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Dr Cyril Scurr CBE LVO in interview with Lady Wendy Ball
Oxford, 29 May 1997, Part Two

WB Dr Scurr, it's nice to know that all your children have been so successful but can we now go to a slightly different subject? About the same time as the children were being born, I think you founded the George Club(?). Can you tell me what that was for?

CS The George Club(?) was at a time when I thought that the London hospitals were possibly, as indeed they have always been, in rivalry with one another and that amongst the anaesthetists in particular there wasn't enough lateral communication. And the importance of this is really because anaesthetists were represented on their own particular bodies. Such as: the section of anaesthetics of the Royal Society of Medicine which has to elect a president and a secretary and so on every year or two, and the Association of Anaesthetists with quite a large council with members to be elected from all over Great Britain and Northern Ireland and, of course, above all the Faculty as it was then or the College as it is now. I think a lot of people got elected to these things for the wrong reasons, very often because they were well-known, because they'd written a book, sometimes because they were teachers with a number of acolytes who'd voted for them, but very often the wrong people got elected. One other thing was that of course it was fairly important to keep a reasonable regional representation. Somebody coming from a small regional centre, however important, might stand a very poor chance of getting on and indeed for a long time the Scots as a whole, from Scotland, had great difficulty getting anyone on by a majority to the Faculty. But at any rate in London it seemed to me that it was a pity that various London hospitals were putting up people for election against each other. And so in the George Club(?) I started with the idea of having at least one representative from each of the London teaching hospitals, of which there were at that time about a dozen, and they as a dining club would agree on which candidates they were going to back. And to some extent this limited unreasonable competition. Sometimes two people from the same hospital were put up against each other which of course was very counter-productive because there wasn't a chance of either of them getting on by a split vote of that sort. It's interesting to note that the George Club which I founded I think in the fifties is still going today and is quite an important body, not [only] for lobbying for election purposes but also for discussion of political points which they can put to the College or the Association for the major body to consider. And it is quite a useful club. I haven't been for some time now because I find it difficult to get there in the evenings and so on but I believe it's a good, thoroughly good going organisation. One of the fruits of it was that when we had the World Congress the organising committee, which was largely based in London, consisted almost entirely of members of the club. One of them organising the scientific programme, another one organising the ticketing and the admission and another one organising the social programme and so on. And it worked out very well. So it did pay off in that respect.

WB Did it also have the effect of producing cross-fertilisation of ideas in anaesthesia or was it not really concerned with that?

CS Not in the scientific sense of anaesthesia, but I think it did in respect of political movements in anaesthesia such as the transition of the Faculty to a college and that sort of thing.

WB So can we talk a bit more about your political career? I think you said earlier that Sir Geoffrey Organe encouraged you?

CS I think Geoffrey Organe encouraged me to apply for election to the Faculty. I had been already chosen to sit on various committees of the Association of Anaesthetists, which I must tell you is more of a trade union than an examining body in the way that the Faculty is. The Faculty is more comparable, or was comparable with the Royal Colleges whereas the Association was essentially a political body. And you must bear in mind that the Royal Colleges are not concerned with terms and conditions of service, that must fall to something like a trade union.

WB But you joined the board of the Faculty fairly early on?

CS I was elected to the board of the Faculty, yes, fairly early. I can't remember exactly the date. I think at that time one had two periods after election, two periods of eight years I think. So I was probably on there for sixteen years and I think it was towards the end of my first term of eight years that I was elected as the dean of that body to follow Derek Wylie.

WB And just before that you had become chairman of the scientific programme of the World Congress in 1968?

CS Yes, indeed. That was a fascinating job really and my colleagues on that were Patrick Shackleton who was the president of the Congress and Geoffrey Organe who was my colleague. There were three of us on the committee. I had a very good secretary at Westminster who was in fact Geoffrey Organe's secretary who he lent to me, Anne Sweetland(?). She was absolutely first-class. I tried to run it as a committee of one and I made very rigid rules so that if people wrote from Austria and places and wanted to read a paper three times as long as their allocation, they got short shrift.

WB So, you got the whole thing very organised for the next time.

CS Indeed. We had four auditoria because we had it at the Royal Festival Hall: the Purcell Room, the Queen Elizabeth Hall and the National Film Theatre we had as well. So, we had four auditoria, and we had a large number of papers. We had people from all over the world and it really was a great success.

WB How many people came?

CS I think it was about four thousand, something of that order.

WB So, again, another very good way of disseminating all the latest ideas?

CS Yes, indeed. Yes, yes. And it was all published in a volume afterwards edited by Tom Boulton and that has been a useful thing to have on the bookshelf in the years afterwards.[1] It's going back a fair time of course, isn't it?

WB Well, back to 1968 that was. Then in 1970 you became dean of the Faculty which put you in a very influential position?

CS Very interesting position, certainly. But, within a matter of hours of being elected to this position, I thought I was taking over a going concern in the Faculty of Anaesthetists within the College of Surgeons, to whom the anaesthetists really owe their consultant status and so on. Because if it had not been for the College of Surgeons encouraging us and supporting us in the setting up of a professional qualification of anaesthetic specialists in the late thirties they would not be a real specialty as they indeed are now. So that was really quite an important point.

WB So what was the situation when you arrived as Dean?

CS The point was that there was a great under-swell of anaesthetists who wanted to have their own Royal College of Anaesthetists and not be within the College of Surgeons. They felt subservient to the surgeons. I never found that this was the case. I think as I said just now that but for the support of the surgeons, the anaesthetists would not be a specialty as they are now. I think we owe a great deal to the surgical support and so to me it was a reverse to find that there were people who wanted to secede from the College of Surgeons and get their own charter as a royal college. It was a fine idea, rather like the African countries wanting self-government, but it wouldn't have worked. They hadn't got the money.

WB To get a royal charter you needed certain things, didn't you?

CS It took about twenty years, I think, for it to actually come about. There wasn't too much difficulty I think about the political side of the royal charter, but we had to have our own property. I didn't realise that we couldn't just politically get our royal charter and stay within the portals of the College of Surgeons. I knew that the anaesthetists wouldn't raise the money to have a building that would represent their dignity and which could undertake their work. I said 'I'm not prepared to see the dignity of the specialty represented from behind a painted shop window in Camden Town.' Well they've gone to Russell Square, which is only a half a mile south of Camden Town, but they have got a reasonably decent building. But, I think this is important, to call the bluff of all those people who said that we must have our own college I started off when I later went to the Association by initiating a thing called the 'Anaesthetists Academic Foundation' by which they could subscribe or leave legacies to raise enough money to build their college, or to acquire a building for the college, which would have cost something of the order of £2 million, I think, and in fact did. But, after fifteen years, all they had contributed was £100,000 so I thought this rather called the bluff of these braggarts.

[1] *Progress in Anaesthesiology: proceedings of the fourth World Congress of Anaesthesiologists, London, September 9th-13th, 1968,* Amsterdam: Excerpta Medica Foundation, 1970.

WB Did you think there was more to it at that time? Did you think that there was perhaps a division between the anaesthetists and the surgeons, that some people didn't like working with surgeons and wanted to separate from them?

CS I think on an individual basis that was the case but I never thought this was necessary and I thought it showed a rather poor local spirit where that was the case. I think that, I've always found that you could work very well with the surgeons, particularly the members of the council of the College of Surgeons who bent over backwards to look after the anaesthetists' cause.

WB So, you felt the time wasn't ripe. Were you in a minority of one or were there some people who also felt like you?

CS I was in a pretty small minority, but most of them I think couldn't see the reality of it. And as I say, the reality is that despite the best efforts of the people who succeeded me as dean it took them twenty years I think to actually raise the funds and get the support and acquire their own building in Russell Square.

WB Who were the prime movers when that came about?

CS I don't think I could isolate any one. I think it was done by pretty delicate negotiations over the years between the deans and the College of Surgeons. And I think the political split between the two was difficult, the Privy Council came into it for a start to get the charter. And then I thought, and not everybody thought, in view of what we owed to the surgeons it was important that we should negotiate the departure from the College of Surgeons on the very best of terms and not on acrimonious terms. But there were those who didn't see that this was an important way of doing things.

WB How long were you dean for?

CS Three years. This was the statutory period.

WB So apart from managing the situation about the cessation, you also set up the Professional Linguistic Assessment Board, didn't you?

CS Yes, that was when I was on the Joint Consultants Committee. And there was always, and indeed it goes on now, a question of how many foreign doctors we should admit to this country to practise bearing in mind that their standards of qualification are often very different to our own and sometimes grossly inferior to our own. I knew about this because as an examiner for the Fellowship we had a lot of people coming from other countries, for some of whom English was not their first tongue, and their basic standard of medical education showed up during the examination process to be totally inadequate. I also used to see – looking at the General Medical Council's punitive if I can put the word arrangements for various doctors – that they were nearly always people from these countries where the education was substandard. So that… I pointed this out at the Joint Consultants Committee and found very wide support. And it was handed over to the Conjoint Board, which is the examining board which used to be run jointly between the College of Surgeons and the College of Physicians. I happened to be on the Conjoint Board. And they were appointed I suppose by the

General Medical Council to set up this exam of Linguistic and Professional Assessment for people wishing to come into this country and practise as doctors on the basis of their basic qualifications in some foreign country.

WB And what was the failure rate at that time?

CS Well, the failure rate in the case of some countries was well over fifty per cent. So it shows that until this process was introduced there must already have been on the British register in previous years a large number of unsatisfactorily qualified doctors.

WB What was done about the doctors who were already unsatisfactory? Were they put through the exam?

CS Nothing could be done about that.

WB So, they still stayed with impunity?

CS Still practised, yes.

WB What is the failure rate like now? Has it improved the situation?

CS It's still quite high. I noticed in the last GMC's [General Medical Council's] annual report they've stopped specifying the countries although they do I think show overall failure rates, which are still pretty gruesome in some cases.

WB And if somebody came obviously with great hopes and failed, was there some mechanism that you installed for training them?

CS If they can find a job to train in or they can train themselves up, they can have another go and see if they can get through.

WB Indefinitely, or…?

CS As far as I know repeatedly, yes, yes.

WB So, there was no final barrier?

CS Well, of course they've got the economic barrier as to whether they can sustain themselves. And of course after a certain small period they would be unemployable in this country in even a menial post.

WB And did you have political, in the outside sense, trouble over setting up that board from the race relations people?

CS No political trouble with setting it up on our side but a certain amount of abuse from countries who felt themselves threatened.

WB From the actual countries?

CS Yes, well, from the doctors belonging to those countries who were seeking to set up here.

WB Did they write articles or come and talk personally?

CS They stuck posters up on the wall in the College.

WB Really?

CS Yes.

WB That must have been a very unpleasant time for you.

CS Yes, I didn't think it was a very good idea.

WB What other achievements do you consider were of great importance that you made while dean?

CS Well, in the early years, after I was dean I was invited, well as dean, yes, its difficult to think back now… I set up the Scottish committee, of course, which was important for political reasons I said in order that the Scots could be represented by their own Scottish Home & Health Department and also that they could get adequate representation on the College. They've had more than adequate representation since that time and in fact two most excellent deans of the College have been Scots and one was president of the new College, Alastair Spence. Most excellent people, so we're very fortunate that it worked out the way it did with regard to Scotland. I was actually when I was dean appointed by the surgeons to be chairman of their charter committee because the surgeons were due to have a new royal charter which needed updating. So to be chairman of that committee and not being a surgeon was a great honour. And so I had negotiations with the Privy Council and so on which was of course a useful entrée in seeing the situation and what it would be if the anaesthetists were trying to set up their own college, which was a separate issue. But, the new charter did give enormously increased influence and representation on the council to anaesthetists. I felt the surgeons had really gone further than they need have done to try and appease the anaesthetists and induce them to stay. Because they put a large number of anaesthetists on their council and distorted their own, the structure of their own charter to a degree which I thought was more than could be expected. I felt somewhat guilty in the fact that the anaesthetists still rejected this as being a solution to their problem when the surgeons had been so good about it. So, that was quite important. But other things happened when I was invited to join, to become president of the Association of Anaesthetists, which as I explained earlier is a political body and not an academic body in the sense that the College and the Faculty were. In that, one of the things I initiated was a study into post-operative mortality and operative mortality in relation to anaesthesia. There had previously been a committee of this sort in the Association of Anaesthetists in the fifties. And this made two or three valuable published reports but was then wound down, which I thought was wrong because I thought it should have been ongoing. Well, when I became president I was able to start it up again and get a generous grant from the Nuffield Provincial Hospitals Foundation to set it up. And they made a report within two or three years on post-operative mortality within the first twenty-eight days after operation. And

this was a great success when it was published and gave a very important overview of the sort of people who died following operation, and the possible causes and the part that anaesthesia may have played. This caught on and the Association of Surgeons – which is similar to the Association of Anaesthetists - began to co-operate with the Association of Anaesthetists' body. And that eventually became CEPOD, the Confidential Enquiry into Peri-operative Death, which eventually the government took over and it is now an on-going and very important monitoring process. That's one thing.

WB This was while you were president of the Association of Anaesthetists?

CS Yes.

WB Was it not while you were still dean of the Faculty that you set up the committee on international standards?

CS Yes, that's true. In my last time as dean, we'd always considered it important that we had reciprocal arrangements for the anaesthetic postgraduate qualification with the anglophone countries. We had it with Ireland for many years and still have, of course, and with the Australians and the South Africans and so on … and there was a little murmuring going on at that time about South Africa being unpopular, I think because of apartheid. I went down to South Africa myself and they were kind enough to get me to examine with them and I found that the standards of their examination were very, very good indeed, particularly with regard to the clinical side of the patient's condition and that sort of thing. Excellent. So it stopped in its tracks any possibility of excluding the South Africans, so we then had Australia, New Zealand, South Africa, Ireland and the British altogether with some degree of reciprocity. They didn't give people total exemption from their exams. But, say, if you'd been trained in Australia for three years and you got their degree, we'd agree that you'd been trained to our standards and you can sit our Final exam only to get through. That sort of thing. Then, through Bill Mushin's friendship with Rick Siker[2] who I think was president of the American Boards, which is the equivalent examining body in America, we got the Americans to join in. The Canadians joined in after a bit of delay because they were in the College of Physicians who were on the whole less accommodating and less understanding than the surgeons. Eventually, we got the lot in. The only trouble is now there has been a bit of a breakdown for medical and legal reasons in that as you know litigation for medical malpractice and accidents in America is absolutely rife. And so they had to get out because if they had an anaesthetist who had an accident or something litigious in America, he was playing one foot down really if he was working on a British qualification. So, that bit has gone which I think is a great pity. Otherwise we had complete anglophone consolidation. Later on, I went to Paris at the time and we had negotiations with the French whose structure of their training exams is very similar to ours curiously enough. The Germans aren't. The Germans are parochial, they have, the local professor sets the standard as far as I can make out in Germany. But the French have a very similar [system] in respect of the time of training and that sort of thing to ours. They have this *Code Napoleon* of their education and this is where it comes from. So, we founded with them the European Academy of Anaesthesiology and I signed it with

[2] ES Siker.

Jean Lassner who was in a similar position to me in Paris. We set up a governing body of the European Academy and they now have a thing called the European Diploma of Anaesthesiology, the DAEA, the Diploma of the European Academy of Anaesthesiology. And this has caught on to such a degree that I think the Scandinavians have embraced it as well. And it really appears to be a going concern and it's run from this country by John Zorab, one of our best anaesthetists who is based in Bristol, and he runs the whole shooting match and it is examined in various centres in a multilingual way all over Europe. It's a great success.

WB That's very important. What about the countries outside the European Union and the English speaking world? I mean, say you come from Turkey, how do you…?

CS Well, the Turks, I think the Turks would like to get in, and I think the Egyptians would like to get in and we do hold some of our exams in Cairo and so on. I don't know about the Turks but the Israelis slipped into the European Academy and I assume they accept it.

WB So, there are lots of external examiners going from here, are there?

CS Yes. The other thing I started off when I was in the Association was the 'sick doctor,' because I'd been on the committee on competence to practise, which was all the specialties running this. And I represented the College of Surgeons, and the anaesthetists and so on, on this and it went on for about a year and published a report. It gave me a great insight really into doctors unfit to practise, mainly by reasons of addiction or psychiatric illness rather than sheer incompetence, although the GMC is now taking up this bit of the thing, incompetence from point of view of loss of professional skills. I started this off and it was done on a confidential basis, whereby the College of Psychiatrists were in it with us because they were an essential part of the assessment and the treatment of people who were unfit to practise. And if anyone had a colleague who they thought was always turning up drunk or unfit to practise through addiction or one reason or another, he could ring up for a confidential number from the Association. And one of their assessors would then get hold of suitable psychiatric help and they would offer to this man, the victim, the man who was afflicted, on a confidential basis help from the psychiatrist to assess him and to help him. If he then rejected it the matter was allowed to drop, but it was entirely confidential and all the correspondence was torn up and thrown away at the end of the process. That also has caught on now for all specialties and is government sponsored. So, that was another thing where the anaesthetists actually led the way. That I initiated as a result of being on the committee on competence to practise, and being president of the Association I was able to actually set it up.

WB And if the victim, the doctor turns down the help, you say everything is torn up and thrown away?

CS Yes, yes.

WB But then that doctor is then left in a position of considerable trust.

CS Until the managerial process catches up with him or somebody else does, until that happens. On the other hand it would be better to pick him out earlier if we could.

WB Well yes, it might be rather a long time before the…

CS Well, I don't know about that. It's out of our hands to an extent there, but at least we've done our best. You can't say, you see, on a confidential basis that our process should then be to get in touch with the managerial, saying 'Dr Snookes is not up to standard, you had better do something about it.' You can't do that.

WB But, obviously that was a great advance for the safety of patients?

CS Yes, it's working quite well, yes. And as far as possible, non-coercive on the sick doctor.

WB Yes. And the, going back to the confidential enquiry into perioperative deaths, can you tell us a bit more about that being set up, because I think Archie Cochrane was involved in that?

CS Who?

WB Archie Cochrane. Was he not involved in that?

CS Yes indeed, yes, he was. When I got the grant from the Nuffield people they specified that it would be helpful. Of course he was an arch-expert epidemiologist and he was of the greatest importance in setting it up and making it work, I think.

WB So you talked to him about it, did you, originally?

CS He was brought into the initial team that runs it. I didn't in fact run it. I only conceived the idea.

WB But, you had the idea and you talked to Archie Cochrane. And others were involved?

CS Yes. People like Mike Vickers who was the professor at Cardiff and Rosen[3] who was also at Cardiff. It was largely Cardiff-based and that, again, was a great success, I think. And still ongoing, as I say, and taken over by the government.

WB What was Archie Cochrane like as a person?

CS Well, very helpful to us. Ascetic, I thought. He was a bachelor and I would have thought perhaps a lonely man, that I don't know, but he was a genius at his own style of thing.

WB Did you ever work with him?

CS Only over the committee table.

WB So, not in any anaesthetic capacity at all?

[3] Michael Rosen.

CS No, no.

WB No. And then you were a member for I think eleven years of the advisory committee on distinction awards?

CS Oh, distinction awards, yes. That was an interesting thing. As you probably know, the distinction awards are given to people on top of their ordinary salary when they are assessed by their peers, I suppose I should say, and certainly by the central committee on distinction awards to be worthy of getting this bonus payment to their salaries. I think it was put in by Nye Bevan at the very beginning with a view to encouraging people to excel academically and administratively and so on, not to be purely on a seniority basis, otherwise people will say 'Well, I've been an anaesthetist or a consultant for thirty years, it's time I got this thing.' Well, it was not intended to work in that way. This was set up again on a basis of confidentiality. It was a question of having some assessment process for these people and on the whole they were put up by local committees within their hospital or hospital group. But there was a central committee with a chairman appointed by the minister of health who was usually a knighted and senior member of the consultant cadre, and supporting him was the secretariat of course at the Department of Health. And this committee with one member from each of the specialties: the surgeons, the physicians, the psychiatrists, the radiologists and so on, and they would cull such information as they could from their constituents. I used to have a meeting every year of the Higher Award holders, people who had already got the award, at the College of Surgeons, and get them from each region to bring their recommendations from within their region. They would no doubt have meetings within their region to see what local support there was for particular people, and that was the way it worked. So, then I had to go forward having compiled a list of priorities for A, B and C awards and give this to the chairman of the thing and represent it at the annual meeting of the committee on distinction awards.

WB And this was entirely separate from the Health Services Board which you also served on?

CS Oh yes. The Health Services Board was all to do with private practice in the Health Service, to do with doing... It was Barbara Castle trying to do [away] with the private beds.

WB Why was Barbara Castle trying to do this?

CS She was minister of health at the time.

WB Yes. And she was taking advice from various people on the possibility?

CS I think only her own opinion. She had some very bizarre opinions. One of the most bizarre ones was where she insisted that there be male midwives. Well, the thought in some mining town of a male midwife going round giving postnatal examinations to a miner's wife beggars belief, don't you think?

WB Did it happen?

CS It was supposed to, yes.

WB And you don't, you haven't heard of any dreadful outcomes?

CS I didn't hear of any murders occurring.

WB She was a very powerful personality?

CS Oh yes, yes. We used to go in to see her occasionally at meetings at the Department of Health and her husband who was a journalist used to be sitting in a chair and he would say when we came out 'What's she like this evening?'

WB Oh, really. But, you met quite a lot of NUPE people at the same time, didn't you?

CS Oh yes. Well, on the, that committee, with the health services board, on one side of the table was Ray Buckton, the ASLEF general secretary I suppose, and on the other Bernard Dicks from NUPE. I had Derek Stevenson with me representing the doctors and the chairman was Basil Wigoder who was the Liberal Whip in the House of Lords who is a good friend of mine. I know him quite well. This went on for a year or two and we pruned away at all the private beds at the hospitals and in the meantime the private hospitals were fortunately beginning to catch up, so there was never really any great trouble.

WB So, what was your view of the situation, that there should be private beds?

CS Yes, because they were short of money in the Health Service. A lot of people wanted their private beds and to have their privacy and not be shoved into a ward, not have the long waiting lists, have the operation at a convenient time and to have the operation done by a surgeon of their particular, or be looked after by a physician of their particular choice. All these things you couldn't get in the Health Service.

WB And you didn't think that this would detract from the Health Service? I mean, you were very keen on the Health Service, were you not?

CS I think it helped the Health Service because it put extra money into it at a time when it was short because the people who had already paid their whack through their rates and taxes into a Health Service bed weren't costing it anything to go into hospital. They were paying their own way. Oh no, the philosophy behind the abolition of private beds was entirely bent I'm afraid. I don't think if there was a Labour government next week they would be able to do away with all the private beds, because the private sector is contributing so much now to dealing with certain cases that it has taken a terrific burden from the overloaded Health Service.

WB There must have been some very fierce arguments over that committee.

CS There were a few, yes. I used to say to the trade unionists 'You know, if you, in your town you do away with all the private beds, you are not going to get the very

best quality of surgeon or physician come to run his practice.' I said 'The clap doctor will be able to run things in his front parlour for you and your nasty diseases, but when it comes to you being really ill, you won't get the very best attention.' So, there was some tough talking, yes.

WB It must have been a fascinating time actually, because it was quite a…

CS It was very amusing for me to say this sort of thing to them! I used to take them over to the pub and give them drinks. I got on quite well with them individually, but they didn't know much about it.

WB How many other medics were involved apart from yourself?

CS Only Derek Stevenson and myself. Derek Stevenson had been the secretary of the BMA and just retired.

WB And did you enjoy your time as president of the Association, looking back?

CS Yes, I did. I thought it was worthwhile, yes, very worthwhile.

WB What did you enjoy most about it?

CS One had to go to annual meetings in Dublin and I remember going to Dublin and being in the chair at the annual dinner of the Association; it happens to be the Association of Anaesthetists of Great Britain and Ireland. And in making the after-dinner speech I had to propose the loyal toast for it and I thought well, I cannot in Dublin stand up and say 'The Queen,' what do I do? They said 'You've got to say 'To Ireland'.'

WB Really? And did you?

CS Yes, I had to really. I couldn't in a foreign country propose the Queen, but it went over all right. But a year later, a chap came to me who was at this dinner and he said 'I said to them Cyril Scurr proposed a Catholic grace at the beginning of the meal.' 'Well,' they said, 'all his sons go to Stonyhurst, he happens to be an RC, he didn't have to learn it especially for the occasion.' That was an amusing time. Then we had ones in Edinburgh and various places.

WB I believe the fact that you are a Roman Catholic has actually coloured some of your political moves?

CS Well, I wouldn't go so far as David Alton on the abortion scale. But at one time when abortion became legal, you'll remember it was a good few years ago now, it must be about twenty years or more ago, there used to… When anaesthetists were up for appointment as a consultant the people on the advisory appointments committee always used to ask them, if they knew they were an RC, 'Are you prepared to anaesthetise for abortions?' And if they said no they didn't get the job. So, I went to the Department of Health and I spoke to George Godber who was a very good CMO [Chief Medical Officer], the last good CMO we've had actually. And I said 'This is the situation going on. And in view of the fact that the Act gives people the

right for conscientious objection, it's not fair that people are being turned down for jobs because they won't accede to doing this thing.' So he then brought in a regulation saying that this question was inappropriate on consultant questions. That's one of the things I did from that point of view. Then another time, the Cardinal went on record as saying 'Nobody in hospitals should in any way assist in the procedure of an abortion because it is a sin,' and so on and so forth. Well, all our theatre porters who had to wheel patients up from the ward were Italian. So I said to him 'This really won't do, you know, because these porters, they know what's on the operating lists and if it says, was it 'D&C,' or 'termination of pregnancy' I think it said, they are going to refuse to porter the patients up if you are going to make it a sin for them to play any part in the process. And you've got to temper it down a bit.' That wasn't the present Cardinal, it was about three Cardinals ago.

WB So what happened? How was it tempered down?

CS I think he watered it down a bit. I think I said 'It's only the people who are immediately involved, and furthermore any other people who are in the operating theatre aren't directly involved in the decision, which is taken by the surgeon who does the operation. It's not a decision-making process.' And in fact the nurses, you see a good few of the nurses were Irish and Catholic and wouldn't do it, so they never would scrub and do it. And it was a bit hard because in our theatre it left it to only one sister who wasn't and who would do them. And a lot of nurses don't like participating anyway whether they are Roman Catholics or not. It's a disagreeable process to a lot of them. So, that was it.

WB Was this the only area in which your religion affected your profession?

CS Yes I think so, yes I think so. It would have given a scandal, you see, if I had participated in sterilisation and abortion and that sort of thing. Everybody knew I was a Holy Roman Catholic and it wouldn't have been seen to be done, to be doing these things.

WB Can you tell me a little about your books now? Because you have published at least two very important books.

CS Yes, it was rather interesting. Of course there was a series going, and I think there had already been one book by Heinemann, on 'Scientific Foundations of Surgery'[4] I think was the beginning of the series. There have been other ones since in other specialties, certainly surgery, and ours and there's another one - gynaecology, I think, have got one. The medical adviser to Heinemann at that time was Raymond Greene who was an, had been an endocrinologist at Westminster who was the brother… No, he was the physician who went up with the pre-war Everest expedition, Raymond Greene. He was Graham Greene's brother, the novelist, and he invited me to go and do this, and with Stanley Feldman we went and we set it up, the 'Scientific Foundations.'[5] So, it was very much in my own ethos, as you can see from the beginning when I began to speak today, and that's gone into about four or five editions now.

[4] Kyle James & Charles Wells, *Scientific Foundations of Surgery*, London: Heinemann Medical, 1967.
[5] Stanley Feldman & Cyril Scurr (eds), *Scientific Foundations of Anaesthesia*, London: Heinemann Books, 4 editions, 1st edition 1970.

WB This is a teaching book?

CS Yes indeed, yes, for people… and it's widely embraced on the Continent by other countries who, for their primary scientific basis for becoming anaesthetists... As you will see from what I've been saying today, you can't really become an anaesthetist without some scientific background. You've got to have a good physiology, a good physics and so on in order to understand what you're doing, otherwise you're an empiricist(?) So that really, as I say, other countries have now adopted it more or less as their syllabus, which is rather good. And the other book I did was, with Stanley Feldman also, and with Bill Paton, is that book on 'Mechanisms of Drugs.'[6] And as I say, every time we dig deep enough to really elucidate the mechanisms we find we are at the limit of knowledge at the present time, but its going at a great speed, molecular pharmacology.

WB And you, are you still keeping that revised yourself?

CS I keep files on it in case we go into a new edition. It rather depends on Stanley Feldman who is about ten years younger than me as to whether he wants to go into another edition.

WB But presumably, as you say, you can update it every day. I mean, things are going so quickly.

CS Yes, I keep files on it in case we get into it, but always looking for someone cracking the jackpot, you know, and giving us something really epoch-making in new knowledge.

WB Looking back over your career, what do you think gives you the greatest satisfaction? Which particular piece of work?

CS Well, satisfaction… I suppose the thing I think was the most worthwhile was really the anaesthetics in the war to the wounded, and resuscitating the wounded, and similarly during the bombing and so on. That time was well worthwhile, I thought. All the things that came after seemed to fall into one's lap and I was just lucky.

WB But, you can see presumably the widespread effects of some of the work that you've done, and that gives you a feeling of achievement?

CS Yes, I think more on the political side, curiously enough, in which I didn't think I had anything at all. But the on-going nature of the 'Sick Doctor', the on-going nature of the mortality study and the other thing, I've forgotten what it was now, those seem to have stood the test of time. Oh, the(?), the linguistic assessment for foreign doctors. They seem to have all stood up. They were originally conceived by me and widely adopted, so they must have been okay.

[6] Stanley Feldman, William Paton, & Cyril Scurr, *Mechanisms of Drugs in Anaesthesia*, London: Edward Arnold, 1993.

WB That's excellent. And is the College now in the sort of shape that you would like to see it in?

CS Well, I go to the past presidents and past deans meeting each year, except I shan't go this year because it is the wrong date. But the advent of the European Union and so on is making life very difficult. I think they are trying to shorten the period of training of anaesthetists which of course we wouldn't approve of and … alter the training period generally. It's getting very, very complicated with new drug regulations and so on all spewing out of Europe. And I know how they're made. They're done by a set of civil servants round a table, most of whom don't know the answer and they give a majority vote on something which may be totally inappropriate. I do not think that, I don't know how the Europeans think we are going to go into this federal state when they are spewing out little regulations about slaughter-houses and God knows what besides in this country which they needn't be doing. They should leave us to do it on our own. And that is making life difficult for the College, having to sit on those new regulations. You see, as I said earlier, we set up this European Diploma of Anaesthesia which harmonises standards pretty well throughout Europe and they wanted to take this over and have it run by Departments of Health in the various countries. And so the idea of it being run by Departments of Health in various countries is utterly repellent to any people with an academic view of training in anaesthesia.

WB Yes, it does seem that the civil servants should meet with representatives from the College.

CS Well, they don't understand what we are talking about anyway. We do meet on the Joint Consultants Committee, but they don't half the time know what is going on. The only one who does is the chief medical officer and you'll find he's usually in public health or medicine, and very little insight into surgery or anaesthesia.

WB And in terms of the anaesthetic profession, what do you think in the future are going to be the greatest strengths or the greatest improvements?

CS I think the great thing is that the patients should be put to sleep with the least suffering and that came with intravenous anaesthesia. The other thing is that the mortality, unanticipated mortality in good risk patients should be nil. And lastly, as I said in my valedictory address, the great thing is that post-operative pain should be reduced, if possible, to zero. Well, we're nearing that point with epidural anaesthetics now for abdominal surgery and people can expect a pretty pain-free recovery most of the time in areas where this is available. It's not always available and the nurses are a bit stick in the mud about it because they won't give top-up doses, so it means there's got to be a doctor go and give top-up doses every four hours, every six hours and so on. That, and patient controlled analgesia and so on, and one hopes for new agents which give better analgesia. I think this is, the new jackpot is post-operative pain.

WB Dr Scurr, thank you very much indeed.

CS Thank you.