram

The Perth Anaesthetic dept has navigated steady course over the past year under the (reluctant) leadership of Michael Forster.

After external delays and wranglings (which discretion prevents me from going into) we were finally able to advertise for a replacement for Dr Dave Magahy who retired over a year ago. Dr May Mok is due to take up her consultant position in the New Year, and is warmly welcomed to the department.

A revolution has happened now that Arthur has taken on the rota - for the first time in over 12 years at PRI I know what I'm doing a month in advance! Organisational abilities which would put Heathrow air traffic control to shame. Sine has performed similar feats with the trainee rota.

Dr Bell has revealed an alternative existence as a beanie-hatted "nature" photographer. Wil Elsdon continues to shame us all with his all-weather cycling to work, and is currently preparing a trip to the Himalayas for his annual top up of the elixir of youth (I don't think he's had any 'work' done). Similarly Shelagh Winship is trialling the 'cycling round Brittany programme' as an aid to recovery from knee surgery.

Coffee room chat has moved on from Yevgeniy's insightful appraisal of the Georgia conflict ('mafia', and 'taught a lesson' seemed to feature, a lot) to Ravi's new house and forthcoming house-warming party, and the safe arrival of Jo's new baby girl - congratulations from all of us. Hair in the department seems to be in a worry-

ing state of flux (?climate change) - it's either becoming greyer (mine and Duncan) or scarcer (Michael and Ewan). There's also a rumour that Barbara's planning to make it to Associate Specialist before heading off to the sun with the loot.

I've been asked not to mention Dr Ritchie's increasingly frequent outbursts of swearing related to the tutorial programme and computers in general.

Best wishes to all from the Perth Anaesthetic Team.

Raigmore - Ian Johnston

It is unusual to start a report from Raigmore concentrating on the fabric of the establishment rather than the personnel, but the skyline of our once green site has now changed forever with the appearance of the magnificent Centre for Health Science, the third phase of which is now open. We are grateful to Ross Clarke for his input into this and taking the unenviable responsibility for procuring the anaesthetic training equipment in the new Clinical Skills Centre. The CHS should prove to be an excellent venue for the Society's Scientific Meeting in November. Please book your study leave early and encourage all your colleagues and trainees to attend!

We now await with eager anticipation the next major project, an Ambulatory Care Unit, the building of which will hopefully commence next year. When Ken Barker took charge of the Steering Group, he had a full head of dark hair - ... here's hoping that it's completed whilst he still has any hair at all!! One of the down sides of this is that we will lose our recently created Maternity Unit car park. To compensate, however, the management team have craftily reorganised the traffic system round the hospital into a 2-directional "one-way system" thereby ensuring that most of the staff's cars will have met an untimely end before more parking space is required!

It is with great regret that I report the sad and untimely death of Sheelagh White. Sheelagh was greatly admired and respected by all the staff with whom she worked and a friend to all. Our thoughts are with Allan. We also wish Suzie Dempster continuing progress in her recovery from ill-health and return to work. On a lighter note, however, it is a pleasure to welcome new members to the department. Firstly, Deepak Mathur returns to Raigmore for the third time, but the first as a consultant, charged with keeping the "auld piper" John May and myself up to date in obstetric anaesthesia. Little did he realise when accepting the job what challenges lay ahead! Two very young members have also appeared on the scene in the last few months and congratulations are due to Vanessa and Gordon Bathgate on the birth of

Abbie, and also to Noreen and Ross Clarke on Megan's arrival a few weeks later. Gordon obviously took heed of last year's report and managed to spend a little more time in his bed!

Congratulations (or is it commiserations?) are also due to the V-P, John May on his appointment as Clinical Director of Surgery and Anaesthetics, the first anaesthetist to hold this post. We are all benefitting from his usual non-confrontational self-effacing efficiency - and a few tunes to boot! The Society is sure to be in safe hands for the next year.

Royal Infirmary, Edinburgh - Anon

We're back! Despite extensive enquiries it has proved very difficult to discover why there has been a lack of news in the Annals from the Royal Infirmary over the last few years. Janet Jenkins in her retiral speech from her post in the Department and as Associate Medical Director in October 2007 certainly gave no indication and her successor as Associate Medical Director, Dr Simon Mackenzie, is very much towing the corporate line. Word on the street is that Janet has been attending numerous luncheon outings and has been seen at the airport queuing for the South American flight. We wish her well and hope her vaccinations are up to date.

Although there are many golf courses in South America, Sandy Buchan prefers to stay nearer Gullane and has finally retired, full time. Geoff Sharwood-Smith has indicated his intention to retire full time at the first attempt in December this year, and tram line work permitting, is looking forward to a night out to mark the occasion in Leith. We wish them both well.

As some colleagues and friends leave, others arrive. Rachael Hinget, watching 'escape to the country' on television one day made the decision to leave London and practice obstetric anaesthesia in a rural setting. We welcome her, Fresh from his travels to Australia, Ian Mackle has taken up post with a major interest in ICU and is joined in ICU as new appointments, by Monika Beattie and Alastair Hay. The enthusiasm for travel continues to be reflected in our trainees with Jonathen Chung at the races in Melbourne, Donald Johnston in Perth, Ian McCulloch fur trapping in Canada, Alastair Milne in Auckland, Kitty Duncan at some extreme event in New Zealand, Lee Ferguson at a childrens' tea party in Boston and Rene van der Most bulb growing in Holland. The new clinical lead, David Watson, succeeding Charles Morton, is reportedly considering opening up a travel agency to boost department funds. Meanwhile, David Brown as the new Clinical Director for Anaesthesia and Theatres is doing a stalwart job ensuring none of the responsibility for any failure in the organisation lands at the feet of the department. His counterpart in

Intensive Care, Brian Cook is equally sure footed.

Despite the best efforts of EWTD, MMC and PMETB, we continue to occasionally spot the odd trainee around the department. It has even been rumoured that some consultants have seen the same trainee more than once in a six month period and we are reassured that the illusion that we are only training emergency medicine, general medicine and ICU ST1&2 trainees is just that, an illusion! There are, apparently, ST1&2 posts in Anaesthesia still available in South East Scotland. However we give our full support to Colin Young as the Regional Advisor and his man on the ground in the Royal, David Semple, in trying to unravel this ball of string. Carl Moores has entered the fray but with wider responsibilities and taken up post as the Postgraduate Clinical Tutor for the Royal Infirmary. Duncan Henderson, with occasional duties at St Johns Hospital and a map to remind him how to get there, has taken on the role as Associate Postgraduate Dean for Foundation Doctors.

The University department continues to thrive. Following its recent visit to 'Land of Leather' Honorary chairs have been awarded to Pete Andrews and Tim Walsh and we congratulate them both on well deserved achievements. In recent times, a University initiative – now there's news – launched the Edinburgh Clinical Academic Track. This scheme is designed to promote training in Academic Medicine across all specialities, with speciality training linked to work towards a Ph D. Under this scheme Ken Baillie has been appointed as a Lecturer in Anaesthesia, Intensive Care and Pain Medicine and gained his appointment in open competition against trainees from all other specialities. Our congratulations go to him in what is clearly a very prestigious post both for him and the Department. Jonathon Rhodes has moved over to give him desk space and gone as a Consultant to the Western General, whilst Jon McCormack obviously still keen on travel, takes up post at the Royal Hospital for Sick Children with responsibilities in the retrieval service. Ben Shippey has taken his expertise in ICM to Fife and Hallia O'Shea joins Jonathon at the Western. John Aldridge and Immogen Hayward, preferring views of the Eildon Hills to Craigmillar Castle, have moved to Melrose to work at the Borders General. Meanwhile there are several accredited and more than capable trainees waiting in the wings, although given the current financial climate and the number of collection tins around, retiral is not a word often heard in the Department.

Our first group of Physician Assistant (Anaesthesia) (PA(A)s – not to be confused with PA's, SPA's or indeed the ever growing number of PA's who have replaced the non PC secretaries) have passed their final

exams and we congratulate them. At the same time we watch with interest.

The Anaesthetic workshop and the Department have said goodbye to two long friends in Selwyn Johnston and Andy Ferguson. We wish them well in their retirement. However that request for a small favour is still met with the retort of 'its mechanically impossible but come back tomorrow' under the guidance of Stuart Leitch.

No doubt there are individuals and gossip I have forgotten to mention for which I apologise, but we'll catch up another day. In the meantime the rest of us are beaver-ing away planning our jobs, appraising through 360° and still spinning, revalidating and yes, giving anaesthetics!

RHSC, Edinburgh - Alistair Baxter

This has been another busy year for us at the RHSCE. It started with the departure of Fiona Kelly, our Staff Grade in anaesthesia and pain medicine, for the allure of Vancouver. This left a vacancy for a consultant with an interest in chronic pain to join Dr Mary Rose in this expanding service, and we were delighted when Dr Suzanne Krosnar returned from her locum appointment at Yorkhill to take up the post in May. At the same time Dr Eddie Doyle was lured to the 'Dark Side' taking up the post of Clinical Director of Children's Services. Again we wish him all the best in this new role.

The PICU retrieval service continues to expand under the guidance of Dr Dave Rowney, and we received funding for the first permanent consultant with an interest in retrieval medicine. Dr Jon McCormack, fresh from a fellowship in Vancouver Children's Hospital, was appointed to a combined retrieval/anaesthesia post and took this up in October.

Our already strong links with Tayside have also developed further with a regular attachment of trainees from the East of Scotland School of Anaesthesia now visiting the RHSCE for increased experience in paediatric anaesthesia.

With a new hospital the main topic of coffee room conversation, it is good to see that our department will be in a very strong position when this occurs. Apparently it is due in 2012 - but don't hold your breath.

Shetland - Catriona Barr

2008 has seen another permanent consultant post holder in anaesthetics arrive in Shetland. Jacek Swierczewski trained in Poland and had worked as a consultant locum in Kings College Hospital before agreeing to throw his lot in with Brodyn Poulton and myself in March 2008.

Having completed 6 months with us he is still smiling, has become our website manager and photographer in residence. He is also supporting Brodyn in the running of the chronic pain service when not tinkering with his new boat!

We have sadly also seen the departure of our colleague Andrew Cooper who has provided anaesthetic services in Shetland for 25 years and who is expanding his role in primary care to include GP appraisal. He was given an excellent send off in May and is very much missed.

Areas of work under active development at the moment include the pre-operative assessment service which has been seeing all elective cases operated on in Shetland since March 2008. A new temporary 5 trolley, day unit will open in October and it is hoped that both these developments will support work on the 18 week referral to treatment target. The ENT video-endoscopy project continues in more suitable premises in the new outpatient department. We are hoping to restart immediate life support courses next year along with the paediatric life support courses already run 6 times a year. Jacek is working with local coast-guard personnel to bring them into the hospital for hands on clinical training which has been great fun and led to several members of the department going on exciting trips out on the local helicopter.

The anaesthetic department continues to contribute actively to the Scottish Intensive Care Society Audit Group through Ward Watcher and have started uploading critical care and venous thromboprophylaxis data to the Scottish Patient Safety Alliance. Our problem is now surgical recruitment and we look forward to the advent of suitably qualified candidates from the remote and rural surgical training scheme who can fill our two existing vacant surgical consultant posts.

St John's University Hospital - Duncan Henderson

We've appointed four new staff this year, to cover increased workload and start preparations for August 2009. Congratulations and welcome to Claire Caesar and Morag Renton (Consultants) and Du Toi De Wet and Raoul Sirdar (Staff Grades). Our current trainees have just switched to a full shift system to ensure monitoring compliance. After a few quiet years, there are major developments pending for St John's. We're converting 3 wards into a large 23 hour stay Unit for Lothian, developing an acute receiving area for medicine and melding 3 specialties into the Lothian Head and Neck Unit (ENT, Max-Fax and Plastics). Patrick Armstrong is lead clinician for these projects.

Aidan O'Donnell is an editor for the RCA elearning project, producing FRCA material as interactive online

study modules for anaesthetic trainees. Simon Edgar and Duncan Henderson are part of the RCA eportfolio development team. Duncan has also acquired a new office (literally) by becoming Associate Postgraduate Dean for the Foundation Programme in South-East Scotland. Jean Bruce, our Lead Research Nurse, aided by Mike Fried, has undertaken a National Audit of Scottish Inter-Hospital ambulance transfers. This is the first time such a large survey has been undertaken in the UK. It will inform the way forward for both the SGHD and SAS. Shona Neal won gold in the British Veterans trampolining competition. Jeremy Thomas is a dad (again) – boy number four.

Southern General, Glasgow – Kenny Pollock

There is now a flurry of activity at the Southern site following the formal signing up to a £800 million hospital plan due for completion in 2014 (unless the building firm/GGCHB/UK Government goes bust). Thanks to a change of government this will no longer be PFI funded, instead through some public shell organization thought up by those clever people in the Edinburgh banking sector. Most of the new Maternity building's structure is finished and is due for completion at the end of 2009. The paediatric and adult hospital plans are at the 'wrangling' stage. The new builders' car park is particularly impressive and gives us all high hopes for the quality of the rest of the place.

Regina O'Connor has taken over from Phil Oates as lead clinician, promising at least a velvet glove over the fist of rule. Andy Crockett left his locum post for a job north of the river, and Pam Doherty joins us for a few sessions per week from her new Victoria infirmary post. Once again the turmoil of MMC interviews has purged many able trainees from the department and anaesthetics. Happily Douglas Russell is back at work, and Pete McKenzie hopes to return in the New Year. Sadly Linda Hogg, the department secretary/organiser for the last 16 years has finally had enough of the actuarial maths required to do the rota. She decided to take early retirement last month and with great insight, has left the Southern and the country. We wish her well for her new life in the Spanish sunshine.

The whole department looks forward to the New Year with relish at the prospect of complete job plan changes and the opportunity of split site working involved in the opening of the new ACH/ACAD at the Victoria site. We welcome the abolition of the parking charges at the hospital, but are wary at the plans to introduce car number plate recognition and retinal scanning as the replacement control method. Like other departments in Glasgow we welcome the managerial help in improving theatre efficiency. Many consultants have signed up to the bar code tattoo, and the timed toilet break competi-

tion is proving very popular.

Finally in a twist of irony, the local council has proposed to 'cap' the tanks at the nearby sewage treatment works, while GGCHB mulls centralisation of lower GI surgery to the Southern site – thus ensuring the continued sweet smell of success.

Stobhill - Roger Hughes

This will definitely be the last year I will report that little has changed at Stobhill. It has been a pleasant time for those older ones among us who are tranquilly progressing towards our lump sums etc but probably frustrating for younger colleagues maybe wishing for more excitement.

The Ambulatory Care Hospital is scheduled to open with 6 Day Theatres in May 2009 resulting in transfer of work from GRI to Stobhill and lots of reorganisation.

The corresponding transfer of Acute work to GRI is currently scheduled for some time in 2010 but don't hold your breath. However Management is trying to make the remaining time here as stressful as possible. Attempts are being made to run the acute service without labs using motorcycle couriers to take samples to GRI. To allow further development of the ACH it is proposed to demolish our 10 year old state of the art ICU next summer and replace it with a Portacabin aka a "purpose built mobile ICU". After 8 months of paying for parking we are to go back to the previous system or a new variant yet to be announced.

At Consultant level David Ure decided he had had enough of uncertainty and moved to Paisley - described as "going from the frying pan to the fire" by a senior manager. His locum is Tariq Chaudhry and Jennie Cuthill is taking up the substantive post in February. We continue to get most of our juniors from GRI for 3 months at a time - just about long enough to get to know them. However we are beginning to get some repeat offenders which is nice for us.

Susan Smith is back from child 4 (? the last) and Lisa Manchanda will soon be off for number 2 – hopefully returning for the centralisation of North Glasgow Pain Services in the ACH.

The Top Left Hand Corner of the Weather Map – Stormy, but Maybe More Sunshine Later.

Stornoway - Andrew Hothersall

Another year, another Chief Executive, (or two if you count the same one twice).

In fact, for a time we had three CEOs at once; one "on secondment", one under suspension "as a neutral act"

and an interim for the latter.

Fortunately our Board was only paying for one at a time. The Audit Commission investigation which preceded the partial resolution of this situation made entertaining on-line archive viewing and was the second time during my sojourn here that financial scandal within our health board has hit the international press. The other time was the BCCI debacle. I was doing a locum in Saudi Arabia at the time and was astounded to receive such a reminder of things I thought I had left at home.

The optimism with which I spoke last year has not proved entirely well founded. Though we did manage to finish the last financial year with a modest surplus, the offer from the government of brokerage for the outstanding three and a bit million cumulated deficit is dependent on our convincing them that it is sustainable, which at the last count we had failed to do. We still have more than two months to run, and there are plenty of things, such as junior doctor hours, which could jump out of the woodwork and bite our backs.

When the previous Interim Chief Executive (very sensibly from his point of view) announced to the Executive team that he was moving to a better (and definitive) job, it was as if Banquo's ghost was attending the rest of the meeting. I was very much reminded of the day John Lennon died. We had a rehearsal planned that evening for the Western Infirmary Christmas Show ("Transplant, or Her Heart Belongs to Another"). Serious rehearsal was out of the question. We all just sat around the piano numbly singing Beatles songs, united in our mourning.

His departure of course led to an opening for a new Interim CEO, which was filled from below by the definitive Director of Nursing Services/Chief Operating Officer (COO), in turn creating the need for an interim COO, seconded from Edinburgh, adding to the huge number of interims and locums.

One inevitable feature of our small size is the devastating effect on the medical budget when a consultant is absent on long term sick leave or suspension. We still have to pay his salary plus frequently extortionate locum fees, more than doubling the cost of the service. Out of eighteen consultants we currently have nine locums. It would not be so bad if there was any guarantee of locum quality, but in fact dealing with a constant stream of complaints against an admittedly (and gratifyingly) few is the bane of my life. I often live in fear of my own registration through adopting a "better the devil you know . . ." attitude but waiting time targets have to be met, even if their relevance to a remote community may seem scant. My previous policy of virtually elimi-

nating the need for anaesthetic locums by employing a fourth established member of the department has well paid off.

The locum/interim problem cannot be tackled properly until the new Clinical Strategy is decided. This has in itself been a source of increase in interims with "advisers", project leaders and officers being brought in from afar. Nevertheless the holy grail still seems elusive. At one time over a six month period the target date had been put back a year. But we know it will be finished by July as this was promised to Nicola Sturgeon at the annual review, along with Junior Doctor compliance by August 2009 (without additional resources).

Sitting in a car watching the Atlantic breakers on a beach in Benbecula while writing this on my laptop reminded me of the comedy of errors last time I had a list at the Ospadal Uibhist agus Bharraigh (OUaB). I'll try and make it brief.

Once a month a consultant surgeon, an anaesthetist and an ODP travel to the OUaB to do a list; clinics/pre-op assessment Thursday morning, list in the afternoon, post-op and short clinic Friday morning, 11.00 flight back to Stornoway in time for lunch.

Unfortunately on this occasion the flights had not been booked in time, and the knee jerk reaction of cancellation was initiated.

But wait, if we left Stornoway at 07.00, we could get the 08.30 Sound of Harris ferry and be in Benbecula by 11.00, do half the cancelled clinic and the list, and re-schedule the remainder of the clinic patients for Friday morning leaving time to catch the 15.30 SoH ferry back. Accordingly all patients previously cancelled were informed of the change of plan.

All went well until, already under way on the ferry, we discovered quite by chance that the Friday 15.30 sailing had been rescheduled for 09.30! No effort to communicate this gem was ever made to those booked on it. The excuse given was "unfavourable tidal conditions" (shades of Reginald Perrin) which are only predictable years in advance by consulting a nautical almanac. Accordingly the patients rescheduled for Friday morning were cancelled.

The clinics and lists were uneventful, and apart from the uncomfortably early start on Friday morning things seemed to be going well until, two miles short of the ferry we met our ODP traveling back south. The ferry was cancelled due to bad weather, and we were referred to Lochmaddy. The best they could offer us was a 10.45 sailing to Uig on Skye, where we could kick our heels

until a special extra sailing Uig/Tarbert at 19.30 (don't ask). The alternative was to stay an extra night and try to salvage something from the devastated clinics, returning on the Saturday a.m. ferry.

In the event all but one of the cancelled clinic patients were contacted and able to attend and waiting times were not disrupted. The missed Saturday breakfast necessitated by early departure for the ferry was almost compensated for by the ferry journey itself. The saloon was transformed to a scene from Little Miss Sunshine as hordes of pre-teen girls were being prepared by their mothers and others, out-glamming each other for a dancing competition in Tarbert that morning. What is the MAC for hairspray? Sharath Shetty even made it back in time for golf.

This sort of event will either drive you mad or endear you to the islands forever.

This may be my last contribution to the Annals in my present role, as I have 1 August 2009 pencilled in for retirement, this being exactly twenty years since I started here, and has nothing to do with the Junior Doctors' 48 hour EWTD compliance, honest. In that time I have seen many changes, not all of them for the better, but have never regretted my decision. I wish every success to those who follow and hope they get as much out of it as I have.

Anyone looking for a locum?

Stracathro Hospital - Charlie Allison

We have started doing joints again, chiefly through the enhanced infrastructure of the Scottish Regional Treatment Centre. This usually operates in a parallel universe (like Elvis - after we have "left the building") but they also utilise an empty theatre on Thursdays & Fridays. We in the core NHS celebrate the investment it has brought us - three new anaesthetic machines for a start. We also see colleagues up for lucrative private sessions.

Ian Mellor now works full-time in Dundee (including ITU), so Neil Mackenzie volunteered for a relaxing country jaunt - not far to travel for a man who's bought a bolt-hole in Moray!

Your correspondent's main excitement has been a visit to CCU with high blood pressure and his election as Dean of the Brechin Guildry (established 1629) - these events were unconnected! Now fine ("on the peels") and well enough to go to the World Congress in Cape Town, where I enjoyed a brief dialogue with Desmond Tutu and convivial meals with John Mackenzie & Ian Smith, as well as meeting celebrated ex-Dundonians

Syed Takroui & Peter Kempthorne (from Riyadh and Christchurch).

Victoria Infirmary - Neil Smart

Liquidity crises, budget deficits, poor money supply, our departmental funds remain as critical as ever if our management team is to be believed. Dwindling trainee numbers, dropped EPAs, and no money for replacements.

Yet nostalgia just ain't what it used to be. Who can forget the good old days when we had enough trainees not only to run a rota but to have a middle grader? Now, the prospect of consultant first on call looms. In response, Graham Gillies and Gordon McGinn have taken up neurolinguistic programming, which in my (limited) understanding is a bit like meditation. At least it's better than sitting there doing nothing.

The Ambulatory Care Hospital, or new Victoria, is nearing completion and is scheduled to open its doors to patients over the summer. The 'old' Victoria soldiers on in the meantime so that the majority of cases in South Glasgow will receive their care at the Victoria site. Looks like we're going to be quite busy.

A big welcome to new arrivals Pamela Doherty, a sixth consultant for intensive care, and Carol Stuart, our new secretary. Carol, a vivacious redhead, turns out to be related to Brian Stuart, now nearing national treasure status. Perhaps understandably, we were slow to pick up on the family resemblance. Congratulations too to Jenny Cuthill, appointed consultant with an interest in intensive care at Stobhill Hospital.

The social event of the year was undoubtedly Jane Purdie's 'big birthday' which was celebrated in some style with a surprise party and what seemed to be hundreds of coloured balloons. Jane is still hunting the trainee who thought it so unusual to admit to your age that this must be a 'misunderestimation'.

Western General Hospital - Susan Midgely

Avid readers of this august journal could be forgiven for thinking that the Western General in Edinburgh no longer existed as for the past 2 years no report has been published. This is what you have been waiting for.

We now have 29 permanent consultants and 1 staff grade. Glenys Jones retired in September 2007. She has already completed an MSc in osteoarchaeology and is now off on her gap year. Lynda Rutledge retired in May 2008. Halia O'Shea joined the department in April 2008 and Jonathan Rhodes in August 2008. Susan Rae is currently off on maternity leave following the birth of Matthew in July 2008. Alasdair Waite and Janet Braid-

wood (formerly of Borders General Hospital) have been filling locum positions.

ENT surgery has moved out to St John's so a number of WGH consultants have split site working. I believe it is easier to park your car out there. Neurosciences are scheduled to move to the Royal Infirmary site at Little France in 2012 or is it now 2013? After much deliberation colorectal surgery will stay on site at WGH. There were sighs of relief all round as without colorectal and neurosurgery the viability of the intensive care unit was very much in doubt.

On the academic front Pete Andrews has been made honorary professor in the University. Lesley Colvin is on the board of the British Journal of Anaesthesia and Irwin Foo is an examiner for the Primary FRCA.

The department has been training physician's assistants in anaesthesia for the last two years. Support for this project has been mixed. We wait to see what happens when the first cohort qualify early in 2009.

The South East of Scotland School of Anaesthesia continues to send us trainees. We are all getting to grips with the new terminology - ARCP, DOPS, MSF, ACCS etc. Kirsteen Brown, Liz Steel and Jeremy Morton run the various rotas and are currently devising rotas compliant with the 48 hour week.

To conclude, the Western General Hospital is alive and well so don't miss next year's report.

Wishaw General Hospital - John Martin

A fairly settled year in darkest Lanarkshire. No-one retired, no-one joined. No-one died. One was born. (I'm sure there's a song there somewhere)

Unfortunately little has changed, too, in the problem areas, such as bed shortage, number crunching to hide the truth, and an almost fanatical approach to prevent "breaching", the last at the expense of emergency activity! As always, no-one knows whom to confront with this problem which seems to have evolved spontaneously.

Other hospitals in Scotland are relieved at the removal of car parking charges. Here they are now digging up beautiful (and expensive) landscaping to provide more parking spaces.

At least our trainees are coming up trumps with good exam passes, so we must be doing something correctly!

RIISC Yorkhill - Ross Fairgrieve

Hello colleagues. The time of year has come again to reflect on changes both good and not so good over the past twelve months and to look to the future.

Plans for our new hospital across the river at the moment are high on everyone's agenda and there seems to be considerable uncertainty surrounding the final build. Of particular concern is the suggestion of limited or no office space for consultants. This will undoubtedly impact on both our well established and effective ways of working and communicating as medical professionals and on our morale. Specifically within the proposed new theatre suite it has been suggested that a more efficient use of space may result from the abolition of anaesthetic rooms!!!! I am sure that even some of our less senior consultant staff experienced chest pain and palpitations at this thought. I myself feel that any space advantage would be lost as we would obviously have to hold huge stocks of aspirin, GTN and a separate oxygen manifold in each theatre to allow for the physiological effects that would ensue. Furthermore it may be necessary for Greater Glasgow and Clyde to double the size of their current Stroke Unit. I do hope someone has thought of this.

Within the current theatre suite things have been extremely busy. There is an obvious lack of theatre capacity and an increasing workload. This is a situation that can only get worse as we are soon to increase our age cut-off to 16. Somewhat surprisingly there is to be no obvious increase in capacity in the new build (same number of theatres I hear!). The anticipation is presumably to increase capacity around a 3-session day instead.

Our all-singing all-dancing 'OR 1' laparoscopy theatre opened early in the year. We mourned the laparoscopic appendicectomy. We are now mourning the laparoscopic pyloromyotomy! It is very sci-fi in there and has weird green lights that make one look and feel like an alien. In fact it is rumoured that surgical appointments henceforth will be organisms from the planet Skaro integrated within a tank-like mechanical casing sporting metal appendages instead of limbs. Commonly known as Daleks I believe. These ones have been trained not to 'ex-ter-min-ate' but to 'C-O-2-in-flate'.

Continuing on a surgical note the department wishes a fond farewell to Mr Alasdair Fyfe who retired earlier in the year after many years of distinguished and dedicated service.

Further afield our paediatric radiotherapy provision moved in the middle of the year to the new Beatson site on the Gartnavel campus and is working extremely well. The change has been welcomed by both staff and parents.

Dr Jane Peutrell stood down as CD for anaesthesia, surgery and theatres in the spring of the year. We would like to express heartfelt thanks to her for all of her hard work and dedication.

Finally we would like to welcome Dr Rob Ghent to the department. He commenced a consultant appointment in August. A welcome also goes to Dr Colin Lang from Stirling Royal Infirmary. He is with us one day a week as a six month pilot of DGH paediatric outreach working.



Scottish Winter Meeting

Aberdeen

November 2008

The Scottish Winter Meeting took place in Aberdeen on the 20th and 21st of November 2008 at the Mercure Ardoe House Hotel. In 2007, the Society had a joint meeting with the South of Ireland Society of Anaesthetists. This year the Society's Winter meeting, organised by Andrea Harvey, was combined with the RCA Scottish Winter Meeting, organised by John Reid.

On Thursday the leadoff hitter for the Scottish Society was Harry Burns, our CMO, on the topic of the Scottish Patient Safety Programme. This is an attempt by the Scottish Patient Safety Alliance to embed a culture of quality improvement and patient safety in Scottish hospitals. Members of the Alliance include the Scottish Executive, NHS Scotland, QIS and the Institute for Healthcare Improvement (a US organisation). 10-15% of hospital patients have an adverse event associated with treatment and the aims of the SPSA are to reduce this by 30% by 1st January 2011 with an accompanying reduction in mortality.

Some of you will remember the exceptional talk Harry gave at the Society's meeting in Peebles 2007 on the Biology of Poverty. The intellectual lustre of his material then was matched only by the sheer verve of his delivery. He was less enthused about the SPSA – though clearly rather taken with the notion that only in Scotland has an entire health service made a formal commitment to improving patient safety. Brian Cowan covered related material later in the day in the Gillies Lecture.

Hitting in the second spot, and slightly speedier on the basepaths, was Tom Reader, a psychology

Research Fellow at the University of Aberdeen. His PhD research looked at patient safety and teamwork in ICU in Aberdeen. He found that issues with non-technical skills underpinned more than 50% of adverse events in ICU and is currently looking at leadership behaviours and skills in ICU. His colleague Evie Fioratu then spoke briefly about her plan to study anaesthetists' intra-operative cognition using the DEEDS framework which is, of course, "a philosophical and empirical coalition in cognitive science comprising the Dynamical, Embodied, Extended, Distributed and Situated approaches to knowledge and cognition".

The second session, chaired by our President John McClure, comprised the meat of the lineup. In the 3-spot, and hitting for both average and power, was Carol Brunton, the Lead Clinician in Renal medicine in Aberdeen. She gave some guidance as to how to approach dialysis dependent patients on our lists. Dialysis patients are older and with more comorbidity than in the past. It is helpful to know their "weekly averaged BP" but pulse pressure is a very useful alternative. Anti-hypertensives are best avoided on the day of operation and nephrologists can advise which patients will tolerate hypovolaemia well (or not) and which will have a labile BP.

Newer buttonhole fistulae are much smaller than before and perhaps difficult to identify. Hypotension and thrombosis are a major risk to their viability and they should be checked for a bruit and thrill pre and postoperatively. She cautioned against Hartmann's solution and low molecular weight heparin and advised that we seek nephrological advice about fluid status and post-operative medicines.



Ewan Jack and Bryce Randalls



Speakers (clockwise) - Brian Stickle, Tom Reader, Harry Burns, Andrew Ronald and Carol Brunton.



John May



John McClure presents Brian Cowan with the Gillies rose bowl.

The next speaker was Brian Stickle of Aberdeen, hitting cleanup and speaking about the practicalities of novel analgesic drugs. These are needed for novel analgesic problems like the tendency of intraoperative remifentanyl to induce hyperalgesia. Of the many available agents, he recommended modest doses of gabapentin and ketamine.

The last morning speaker was the 5-tool phenom, Andrew Ronald of Aberdeen. He spoke about the indications for transoesophageal echocardiography in non-cardiac surgery. The diagnosis and treatment of undiagnosed severe haemodynamic disturbance received a keen thumbs-up. Its value in stable patients with ischaemic heart disease is unclear, with little useful evidence to guide us. Andrew recommended it for patients with right heart failure OR the combination of preoperative regional wall motion abnormalities and a history of LVF. We retired to muse upon this over lunch.

The first of the afternoon sessions was chaired by our Vice-President John May and took the form of 2 debates, a format with no easy baseball analogy. The first debate starred two local speakers. Bill Brampton proposed that elective patients should be extubated awake while Harry McFarlane opposed the motion. I have not extubated a patient deep since 1992 and cannot comment impartially on the exchanges.

The second debate was proposed by Ewan Jack of Forth Valley (anaesthetists should be part of cardiac arrest teams) and opposed by Bryce Randalls of Aberdeen. Ewan and Bryce both wore contemporary footwear and pastel colours with shirt sleeves rolled up. They eschewed jacket and tie in sharp contrast to their predecessors. Ewan abandoned the podium to deliver his chat on the move with no notes (David Cameron/American evangelist style). Bryce's nihilistic but persuasive arguments were delivered in straightforward fashion with a leaning towards Anglo-Saxon expressions. I very much enjoyed his remarks. He even managed to begin with some classic humour (How many consultants does it take to change a light-bulb? - ??Change??).

The final Thursday lecture was Brian Cowan's Gillies Lecture and a transcript can be found else-

where in this publication. Chief Executives of Health Boards are now responsible for implementing the Scottish Patient Safety Programme. Brian concluded with the message that this has finally brought patient safety (and thus clinical issues) on to the agenda at Health Board meetings. There was nary a dry eye in the house, your correspondent included.

The RCoA Winter Meeting on Friday 21st contained an array of fine speakers. The chat with greatest resonance for Scottish Society members was delivered by Catriona Ferguson, a consultant anaesthetist at the Royal National Throat, Nose and Ear Hospital in London. She has spent ten years as a consultant doing only ENT and manages 4-5 patients with severe stridor per week.

Her approach is relatively simple. Large anterior mediastinal masses merit placement of cardiopulmonary bypass cannulae under local anaesthetic. If she predicts difficulty with intubation – supraglottic or large tongue-base tumours – then she inserts a transtracheal catheter under LA prior to induction. She showed a video of this technique and has described it recently in "Anaesthesia and Intensive Care Medicine". Induction is virtually always with propofol and a relaxant.

Those who attended the last joint SSA/ RCoA meeting in Hampden in Nov 2006 may remember Gordon Todd's lecture about difficult airway work. His use of propofol and a relaxant, backed up by his surgical colleague's ability with surgical laryngoscopes resonated with Catriona Ferguson's induction choices backed up by LA transtracheal catheter in selected patients. A description of her colleague David Enderby's technique during 30 years in the same job – a straight-bladed laryngoscope, Magill forceps and a "firm hand" – was in similar vein.

At the end of the day poor weather mandated a speedy departure but the joint meeting was a splendid event. Andrea Harvey and John Reid can be proud of their efforts and their choice of venue, hotel, restaurant and speakers.



Roger McMorrow & Jonathan McGhie



The morning speakers - Brian Cuthbertson, John Kinsella, Derek Paul and Paul Wilson.



Dr Lowe receives first prize for the poster competition

...and Dr Cross receives second prize.



Robbie Zimmer & Graham Bell



Sarah & Jenny

Trainees' Meeting

Peebles Hydro 18th April 2008
Sarah Hivey

For the second year the Annual Trainees' Meeting was held at Peebles Hydro with the Scottish Society of Anaesthetists Spring Meeting. It proved once again to be a resounding success with a great turnout of trainees from all over Scotland. There was a superb selection of lectures, an impressive array of posters and the event was supported by a wide variety of trade exhibitions.

The meeting was opened with a welcome from the Society President Dr Alf Shearer. The first lecture was given by Dr Derek Paul from the Golden Jubilee National Hospital on Cardiothoracic Anaesthesia. This was complemented by Dr Brian Cuthbertson's lecture on assessment of cardiac risk for non-cardiac surgery. Dr Paul Wilson began session 2 with an insightful and thought-provoking talk about the recent changes to Anaesthetic Training and MMC. This was followed by Professor Kinsella describing the research process and opportunities available to trainees.

A splendid buffet lunch was served by the hotel in the dining room which provided delegates with an opportunity to socialise. The break also included time to study the wide variety of posters and visit the trade stands.

The first of the afternoon sessions was devoted to the use of Ultrasound and Regional Anaesthesia. Dr Graham Bell from the Royal Hospital for Sick Children in Glasgow explained some of the principles of ultrasound and described its many uses in Paediatric and Neonatal Anaesthesia. Dr Robbi Zimmer of the Golden Jubilee National Hospital followed on from this with the adult perspective and some video demonstrations of ultrasound guided upper and lower limb blocks.

The final session of the day was opened by Dr Jonathan McGhie from the Western Infirmary who gave an enlightening and informative lecture on the benefits of Out of Programme Experience by describing a Pain Fellowship in Australia. The final lecture of the day was given by Dr Roger McMorrow from Dublin who gave a fascinating account of his experiences with the Everest Expedition. This included a revision of the physiological effects of altitude and a description of the experiments performed by the group with some extraordinary photos and video footage.

The poster presentation first prize was awarded to Dr Genevieve Lowe of The Victoria Infirmary in Glasgow for her poster entitled 'Educating patients about anaesthesia: Effect of a patient information leaflet on anxiety, perceived information gain, and patient satisfaction'. Second and third prizes were awarded to Dr Sarah Cross from Edinburgh and Dr Alistair Meikle from Paisley for their posters on patient identification and performance of medical suction devices.

The meeting was drawn to a close and the social activities began with a 5k fun run in which many trainees participated although the winner was not among them. Later in the evening there was a champagne reception and dinner at the hotel followed by a traditional ceilidh.

Overall the meeting was extremely well received by delegates and speakers alike. We would like to thank all the speakers, the trade sponsors and the hotel staff for their part in ensuring the success of the meeting and look forward to seeing you all again at next year's meeting.

Annual Golf Outing

Balcomie Links, Crail June 2008

Balcomie Links in Crail was the venue for the Society's annual golf outing in 2008, organised by Jim Dougall for whom Crail is his home-from-home course. It is laid out on a narrow promontory on the easternmost tip of the Kingdom of Fife, 12 miles from St Andrews and with views across the Forth and Tay estuaries.

Crail Golfing Society was formed in 1786, making it the seventh oldest golf club in the world. Originally members played at Sauchope but in 1895 Old Tom Morris laid out 9 holes at Balcomie and extended it to 18 four years later. Old Tom was, of course, instrumental in setting up the first British Open Championship at Prestwick in 1860 and went on to win the Open 4 times.

The format of the day was a Stableford competition in the morning and the traditional East v West contest in the afternoon on the same course. The weather was largely dry with a little sun and much wind and set the scene for a day of classic links golf. My recent experi-

ences of links golf have been on courses like Kingsbarns and the courses at St Andrews Bay which are modern interpretations of the genre. Balcomie's traditional layout, plus the wind, was a slice of authentic old-style links golf. The combination of stiff wind, running fairways, fast but true greens and blind shots was both a treat and a challenge. The additional pleasures of jovial badinage with one's companions and magnificent views out over the Fife coastline to Angus made for a splendid day.

The catering was good all day - bacon rolls on arrival, soup and sandwiches at the interval and evening meal at the conclusion. The Stableford competition was won by Cammy Howie from Glasgow with 35 points. Paul Wilson, Eddie Wilson and I tied for the runner-up position with 34 points and the booby prize went to Hugh Neill from Crosshouse. Alistair Macfie received 3 golf balls for the nearest-the-pin competition. The annual West v mix of East and West contest was won convincingly by the mixed team.

Donald Campbell Quaich



2009 Trainees' Competition

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

As well as the Donald Campbell Quaich, the author of the best paper will receive a prize of £250 (and will get to go to Peebles at the expense of the Society in 2010)

There will also be prizes for the runners-up.

Entries by the end of February please. Details from Secretary, Elizabeth McGrady.

