NEWS LETTER

The
SCOTTISH
SOCIETY of
ANAESTHETISTS

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THE SCOTTISH SOCIETY OF ANÆSTHETISTS

Office-Bearers for 1963-64

President	Dr. ALEX. C. FORRESTER, Glasgow.
Vice-President	Dr. J. D. ROBERTSON, Edinburgh.
Past President	Dr. MARGARET C. MUIR, Dundee.

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Honorary Secretary

Dr. A. H. B. MASSON
13 Osborne Terrace, Edinburgh, 12

Honorary Treasurer

Dr. ARCH. C. MILNE
84 Pentland Terrace, Edinburgh, 10

"The objects of the Society shall be to further the study of the science and practice of anæsthetics and the proper teaching thereof, and to conserve and advance the interests of anæsthetists."

"Ordinary membership shall be restricted to members of the medical profession practising the specialty of anæsthetics."

—Extracts from the Constitution.

Subscription

£1 per annum.
10/- for Registrars and Senior Hospital Officers.

Presidents of the Society since 1950

1950—Dr. John Gillies.
1951—Dr. H. H. Pinkerton.
1952—Dr. T. J. C. MacDonald.
1953—Dr. W. M. Shearer.
1954—Dr. I. M. C. Dewar.
1955—Dr. F. G. Gibb.
1956—Dr. H. Bruce Wilson.
1957—Dr. R. Lawrie.
1958—Dr. R. N. Sinclair.
1959—Dr. Alison Ritchie.
1960—Dr. A. Tindal.
1961—Dr. J. W. L. Bain.
1962—Dr. Margaret Muir.
1963—Dr. Alex. C. Forrester.

Guest Speakers at Annual General Meeting

1951—Dr. W. W. Mushin.
1952—Dr. M. H. Armstrong Davison.
1953—Dr. Ivan Magill.
1954—Prof. R. R. Macintosh.
1955—Dr. T. Cecil Gray.
1956—Dr. M. D. Nosworthy.
1957—Dr. J. Alfred Lee.
1958—Dr. L. B. Wevill.
1959—Dr. Margt. Hawksley.
1960—Sir Dugald Baird.
1961—Dr. G. S. W. Organe.
1962—Prof. W. D. M. Paton.
1963—Prof. E. A. Pask.

Honorary Secretaries of the Society since 1950

1950-53—Dr. R. N. Sinclair, Glasgow.
1953-57—Dr. A. G. Miller, Glasgow.
1957-63—Dr. M. Shaw, Glasgow.
1963 —Dr. A. H. B. Masson, Edinburgh.

Honorary Members

Dr. D. Keir Fisher, Glasgow.
Dr. John Gillies, Edinburgh.
Dr. J. Ross McKenzie, Aberdeen.
Dr. D. S. Middleton, Edinburgh.
Dr. W. B. Primrose, Glasgow.

The President Speaks . . .

. . . DR. ALEX. C. FORRESTER

Applied Science and the Anæsthetist

"To-morrow Science will have moved forward yet one more step, and there will be no appeal from the judgment which will then be pronounced on the uneducated."

A. N. Whitehead wrote these words in 1916, and the warning is still true to-day. More recently the present Lord Rector of the University of St. Andrews, the physicist and novelist, Sir Charles Snow advocated the integration of Science and Government. Likewise in medicine and certainly in anæsthesia, the rapid developments of recent years are due in no small measure to the co-operation with other sciences.

Dr. John Gillies has described anæsthesia as a physiological trespass, but with the help of the physiologists we can now measure the magnitude of these disturbances. Monitoring of arterial and venous pressure, for instance, is now standard practice in cardiovascular units, and more recently changes in regional blood flow through various organs have been studied.

This principle of accurate measurement during anæsthesia is well demonstrated by the increasing application of biochemical techniques and methods of analysis of gas and vapour mixtures in the clinical field. Probably the most important contribution of recent years has been that of the Danish biochemist Astrup and his colleagues. The micro-Astrup technique has put at the disposal of anæsthetists a quick and simple method whereby changes in the acid-base balance of the patient can be followed closely. Similarly the measurement of arterial oxygen tensions, rather than oxygen saturation, has shed light on the most fundamental problem of all—the presence or absence of hypoxia. Changes in the oxygen and acid base values in the patient may depend to a large degree on the relative concentrations of the anæsthetic agents in the inspired mixture. The technique of gas chromatography, first used by petroleum engineers, now makes possible frequent analysis of these concentrations thus adding a further safety factor to the anæsthetists' clinical skill. Development of accurately engineered "compensated" vaporizers has also ensured that the slogan of the anæsthetist, "In somno securitas," is not an empty boast.

It is generally recognised nowadays that the anæsthetist has something of value to contribute outside of his normal province in the operating theatre. Clinical pharmacology represents an important field of interest for the anæsthetist with special reference to the action of the muscle relaxant drugs and narcotic analgesics. It has been but a short step from this to the investigation of new drugs, and the technique of electromyography is one of many methods used in these drug trials. An understanding of pulmonary function, and in particular the mechanics of ventilation, is essential to the practice of anæsthesia, and it is not surprising that anæsthetists have been prominent among research workers who have made many of the most important contributions in this field. This work has been facilitated by the development by the medical physicists of instruments such as the pneumotachograph.

The knowledge gained from all these scientific developments in the field of measurement, and the greater understanding and control of the physiological disturbances which has resulted, have made possible great advances in surgical techniques. The present scope of the cardiovascular surgeon owes a great deal to this marriage of anæsthesia and the sciences. The technique of surface air cooling for intra-cardiac surgery provides a good illustration of this. With apparatus designed by heat engineers it is possible to arrive at any desired body temperature with safety and certainty.

Finally, while the art of anæsthesia must always be an essential ingredient of the mixture, anæsthetists must recognise the debt they owe to science and that a sound training in scientific method is an essential in the education of the modern practitioner of anæsthesia.

"If we decline to measure we abrogate the right to base upon personal experience any argument proffered in serious discussion."—Selwyn Crawford.

The Secretary Reports . . .

. . . Dr. A. H. B. MASSON

FROM Edinburgh to Paris as the crow flies is more than 500 miles, but Midlothian is only 60 miles from Athens. Dallas, the second city of Texas (in population only!) is situated 100 miles south of Paris, Texas, and only a few miles north of Midlothian. Once the meeting place of cattle trails, it is to-day a centre for the airlines of America. In 1961 nearly a quarter of a million arrivals and departures were recorded at Dallas Love Field, of which private aircraft accounted for almost 100,000.

Expecting to see cacti and oil wells, I was surprised at the amount of vegetation in the surrounding countryside. The desert areas of Texas lie some distance to the West, while the East Texas oil fields, with derricks stretching as far as the eye can see, lie 100 miles to the East.

One is immediately struck (metaphorically if not literally) by the cars — thousands upon thousands of them—moving as on an endless belt along the magnificent roads or trying to park in one of the huge and expensive car parks. Life in Dallas would indeed be difficult without a car, for the public transport system is very poor. To accommodate the cars there are great super-highways, toll roads, expressways, flyovers, underpasses, clover leaf intersections and so on. Lane discipline is very strict and one may overtake a car on either side. It is somewhat disconcerting at first, when driving on a centre lane, to be overtaken and passed by two cars simultaneously, one on each side.

In a recent number of the British Journal of Anæsthesia,[1] Buxton Hopkin gave a good account of the organisation and methods of training in the Anesthesiology Department of Parkland Memorial Hospital in Dallas. It might be of interest, however, to make a few more personal observations. The anæsthesia residents (equivalent to our registrars) hold a two-year appointment. The youngest of these men is 26, for the undergraduate training in medicine takes eight years in the United States. Many are a good deal older and have been in general practice prior to starting their residency programme. When he starts, the resident is supervised and taught by a staff man (consultant), at first closely and soon with less immediate supervision. To our eyes, he is given a great deal of responsibility at a very early stage of his career. As he progresses, he is given even more responsibility and as a senior (second year) resident he is in charge of the emergency "crew" (though he has a staff man on call), and is by then himself supervising the more junior residents for emergency work. Regular didactic teaching in the form of films, quiz sessions and discussions ensure that he has a good grasp of the theory as well as the practice of anæsthesia. The time these men spend working may come as a surprise to many of their British counterparts. Each working day starts at 7 a.m. and goes on till about 4.30 or 5 p.m. In addition, residents are on call every third day and this means that they are in the hospital from 7 a.m. till 5 p.m. on the following day. Leave is two weeks per year. It is something of a mystery how they ever find time to read or to relax, especially when one considers that 47% of all the operations in the hospital last year (excluding those in the casualty department) were performed between the hours of 7 p.m. and 7 a.m. The working staff consists also of surgeons rotating through anæsthesia, and of final year medical students who opt to spend two months in anæsthesia. They have similar responsibilities to and share the emergency and elective work with the residents.

During the training period a wide variety of regional and general anæsthetic techniques is taught. Spinal analgesia is used very extensively, much more than epidural or caudal blocks. Other regional techniques used are brachial plexus block (axillary) and sciatic-femoral block. Cyclopropane and halothane share pride of place among general anæsthetic agents used, though trichlorethylene, fluoromar and methoxyfluorane are also taught. Succinyl choline is used extensively, gallamine much less often and d-tubocurarine rarely. Assisted respiration is used much more frequently than controlled respiration, and this can be readily understood when one considers the duration of surgery. In this teaching hospital most of the surgery is done on charity patients by second year residents, often without immediate supervision. As a result, surgical procedures take much longer than in Britaian.

The type of surgery is varied. Little minor surgery is seen, for this is dealt with almost exclusively under local or regional block by interns in the casualty department. A high

proportion of the work is the result of the early or late effects of trauma — gunshot wounds, stab wounds, automobile accidents, in that order of frequency. In 1962 there were 258 patients treated for gunshot wounds, 102 for stab wounds. Recently, out of six theatres in use, one operation was for transplant of tendons following nerve injury, the result of stab wounds; one was a disarticulation of hip —a late result of spinal cord transection by a bullet — and a third was on the eyelids of a man blinded by having lye thrown in his face. Appendicitis, on the other hand, is seen only rarely.

Residents are taught to monitor all patients very carefully. A detailed chart is always kept. Before induction of anæsthesia, pre-oxygenation is a routine. A monaural stethoscope is strapped to the patient's chest and the blood pressure is closely followed. Continuous ECG monitoring is also frequently employed. It is true that every patient has an intravenous infusion set up prior to the induction of anæsthesia, even for such minor operations as cystoscopy. This is done primarily to have ready access to a vein, though fluid replacement assumes great importance during long operations in a climate where, in mid-October, the weather is beginning to cool off and reaches only 90 F. maximum. In this medical school much work has been done on fluid balance, and the visitor is somewhat surprised to see Parkland's "white blood" —Ringer's lactate solution—being given in vast quantities (literally by the gallon on occasion). With simultaneous measurement of red cell mass, plasma volume and extracellular fluid by triple isotopes, it has been shown that there may be a loss of up to 28% of the functional ECF during abdominal surgery, and that when this ECF is replaced with lactated Ringer's solution the kidneys continue to secrete salt postoperatively, contrary to the traditional concept of salt retention.[2]

At the end of two years the resident can apply to take his Board examinations, and, if permission is granted, he has a written paper (multiple choice, electronically marked). This period is shortly to be raised to three years. If successful, he can sit the oral part of the Board three years later if he can give evidence of having been full time in the practice of anæsthesia during that time. Having his Boards, though desirable, is not, however, essential to a man practising anæsthesia.

There are many differences in the practice of anæsthesia and of surgery in Britain and in the United States, the reasons for which may not always be immediately evident. A full appreciation and understanding of the particular problems and training methods which lead to these differences can probably be obtained only by an extended visit to or by working in the other country. It is a matter for regret that the traffic is so much in one direction and that it is not possible for more American anæsthetists in training to visit and work in British hospitals. For my part, I have found living and working in the United States a stimulating and invigorating—if exhausting—experience and one which I count a privilege and a pleasure to have been allowed to enjoy.

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[1] Hopkin D.A.B., Brit. J. Anæsth. (1962) 34.580.
[2] Shires T. Williams J. and Brown F., Ann. Surg. (1961) 154.803.

Scientific Section

. . . Edinburgh, May 25, 1963

THE fourth Scientific Session to be promoted by the Society was held in Adam House, Chambers Street, Edinburgh. A party of 102 members and guests assembled, and the President, Dr. Forrester, opened the session.

The following programme was sustained, with Dr. Robertson introducing the speakers:

Prof. W. W. Mushin, Welsh National School of Medicine,
Dean of the Faculty of Anæsthetists R.C.S.,
"Controlled Respiration."

Mr. B. Nolan, Senior Lecturer, Dept. of Surgical Science,
The University of Edinburgh,
"Renal Transplantation."

Dr. J. W. Sandison, Senior Registrar, Dept. of Anæsthetics,
The Royal Infirmary, Edinburgh,
"Experiences in the Assisted Respiration Unit."

The Registrars' Prize

THE Society awards annually a prize of £30 for the best original paper submitted by an anæthetist in Scotland, holding the grade of Senior Registrar or under. It is not necessary that he/she be a member of the Society.

The conditions attaching to the award are as follows:—

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

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

3. Papers for adjudication **must** reach the Secretary by the **end of March** at the latest.

4. The winner of the prize will be required to give a digest of the paper at the Annual General Meeting of the Society towards the end of April.

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

No Entry for 1962-63

As was indicated in Newsletter No. 2—that for 1961 — the Council has been concerned that this competition has not been meeting with the attention it so obviously deserves. Perhaps it was inevitable that some year would find no entries at all for the award — and 1962-63 proved to be that year. The first award was made in 1951 and this was the very first occasion since then that not a single paper was received.

Note for 1963-64 Award

The Council has decided to do something special to mark the Jubilee Meeting of 1964. The amount of the award not paid out this year will be carried forward and added to next year's to make a total of £60: it is intended to disburse this sum as more than one prize, and the winner of the premier award will be requested to read the paper at the Jubilee Meeting in Edinburgh. This competition is commended to all those eligible to compete, with the assurance that the winning of a prize can go a long way towards acting as an extra qualification.

Previous winners of the Award

1951—Dr. J. G. Robson, Glasgow.
1952—Dr. J. P. Payne, Edinburgh.
1953—Dr. F. S. Preston, Glasgow.
1954—Dr. J. B. Stirling, Glasgow.
1955—Dr. A. H. B. Masson, Edinburgh.
1956—Dr. D. B. Murray, Glasgow.
1957—Dr. D. B. Scott, Edinburgh.
1958—Dr. D. C. C. Stark, Edinburgh.
1959—Dr. Brian Kay, Dundee.
1960—Dr. Geo. R. Dow, Glasgow.
1961—Drs. D. D. Moir and J. M. Reid, Glasgow (jointly).
1962—Dr. D. J. F. MacDonald, Dundee.
1963—No award.

ACTIVITIES OF THE YEAR 1962-1963

1. Meeting of Representatives with the Wright Committee—20th June, 1962.
2. Visit to Victoria Infirmary, Glasgow—29th September, 1962.
3. Registrars' Meeting, Royal Infirmary, Glasgow—12th October, 1962.
4. Visit to May & Baker, Ltd., Dagenham—8th November, 1962.
5. Proceedings of Neurosurgical Travel Group.
6. Annual General Meeting—St. Andrews, 26th to 28th April, 1963.
7. Scientific Session—Edinburgh, 25th May, 1963.

Visit to Victoria Infirmary, Glasgow

Saturday, 29th September, 1962

This visit was really organised to view the new Theatre Block and to examine the functioning of the C.S.S.D. A company of 38 attended. The Medical Superintendent explained diagrammatically the structure of the theatres, and the sterilising and supply system employed. Dr. Duncan Ferguson, Senior Registrar at the hospital, gave a preliminary account of an investigation into the effects of different temperature environments on patients undergoing surgery in the new air-conditioned theatres. Thereafter parties were escorted round the buildings, and there was a display of the products of the C.S.S.D.

Visit to May & Baker, Ltd., Dagenham

Thursday, 8th November, 1962

This was the third party of 30 to visit the firm's premises, and completes the programme so generously offered by May & Baker to enable all our members to view the works and to witness the research work undertaken in the laboratories.

Registrars' Meeting, Royal Infirmary, Glasgow

Friday, 12th October, 1962

This meeting attracted 64 junior anæsthetists, the highest number ever to attend since the scheme was inaugurated. Listed below will be found the programme sustained by Dr. A. C. Forrester and his staff, and its range is evidence of the enthusiasm which went into the preparation of this meeting. It is indeed little wonder that many consultants wish they could have its counterpart.

THEATRE DEMONSTRATIONS.—Apparatus for Cardiac Bypass, Air Cooling Unit, Anæsthesia for Cardiac Catheterisation, Cardiac Angiography, Halothane and oxygen anæsthesia for Thyriodectomy, Electromyographic Technique, Continuous Epidural Anæsthesia.

DEMONSTRATIONS. — Pneumotachygraphy, Measurement of PO_2, Electronic analogue of lung, Micro Astrup Technique of blood gas analysis, Gas Chromatography, Ganglion Blockade, Management of emergency resuscitative procedures.

SHORT PAPERS. — Parameters of Sedation, Demonstration of hypnosis, Choice of anæsthesia in pre-eclampsia, Techniques and apparatus for resuscitation, Deep hypothermia.

Proceedings of Travel Group in Neurosurgical Anæsthesia

Dr. Allan S. Brown of the Department of Surgical Neurology, Western General Hospital, Edinburgh, 4, took on the organising and running of a group devoted to anæsthesia for neurosurgical work and problems pertaining thereto. In his absence from the Annual Meeting in St. Andrews, Dr. Jean Horton gave a brief review of the activities of this most active group.

The first visit was to the High Pressure Oxygen Chamber at the Western Infirmary, Glasgow, where Dr. Pinkerton acted as host on behalf of the hospital. The physics and physiology of high pressure oxygen therapy; dangers, complications and difficulties encountered; certain clinical applications; these were all minutely discussed before the members of the group experienced for themselves a stay in the chamber while the pressure was raised to working level, then decompressed in the normal way. After lunch there was a further period of discussion. It is proposed to visit other centres where neurosurgical work is carried on, and anyone interested in this specialty should contact Dr. Brown.

Annual General Meeting

St. Andrews

Friday, 26th, to Sunday, 28th April, 1963

ST. ANDREWS is a lovely place to have a conference ; it has everything—history and atmosphere, the University, golf, seaside and shops. We were there in 1960, but better weather favoured us then than on this occasion. Friday was superb ; Saturday was for the most part poor, especially for the golfers who had a dreich round — sed nil desperandum! The Conference Hotel was the Atholl Hotel and we really must congratulate the management for the excellence of the fare. On Friday evening, after dinner, Messrs. B.O.C. put on their Film Show which is now a feature and always so much enjoyed ; this item seems to get better and better, and " Very Important Person " was a happy choice. On Saturday morning there was the golf competition arranged by Dr. Gallie (Glasgow). The competition is deservedly popular—any drooking the players got was little in evidence when the prizes were announced at the reception in the evening. The men's competition resulted in a tie between Dr. Dangerfield (Dundee) and Dr. Baird (Glasgow), with Dr. Dangerfield winning the toss. There was also a tie in the ladies' competition, with Mrs. Bain (Aberdeen) winning from Mrs. Gallie (Glasgow).

The Business Meeting was held on Saturday afternoon within the precincts of the University of St. Andrews, and a company of 78 assembled, with Dr. Margaret Muir in the chair. The Secretary gave the membership at the time of reporting as 181, there having been several resignations due to members securing promotion furth of Scotland and joining the regular military services. The financial situation continued to be satisfactory, the cash balance at the audit being £128 as against £114 last year. The recently introduced scheme for the payment of the subscription by Bankers' Order was working well and bringing in an annual income of some £70.

There followed a long discussion on the question of Honorary Membership. The President explained that, on the occasion of their retirement from hospital practice, it had been our custom to confer Honorary Membership on those members who had been Presidents of the Scottish Society. There is, however, no machinery to recognise those other members who were faithful attenders and gave their full support to the Society, but who were not Presidents. More and more are going to come into this category, and either we make some recognition of their services or we just stroke them off the roll as no longer eligible for ordinary membership. Should we confer Honorary Membership on all who retire? Or should we retain the Honorary Membership as at present and create a separate category of Senior Members for those who had not been Presidents? The President confided in the meeting that the Council was seeking the feeling of members on a rather delicate matter and her statement elicited considerable discussion. The opinion was expressed that we should retain Honorary Membership as at present constituted for those on whom we wish to confer some special honour and to include past Presidents, and to create a new category of Senior Members. This will entail a change in the constitution of the Society, and a formal proposal will therefore appear in the printed agenda for the next A.G.M.

The Council had nominated Dr. A. H. B. Masson, Edinburgh, as Hon. Secretary for 1963-64 and this announcement was received with warm applause. It was explained that as Dr. Masson is not expected to return from U.S.A. until August, 1963, the Council had asked Dr. Shaw to continue with the duties until such time as Dr. Masson could take over. Dr. A. C. Milne, Edinburgh, was elected to the new post of Hon. Treasurer, and in his place, as Regional Representative for Edinburgh, the name of Dr. D. B. Scott was put forward as co-opted for the year remaining of his period of duty. As Auditors for 1963-64, Dr. F. Holmes and Dr. R. T. Pettigrew were elected ; the President paid tribute to the auditors for the past number of years, Drs. Grieve and Grigor of Glasgow, who had been most painstaking in their task and without whose co-operation the financial statement could not have been prepared in time for the A.G.M.

Dr. Margaret C. Muir, in introducing Dr. A. C. Forrester as the new President, said he was one of the most distinguished and widely-known anæsthetists in Scotland and beyond ;

he was Reader in Anæsthetics to the University of Glasgow, and in charge of the Dept. of Anæsthetics at the Royal Infirmary, Glasgow, one of the biggest in the country. She then handed over the Presidential Chain of Office, and Dr. Forrester took the chair as President for 1963-64. Dr. Forrester announced to the meeting that the Council had nominated Dr. J. D. Robertson as Vice-President for 1963-64 and this was warmly applauded.

Dr. Alex. C. Forrester then delivered his Presidential Address to which he had given the title "Applied Science and the Anæsthetist." With the aid of numerous slides he told how the practice of anæsthesia to-day has come to rest on the application of numerous scientific principles, and that they are more and more crowding in upon us. The guest speaker was Prof. E. A. Pask, Newcastle—with the use of film and slides he spoke on the Design and Testing of Life Jackets.

On Saturday evening, Dr. and Mrs. Alex. C. Forrester held a reception in the Atholl Hotel, St. Andrews. The golf prizes were duly announced by Dr. Gallie and handed over to the winners by Mrs. Forrester. This was followed by dinner to which 72 sat down, and dancing concluded the evening.

Trade Exhibition

Throughout the period of the Conference there was a display in the Atholl Hotel put on by the following firms:—

Ambu International, British Oxygen Co., Ltd., Cardio-Pulmonary Instruments, Garthur, Ltd., Medical & Indust. Equipment, Ltd., Duncan Flockhart & Co., Ltd., Imperial Chemical Industries, Ltd., and May & Baker, Ltd.

Obituary

Dr. A. Gordon MacLeod, Glasgow.
Elected to membership 1928.
Died 27th December, 1962, aged 76.

Dr. John Johnston, Aberdeen.
Founder member 1914.
President of Society 1936.
Died 31st December, 1962, aged 84.

Dr. Joseph I. Lawson, Dundee.
Elected to membership 1950.
Died 24th April, 1963, aged 71.

With great regret we have to announce the death of these three anæsthetists of a generation now gone. It is with peculiar feeling at this time when we are looking forward to the celebration of the 50th anniversary of the founding of the Society: the Council had decided to invite specially to the functions in connection with it all those members who because of their infirmity do not attend the ordinary meetings. It is particularly appreciated that with the passing of Dr. Johnston there is now no representative of the original small band who founded the Scottish Society in 1914.

Payment of Annual Subscription by Banker's Order

FROM time to time, members have requested that they be allowed to pay the annual subscription to the Society by Banker's Order. It was realised that this would be of benefit to the member and to the Society alike, but with successive secretaries operating through different banking accounts it was not considered workable to inaugurate such a scheme.

Arrangements have now been made whereby those members who prefer to pay the annual subscription by Banker's Order may do so through the Head Office of the Bank of Scotland, The Mound, Edinburgh. The Society's financial year ends 31st March, and payment by Banker's Order may therefore begin with the subscription for the ensuing year, payable 1st April. The scheme is commended to members for their own convenience, for the Society's financial situation, and for the facilitation of the Hon. Treasurer's duties.

A form suitable for use is available on application to the Hon. Treasurer.

The Platt Report and the Wright Committee

IT was explained at some length in the Newsletter for 1962 how the Society had been invited early in 1962 to submit its views on how the principles of the Platt Report could be applied in Scotland with particular reference to anæsthetic departments. After a considerable amount of work in digesting the Platt Report, and in getting to know the anæsthetic staffing position in Scotland, a communication to the Wright Committee was formulated and submitted at the end of May, 1962. Thereafter Dr. Wright paid us the honour of asking the Society's representatives to meet the Committee and give evidence on several aspects of the specialty. Owing to the short notice given only two representatives were available—Dr. Forrester and Dr. Shaw—and the meeting took place in Glasgow on 20th June, 1962.

At the Annual General Meeting 1963, Dr. A. C. Forrester gave a detailed account of what had transpired at the interview with the Wright Committee, and the following points were outlined as the salient features:—

A.—Consultant Establishment

The Wright Committee agreed that the Consultant Establishment should be adequate. There should be sufficient consultants—

1. To avoid junior anæsthetists being called upon to give anæsthetics for major surgical procedures, or for minor procedures in ill patients without supervision.

2. To allow junior anæsthetists to have adequate time free for study and for ward work.

3. To give proper anæsthetic cover for intensive care units and post-operative recovery units where these exist or are envisaged.

4. To cover a certain amount of work outwith the theatre such as ward work or research.

The Wright Committee was anxious to find a yardstick by which the number of consultant anæsthetists required for the above purposes could be assessed. Reference was made by the Society's representatives to a suggestion by the Assoc. of Anæs. of G.B. & I., and also the Scot. West Reg. Sub-Committee, which related consultant anæsthetic sessions to consultant surgical sessions; this formula also to embrace the specialties of Radiology and Psychiatry. This was not favoured by the Wright Committee, who in turn asked the representatives to relate the number of consultant anæsthetists to that of acute surgical beds, as this method had proved satisfactory when applied to medicine and surgery. This was, in fact, worked out at a later date by Dr. Forrester, and was of little value because of the tremendous variation in the different types of hospitals. The establishment will have to be worked out individually for each group of hospitals therefore.

B.—Medical Assistants

The Wright Committee was somewhat vague about where exactly this grade would fit into the service, but they did suggest that it might be used with advantage in small numbers to fill the gaps after adequate consultant and registrar appointments had been completed. The representatives were given the assurance that this grade would not be used to dilute the consultant grade, and would not be used to flood the specialty with cheap labour. On the contrary, the Committee was of the opinion that the introduction of this grade would enhance the status of the consultant.

C.—Rotation of Anæsthetists

The question of rotation from the teaching hospitals to the periphery was one that affects all specialties, and no decision had been taken regarding this by the Wright Committee.

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SILENT COMMENT FROM ENGLAND

"Medical News"—3rd May, 1963

"An official of the Manchester Regional Hospital Board told 'Medical News' that for several years his area had had on an average six vacancies for consultant anæsthetists. It had been impossible to attract enough suitably qualified people to keep the anæsthetic establishment up to strength, no matter how often vacant posts were advertised. . . . When the recommendations of the Platt Committee are implemented there will be yet more posts to fill and nobody knows where the fillers will come from." The problem, said the Manchester spokesman, is common to the north. "Ambitious registrars," he said, "regard the Barnet bypass as the northern limit of civilisation."

50 years 50 years

1914 <——— 1964 ———> 2014

Retrospect Prospect

. . . MALCOLM SHAW

IN November 1961, Principal Sir Thomas M. Taylor, presiding at a graduation ceremony at Aberdeen University, told the new graduates that they were going out into a world where events were moving at an exciting, not to say a terrifying pace. Out of their number now launching out into the world of the 1960's it was probable that some would live to see the year 2000—only some 40 years ahead. With the coming and consolidation in use of atomic energy it was certain that many things would disappear altogether, and with them much that had been familiar and perhaps much that had been dear. What would they see, we may well ask of these new graduates? One writer in 1963 contrasts the world of 2000 with that of to-day with its slaughter of people by diseases: he foretells these killers being smashed and annihilated, so that the sun will rise on an earth which is practically free from disease which has hung like a cloud over our beautiful planet for thousands of millions of years. Indeed he goes on to ask if death itself need occur: will the process of ageing still be regarded as normal and carry a person off remorselessly after only a hundred years or so of life? He confidently predicts that this will not be so: that death will not really be necessary. Still another prediction, this time from Jodrell Bank, will have the Russians colonising other planets of the solar system, probably beginning with Mars, within 25 years, i.e., in the 1990's. A Leading Article in the Lancet of November 18, 1961, gives the Earth's population to-day as three thousand million, and quotes Huxley as saying that by the end of the century there will be six thousand million people — a real population explosion—unless there is catastrophic destruction of some kind. This is exactly what Bertrand Russell believes is going to happen. In his collection of essays, " Fact and Fiction," he declares that every day it becomes less likely that there will be living men and women in the world at the end of the present century. What compels this conclusion in such a mind as his? and to what agency does he attribute this impending holocaust? None other than the handiwork of man himself, unleashed and untrammelled in the shape of the bomb. In other words, the human race has forty years ahead of it—no more: and it follows therefore that the Scottish Society of Anæsthetists will not see the centenary of its founding.

We are on the threshold of its half-centenary and inevitably we look back to the days of its founding. A Founder Member and latterly one of our Honorary Members told us that if we think the present era in our specialty is interesting, it is no more so than theirs. They had to fight against the belief and teaching of surgeons that chloroform was the one and only anæsthetic even although the death-rate on the table reached an average of fifty annually in one Glasgow hospital; they had to oust the vested interest of general practitioners for whom the fee for the administration of chloroform was a valued perquisite; they had to live through the time when anæsthetists, experienced and non-experienced alike, were only regarded as housemen; and they had to bring home to the surgeon, and to the general practitioner too, the indispensability of the specialist anæsthetist. They lived through the stages of the introduction of mixtures of chloroform and ether; open ether preceded by chloride of ethyl; spinal anæsthesia with its many crises of fall in blood pressure; next came Boyle with gas and oxygen bubbling more or less continuously through chloroform and/or ether; there were the dreadful post-operative pneumonias so often associated, as was later found, with upper abdominal sepsis and with the development of empyema. The lot and the status of the anæsthetist was not a happy one. Even in 1946, John Elam could write in the "British Journal of Anæsthesia": "People will not pay for a good anæsthetic, given by a professional, as I well know after twenty-one years in general practice. So young people on completing their medical education have no encouragement whatsoever to take up the art and science of anæsthesia as a specialty. For my own part, with things as they are, I would be the last person to advise our young people to become full-time anæsthetists. . . Anæsthesia is not a popular

branch of medicine because the responsibility of the anæsthetist is great, the work hard, and, even in London, the reward ridiculous."

That was written less than twenty years ago: conditions — and status — have changed. We realise that as for the scientific aspect of our specialty we are only now nibbling at the edge of a vast and exciting domain: the present is no treadmill of drudgery but forms part of a voyage with discoveries ahead to which our thoughts at this juncture cannot even aspire. Recently in this Society we have had two Presidential Addresses in particular which lifted our gaze to the shape of things to come. Dr. Tindal will have us operating in pressurised theatres, with bloodless surgery on exsanguinated patients, and the restoring miracle of artificial blood. Dr. Forrester is rearing his future anæsthetists on a solid foundation of basic sciences, and bids us wake up and pay attention because science is overtaking us. A third address—that of Dr. Alison Ritchie who was the first lady to wear our Presidential Chain of Office—sounded a precautionary note in "Lest We Forget": she would have us count our blessings in this day and age, here and now, and while we ever look forward towards a new century, it is always salutary occasionally to look back over the road we have come.

One of the most revered names in our specialty to-day is that of Prof. H. K. Beecher: in the journal "Triangle" for April, 1961, he has given us an article which should be prescribed reading for all who claim to be specialists, both senior and junior alike—"The Present Status and the Future Development of the Physician Anæsthetist." Just as any substance is defined by its properties, so the specialist is revealed in his activities. He controls the vital functions of sensation, of consciousness, of respiration, of circulation, of neuromuscular action and of metabolism, and all of this he does under the adverse circumstances of disease and surgery. It is a curious thing, he says, that it is technically easier to take away consciousness with its vast consequences than it is to take out a lung.

Prof. Beecher goes on to deal with the growth in status of our specialty and with the broadened activities involving control over the body's functions, integrating the anæsthetist into the general medical scheme; but it is also apparent that with the remarkable contrast in the status and stature of the anæsthetist nowadays to that of his former colleague, there is an equally remarkable contrast in his responsibilities. This competence to lead our specialty both within and outwith the operating theatre has largely been demonstrated by our present generation of senior anæsthetists, but with the rich opportunities now presenting to the young and vigorous, let us hope that Dr. Forrester's cry at St. Andrews will not go unheeded. At the conclusion of his address he said to the annual conference:

> "It is implied that adequate time and money is available for the projects and for the instruction of trainee anæsthetists in the principles of scientific measurement. This is in fact rarely the case, and I would like to make a plea for assistance of this nature to be made available, not only by the Universities but also by the Regional Hospital Boards; to whom we might say, with apologies to Lewis Carroll:
>
> Can we walk a little faster?
> Must we emulate the snail?
> For Science is upon us,
> And it's treading on our tail."

Do You Know . . .

. . . the identity of the speakers in the following quotations?

1. We have seen something to-day that will go round the whole world.
2. Surgeons have about the thickest heads of all medical people and you can get very little through to them.
3. I would have a spinal anæsthetic to-morrow if I knew who was going to give it.
4. After all, even water becomes a lethal substance if one's head is under it too long. Here the remedy is obvious. Equally so with curare—do not give too much.
5. It is because I hold this view that I consider the introduction of halothane to have been the most retrogressive step in the history of anæsthesia. Dr. Michael Johnstone's use of such terms as "Universal Anæsthetic" carries us in one leap back to the days of John Snow . . .
6. We do not believe that any routine examination such as would normally be made by an anæsthetist in the dental surgery is in any way helpful, and therefore we do not consider it to be negligence to omit examining such a patient before an ordinary short dental extraction.
7. It is a counsel of perfection that respiration should not be obstructed even for a single breath, but in practice we are in agreement with those who consider that provided the anæsthetist is experienced and can at will correct the obstruction, this rule need not always be strictly adhered to.
8. It is a fact that to anæsthetise a human being, to deprive him of consciousness outright, is to take a considerable step along the road to killing him . . .
9. For my own part, with things as they are, I would be the last person to advise our young people to become full-time anæsthetists.
10. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.
11. If my duties included teaching of students, I should be quite happy to see them handle a syringe which contained half a gramme of hexobarbitone, but full of anxiety if the syringe contained the same amount of thiopentone. If I were called upon to anæsthetise a V.I.P., I would use hexobarbitone . . .
12. The surgeon is allowed to operate as long as his manipulations do not disturb the anæsthesia: to complain that narcosis is not sufficiently profound is as unthinkable as sending back the specialty at a famous restaurant.

For answers and references see page 15.

In the "Howler" Tradition

The following are given in complete seriousness as absolutely genuine:—

1. Intravenous anæsthesia is a wonderful idea, because by giving the anæsthetic by the bloodstream you do not need to worry about the airway.
2. It must be extremely difficult to infect the bloodstream, otherwise the anæsthetists would do it every day.
3. Answer to question on Brachial Plexus Block: In a neurotic young lady the axillary technique may be so difficult to perform, especially when the anæsthetist is a young and smart one. The reason is because of the tickly sensation in this type of patient it may be unsuccessful.
4. I may be a rotten anæsthetist but I am a jolly good resuscitator.
5. With a good anæsthetist and a good assistant, any old thing will do for a surgeon.
6. It is well known that the middle finger is the longest and strongest of the hand: it is not so well known that it was made like this specially to support the patient's jaw. This is an example of design in evolution.
7. As an anæsthetist watching how well I can extract teeth, you must have a good laugh when you see these other chaps trying to do it.
8. Anæsthesia has become so ritualistic and streamlined that the operation now forms only an interesting incident somewhere in its course.

It Has Been Said . . .

Promotion is based on seniority: we would like it to be on merit if God would do the choosing.—B.O.A.C. Pilot-Instructor on B.B.C. T.V.

Sister has even asked the surgeon if he would like her personally to supervise the manufacture of the damned catgut. — Sister Leckie: Surgo 1951 17 3 164

It is not desirable that the patient should be half awake, and I would suggest that the anæsthetist who does not consider the patient's viewpoint is half asleep. — Dr. Margaret C. Muir.

The pharmacologist would like to be able to predict the complete effect of a drug given its exact structure, or conversely be able to predict the chemical structure that a compound must possess to produce a particular spectrum of pharmacological effects. We are a long way from this goal. — M & B Pharmaceutical Bull. Aug. 1962, pg. 86.

(a) I have personally been at the receiving end of this unpleasant drug (suxamethonium) and experienced the hell of regaining consciousness while totally paralysed. It did not end there; this was followed by meningismus and very severe joint pains. On another occasion 26 hours after a minor surgical procedure I was unable to walk without help. —Letter in B.M.J. 3rd Nov. 1962, Pg. 1190.

(b) I would advise any anæsthetist who is to have an operation to choose not only his anæsthetist but also his anæsthetic agents with care. . . . There should be no relaxant used without unconsciousness, there should be no return to consciousness without abolition of the relaxed state.—Letter in B.M.J. 1st Sept. 1962.

Evidently a large number of British prefer to be treated in out-patient surgical clinics, rather than as in-patients in the Royal Infirmary of Aberdeen under socialised medicine. —American comment on "Anæsthesia for the Out-patient Treatment of Hernia and Varicose Veins." Survey of Anæs. 1963 7 1 44

Instruments do not relieve the pilot of an aircraft or an anæsthetist from the necessity for constant watchfulness. — V. J. Keating: B.M.J. 1962 22nd Dec., Pg. 1684.

I don't like gas at the dentist's: you never rise from that chair quite the same after it: you leave some part of yourself behind. — B.B.C. Radio: Woman's Hour.

The ability to make a long hard day's work in the operating room run smoothly is no mean asset to an anæsthetist. . . . I do not think a man like this ought to be rejected for training as an anæsthetist because he is not laboratory minded.—Sir R. R. Macintosh: Anæs. 1956. 11.

. . . although it is not without interest that at least one manufacturing firm has found that purification beyond a certain point calls for complaints on the score of "weakness".—Said of di-ethyl ether: Rec. Adv. Anæs. & Anal. 7th Edit. Pg. 90.

Dumfries and Galloway Royal Infirmary had the honour of introducing ether anæsthesia into Great Britain. I thought that this fact was well known to all practising anæsthesia in the last fifteen years. . . . I venture to suggest that had this historic landmark been situated south of the Tweed it would have been restored and preserved . . . — Glasgow Anæsthetists: O.M. Watt Pgg. 6 & 7.

Dr. Borland was anæsthetising aged, bronchitic, under-nourished physical wrecks when the term "Geriatric" was unknown, and when "Relaxant" was a drawing-room word for a purgative.—Glasgow Anæsthetists: O.M. Watt Pg. 30.

One of my earliest memories in life is the intense satisfaction I derived from "landing" my heel with all my puny force behind it on the nose of the surgeon who was about to perform some minor surgery on my person.— And. Tindal: Surgo 1950 17 1 26.

Preliminary Statement on the 1964 Annual General Meeting

. . . being the Jubilee Meeting to mark the 50th anniversary of the founding of the Society

THE Council of the Society is very conscious that this particular Annual General Meeting is an historic occasion and that to all the present members there falls a privilege quite unique. A special committee has been formed to plan and organise the details of this meeting, and the following is a preview of the arrangements at present decided upon.

As a compliment to Edinburgh, where the Society was founded in 1914, the Jubilee Meeting will return there for our usual week-end—the last week-end in April, 1964, being April 24 to 26.

Friday Evening, April 24

Cocktails and Buffet Supper supplied for members and wives. It is also hoped to have a distinguished speaker who will address the entire company.

Saturday Forenoon, April 25

As this is a very special occasion it is proposed to introduce a feature new to our annual meetings: it is hoped to have scientific papers, perhaps four or five depending on length, read by anæsthetists representing all parts of Scotland. Heads of departments have already been acquainted with this innovation and the response is most gratifying.

This scientific session is not necessarily to the exclusion of the customary golf competition on Saturday forenoon, but it is proving surprisingly difficult to secure a course at all accessible, and that is the position as we go to press.

Saturday Afternoon

This will take the usual form of the Business Meeting, followed by the Presidential Address (Dr. J. D. Robertson), Registrar's Paper, and Guest Speaker.

Saturday Evening

Reception and Dinner at which there will be distinguished guests.

Do You Know . . .

(From page 13)

1. Jacob Bigelow leaving the theatre after Morton's demonstration of ether anæsthesia: Anæs. 1960 15 69.
2. Dr. Andrew Tindal to a conference in London: Glas. Herald 14 Nov. 1962.
3. Sir Robert Macintosh *ipse dixit.*
4. Prof. W. W. Mushin: "Anæsthesia for the Poor Risk" Page 42.
5. J. Selwyn Crawford: Brit. J. Anæs. 1962 34 11 830.
6. Macintosh and Bannister: Essentials of General Anæsthesia: Pg. 363.
7. Macintosh and Bannister: Essentials of General Anæsthesia: 5th edition 232.
8. Mr. Justice Oliver: Anæs. 1954 9 4 247.
9. Dr. John Elam: Brit. J. Anæs. 1946 20 1 9.
10. Lord Justice Denning: Anæs. 1954 9 4 270.
11. Dr. J. K. Hasler: Anæs. 1955 10 91.
12. Richard Gordon: "Sleeping Partner" Punch Oct. 7, 1953.

Appeal for Information

. . . Annual General Meeting 1938 at Dundee

FOR some reason the minutes of the A.G.M. of the Society for 1938 have never been written. The meeting and the activities of the Society for 1937 are documented, and signed by Dr. D. Keir Fisher as President, and among the items of business it is given that the next meeting would be held in Dundee on the second Saturday in October, 1938, with Dr. J. D. Stewart (Dundee) as the incoming President, and Dr. Napier (Glasgow) continuing as Hon. Secretary and Treasurer.

We know that the meeting did actually take place, and the Council would be grateful to any member who may be able to supply details, however sketchily remembered. It is proposed to compose a factual account of the Dundee meeting, compiled from replies, so that the records of the Society will be complete.

THE SCOTTISH SOCIETY OF ANÆSTHETISTS

. . . Programme for 1963-64

1. Registrars' Meeting: Dundee Royal Infirmary.
   Tuesday, 22nd October, 1963.
2. Tuesday, 31st March, 1964.
   Closing date for submission of papers for Registrars' Prize.
3. Annual General Meeting: Edinburgh.
   Friday, 24th, to Sunday, 26th April, 1964. See special Preliminary Notice on Jubilee Meeting.
4. Scientific Session: Glasgow.
   Saturday, 30th May, 1964.

GLASGOW AND WEST OF SCOTLAND SOCIETY OF ANÆSTHETISTS

Syllabus for 1963-64

Saturday, 26th October, 1963.
Combined Meeting in Glasgow with the Edinburgh Association of Anæsthetists.
"Thoracic Surgery"—Mr. R. S. Barclay, Mearnskirk Hospital.

Wednesday, 4th December, 1963.
"A new Anæsthetic Apparatus for Dentistry and Short Surgical Procedures"—Dr. H. Rex Marrett, Coventry and Warwickshire Hospital.

Monday, 20th January, 1964.
"Turkey: Aæsthetics and Anæsthetics"—Dr. D. A. N. Barran, Vale of Leven Hospital.

Tuesday, 18th February, 1964.
Members' Night: Brains Trust.

Tuesday, 24th March, 1964.
Presidential Address—Dr. T. P. Griffin.

Friday, 17th April, 1964.
Annual General Meeting.

* * *

With the exception of the Combined Meeting, all meetings are held in the Royal College of Physicians and Surgeons, 242 St. Vincent Street, Glasgow, at 7.45 for 8.15 p.m. The Hon. Secretary is Dr. Don. Campbell at the above address.

NORTH-EAST OF SCOTLAND SOCIETY OF ANÆSTHETISTS

Syllabus for 1963-64

Friday, 18th October, 1963—Aberdeen.
"The Management of Cranially Joined Siamese Twins"—Dr. Ian Jackson.

Thursday, 28th November, 1963—Stracathro.
Registrars' Papers.

Wednesday, 18th March, 1964—Dundee.
"Regional Analgesia"—Dr. R. Bryce-Smith.

Friday, 15th May, 1964—Aberdeen.
"Underwater Medicine"—Surgeon-Captain Stanley Miles, R.N.

* * *

All details of these meetings may be had from the Hon. Secretary, Dr. J. I. Murray Lawson, Dept. of Anæsthetics, The Royal Infirmary, Dundee.

ASSOCIATION OF ANÆSTHETISTS OF EDINBURGH

Syllabus for 1963-64

Saturday, 26th October, 1963.
Combined Meeting with Glasgow and West of Scotland Society at Royal College of Physicians and Surgeons, 242 St. Vincent Street, Glasgow, C.2, at 5.15 p.m.
"Thoracic Surgery"—Mr. R. S. Barclay, F.R.C.S., Cardio-vascular Surgeon.

Tuesday, 12th November, 1963.
Presidential Address—Dr. D. W. Shannon.

Tuesday, 10th December, 1963.
"Recent Trends in Therapeutics"—Prof. R. H. Girdwood.

Tuesday, 14th January, 1964.
"Respiratory Physiology"—Dr. Harris and Dr. Slawson.

Tuesday, 11th February, 1964.
Associate Members' Night.

Tuesday, 10th March, 1964.
"Metabolic Acidosis"—Dr. C. F. Hider.

Tuesday, 28th April, 1964.
Annual General Meeting.

* * *

With the exception of the Combined Meeting, all meetings are held in the Royal College of Surgeons, Nicolson Street, Edinburgh, at 7.45 for 8 p.m. The Hon. Secretary is Dr. Allan S. Brown, 53 Braid Road, Edinburgh, 10.

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