AN ANAESTHETICS SR IN THE LATE 1960s

Bernard Hayes

In the late autumn of 1967, I was walking the seemingly deserted corridors of the Queen Elizabeth Hospital (QEH) in Birmingham. This was the start of my post as Senior Registrar in Anaesthetics in the United Birmingham Hospitals (UBH). The “QE” had been built in 1937 and was architecturally imposing. After Shrewsbury, where I had spent a most satisfactory four-and-a-half years, the relative absence of doctors, nurses and patients, with the exception of the ground floor of the six-storey building, was unusual. Such places in hospital were usually buzzing with activity. Yet in the wards, departments and operating theatres, the usual rounds of engagement proceeded and people were friendly enough.

Margaret, my wife, and I had qualified from King’s College Hospital in London, she as a nurse. We considered we had been fortunate in securing a flat in a modern high-rise on Richmond Hill Road that I had admired, passing it on the bus that had served that road in those days, when attending the sessions that Dr. J.J. Polland, Consultant Anaesthetist at Shrewsbury, had arranged for me at the QE. At that time, I had been gaining extra sub-speciality experience towards the FFARCS, which I had passed in September.

A Spell at QEH

My induction into the Department of Anaesthetics was brief and straightforward. First and foremost, it was suggested to me from several quarters that it was important in the “Marble Halls”, as the hospital was dubbed, to “just keep your nose clean”. I interpreted this to mean jumping when summoned and keeping everyone in authority happy. There was a one-in-three on call roster with a satisfactory on-call bedroom available. On my first day on call, I was presented with a major vascular case in the late afternoon. Dr. Jason Mather, a consultant in theatre just then, probably knowing I had come in from a non-teaching hospital, generously advised me on how best to approach the procedure, including monitoring that was appropriate then.

Anaesthesia for major vascular surgery would feature prominently during my stay at the QE and was generally both instructive and pleasurable. It was conducted by surgical Professors Slaney and Ashton. The QE had a small A&E department, but apart from specific and specialist emergency referrals, it appeared to me that we accepted few other major emergency surgical cases. Accident work was more than adequately dealt with by the Birmingham Accident Hospital on Bath Row and there were two other large hospitals at Selly Oak with 1,000 beds, and Dudley Road Hospital with more than 700.
Thoracic surgery was conducted by Prof. “Jack” Collis. Working with him was Dr. G.A. Rawlins, who had instructed me during my previous training visits. I noted that he used the Williams “Pneumoflator” ventilator. This was an unusual and delightfully simple pressure-cycled device, roughly the size of a small carbon dioxide absorption canister, placed in line in the anaesthetic breathing system (or “circuit” as we called it then). The principle was similar to that used in Robinson and Bushman’s design for the British Oxygen Company’s “Harlow Ventilator” shortly afterwards. Professor J.S. Robinson had not long before been appointed to the new Chair of Anaesthetics in Birmingham with Dr. Peter Tomlin, a Bart’s man, his Senior Lecturer. They anaesthetized with the Slaney and Ashton professorial unit. Dr. A. Mortell also anaesthetized for thoracic cases. She was good fun to be with and I learned a good deal from her. It was harsh, but I suppose, inevitable that she was nick-named “Mortal Annie”. We can do nothing about the names we are born with.

Cardiac surgery was in the care of Mr. Leon Abrams, Mr. David Clarke and their senior registrar Maurice Nelligan. Here, I met a consultant anaesthetist whose name I had heard mentioned many times by the junior anaesthetists at the QE in my first week or so. “Eddie’s wonderful” they would say. A gentle, genuinely humble man, Dr. E.T. Mathews was and is a legend for the generations of anaesthetists exposed to his clinical judgement, technique and unceasing teaching. I, too, gained much practical benefit and clinical insight at his hands.

Neurosurgery meant sessions with Professor Brodie Hughes, regarded as a fearsome martinet by some. My experience was different and may have been accounted for by the fact that, when visiting from Shrewsbury, I had accidentally hit the right note with him. Dr. Rawlins, besides taking me into his thoracic lists had kindly arranged sessions in some of the other anaesthetic sub-specialities. One morning, I had arrived in the neurosurgical theatre to join Dr. “Bill” Woodward. I had been the first to arrive in the theatre rest room and, doing what all juniors and visitors do, took care not to sit in the well-upholstered chair in the corner and, instead, selected the spindly upright chair opposite. Next to arrive, was a portly gentleman. “You’re sitting in my chair”, he said. Rising quickly, I had explained that I was a visitor and was unaware of the seating arrangements. When I explained, he seemed to be intrigued by my quest for experience. When I now reappeared as a senior registrar, he was charming and I could, henceforth, do little wrong.

As Dr. Victor Campkin explained when I accompanied him on his neurosurgical lists, air embolism was a significant hazard. Dr. Campkin also was on at the Midland Centre for Neurology & Neurosurgery (MCNN) in Smethwick and I should meet him again in another forum some years afterwards. Yet, my brush with air embolism came in other circumstances. The consultant surgeon was operating around the base of the neck, when I thought I heard the slightest “whoosh”, whereupon the patient’s blood pressure fell sharply. I informed the surgeon that I suspected that an air embolism had occurred. The reaction
suggested that this might imply criticism from a non-surgical quarter. I felt it necessary to repeat my warning. To his credit, the surgical registrar, Ron Parker, immediately demanded a 20 ml. syringe and a large-bore needle from the scrub nurse and plunged it into the right side of the heart, withdrawing a large quantity of air. The circulation was restored and the patient’s recovery was uneventful.

A Centre of Excellence
As I became more familiar with my surroundings and the activities that I was involved in, I became aware of a certain inward-looking, parochial tendency among the medical staff. Indeed, it seemed that all but a few were Birmingham graduates. The UBH was usually referred to by its more senior consultants simply as the “United”. The term is used to this day, despite many changes of regime, and the full name is still borne above the main entrance. It will be interesting to see if it survives with the “much needed” new hospital, now under construction only 52 years after the QE was built. Later on, a phrase became common currency in teaching institutions such as the QE. In the absence of league tables or any other objective measurement it, too, was a self-proclaimed “Centre of Excellence”. Like other such centres, the QE, of course, harboured much true excellence, but it was not universal.

Exposure of SRs to consultant anaesthetists at the QE was relatively infrequent. For the most part, we would be deputizing solo for absent consultants and would encounter others only in passing. The five operating theatres were stacked on top of one another at the west end of the hospital and were connected by the common fire escape. These “back stairs” were the means of flitting from one theatre to another as private cases arose on the various lists. For the first time, I encountered the aphorism that the hallmarks of success in private anaesthetic practice were “Availability, Affability and Ability, in that order”. This was usually spoken in jest, but contained more than a grain of truth.

Intensive Therapy
The Intensive Therapy Unit (ITU) was of especial interest to me. Set up in 1967, it was one of the earliest to have been established in the UK. There was a staple throughput of cardiac surgical cases and many patients required what was then quaintly described as “mechanical” ventilation”. Prof. Robinson was prominent. He had, after all, been instrumental, with physician Dr. E. Sherwood Jones, in the development of the Intensive Therapy Unit at Whiston Hospital near Liverpool. At first meeting, he came across as one of those people who natively combine clinical astuteness, authority when teaching, and a core of infectious humour. A few places in a hospital have some trivial, yet distinguishing feature that attracts attention or intrudes unpleasantly. The ITU had a sliding access door that automatically slid gently back to its closed position with a similarly gently, soft thud. It was part of the background accompaniment. For the patients however, it was omnipresent, day and night. When later on, Prof. himself was a patient in this ITU, he would report how it was not just the quiet thud that nearly drove him
to distraction, but waiting for it during the time it took for the door to reach its closed position...every time

Day-to-day in the ITU, I worked alongside Drs. Keith Harding and David Young, two of the medical SRs who spent a good deal of time with their critically ill patients. I would know them even better later in my career. I noted that the nurses on the ITU were competent, diligent and extremely affable. The ITU was the high spot of my brief stay at the Queen Elizabeth Hospital.

While many cases treated in intensive therapy units present clinical challenges, there are rarely political overtones. An exception was the admission of a soldier, the diagnosis of whose critical illness remained obscure for some days. Supportive treatment in the meantime included ventilation. There was neurological involvement and it was accidentally discovered that, when relaxants were reversed for neurological assessment, neostigmine had a disproportionate effect. Laboratory tests were reported as confirming organo-phosphorous poisoning. Despite the evidence, this was officially denied.

On my way into the ITU one morning, I was walking down the main drive of the hospital and was passing the entrance to A&E, when an ambulance drew up and the back doors flew open. Inside were two ambulance men, attempting to ventilate a patient with an Ambu bag, but clearly having difficulty. Since I was only yards away from A&E, I dashed in, grabbed a laryngoscope and endotracheal tube and joined in the resuscitation effort. Intubation was immediately successful, so I returned the laryngoscope and hurried off to the ITU. This was, of course, before the days of “paramedics”. I cannot imagine that today one could intrude as I had done with no questions being asked.

Clinical Meetings and a Rare Gem
Clinical meetings for anaesthetists from the QE, many of them open to anaesthetists from elsewhere, were usually of high quality. Nevertheless, some of the best attended, even in those times, were the Round Table conferences for anaesthetists mounted by a leading manufacturer of drugs for the anaesthetic market. The drugs were well established, the supporting package information excellent and the company respected. Yet, the “conferences” took the form of a gathering of consultant anaesthetists from Birmingham and the surrounding area, who related purely anecdotal experiences, all naturally favourable. Just like today: nothing changes.

One of the Saturday morning meetings produced a magic moment. Intensive therapy was the core topic and one section consisted of presentations from clinicians from three disciplines, a physician, a surgeon and an anaesthetist, concerning which might be best be given charge of an intensive therapy unit. The physician gave an exposition that made reference to the fact that although decisiveness was required it should be tempered with due consideration. He thought in hours and a physician would be the best candidate. The surgeon
followed, urging that surgeons had to think in minutes and believed that his speciality would be best equipped. As he concluded, Peter Tomlin leapt into the fray. “But I am an anaesthetist. I think in seconds”, he proclaimed. “The anaesthetist must be in charge”. It was clearly no contest. At this point, there was a breathless pause. Then, the chairman of the discussion rose…very slowly. Putting his hand to his forehead, “I am a morbid histologist. I wonder how long it takes me to think”, he said wanly. By Christmas, I should be rotated to the Birmingham Children’s Hospital.

“The Children’s Hospital”
The Birmingham Children’s Hospital on Ladywood Road near the Five Ways junction was, for the most part, an old building. Entering from the road outside, one was in a large hallway. The Residents’ Mess was to the left, a corridor and a stairway to the wards on the ground and first floors lay ahead. The anaesthetic junior staff comprised two senior registrars, Dr. Jennifer Edwards and me, and Dr. T.E.J. Healy, the anaesthetic registrar. The posts were non-resident, though resident when on call.

Jenny Edwards had come to Birmingham from the excellent and renowned Adelaide Children’s Hospital. At first, coming as I did from Shrewsbury, I think she wondered what I was doing there. By the standards she had left behind, I was indeed a tyro. Yet, from that point on, Jenny unstintingly taught me just about everything she knew. I am forever grateful. Tom Healy was a Guy’s man and I immediately recognized him as the outspoken SHO anaesthetist I had seen pleading the cause of junior doctors in a recent television programme. He had been seated at a bar and declaimed his position with skill, brevity and clarity. Very impressive, I had thought. Tom was quick to learn and highly competent. I thought he would go far. He did, subsequently, as Reader in Nottingham and Professor in Manchester. We became friends at the Children’s and remained so.

In the Residents’ Mess there was a snooker table that was in good condition, a dart board and a continuous supply of hot, milky coffee. It was here that I also met other members of the junior staff. I recall a paediatric SR, later a notable expert witness, who swept in from the wards. He never acknowledged anaesthetists, believing that we were not medically qualified. Most were, however, knowledgeable and amenable. I remember especially paediatric registrar Jim Wilkinson and the remarkable Jill Mann, subsequently Professor of Paediatric Oncology and distinguished in cancer care. Although I did not know her well and had admired her clinical acumen from a distance, she wrote me a touching letter of congratulation when I later became a consultant. I met Dr. “Vic” Melikian there, too. I would have the pleasure of working with him again later.

A Sense of Isolation
While sub-speciality anaesthesia was of a high order at the Children’s, I was not so sure about some aspects of anaesthesia for general lists. The surgical
registrar, Chris Smallwood seemed excellent and was good to work with, but consultant cover for general surgical lists and their anaesthetic support was afforded by a range of consultants from the UBH, some of whom appeared to contribute only a session or two to paediatrics. There were exceptions, of course. Dr. Mike Barrow, to whom I had been attached when visiting from Shrewsbury, I knew to be a first-rate anaesthetist and teacher, but I saw little of him, as we SRs were usually occupied solo on lists already. Otherwise, I saw little of the anaesthetic consultants and was sometimes apprehensive when anaesthetizing with the somewhat peripatetic consultant surgeons.

In this respect, the Children’s could seem a lonely and isolated place to be a junior anaesthetist. I felt vulnerable when a consultant paediatrician with an interest in diabetes challenged me when I judged that a child needed further preparation before being fit for surgery and anaesthesia. In fact, I was rather publicly bawled out. Nevertheless, I believed I should hold my position on clinical grounds. I was naturally worried, but the child was treated further and surgery proceeded satisfactorily on the next day. In the evening, I was approached by Miss Greene, then Chairman of Anaesthetics in the UBH. I thought this was to be a time of reckoning. However, it appeared that the Theatre Superintendent, Sister Evans, had heard it all and had tipped off Miss Greene. The latter, far from upbraiding me, praised me for taking my stand. Sister Evans, by the way, furnished the most satisfactory fry-ups in theatre when we were up at night.

**Cardiothoracic and Neurosurgery**

There were two cardio-thoracic surgeons at the Children’s. One was Mr. Leon Abrams, whom I had previously encountered at the QE. I knew him to be a hard taskmaster, though eminently fair. At first, I was apprehensive when assigned to his operating list, but soon appreciated the real privilege of working with him. I particularly recall two incidents.

In the first, when “Abe” was operating on an infant, the endotracheal tube became dislodged. I informed Abe immediately and expected to be chastised. Not a bit of it. He coolly whipped off the enveloping surgical drapes, regarded me serenely and asked, “What do you want me to do?” In fact, he had already done what was necessary and I replaced the tube quickly without difficulty. The small patient was re-draped and the operation proceeded uneventfully. I approached Abe after the operation, apologizing profusely. “It should never happen”, I concluded. Abe smiled and thanked me for having informed him of the problem straight away.

Some time later, a 2-year-old presented for aortic valvotomy. I was covering for a consultant absent on leave. The day before surgery, I was on the ward with the child and sensed that there was an air of extreme anxiety among the nursing staff on the ward. Here and on other wards I visited that day, I was repeatedly asked “Will it be all right”? One is used to patients and relatives making such an
enquiry, but it was strange coming from nurses. In the event, the operation went well. On the wards afterwards, the sense of relief was palpable.

The Cardiac Theatre was very well run. However, children who had to be transferred to this theatre were pushed in a pram across a yard by a covered way open at the sides to the elements. A public appeal was launched by a local newspaper to fund a properly covered corridor. Citizens delved into their pockets and the appeal reached its target quickly, but the new structure did not appear. After I left, similar appeals were launched with the same objective but, some time later, there was still no new covered way. As an aside, both Theatre Sisters in the Cardiac Theatre had sporting connections: Sister-in-Charge Mottram’s uncle was Tony Mottram, the tennis player; while Sister Bousfield’s brother was Ken Bousfield, the golfer.

The other cardiothoracic surgeon was Mr. Keith Roberts. Operating lists with him were pleasant and entertaining. He was also the Director of the Paediatric Intensive Therapy Unit.

**Paediatric Intensive Therapy**

It was in the ITU that I also received the further benefit of Jenny Edwards’ experience and teaching. The ITU was splendidly nursed and I very much enjoyed my time there.

One incident was notable, in that it pointed up the deficiencies of clinical monitoring then, as compared with what we take for granted now. A baby was being ventilated by the then popular Bird Mk VII pressure-cycled ventilator. I checked him and all was well. I turned my attention to the baby in the next cot. Having satisfied myself, I glanced back at the first baby and was shocked by how pale he had become. Yet, the ventilator was “tush-click”-ing away merrily, as it had been while I was tending the other baby.

I noticed that the ventilator had become disconnected from the patient and the outlet of the patient connector was embedded in the pillow just sufficiently to permit a limited amount of gas to escape. It was cycling normally simply because the leak and the associated pressure drop were critical. Had I not turned when I did, the baby might not have survived. Ventilator monitoring and alarms would alert the attendants nowadays.

There was quite a stir when the hospital admitted sextuplets. At least two of them were admitted to the ITU. They were tiny indeed and we did not have commercial endotracheal tubes that were small enough for them. Small bore plastic tubing had to be specially fashioned as required and sterilized on site before use. Intubation was very difficult sometimes. Many neonates just as tiny require ventilation these days and neonatal paediatricians with appropriate equipment are thoroughly used to dealing with them. Most disturbing, however, was the
manner in which members of the press harassed the parents and ITU staff. Some were even taking photographs through the windows.

**A Coup by a Master Tactician**
Not long before I completed my year on rotation at the Children’s, a vacancy was announced for the post of Consultant Anaesthetist based wholly at the hospital. Internally, Jenny was an obvious candidate, but I debated with Margaret whether or not I should apply, fearful that not to do so might indicate apathy. I applied and was supported in doing so, but the right person got the job when Jenny was appointed. In her place, Stewart Dallas was rotated into the now vacant SR slot. I would know Stewart well later on in his role as a consultant anaesthetist at MCNN.

At the Children’s, Stewart had presence also. This was demonstrated when he told Tom and me that he thought something should be done about the fact that we did not have a half day, even though that was then supposed to be the norm for junior staff. We responded to the effect that we believed the UBH would not wear it. “Never mind”, said Stewart. “Let’s just do it”. Shortly afterwards, when it was Tom’s turn to be off, the telephone rang in the Mess and Stewart answered it. It was Miss Greene. She wished to speak to Dr. Healy. “He isn’t here”, said Stewart. Miss Greene: “Where is he, then?” Without a change in inflection, Stewart replied, “He’s on his half-day, Miss Greene”. It was typical of the effect that Stewart Dallas had, that she did not pursue the matter, we heard no more about it and thus was the half-day was established. I recall with some satisfaction that the fact that once, when I was on such a half-day, this enabled me to attend a conference that took place at the hospital on aspects of paediatric cardiology and was able to witness at first hand Drs Celia Oakley and Michael Tynan, gladiators in cardiology, crossing swords across the floor in an exquisite no holds debate.

**The “Prof” Unit**
Meanwhile, we had not been too happy at the flat in the high block at Richmond Hill Road. The under-floor heating was expensive and provoked a great deal of static dust. When the wind blew, it howled around the building. Moreover, I was frequently out at night and, despite the presence of a janitor at the foot of the building, there were often footsteps on the stairs and knocks on the door. These may have been salesmen or other bone fide folk, but we did not expect friends or neighbours and Margaret was, quite reasonably, apprehensive. She found it spooky. In time, we saw an advertisement for a semi-detached house in Grove Lane in Harborne, opposite some parkland, managed to raise a mortgage and moved in.

To my great surprise, my rotation when it was announced, was to the Professorial Unit in Anaesthetics at QEH. I had not previously demonstrated any leanings towards research, but jumped at the opportunity. The unit operated in a
relatively recently-built Clinical Research Block, approached from a suitably convenient small car park.

When I got there, two flights of stairs took me to the first floor, where the door to the University Department of Anaesthetics faced me. Across the room inside sat the departmental secretary, Miss Doreen Doody, and her assistant. As I awaited admittance to Professor Robinson, I sat in a low-slung chair such as was the fashion in contemporary reception areas. As I sat there, I gazed at the wall on which were cartoon diagrams. One was subtitled “I am waiting for the meek to inherit the land”. In a small fish tank, goldfish were twitching desultorily. Beside the tank was a tin of “Flaked fish food”. I thought there were two ways one could interpret that.

My experiences with professors of this and that during my medical student days had led me to expect to stand to attention and show due deference. My reception at the hands of “Prof” dispelled any such notions from the start. “Sit down”, he said cordially. “Tell me about yourself. What do you want to do?” I have virtually no recollection of the conversation that followed, except that I gleaned that he had previously been an automotive engineer and done some motor racing. In response to his enquiry about my vacation work as a medical student, I told him I had been a bus conductor, whereupon he also volunteered that he had driven bus chassis for Leyland Motors.

Prof. had, it seemed, been one of those chaps one used to see perched on an unprotected seat, in bomber-jacket and goggles, braving the hazards of highway and weather, delivering chassis to their prospective bodybuilders. Not only that, he then added that the incumbent Professor of Anaesthetics at the Royal College of Surgeons had been an engine driver. I was, therefore, in good company.

I mention this because it may convey something of the informality of the department into which I had instantly been absorbed. Dr. Peter Tomlin was there as well and I was introduced to Dr J Gareth Jones, currently sequestered with the department after research grounding in the Department of Medicine under Professor Sir Melville Arnott, and to Dr John Bushman, also doing research. I immediately took to Mr. “Wally” Wood, the Chief Technician. We formed a good mutual working relationship that would last for some years. Wally and John Bushman occupied adjacent offices in the lab.

**Research and Presentation**

It took me a little time to settle to what was, for me, the alien atmosphere of research. However, I was keen to learn and Prof. drew me into some work he was doing on the humidification of patients and the equipment used for this. He pointed out the inadequacies he perceived in both the clinical apparatus and the laboratory measurement techniques used in this particular field, in particular, referring me to Davies important work in the chemical and physical aspects. In his book “Interfacial Phenomena”, Davies had emphasized the significant
differences in behaviour between water and other liquids at the gas-liquid interface.

Moreover, most research into humidity was not into wetness at all but, as in the paper, tobacco and food industries, for example, into dryness. Most available measuring instruments could only measure up to the ambient water saturation level. The upshot was that mass spectrometry was necessary and that, to take account of the ambient temperature being in this case body temperature, the inlet would have to be hot enough to get rid of any adsorbed surface water. For this Prof had managed to obtain a Krupp “Atlas” mass spectrometer that satisfied these criteria.

What is the point of this necessarily detailed description? It formed the basis of a fundamental lesson for me. Prof. asked me to use the instrument to construct a calibration curve for water v. temperature. First of all, I learned how to calibrate a scientific instrument properly and then was left to construct my curve. After making the necessary measurements and plotting the points, I had an almost straight line, but not quite. Perhaps some of my points were errant, I thought. Some repeat measurements yielded suitably “corrected” points that now yielded a perfectly straight line I could proudly present to Prof. “Very good”, he said, with a twinkle in his eye that could be interpreted as scepticism. “Let’s see what the tables say”. The table in question in fact revealed a specific form of curve. I had demonstrated to myself how easy it is to fool oneself, a cardinal error in research.

This was very much the style of Prof’s approach. Suffice it to say that I believe I learned reasonably quickly. However, the process was assisted not a little by the fact that working with Prof. was usually a laugh a minute regardless of the seriousness of the inquiry. Sessions in the lab with him were thoroughly enjoyable.

From time to time, I had to seek assistance elsewhere and found John Bushman to be just as amusing in a different way and, with his background in mechanical and electrical matters, he proved to be a mine of practical and theoretical information. Gareth Jones, meantime, was researching the behaviour of the airways in relation to pressure drops across them and the consequent effects on gas distribution within the lung. He demonstrated this to us. The neologism he employed when speaking of the airways “graunching” down was so apt. He also was a very amusing chap, but in a more esoteric way.

An MD beckons
A few months later, a fellow anaesthetic SR, Jayantilal “Janti” Shah, a Birmingham graduate, joined us in the Prof. Unit. Janti’s interest lay in epidurals and the associated mechanics. He quickly set to work and, I believe, was much more natively attuned to the research method than I. He was soon producing results and writing them up and proved adept at devising new methods of approach to the matters under study.
Janti and I were separately called into Prof’s office, where he suggested that we should consider doing an MD. I frankly had no idea what this might entail, but thought I should give it a go. Janti clearly had more idea and got down things there and then. I made enquiries of Prof. as to how I might proceed and he gave me directions as to some lines of inquiry I might pursue. He suggested I start in the Medical School Library, arming myself with reprints of the relevant literature. He also told me who my mentor in an independent centre would be.

I somehow assumed that I should devise a study concerning respiratory physiology along the lines of the work already being undertaken in the department. Before I knew it, I had a mass of reprints that seemed to have cost a small fortune, but I still did not have any clear sense of where I might be heading with it all. While all of this was taking place, I had a continuing commitment to anaesthesia as part of the Prof. Unit team and to its contribution to the ITU. These I continued to find thoroughly satisfying; but on the research front, regrettably, I drifted.

As an aside, I was invited to a dinner which was attended by a number of researchers in the field of respiratory mechanics. One of the distinguished guests was Professor Milic-Emili who, following pioneers Christie and Bates, was conducting landmark research in Montreal. Attendees fussed round him like the proverbial bees round a honey pot and I felt rather out of it all. When we had all taken our seats for dinner, a voice from my right unexpectedly engaged me in conversation. It was Prof. Milic-Emili. After he had expressed relief at getting away from the inevitable “shop”, we mutually enjoyed light but interesting conversation about Montreal, where I had myself lived for three years while serving with the Royal Canadian Army Medical Corps.

In the end, neither Janti nor I completed an MD. I felt sure that Janti had it in him to achieve the higher degree and he subsequently published many papers in his chosen field, but I knew that my efforts had been unsatisfactory.

An Inauspicious Debut: Success Later
However, the humidity work was going well and I was interested in it. Prof. suggested I present our work to a forthcoming meeting of the Anaesthetic Research Society (ARS) in Birmingham. I prepared my script and slides and rehearsed my script; but it was only as I was rising to ascend the platform to deliver it that Prof. murmured “You know you aren’t allowed to read it, don’t you?” Well, no I didn’t. I think my delivery was very poor and I certainly did not handle questions well at all. Several times, John Bushman came to my rescue from the floor.

At a subsequent gathering of the ARS in Birmingham, I had some further work to present and was much better prepared. On the day, the mass spectrometer that was to have been used to demonstrate our methodology had failed, and even
Wally Wood had not been able to fix it in time. This time I had included extra slides, just in case, and it went well. Afterwards, Dr. Keith (later Sir Keith) Sykes came up to me and complimented me on the work and my exposition, adding that “the trouble is, nobody really understands water”, which I think remains largely true even today. Had I got to grips with the MD, he would have been my mentor. I have often reflected since that I missed out badly there.

I subsequently went with Prof. to a gathering at Ashridge in Buckinghamshire, where I presented further work including extensive testing of clinical devices using mass spectrometry. My paper was included in a book that was a symposium of the proceedings of the meeting.

A Fortunate Outcome
Once in a while I was called upon to give the induction agent as part of a study into dental analgesia and anaesthesia that Prof. and others were conducting at the Birmingham Dental Hospital. The purpose of the investigation was to establish whether anaesthesia was achieved and whether the techniques carried any risk in the dental chair. The techniques concerned were by this time in general use by members of the Society for the Advancement of Anaesthesia in Dentistry (SAAD). When its results were published, one of its prominent members, Dr. Drummond-Jackson brought an action against the authors of the resultant scientific paper and its publishers the BMJ.

The case dragged on for a long time thereafter. Eventually, a settlement was reached. I was mightily glad that I had not been included as one of the multiple authors.

A Consultant Appointment
In the autumn of 1969, a vacancy was advertised for the post of Consultant Anaesthetist at Dudley Road Hospital (DRH) in Birmingham. I thought I was still short on SR time to be applying, but had had good vibes about this hospital. It was a large District General Hospital (DGH) in the Winson Green district of the city, just a mile-and-a-half from the city centre and next to the prison of that name. Dr. Michael Vickers, Senior Lecturer in Anaesthetics in Newcastle, had been attracted to DRH by Prof. Robinson as the first incumbent of a newly-built Clinical Investigation Unit there.

Even this development, though, was not the main attraction for me. Junior staff who had worked at DRH had been extremely enthusiastic about their training there and attributed this largely to one of the DRH consultant anaesthetists, Dr. D.C. Pearson. It seemed his enthusiasm for organising and supervising training was unbridled. DRH seemed a good place to go. I therefore applied, with support from Prof. Robinson and from Keith Roberts at the Children’s Hospital. In the event, the selection panel was satisfied at interview and I was appointed to the post.