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Dr Aileen Adams CBE in interview with Dr Max Blythe
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Part One

MB Aileen, when first we talked I remember you saying that 'I'm part Scottish, part Irish, part Yorkshire, part Lancastrian,' but not a bit Welsh perhaps?

AA That's right, that's correct. My father was an Ulsterman and he married the daughter of a Scotsman who was living in Wigan in Lancashire and I was brought up at the other side of the Pennines in Sheffield.

MB Right. Aileen, he was a doctor at that time. You pinpointed Wigan. He was doing hospital work at that time, some time in the post World War I years?

AA Yes, he qualified from Queen's [University] in Belfast and, like everybody else did, he went into the Army straightaway and found himself out in Flanders in 1917. So he had a year of the Army and he must have done something rather well there because he got an MC, which he would never tell us what he got it for.

MB He didn't talk about it, did he?

AA No, no. People didn't talk much about it. And then when he came out he went and worked in Wigan for a while where he picked up his wife.

MB She worked in a bank there?

AA That's right, yes.

MB So, they met there?

AA Yes.

MB Just tracing both their family backgrounds, you say he came from Northern Ireland, from quite a big family, farming family?

AA Yes, yes. There were eleven in the family.

MB And he was the youngest?

AA And I think he was the youngest. Yes, that's right.

MB Qualified at Queen's, as you say, and then had a career in medicine?

AA That's right. It's quite surprising because, of course, the Irish families, like the Scottish ones, tend to put people into the professions: the law, the church and medicine. And, funnily enough, they waited until their youngest son before anyone went in for medicine in his family, but that was how it worked out.

MB What of mum's family?

AA I don't know very much about them. They came from the north of Scotland, from Sutherlandshire, and my grandfather was a Munro. He died fairly young, he was in his forties, and left my grandmother as a widow. I'm not quite sure why they went from Scotland to Wigan except that I know she had very old friends there who were medical. Dr and Mrs Boyd were people that my mother talked about a lot and I think they were, in a way, sort of second parents and that was probably why they settled in Wigan.

MB So, the Boyds were catalytic in bringing her probably to Wigan?

AA Possibly...

MB For this great meeting with father. And then when they married they moved across the Pennines?

AA They moved across the Pennines because, at that time, you bought your practice wherever it was convenient.

MB Yes, and that was Sheffield?

AA That was in Sheffield, that's right.

MB Which I know a bit about.

AA Yes.

MB I think we have a Sheffield background in common.

AA That's right, yes.

MB And you were at the east side, Pitsmoor?

AA We were in Pitsmoor, yes.

MB And you were born there in …

AA In September '23, that's right, 5th September 1923.

MB So, born into a medical ambience really?

AA Yes. My father was in single-handed practice and, as I say, it was in the east end of Sheffield. We lived in a big Victorian… well, it's not so big; when I go back now it doesn't seem a very big house but, of course, it seemed big then. There were two Victorian houses surrounded by working class properties, sort of back-to-back property. And when I went back there a few years ago, all of it had disappeared and it had been replaced by modern bungalows. But at the time I was there, it was a marvellously supportive neighbourhood because, you know, they were these houses that had communal yards and things, and people were very supportive to each other, and as the doctor's kids we could go anywhere at any time and we were looked after and so forth.

MB It was a world of cloth caps and steelworkers really, wasn't it, and mufflers?

AA That's right. We were up on the hill overlooking the steelworks in Sheffield because Sheffield, as you know, is very hilly. You get marvellous views from the top of lots of hills.

MB We've talked about your parents but we haven't quite talked about… we've talked about how they got to be in Sheffield, we've got them there, but we haven't talked about them as personalities, in fact. What was mother actually like?

AA She was a very handsome woman. I think most of her friends would have taken her for being a rather gentle sort of person. In fact, she was very strong-minded and she knew what she wanted, although she had the knack of getting her own way without appearing to do.

MB She steered you all in a canny way?

AA I think so, yes. I think so.

MB And father, was he close or remote or always busy or…?

AA Well, of course, as a doctor he was often busy. Again, he was quite a handsome person as a young man and he, I suppose… he had a marvellous sense of humour. One of the earliest things I remember is being bounced up and down on his knee while he was singing me all sorts of Irish folk songs, things like 'Paddy McGinty's Ball' and things like that.

MB Great. What a heritage.

AA So, he had time for his children even though he was very busy.

MB You were sent, at the age of five, to a fun school as well on the other side of town at the posh end?

AA Yes, at the posh end, that's right.

MB You went to Miss Barrells, is that how it's pronounced?

AA Miss Barrells.

MB Oh, Miss Barrells.

AA Yes, it had an ‘a’ and not a ‘u’ actually.

MB Yes. She was a force.

AA Well, she ran this private school and I think she was quite well known in Sheffield; it was one of the more desirable schools to go to.

MB Was it called Miss Barrells?

AA It was known as Miss Barrells, yes. I mean, it was also called Birchlands, which was the name of the house it was in - it was Birchlands School - but it was always known as Miss Barrells, and she was pint-sized. She had one leg very much shorter than the other and she limped horrendously, but she was a real character. She ran that school very well and, again, without you realising how well she ran it. And you know how unkind children can be about people with physical deformities, it would never have occurred to any of us to laugh at her because she had a bad limp. I can’t remember ever commenting on it, it was just part of her and we just accepted it, which is more than you can say for other people with disabilities. I mean, we had one or two other people there with disabilities who we did tease like mad as children do, I’m afraid.

MB But not Miss Barrell.

AA No.

MB At that school, you began to make your first friendships. I suppose there were doctors’ families and professional families’ children there?

AA Yes, there were several doctors’ families there, including one or two others from the east end of Sheffield, some of our near neighbours.

MB Aileen, because you stayed there until about the age of eleven, obviously it had some impact. Did you, in that period, feel you began to stack up as a scholar? Did you begin to show any qualities?

AA No, I don’t think so at all, no. I don’t have very good recollections of it. My recollection of all my schooling was that somehow I always had the impression I was a little bit sort of the odd one out. I was very, very shy as a child and I think to some extent I’ve got over that, although basically I suppose you never do. But I didn’t find it easy to make friends and I got on with my work and was bright enough for that not to be a serious problem, I think. So I got on all right, but never for one moment would I describe my schooldays as being the happiest times of my life. I just accepted things as they came along and got on with it.

MB But Miss Barrells was a happier time than the school life that was to follow?

AA I don't think I could say that at this stage, quite honestly. Yes, I enjoyed it all right.

MB You went away to Kent?

AA I went to Farringtons after that.

MB That was a Methodist school?

AA That was a Methodist school.

MB Were your parents strongly Methodist?

AA No, not at all. They were Presbyterian, Scottish Presbyterian.

MB Right. I was just wondering about the choice?

AA Well, I remember being consulted. I was given several brochures to look at and they were non-conformist churches, but that was all. Why they didn't think of sending me to school in Scotland, I don't know. It would have been a fairly obvious thing to do, but I don't think they did, and I don't know why that particular choice was made. I mean, as I say, I was consulted to an extent, but what made the original choice, I don't know.

MB Anyway, by the time you are eleven, you get a uniform and you go to Kent. Was that a culture shock? You said it wasn't too unpleasant.

AA No, apart from the fact that it was a boarding school, of course, and I was away from home for the first time, but I think I settled in to it fairly well. I think for the same reason that I've always been a fairly self-sufficient sort of person, so I think that I do settle into things relatively easily, and again I accepted it. I was tolerably happy there without being ecstatically so.

MB You accepted things and got on with things?

AA Yes, yes.

MB What kind of education was it like there? Was it strong teaching? Was it good teaching?

AA Yes, I think so. I think we did have good teachers, yes.

MB And was there already a thought about a scientific medical career?

AA No, I don't think so. I had all options open and the school, in fact, was if anything marginally towards the arts side rather than the science side.

MB Right, so you felt that slight bias carrying you along for a time?

AA I think it was a very well balanced curriculum. If you wanted to do sciences you could, but it was a smaller number of us that did sciences than did arts.

MB I think that on one occasion you said that there were slight veterinary interests. You became a horsewoman?

AA Well, like an awful lot of small girls and, of course, living in Sheffield you were not far from the moors which was the sort of place that you could go out and hire horses and ponies and go riding. And we had a lot of our holidays down in Exmoor and Dartmoor, so riding was a natural thing to do as a small child and, like many small girls, apart from wanting to run a riding stable, if I wasn't going to be able to do that, then the next best thing seemed to be a veterinary surgeon. I mean, that was when I was beginning to get serious at the age of, I suppose, fourteen, fifteen when I really had to think seriously about what I was going to do. And I think it was really, ultimately, a little bit of parental influence and the fact of the war coming along, because by the time I really had to make my mind up, of course, the war was just about to start in '39 and so forth. And all I remember about my father saying was, 'Well, you know, it's very nice being a vet, but don't you think it would be more useful, particularly in times of war, to be a doctor?' But he didn't put any strong pressure on me and I said, yes, I didn't think there was all that much difference and sure, that would probably interest me quite a lot.

MB So, at the age of sixteen or seventeen, that was the transition in thinking?

AA That was the transition, yes.

MB I'm just going to hold it at that particular point, because there's one ingredient of the story that we haven't quite put in and that's that you had a brother who was a little younger than you and a sister quite a bit younger than you.

AA Yes, my brother was two years younger.

MB Were they close relationships that you developed with them?

AA Well, my brother, yes, because there was two years between us. My sister was ten years younger and, although I'm much closer with her now - that's partly because my brother has died but, I mean, also because he emigrated - but, yes, I did have quite close relationships with my brother.

MB It was just the thought of family holidays brought that in and I thought that there must have been quite a nice overall family flavour and that kind of unity in the family?

AA Yes, I mean, for much of the time it was just the four of us and then Pat, of course, was ten years younger. And, of course, her schooling was very much influenced by the war because she was at school during the war and they wanted her out of Sheffield, which was getting bombed, of course. So, she went to boarding school much earlier.

MB Yes. We'll take you back from Farringtons to that Sheffield because it was about the time that bombing was going to happen…

AA No, that was when I was a student.

MB Yes, when we take you back to medical school from Farringtons, you'd not got higher school cert. You went in, I think, on school cert?

AA I went in on school certificate because the war was just about a year old then and they were taking people in a little bit more readily, particularly if they knew something about you and, I suppose, it was a time when doctors' families tended to go in for medicine and so forth, and my father was pretty well-respected in the medical profession.

MB And he went into the hospitals to do some anaesthetics?

AA Yes, he gave anaesthetics. He gave anaesthetics in the Royal Hospital, actually, mostly dental ones; he used to give chloroform to patients sitting up in the dental chair.

MB That was his speciality?

AA Which was his speciality, yes.

MB That's an interesting link with what's to come. But we have you accepted by what was a very small medical school.

AA It was a small medical school. We were, I think, thirty-two, thirty-three in my year because, again, wartime numbers were down a little bit.

MB And not many women students?

AA About half a dozen of us, yes.

MB But that wasn't a problem, you got started.

AA Yes.

MB Where was that medical school based at that time?

AA It was in Western Bank.

MB It had its own building, did it? Was it in the university building?

AA Yes, it was in the university building. There was a block which was sciences, including the pre-clinical sciences.

MB Which you started on?

AA Yes.

MB Did you have to do a preliminary year because of the school cert?

AA No, I'd done biology, chemistry and physics at school. The one that was not quite up to scratch was physics. I had to work fairly hard on that because physics was not too strongly taught at Farringtons, so I did have to do a bit of extra work on that, but it wasn't too serious a problem.

MB And you did the classical kind of three pre-clinical years?

AA That's right, yes.

MB It was the old-fashioned course?

AA Exactly, yes. And you wondered what you were doing because you never saw a patient or anything like that.

MB Were there any exciting teachers though in those pre-clinical times?

AA Well, there were one or two characters, but none that I had any…

MB No special influence?

AA Nothing very special, no.

MB And those were years though…we were mentioning the Sheffield blitz.

AA Oh yes, the professor of anatomy, he perhaps was rather well known, Frank Davies, Francis Davies, he was very well known in the anatomical field. He was the most distinguished, I think, of the pre-clinical ones.

MB You took to anatomy?

AA Not particularly, no.

MB But he was a good teacher?

AA It was still very much one of the basic sciences that everybody had to learn. I mean, I'm not sure how much detailed topographical anatomy is taught now because it's becoming slightly less fashionable. I enjoyed it all right, but nothing very special.

MB I'm just about to take you back to those memories of the war years in Sheffield which coincided with that pre-clinical course. You going up on trams or walking through desolate parts of the city. It was pretty heavily bombed.

AA Yes, we didn't have blitzes going on week after week after week. We had a relatively short period when there was a lot of bombing and what they managed to do was to bomb the centre of the city rather than the steelworks which was probably what they were aiming at.

MB Yes, they missed.

AA And rather than have lots of disturbed nights, my father and mother very sensibly decided that we'd move our beds down to the cellar and stay there because being a solid Victorian house it had good cellars. So, we slept down in the cellars and we slept through some of them until we had a really big blitz and it was obvious that there had been some bombs dropped quite near us and when we emerged in the morning we found all our windows were broken and so on and so forth. And it was the day I had one of the terminal exams at the university and, of course, I set out for the university and found there were no buses running and no trams running, so I had to walk there through the centre of the town, and buildings were on fire and trams were on their side and all sorts of things. And we sat our exams in the Firth Hall, which had a hole in the roof! They actually brought us coffee around in the middle.

MB They don't do that very often!

AA And then when we came to walk back. As I said, there were three of us from the east end of Sheffield; we had to walk twice as far back because we found that the short way we'd walked was all roped off because of unexploded bombs and things. So, we walked about ten miles - no, more than that - that day to take our terminal exam. We thought we'd earned a pass.

MB Yes, I think that's right. You also did some fire watching at that time – did you take part in? And you made some small arms.

AA Yes, the students were encouraged – those who were pre-clinical - you were encouraged to do what you could and, of course, we had to take our turn at fire watching in the university to put out any…

MB Up on the roof there.

AA I never had to do that, funnily enough, because by the time I got around to doing that the bombing had sort of petered out. But they also set up a small workshop in the university where we could go and assemble sort of bits and pieces and do our little bit for the war effort and earn a bit of pocket money at the same time. So, if you had an odd half an hour at lunchtime, you'd go and put things together and so forth.

MB These were small arms you were making?

AA I don't honestly know what we were making - the sort of bits of steel things that we were putting things in and clipping them in and so forth...

MB But you got twopence an hour or something like that?

AA We got something like that, yes.

MB Aileen, let's take you on to the clinical course. Was Sheffield an exciting centre? I mean, you've got three rather exciting hospitals there.

AA Well, it was good because we were a small number of students and consequently we got a lot of very individual attention. There was, at the most, three people on one firm, sometimes if you were lucky only one or two. So, in a way you were treated almost from the beginning as if you were a houseman, so we got a lot of individual teaching.

MB Who were the outstanding teachers of that clinical time? People like [Ralph] Brockman?

AA Well, Brockman was the professor. I wouldn't say that the professors were the outstanding people there actually. One person I knew very well was the second senior surgeon, [William James] Jimmy Lytle. Now, Jimmy Lytle is an interesting person worth talking about for a minute or two because he became a very well-known surgeon, I mean, one of the best of the provincial surgeons, actually, and he made some fairly significant contributions, particularly to hernia surgery. But he was a very old friend of ours because he was an Ulsterman as well, and he married quite late in life and all the time I was a small child he was a sort of second father, or perhaps an uncle would be more like it, because we always had our holidays together and he always came and spent Christmas with us and so forth. So, I knew him very well and he was one of the surgeons at the Royal Infirmary and because I knew him so well, of course, I tended to avoid him as far as the teaching was concerned, although everybody taught us.

MB But, he was one of the early people to make an impact?

AA Yes, he was, I think.

MB It was good surgery you were seeing?

AA Yes, excellent surgery.

MB Was there a feeling even that early on that you might be a theatre person, a surgical theatre person?

AA I think I kept all my options open. Yes, I enjoyed the theatre work but, at that stage, I think perhaps I was thinking of… well, it was something clinical rather than

anything else, I knew that, but I was becoming more concerned with hospital practice than general practice. I thought it was unlikely I would follow my father.

MB Any other outstanding figures that we should put on the record from the clinical days? Edward Wayne was there at that time, I think, doing pharmacology?

AA Yes, Edward Wayne was there, he was professor of… I think they called him professor of therapeutics at that stage and also, Wilson, of course, who went to Glasgow after that, but I suppose they were probably the most outstanding ones. But I would say they were all good solid people, very competent and a very high standard of work with very few exceptions, but I wouldn't know how they ranked elsewhere because at that time I wouldn't have known how to rank them.

MB Aileen, I'm going to ask you the sixty-five thousand dollar kind of difficult question: how hard did you work?

AA I worked quite hard. I was pretty conscientious. You see there was a certain amount of pressure on one to do that. For one thing, we knew we were privileged to begin with, with the war being on, we knew we were privileged to be there. We knew we were going to qualify in six months shorter than the ordinary course; they shortened the course from five and a half years to five. And although social life was kept going pretty well, it was very much what was local. I mean, one didn't get this chance to travel abroad or go off to interesting places and so forth, so you made your own entertainment. So, I think the answer is yes, I did work quite hard, but again, I think I was coping with it fairly well. I wasn't unduly worried about how hard I had to work. I think I felt I was keeping my head above water.

MB You staged yourself well?

AA I think so.

MB By September 1945, you qualified?

AA Yes, that was when we qualified, that's right.

MB And then went to house jobs?

AA Yes.

MB Applied for the best house jobs, I think, and got them?

AA Yes, yes.

MB Tell me about those house jobs?

AA Well, I did the professorial house job with Brockman and then after that I did a HP job with Dr Leishman, who was the son of Leishman of leishmaniasis.

MB An impressive physician?

AA A good sound solid physician, yes.

MB Middle of the road, good qualities?

AA Yes, yes.

MB Brockman's surgery. We've mentioned little surgery. Brockman was a good surgeon?

AA I was in no position to judge. He was not as well known as Jimmy Lytle, but I think a perfectly adequate surgeon.

MB But you started to give anaesthetics at that time?

AA Well, yes, because at that time the only anaesthetists in Sheffield were the GPs and they would not come in until ten o'clock in the morning because they would have a morning surgery, and they would want to be disappearing at five or five-thirty for their evening surgery. So, it was the job of anybody who happened to be around to give the anaesthetics and usually when you were on a surgical firm you started the list until the GP came along or finished it. And when I was on the medical firm we were on call at night for - I forget what it was - one or two nights a week or something for anaesthetics for the worst sorts of emergencies, of course. But then, of course, there wasn't as much emergency surgery done then as there is now.

MB But you took to the anaesthetics side. I've got an impression that you told me that you used to swap casualty duties to do more anaesthetics?

AA That's right, that's right. I've quite often asked people how they took up anaesthetics and a lot of people have the same answer: that when you are a student, it's the first thing you actually physically do to a patient. I don't think it's quite true now, but then, you sat and you clerked patients and everything was theoretical, but when you did your anaesthetic attachment, you actually did something to a patient. So, it was quite practical, and that interested me and I did more than the statutory twelve when I was a student and I enjoyed it and I suppose, obviously, the more you do the more skilful you get.

MB This was principally cotton gauze masks and ether?

AA Yes, that's right, open ether. Chloroform and ether induction poured on, open ether maintenance, trickle of oxygen from a bit of tube running from an oxygen cylinder.

MB So, the patient was still voluntarily breathing away, but you were supplementing that with a bit of oxygen?

AA Yes, yes.

MB Were there any blocks given at that time? Did you get into giving spinals?

AA We used spinals. We used spinals quite a bit.

MB That must have been quite tricky to get into because I'm not sure how you find out how to get it right?

AA Oh, well, it's a relatively simple technique. I mean, you learn to do lumbar punctures anyway, and it's a matter of being able to do a lumbar puncture and then injecting your local anaesthetic and knowing how to control it. No, it's not technically difficult, not usually. You get the odd patient who's difficult.

MB You got into those procedures quite quickly?

AA Yes.

MB And felt very at home with it, I suspect?

AA Well, the problem then, of course, was that you got very little to compare it with. The GP anaesthetists varied very considerably in their skill. I mean, some people took to it well and others were never terribly good at it, but, of course, the way anaesthetic practice was developing then - we're talking about before the Health Service - the surgeons when they were operating on private patients, part of the *quid pro quo* for a GP sending the patient was if they had to have an operation that the GP would be asked to give the anaesthetic, so it became partly a financial business.

MB Yes. But the GPs doing that got relatively little remuneration compared…

AA They got very little remuneration.

MB Anaesthetics did start off on this very low level of remuneration?

AA I'll tell you something I discovered very much more recently and that is that Florence Nightingale paid Joseph Clover in whenever it was, the 1870s I think it would be, a fee of five guineas. Now, in the 1950s the sort of fee that anaesthetists would get was still round about five guineas. So, that tells you something.

MB It does. You were fortunate to have, was it Eugene Thomas who came into your life around that time?

AA He was the first what you might call proper anaesthetist. I don't know why he was appointed. He was the first full-time anaesthetist that was actually employed by the Royal Infirmary in Sheffield and he'd be, I suppose, the sort of experience that a senior registrar would have now; he'd had a few years experience, and he was a full-time anaesthetist.

MB That is significant, Aileen, because it's putting on the map the beginning of the full-time specialists. Some were trickling out, they had been in the war, trained, but there hadn't been many. But you're marking a point in history?

AA This was towards the end of the war, it would be 1944/45/46 time and, of course, I'm talking about a provincial hospital. They'd had resident anaesthetists in the London hospitals before that, and full-time anaesthetists before that, but certainly in Sheffield we hadn't.

MB Tell me a little bit about Eugene Thomas.

AA Well, he, I suppose, in a way was the one that clinched me for anaesthetics because he was an inspired teacher.

MB He was magical. He had this accent; wasn't he an Irishman?

AA And he had this great sort of charisma and tremendous enthusiasm and he really knew how to teach. He was very keen; he'd come in any time you sent for him. If he wasn't actually holding a patient's jaw up and was anaesthetising them, he would come and help you. I think he lived in the hospital the whole time. He was terrific.

MB And you sparked each other off?

AA I don't know whether I sparked him off, but...

MB You said at one time that you always were challenging him with questions and he would also come back to you.

AA Well, as I say, he was a very inspired teacher, there's no doubt about it.

MB And that, as you say, clinched it, anaesthetics?

AA I think so, I think so.

MB And it was going to be anaesthetics all the way from then?

AA Well, looking back on it, yes, I think so. I mean, that's what got me really interested because I realised how much there was to it.

MB And so you began looking for an appointment with anaesthetics at the core of it?

AA Yes, when I finished my house jobs, which was at the end of '46, you were automatically called up for the services unless you got a job of slightly higher grading. Now, I had no strong views about whether I went into the services or not except, of course, the war was coming to its end round about then, and I saw advertised in the *BMJ* an anaesthetic job in Cambridge, at Addenbrooke's [Hospital], and, knowing that Professor Brockman was an examiner for the Cambridge MB, I went along and waved

this at him and said, ‘Should I apply for this job?’ and he said ‘Mm, I think you should go to Cambridge, I’ll fix it for you.’

MB And he did.

AA So, I applied for it and I got it, yes.

MB And when you arrived, you were thrown in at the deep end?

AA Oh yes, very much.

MB That was an amazing arrival?

AA I remember, because petrol was still rationed then, and my parents drove me down in their car, having saved up their petrol ration, and we arrived I think about five o’clock in the afternoon to an extraordinary meeting because the head porter, Ted Hobbs, said ‘Ah, you’re Dr Adams, yes, I knew your brother in the Army. I was with him on the night he went overseas and very drunk he got too!’

MB So, you had a friend instantly!

AA So, I had a friend instantly.

MB And then he said, ‘Go and get on with it.’

AA It was marvellous and he took me round Cambridge and so forth. I kept in touch with him until about five or six years ago, actually. Then he said, ‘Well, I’ve got a message for you. You are to go to the theatre and relieve Dr Windsor Lewis with Mr [Brian] Truscott’s list.’ This was before I’d even unpacked my bags. So, we dumped everything and I said a fond farewell to my parents, waved them off home, and went up to the theatre, took over from Windsor Lewis, and the first anaesthetic I gave was for a prostatectomy and I used the only thing I knew how, which was pouring ether on. I think he coughed most of the way through; it didn’t matter too much, but still. This was a Friday afternoon and I was then told that the other resident anaesthetist had gone to London for the weekend so I was on call, and that was the first anaesthetic job I’d ever done!

MB Great start!

AA Yes, great start.

MB Aileen, who were the figures who were to mould your life at Addenbrooke’s. I think you had one year there?

AA I had one year there, yes.

MB Who moulded the shape of that work? It became a very interesting year.

AA Well, when I found myself on call for this weekend, I said to Mr. Hobbs, 'Now who do I get if I'm in trouble?' And he said, 'Well, they don't actually have any sort of rota for consultant anaesthetists,' - no, they weren't consultants then, of course, they were honorary anaesthetists - 'but if I were you, I'd send for Dr [Harold] Youngman, he'll always come.' Dr Youngman was a quite remarkable person. He was not quite the senior anaesthetist then, he was a general practitioner. He was incredibly able; he was a man who could have had about four different careers: an extremely good GP, much sought after, a superb anaesthetist. He introduced a lot of things to Addenbrooke's: he introduced epidurals, he introduced the intensive care unit, he introduced treatment of chronic intractable pain and, in addition to that, he ran an ophthalmological clinic in his practice, and he was a very good obstetrician. I mean, he was called in frequently to deliver babies and I think he also had a paediatric clinic as well. Brilliant man. Wonderful. Quiet, self-effacing person but had a great deal of influence on every anaesthetist who went through Addenbrooke's, I think, for many years.

MB You formed a close association with him for that year?

AA Yes, so much so that when he died and when they had a memorial meeting for him, I was one of the people who was asked if I would contribute an address about him at that memorial meeting. So yes, we became very close.

MB That was an important step in that anaesthetics career?

AA Yes, but I wasn't the only one. I mean, he influenced very many people.

MB What of surgeons there?

AA Well, of course, there was Vernon Pennell, who was very noted. He was noted for being, I suppose, the slightly bombastic sort of surgeon.

MB Of course, you were joining a field where the surgeons really at that time were notoriously prima donna-ish?

AA Very much so.

MB Collars up and brimming with confidence and display.

AA Addenbrooke's was a rather odd sort of hospital. Although it is now a major teaching hospital, at that time it really was not much more than a district hospital, but because Cambridge was a super-duper place to live, of course, it had attracted some very able staff who were probably a lot better than had it been, you know, an equivalent relatively small city somewhere else. And, of course, with the university they were involved with the pre-clinical school to some extent and they examined for the MB and so forth.

MB But you were too young to do any teaching at that stage?

AA At that stage, oh, you taught yourself then. All you were concerned about was trying to find somebody to teach you because previously it had been a case of: 'Here's the patient, there's the anaesthetic machine, get on with it.'

MB What of anaesthetic machines, were they in a primitive state?

AA No, funnily enough, the machines they had at Addenbrooke's were the Boyle's machine, which is still the basis of the anaesthetic machine which we've used ever since the 1940s, and its various modifications and developments have been the absolutely standard anaesthetic machine in Great Britain ever since then.

MB Right. So, they pushed McKessons out which had made some…

AA McKessons didn't catch on to any great extent in this country. We did actually have them in Sheffield, but they were more an American machine. Dental anaesthetics they caught on for because they were more suitable for that.

MB But, the Boyle's machine was bottles and controlled flow?

AA The Boyle's machine was flow meters and bottles to bubble the gases through, ether or chloroform or Trilene [trichloroethylene] or whatever you were using.

MB Aileen, at this stage, we've got you in Addenbrooke's in the 1947/48 period. It would be nice to know what kind of surgery predominated in that kind of district type hospital at that time. I suppose, abdominal?

AA Abdominal surgery, thyroid surgery, limb surgery, orthopaedics, I suppose, breasts. Orthopaedics, a lot of it was trauma then, of course, apart from children's deformities. Joint replacements, of course, hadn't started then. ENT, a vast number of tonsils and a lot of mastoids, of course, because it was before antibiotics had come in. Gynae., I suppose, hasn't changed enormously in terms of the routine operations. We did a lot of gynae. Prostates, of course, again mostly done by the general surgeons because urology was just beginning to emerge as a specialty; it was nearly all open prostatectomies, the transurethral operation hadn't started.

MB Aileen, I'm also fascinated to ask at this stage, 1947/48, anaesthetics was really moving into real speciality skills areas at that time, intravenous anaesthesia, curare…

AA It was an absolutely crucial time, the period immediately after the war when a lot of things were coming together. I mean, I've given you a picture as a student of what was probably fairly typical throughout the country. What I haven't filled in is how it developed from the end of the war, because several important things had happened. One was the introduction of curare, a muscle relaxant drug that had no anaesthetic effect at all and which was introduced in Canada in '42, used in America, and came over to this country and was taken up really by two different groups of people, one in London and one in Liverpool. The introduction of curare was one of the key features; it totally revolutionised the techniques of anaesthesia.

MB What I'm interested in is how much of that had filtered through to you by the time you were at Addenbrooke's?

AA Not very much at the time I was at Addenbrookes until a rather sort of dramatic occasion when one of the consultants who had visited Scandinavia came back, not with curare itself, but with suxamethonium or Scoline, and sort of waved it at us and said…

MB Who was this who brought it back?

AA This chap called Harry Richards and he took it to Harold Youngman because although he was a consultant himself, he knew Harold was the skills chap, and Richards and Youngman did something like fifteen cases which were written up in *Anaesthesia* as one of the first two papers in the English literature on the use of suxamethonium and, of course, it was given to us: 'Use it. Here's a new drug, use it.'

MB Those were the days, weren't they?

AA Which you couldn't do now, of course. You couldn't do that now.

MB It was there. Give it a try.

AA That's right.

MB No validation at all.

AA No, that's right.

MB It's a different world. Did you take part in any of that research? Was that your first kind of nibble at research?

AA Yes. My first sort of nibble at research was another drug which came in called mianserin(?) which was a curare like drug. And, at that time, my co-resident was Robert Ballantine, Robert Ian Ballantine, who went back to Barts on the consultant staff and had a very good career and he and I, again, did a small study using mianserin - 'Drug here, give it, describe it, what happens.'

MB Was this a time when you tried any yourself, did you try, because I know you went through a period when you did try muscle relaxants?

AA What, on myself?

MB Yes.

AA That was when I was at the Royal Free later on. I was one of the guinea pigs, yes.

MB Which we'll come to in due course. But that was your first taste at research?

AA Well, we didn't call it research then. It wasn't really research.

MB And you didn't get any names on papers at that stage?

AA Not at that stage, no.

MB Any further reference to Addenbrooke's before we take you to the Royal Free because that was a pretty important transfer?

AA We had a lot of fun. It was lovely, you know, I was away from home and it was great fun and Cambridge, of course, I'd never been anywhere like Cambridge at all. It was enormous fun.

MB It was a special year?

AA Yes, it was.

MB And then you applied to the Royal Free?

AA I applied to the Royal Free.

MB Was there a particular reason for that?

AA The job was advertised, and also I thought it would be quite fun to work in London because, again, thanks to the war, I'd only been to London about twice, you know. My mother took me up once when I was a sort of teenager, so I'd never been in London. It was the great place where everything happened.

MB Absolutely, and this was post-war London. It was all coming awake again?

AA That's right, yes.

MB Did you go down for an interview?

AA Well, yes. I went to the Free and I was astonished to be handed a list of the names of about half a dozen anaesthetists and several surgeons and was told to call on them at their rooms in Harley Street, as far as the surgeons were concerned, and to call on the anaesthetists at wherever happened to be handy.

MB To be vetted?

AA Well, I had no idea what I was meant to do with this. I mean, I just sort of thought 'Well, what's this all about?' I mean, nobody explained to me what it was all about. So, I didn't terribly bother. I went to see the anaesthetists and, of course, the most important one there was Katharine Lloyd-Williams, a very distinguished lady, a marvellous person, and we chatted about what I'd done and so forth and she explained

that what they wanted for this job was someone to do the obstetrical anaesthesia because I think they'd had some deaths from complications and they wanted somebody with a bit of experience to take over that side and, of course, I'd done a fair bit of that at Addenbrooke's. I think probably in her own mind she'd decided that she was going to give me the job anyway because she said, 'Well, you don't really have to go and call on all these other people.' But, you see, it was an introduction to me on how different the atmosphere was in a London teaching hospital to the ones I was used to in Sheffield because there was still this tremendous sort of reverence for the consultant, that you didn't actually go down on one knee and kiss his hand or anything like that, but you metaphorically did.

MB Cap in hand job. You curried favour?

AA Yes, you sort of stood outside the gate in the rain to greet him when he came in to do his ward round sort of thing - or her at the Royal Free, of course, because there were quite a number of women consultants there - and it was very much the distinction which I was quite unused to.

MB What kind of an association did you form with Katharine Lloyd-Williams?

AA Oh, she was wonderful. She was one of the most serene people you'd ever meet. She was tremendously respected. She became Dean of the Royal Free Medical School. I believe she was the first woman to sit on the Senate of the University of London and she represented all the medical schools. I don't know the exact hierarchy, but I know she was a first from that point of view. And everybody loved her because she was such a nice person as well as being so awfully competent. And, of course, she endeared herself to all her trainees by saying, 'I learn something from every trainee.' So, I said, 'Well, maybe you'll learn how not to do it.' And she said 'No, I learn positive things from my trainees.'

MB You watched her and she was good?

AA Oh yes.

MB She was extremely good.

AA And, of course, the other big name amongst the anaesthetists at the Royal Free was Stanley Rowbotham, who was involved with the early studies of curare in England, in parallel with the Liverpool people, with Cecil Gray and [John] Halton and those...

MB And there was a group at the Westminster as well...

AA Yes, that's right. Geoffrey Organe at the Westminster and there was Frederick Prescott who was the chemist involved, and Prescott, Organe and Rowbotham[1] was one of the first papers, and Gray and Halton[2] was the other first paper.

[1] Prescott F, Organe G, Rowbotham S, 1946. Tubocurarine chloride as an adjunct to anaesthesia. Report on 180 cases. *Lancet*, 2, 80-84.

MB I think very early on at the Royal Free when you arrived and got started you actually started going to meetings at the Royal Society of Medicine which had monthly get-togethers for anaesthetists?

AA Yes. Well, it had for all the specialities.

MB All the sections?

AA Yes.

MB And you heard Gray in that first month or two there?

AA Yes. Well, the RSM at that stage, of course, was one of the main places where advances in medicine were actually announced and discussed. I mean, it really was the scientific forum because there were very few scientific meetings held outside - well, not even inside - the teaching hospitals; it was something that hadn't quite happened. And the RSM was where people got together and discussed their findings and, you know, as you say you saw the big names and you rather hoped that they would perhaps notice that you were a young keen type. It was an excellent centre.

MB Did you make a good link with Rowbotham at that time?

AA Although I was mostly doing obstetrics, I did one list a week with Rowbotham which was mostly for abdominal surgery and the one thing I particularly learnt from him was how to intubate in the days before curare. There was a difference in approach between the Liverpool school and the London school. Cecil Gray straightaway realised what the impact of curare was going to be, that it was going to make anaesthesia just quite different and it was going to give you total control, and he realised straightaway that the easy way to intubate was to curarise first, get total relaxation, ventilate, put the tube down. Now, Rowbotham took a slightly different approach, a little more conservative if you like. He said, 'This curare is a drug which stops people breathing, therefore we will not give it until we have secured their airway with an endotracheal tube. Therefore, we will intubate first.' So, he taught and practised the technique of blind nasal intubation which you can carry out under very light anaesthesia when the patient is not relaxed, something I have never regretted learning. It's a marvellous technique. It gets you out of all sorts of difficulties. And it's really only in about the last fifteen or twenty years that anything has come to equal that to get you out of difficulties.

MB So, when all facial muscles are tight, that's one way in for intubation?

AA That's right, yes. I mean, the things that make difficulty for intubating with a laryngoscope should make it easy for slipping a tube down blindly in a breathing patient.

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[2] Gray T C, Halton J A, 1945-46. A milestone in anaesthesia (d-tubocurarine chloride). *Proceedings of the Royal Society of Medicine*, 39, 400-410.

MB So, in that early work at the Royal Free, you were still on to patients breathing for themselves?

AA Yes, and then with Rowbotham, of course, once he got them intubated, then he would give the curare and you would bag squeeze.

MB And the relaxation would follow. Thinking of those years, you specialised in the O and G [obstetrics and gynaecology] work there for two or three days a week?

AA Yes, to some extent.

MB But then did other lists. What kind of other lists were they, apart from the more general lists? Any other specialities?

AA Gynae. I did two gynae. lists a week, I think, and one with Rowbotham which was general surgery, and the rest I was sort of hanging around the obstetrical unit and getting into difficulties and usually getting out of them again, fortunately, but not always getting out of them.

MB So, it was a strong learning period?

AA Oh yes.

MB A lot of discoveries. Aileen, what of surgeons there? Any surgeons there that were impressive?

AA I was hoping you wouldn't ask me who the surgeon was that Rowbotham anaesthetised for. He was very well known, and I can't remember his name now, but never mind, it doesn't matter. The gynaecologists were a characterful group, shall we say.

MB Would you like to put them on the map?

AA I remember Gertrude Dearnley. Again, she was about so high. And it was the time that they were beginning to have some men coming in to assist. She was a very good surgeon, extremely good, because I remember there was a chap who looked rather like you, actually, and was even taller, I think, and he came in as her house surgeon and she stood back, scrubbed up: 'Pump the table up.' He looked a bit taken aback. 'Pump the table up. More, more, more.' By this time, it was up to her eyebrows. 'Right, are you comfortable? Good. Bring me two stools to stand on.' She said, 'You're no damn good as an assistant to me if you're uncomfortable and bending your back.' She was that sort of person. She could operate standing on her head. She was one of them. She also had a rather nice remark. I don't think she'd have gone for all this *in vitro* fertilisation and other things that are happening now because she reckoned that if you were infertile, do the simple things and if they don't work, well, they're just poor breeding stock and they were better not have children!

MB Aileen, this is 1947/48, and there's a Health Service in gestation?

AA That's right, yes.

MB That must have been a fascinating time to be near the centre?

AA I don't think it had much impact on me in hospital apart from the fact that one got better paid after it came in – as a trainee. For the consultants, of course, and for the GPs it had a huge impact, and I knew more about it from my father, I think, than from the hospital side. I mean, my father was not keen on the idea of a Health Service with consultants being paid, because he reckoned that one of the strengths of the previous system was the collaboration between the honoraries and the general practitioners, and there's no doubt that that was very much less after the Health Service than it had been before.

MB Was he ever persuaded otherwise in later years that it was the right move?

AA Oh, I think he came to terms with it eventually. But I think the thing he felt most strongly about was that previously the honoraries depended for their livelihood on patients being referred from the GPs and therefore there was a very good consultation and collaboration, and after that when they got a salary for their hospital work and private practice of course diminished a lot, he felt that that collaboration was much less.

MB Aileen, we've got you in London. You're a woman now in advancing twenties, you were beginning to learn quite a lot about London, theatre visits, you were going to musical events, you were a lively soul apart from the focus you had on anaesthetics. Boyfriends - a lot of things were happening to you. It was an exciting time.

AA No, I don't suppose any more than anybody else. Yes, one was meeting a lot of people of all ages. A lot of the men you were meeting were quite interesting people because they were a little bit older because they'd come out of the Army and they were what they called the ex-service registrars.

MB And you stayed how long in this appointment?

AA I was a year at the Free. I didn't terribly like the Royal Free, actually. I have given you some indication of why I didn't. I was learning a lot but I was not terribly happy there, so I was really ready to move on and I was not particularly keen on doing a lot of obstetrics. It was not desperately the thing that I wanted particularly to do.

MB But partly this hierarchical thing.

AA But the hierarchical thing, I think…

MB And you lived in. Was that also a pressure?

AA Well, no, everybody did live in. You see, I mean, the nice thing then, which they don't have now, was you had a mess life. You had a proper mess life.

MB Very formal.

AA Well, slightly formal, in the sense that we were brought a cup of tea in the morning by one of the maids to wake us up, which was very nice.

MB But you had to come in to dinner at night dressed 'proper'?

AA We came in to dinner at night. You didn't turn up in a white coat. The men were expected to put on a jacket and tie and the senior resident would say grace and you would have a waited on meal, and if you were late because you'd been kept on the wards, you'd just excuse yourself to the RMO and say, 'I'm sorry, I was kept in the theatre,' or something like that. So, there was a slight formality about it which, looking back on it, was marvellous and your life centred around that, because most people were not married and that was your life, your social life was around the mess. And you usually had a pub down the road that you'd pop down to and the telephonist would know where to get you if you weren't in your room. And that's something which I think the present generation of junior doctors, they've never experienced it, they've never had it, and I'm sure partly accounts for some of their disenchantment with their trainee jobs. Because it was a good life; it was a very friendly life.

MB Aileen, we've got you to a major teaching hospital in London, we've got a National Health Service coming in, we've got a revolution happening in anaesthetics, your whole life is opening out in a range of ways. We're going to take a short break there, wind down and then come back to the next step in a moment.

AA Alright, good. Good time to break.

Part Two

MB Aileen, we've not mentioned yet, although you're becoming rapidly a specialist anaesthetist, we've not mentioned your Diploma in Anaesthetics. When did you get that?

AA I got that just after I left the Royal Free.

MB Right. What did you have to do for that?

AA Oh, it was very simple at that stage. You just had to write… I can't remember whether it was one or two papers, and you had a *viva.* It was the only higher qualification for anaesthetists that was available at that time.

MB Did it take much preparation? Did you have to work on any cases and write about cases?

AA Well, by that time I'd done two years in anaesthetics and I think you'd have had to have been rather stupid not to have been able to pass it because it was a very clinical sort of exam and relatively straightforward, at least I found it was quite straightforward. It really was sort of talking about what you'd been doing for the last couple of years. I think the object behind it was to see whether you were a safe sort of anaesthetist.

MB Aileen, I know you've looked at the history of the formation of the diploma courses and so forth. Can we go back a little bit, about the whole growth of anaesthetics as a speciality, because I think it goes back to nineteenth century roots?

AA Yes. Well, it's a very young speciality, of course, because anaesthesia was only introduced in 1846 and for about the first, I suppose really, the first hundred years, certainly for the first fifty years, it developed very, very slowly. Obviously, it took on fairly quickly from the patient's point of view, but it was a craft which you learnt rather than a science, except for one or two very distinguished early anaesthetists. But if you're talking about the development of the institutions that are concerned, the very first anaesthetic society in the world was the Society of Anaesthetists, which was founded in London in the 1890s. And this led in very quickly to the Royal Society of Medicine, because during the early part of the 1900s, all these various specialist societies which had grown up all over London joined in together to form the Royal Society of Medicine, and this was actually started in 1905. We didn't come in until slightly later for a very good reason and that was the reason that the Society of Anaesthetists had four women members, full members, to begin with and the RSM had not initially decided whether to grant women doctors full membership and it was only when they said: 'Yes, they'll be full members and not associate members,' that the anaesthetists joined. As I say, that was the forum where advances were reported and discussed and it went on serving this function until after the First World War and, at that time, Ivan Magill, later Sir Ivan Magill, who was the person who made possible endotracheal intubation - he wasn't the first person to do it,

but he was the first person who worked out a system whereby you could learn to do it relatively easily - he realised that we needed a diploma.

MB So, it was Magill.

AA So, he went along to the RSM and said, 'We need a Diploma in Anaesthetics,' and they said, 'Well, unfortunately, the charter of the RSM does not allow us to run exams, you'll have to go somewhere else.' So, in fact, he said, 'Well, alright, we'll think about founding somewhere that can run exams.' So, to cut a long story short, sir Ivan, or Dr Paddy Magill as he was known then, and several other people as well, got together and they set up the Association of Anaesthetists in 1932. And the Association of Anaesthetists then decided no, they didn't want to run an exam; anyway, why wasn't it done by the Royal College of Physicians and the Royal College of Surgeons just like any of the other diplomas? So, in fact the Diploma in Anaesthetics then started. It was handed over to what was known as the Conjoint Board, which was the RCP and the RCS, and the Diploma in Anaesthetics was set up then.

MB Was this in the thirties?

AA This was in the thirties. It was in '34, I think, was the first one.

MB Right. But there weren't that many people taking that diploma, I would think, then?

AA Not then, but it became quite popular because it was the only exam and it served its purpose really right until after the Second World War. And then we had the problem I mentioned to you that we had a lot of things all happening at once. We had curare coming in which was revolutionising anaesthesia clinically, we had...

MB And we've said that Cecil Gray was the man to seed that revolution. There's no doubt about that.

AA That's right. We had the National Health Service coming in. And I've already mentioned that there were very few specialist anaesthetists, but there was a very good source of specialist anaesthetists, which I hadn't thought of until I talked to people relatively recently - I'm talking about within the last five years - and that was the armed services in the Second World War. Because the Second World War saw the formation of these field surgical units whereby they took an operating theatre as near the front line as they could to operate, instead of bringing casualties back and losing a lot of them on the way. Lots of surgeons available, very few anaesthetists available, so, particularly in the Far East, they trained up a lot of anaesthetists and, of course, after two or three years of this, they were jolly good anaesthetists because they were working right in the wilds. And when they came out of the army, they said, 'We want to be anaesthetists.' Quite a lot of them said, 'We like this job.' And, of course, the National Health Service coming in soon after the end of the war provided those specialist jobs which otherwise wouldn't have been available for them. So, we had everything coming together.

MB It was all happening, wasn't it?

AA It was all happening at once. Then, of course, we went on to needing the academic background of founding a faculty.

MB Yes. Let's just put that in full perspective though because the Association that was started in 1932 was a bit of a trade union. It wasn't academic principally?

AA It did have an academic side. It ran scientific meetings and it had a fund which would give out small sums of money to do research, but basically, it also fulfilled… I'm not sure at that time that it did fulfil a trade union function, I think that was something that developed with the NHS, actually, but it was looking after the interests. I think, again, it didn't see itself as an organisation that wanted to run exams and run training courses and things like that and it wouldn't have been right because the other specialities had Royal Colleges, or at least there were three Royal Colleges then, and we needed an equivalent.

MB And you went to the Royal College of Surgeons.

AA We went to the Royal College of Surgeons because as, I say, the diploma was run jointly by the RCP and the RCS, but, of course, we worked with surgeons the whole time so it was more natural to go to the surgeons than to the anaesthetists. And, in fact, when the Health Service was being discussed with [Alfred] Webb-Johnson and all these people, who was then PRCS [President of the Royal College of Surgeons], he actively encouraged the anaesthetists to do what the dental surgeons had just done a year before and that was to form a faculty within the Royal College of Surgeons. So, there were anaesthetists from the Association coming to talk to the surgeons in the Royal College of Surgeons and saying, 'We need something more than the DA [Diploma in Anaesthetics], we want the equivalent of the fellowship, we want an FRCS or the equivalent of a FRCS, and we need the academic background to run it.' So, that was how the faculty came to be formed and that was set up in '48, so we have our fiftieth anniversary coming up in a couple of years time.

MB Looking back down the line though to the range of institutions arising, coming back to that London Society of Anaesthetists of the 1890s, are there records from that time still kept?

AA Yes, there are some, there are some. Oddly enough their records are within the Royal Society of Medicine, they were kept there, and the minutes of the Society of Anaesthetists, yes, they still have them there. Very interesting. There has been quite a bit of work done on them by various people.

MB Was that a great success going in with the Royal College of Surgeons, did that work quite well?

AA It worked enormously well because we had the prestige of a major Royal College; we had the example of their fellowship and we had the backing, as I say, of a

powerful group whose vested interest, of course, was to see anaesthesia develop. But it took quite a long time; I mean, it was a long time before one got the full development of the specialty within that, because the first fellowship, the first FFA [Fellow of the Faculty of Anaesthetists] was far too surgical because we took for our basic sciences: anatomy, physiology pharmacology. Well, anatomy for anaesthetists, the amount of anatomy you need to learn is very limited. Sorry, the original one was not pharmacology, it was pathology. It was anatomy, physiology and pathology. There again, much more relevant to surgeons than anaesthetists. It took a period of sort of working it out over the years before we lowered the amount of anatomy that was needed. We brought in pharmacology, which was vitally important for anaesthetists, and we gradually got the exam to be right for anaesthetists rather than for surgeons.

MB Did you have to take the Fellowship yourself, Aileen, or did your Diploma....?

AA No, having held the Diploma for some time, I was elected to the Fellowship in '54.

MB But before then, let's take you on your next journey, your next career journey because we've had you at the Royal Free. I think you go back to Cambridge for a short time, you were called back, I mean, it was just the great call of Cambridge?

AA Well, you know, I'd liked it and I had the chance to go back, exactly, having learnt a lot more.

MB And was that about another year?

AA I was there for just over another year, yes.

MB And what developments took place then? Was this a great period of intravenous work?

AA Well, the point about Cambridge was, to an extent, it was more of the same. We'd developed rather better anaesthetic machines; intravenous anaesthesia was coming in more and curare was, of course, coming in in a big way, so it was developing clinically. But as far as the variety of work was concerned, it was not all that much different from what I'd been doing before, so what I needed to do was to look at the things I'd not had any experience in. I mean specifically, neurosurgery, thoracic surgery - there wasn't much cardiac then, there was some, it was just beginning - and plastic surgery. I had gaps to fill in. And that was how I came to go to Bristol because Frenchay Hospital in Bristol, which is on the outskirts of Bristol… the development in Bristol had been that they'd put their special units out at Frenchay. Don't ask me why, I mean, that was just an inherited situation, but for me, it was ideal because it meant I wasn't having to do a great deal more of the general stuff, which I'd already had three years experience of, and I was able to concentrate on the special stuff.

MB What was it like going to Bristol? Was that a really nice development in your career?

AA Frenchay was another lovely hospital. It was a hospital where we had a very nice mess, and because we were on the edge of Bristol and we had Frenchay Common where W G Grace was supposed to have played cricket and things like that, it was very pleasant.

MB And they had all these specialities there. Rather a unique experience for the time.

AA Yes. There weren't too many hospitals that simply had special units and no general units. Now, of course, it does have both.

MB And how did you pitch in there? What speciality did you begin with?

AA Well, I pitched in first of all to the thoracic and that, I think, was partly because Tom Wilton who was the senior anaesthetist there, that was his particular field.

MB He was already a well-established anaesthetist.

AA He was another of my gurus.

MB Perhaps you would like to say more about him.

AA Tom had been in the Navy and he was appointed to Frenchay, very young actually for a consultant. He'd been at St. Thomas' before and I think that was partly the link because the chief surgeon there, Ronald Belsey, was also a St Thomas' chap. And I think the first choice to go there was a chap called Michael Nosworthy, who didn't actually eventually want to leave London so he sent his bright young man, Tom Wilton, along there and Tom did a marvellous job. He set up the anaesthetic side there and one of the things he was particularly interested in was children's anaesthesia. He was one of the first people to write a book on paediatric anaesthesia, particularly paediatric chest anaesthesia, really tricky stuff. So, he was a great person to have known and he was a very considerable influence.

MB It was a good relationship you formed.

AA Yes.

MB Was that from the earliest days there?

AA Yes, we did seem to get on well to begin. He looked after me very well.

MB You went and watched him work.

AA Yes. Well, he actively taught you some techniques which at that time were unconventional. And that was partly for surgical pressure because Belsey was one of the surgeons. He was the prima donna type surgeon, and because he'd spent a certain amount of time in Boston, Massachusetts, he was very much wedded to the American techniques of ether and he continued to demand ether anaesthesia for thoracic and cardiac surgery long after everybody else had given it up.

MB That must have been quite difficult because you couldn't use diathermy.

AA Well, the arrangement that was made was you used ether in a tightly closed circuit while you opened the chest so that no ether was escaping into the theatre atmosphere, but once you'd opened the chest, of course, and the lungs were full of ether, the diathermy was disconnected and for the rest of the operation he did without it and because he was a superbly good surgical technician, he never missed his diathermy. I mean, he maintained that because he didn't use diathermy that he learnt a really sound technique of dissection. And he said, 'I learnt not to make patients bleed,' sort of thing. And there was no doubt he was a wonderful technician, beautiful to watch.

MB He was the best technical figure you met in your whole career?

AA I would say he was one of the best technical surgeons I have ever seen anywhere. Really very, very skilled.

MB Impressive.

AA Very impressive.

MB Not always the most kindly figure?

AA No, he was not an easy person to work with. I was fortunate because I got on quite well with him, but he was very demanding. Other people didn't always get on so well with him. If there was a mistake, it was not his, so to speak.

MB But there was a good link between him and Wilton?

AA Oh yes.

MB They got on well?

AA Well, looking back on it, it was very interesting. They were both quite strong-willed people, but looking back on it, it's quite interesting that Tom was prepared to go on using what most people regarded as an out-of-date technique for very many years because of keeping good relationships with the surgeon.

MB Preserving that partnership?

AA Because the other surgeons, the two other surgeons there, they didn't have the same demands. In fact, they wanted to use diathermy the whole time, so of course one used other techniques, so one learnt two quite parallel techniques. One was using nitrous oxide, curare and pethidine and the other using ether, in the same theatre so to speak. So, one learnt two quite different techniques.

MB Phenomenal. What a unique opportunity. Aileen, at that particular time, you were seeing quite a lot of tuberculosis cases still. Quite a lot of surgery in that thoracic time on tuberculosis, which was soon going to evaporate almost and go?

AA That's right.

MB What kind of work, a lot of thoracoplasty?

AA Thoracoplasties. They were just beginning to do resections then, but thoracoplasties and pneumothoraxes and phrenic crushes were still being done very regularly. And, of course, we went round the various sanatoria too. We went to Ham Green [Hospital, Bristol] and to Standish [Hospital, Stonehouse] in Gloucestershire and down to Tehidy [Hospital, Camborne, Cornwall]. We were a sort of travelling circus almost.

MB But what tremendous experience?

AA And all the thoracoplasties were done under local anaesthesia. I mean, a massive procedure to do under local. It took a really good surgeon like Belsey to be able to do it with a conscious patient.

MB Of course, that was a time when things were happening and people were expecting antibiotics to make a change, but weren't quite sure that they would get to them before surgery?

AA They were just coming in. Exactly, exactly.

MB Patients must have been waiting on the edge?

AA It must have been awful to have been a patient just wondering whether these drugs would come in soon enough to save them, so to speak.

MB You talked about resection, lung resection. That hadn't been possible before either, had it? I mean, this was a new development.

AA No, because the problem was getting the bronchus to heal because the bronchus being very cartilaginous with a poor blood supply, it was almost impossible to get it to heal and particularly if there was any infection there. And Belly's way of dealing with it was to use stainless steel wire sutures. In fact, he used stainless steel wire sutures for everything, including the oesophagus.

MB He did?

AA It was quite extraordinary. And his patients did incredibly well. I mean, his results for oesophageal surgery, I rather doubt if anybody's ever had better results from resecting the oesophagus than he has. Of course, the other surgeon who was there at that time became extremely famous and that was Donald Ross. He and I were both senior registrars at the same time. And, of course, he went on to act at the first heart transplant in this country. But we were both on our learning curves together there and we had many struggles, he at the surgical end and me at the anaesthetic end, when we were learning our way.

MB A great pioneering period for both of you.

AA But he again was obviously somebody who was going to go very far.

MB You could tell that?

AA Oh yes.

MB Aileen, just moving on, Frenchay had other specialities. Did you have a chance to go through the lot?

AA Yes, neuro and plastic. I learnt about neuroanaesthesia and...

MB That must have been an entirely different set of problems?

AA Oh, it was quite different, yes. Also, it was the time that we were moving in neuroanaesthesia from spontaneous breathing, which was thought to be essential in order to make sure that the respiratory centre was still working, to ventilation and using other methods of monitoring. So, that was changing and, in fact, the anaesthetist there, Peter Mortimer, he designed a lung ventilator from a Ford windscreen wiper. The windscreen wiper was doing this sort of thing, you see, on the bellows. Wonderful. It worked very well. It became known as the Mortimotor! And there was plastic surgery as well and at that time...

MB Just keeping to that neurosurgery, were people monitoring very heavily things like CO_2 at that time?

AA No, not at that time.

MB No. So, it was very early days?

AA Very early days. Pulse, blood pressure, not even ECG [electrocardiogram] regularly, although that came in quite quickly.

MB Sorry, I'll take you to plastic now.

AA Well, plastic, we were starting to use hypotensive techniques then for cutting down the bleeding in plastic operations. I learnt an enormous amount there. It's very specialised and very rapidly moving.

MB You were really becoming a very, very experienced specialist in that period?

AA Yes.

MB That's the early fifties.

AA That's right.

MB '51-ish?

AA Yes.

MB And you were there for about a year and a half?

AA I was there until I went to the States, in 1955.

MB Yes, which is a fascinating story because Beecher came over to see Belsey.

AA Yes. Beecher knew Belsey, of course, because...

MB Harry Beecher...

AA Well, you see, Belsey had worked in the Massachusetts General Hospital in Boston where Harry Beecher was the senior anaesthetist, Henry K Beecher.

MB Yes, absolutely!

AA And Beecher was an extraordinary chap. I suppose one could say that technically he wasn't a very good anaesthetist! But he was a very powerful person. He was very much for making people realise what anaesthetists had to offer. He built up a very strong department. He got tremendously good people around him. I mean, his strength was bringing in very good people.

MB He was the great entrepreneur.

AA That's right, and he always published in surgical journals, so that the surgeons knew what was going on and he built up a big research department and it all went into surgical journals. He was very clever from that point of view.

MB He was energetic and powerful, wasn't he?

AA That's right.

MB And you met him when he was in Bristol?

AA He just happened to come over to have lunch with Belsey, who knew him well, of course, and I had lunch with him. And the other thing about Beecher was he recruited a lot of people from Britain because we were better anaesthetists than the Americans, and from all over Europe for that matter, but chiefly from Britain, and so he said, 'What about it. Are you going to come?' So I said, 'Yes please.'

MB Just talking of that about anaesthetists in Britain being a desired commodity in Beecher's unit at Massachusetts General. I mean, we were ahead, the curare story was ahead, everything was ahead, wasn't it?

AA Yes.

MB They didn't like curare in America. Can I just take you to that bit of the story. They had a great suspicion of it, didn't they?

AA Yes. They had a great suspicion of it.

MB I mean, Cecil Gray was forging ahead, Rowbotham, a range of people in England. They'd stayed right off. Why?

AA They viewed curare in a different way. I mean, I think Cecil understood how it was going to revolutionise anaesthesia and make things quite different. The Americans tended to regard it just as an adjuvant. I mean, they were giving the same anaesthetics that they'd given before and if the muscles were a bit tight, they'd give a bit of curare to relax them. In other words, they regarded it as a means of softening up the patient and they also had this idea that if it depressed their breathing, that you could depress their breathing without stopping breathing and if you timed your bag squeezing right, you would augment the patient's depressed breathing. Fiendishly difficult to do, actually. I mean, it's almost impossible to get the right timing for that. So, the result was they were not really ventilating patients very efficiently and I think that Cecil Gray would probably agree that assisted ventilation, which they were trying to do, was just not working. You stopped them breathing and you ventilated for them and that was that.

MB The Americans were up the wrong gum tree, weren't they?

AA Well, I don't know whether I'd go quite that far, but they didn't see its potential.

MB And was there a bit of antagonism between the Liverpool school and the people over here and the Americans?

AA Oh, you'd have to ask the Liverpool school that! I mean, I got involved in a small way because the other British anaesthetist who was there at the same time was Keith Sykes, who came back to being a professor at the Hammersmith and was one of our very leading research anaesthetists and, ultimately, the Nuffield professor in Oxford.

MB He was young and on the way up at that stage.

AA He was just slightly younger than me and obviously was a young man who was going to go far and he, I think, at that time was already very interested in research and they set up a clinical study really to try and find out was curare safer than ether, or was it not?

MB This was at the Massachusetts General, when you got there?

AA Yes.

MB Quite quickly after you got there, really?

AA Yes, it was just getting set up and getting going.

MB And so you helped Keith Sykes get that moving.

AA We had two series going: patients were allocated to the ether series or to the thiopentone, nitrous oxide relaxant series.

MB How did that work? I think the results were quite fascinating.

AA Well, the results were not exactly what you expected because the British anaesthetist who thought ether was old hat and was jolly dangerous and that patients felt awful after it and lay around getting ill; in fact, the results were clinically not too different between the two. I mean, the morbidity and mortality was really rather similar. Ether patients had more drop of blood pressure during their operations, not surprising because you had to anaesthetise more deeply. A light patient in general would have a higher blood pressure than a deeply anaesthetised one, and, of course, the ether ones were much slower to recover, but the slowness of recovery and the fact that they were vomiting a bit more and lying around and going through a period of restlessness, it didn't actually influence either the morbidity or the mortality. And the surgeons were able to work quite well without using the diathermy under ether for upper abdominal surgery as well as under relaxants, so we learnt something from it. We learnt that old-fashioned anaesthetics still worked.

MB Ether wasn't all that bad?

AA It wasn't all that bad.

MB Aileen, I'm just going to put an aside in here if I may because I've let you get away without an exciting story. I'm still want to come back to the time that you were taking curare and having paralysis and I may have overstepped the boat on that and I'm not going to let us escape from it. When was that?

AA Oh, that was at the Royal Free.

MB That was at the Royal Free. I'm just going to sneak that in.

AA There was some evidence that curare caused histamine release. In fact, talking to my veterinary friends, they said if curare had been investigated in dogs, it would never have come on the market because it causes profound histamine release in dogs. And we were investigating to see whether it did the same thing in man and one way of doing it was to investigate gastric secretion and see whether it increased the gastric secretion. So, we set up a little study in which we were going to get volunteers to have a nasogastric tube passed to measure this and then to be given a dose of curare and see whether it caused any histamine release from the gastric secretion point of view. And we thought if we were going to ask for noble students to volunteer, that the other senior registrar, myself, Jack [John] Odell, we thought we'd better curarise each other first. So, we did him first and then he did me afterwards.

MB What kind of experience was that?

AA Oh, it was very interesting. I mean, it was a very relaxing experience!

MB Like this interview!

AA Yes. I would rather have curare again than swallow a nasogastric tube again although, of course, they are much better tubes now. I mean, that I found was not very pleasant. But once you were lying down and relaxed… We were aiming to give a dose of curare where you didn't have to ventilate, just enough to depress your breathing, and it was very interesting. You were lying there quite quietly, you see, well, with your eyes open. Curare has a sequence of muscles that it affects. I mean, your ocular muscles are affected first, so you get a squint and your eyelids fall shut and then gradually it affects all the other muscles and the diaphragm is the last to go. And the dose they gave me which was fifteen milligrams of d-tubo[curarine] intravenously; it knocked out everything except my diaphragm and my fingers, so I was breathing perfectly comfortably on my diaphragm, I was not worried about that, but the problem is, of course, that you can't swallow your saliva, so you find after a while you're breathing… so I wanted somebody to hold my chin up and turn my head on one side and I was trying to indicate that. After a while, Jack cottoned on to it and realised that all he had to do was that and I was comfortable again. Then after about five or ten minutes when you can swallow again, it's not at all unpleasant. But, I did learn something else from it and that is that if you don't reverse it with neostigmine, even though you appear to have got your muscle power back, you certainly haven't, because about three or four hours later, I was up and about and had been walking around for quite some time, I had to walk up some stairs and I couldn't do it. When I came to walk up stairs my legs wouldn't work properly. It made me realise that it takes a long time to wear off if you don't reverse it. In other words, reversal can be apparent and not real. I mean we know that now, it's all been tested and all sorts of things, but at the time we probably didn't know it. But, it was fun.

MB I just had to have that story on record, didn't I? I couldn't go on without that. But we really have you at the Massachusetts General right now and I'm not letting you

escape that. You're with exciting people, you're with Harry Beecher. He really was quite a dramatic influence and force in your life at that stage?

AA Well, it was a very big department, of course, and the hospital worked differently from the ones I was used to. We didn't actually see a great deal of Harry. As I say, he'd surrounded himself with all these bright people from all over Europe and we saw much more of the other staff than we did of Beecher although, you know, every afternoon at four o'clock you assembled outside his office for coffee. I mean, he kept a social contact with people. We didn't see him an awful lot in the theatre and he didn't do an awful lot of teaching. He was...

MB Mr Big, running it all.

AA Mr Big, that's right, yes.

MB But, you had a European community almost around you. What a strange thing. You land in America and you've got a European community around you.

AA Well, there were plenty of Americans as well, but at the time I was there, there were three English people, Keith Sykes, myself and another man. There was also a couple of Scandinavians, both of whom went on to become professors in the States; there was a German girl, an Italian girl, another German, who again went on to become a professor in the States. We were a very mixed group and to some extent we mixed in with the Americans, but there developed just a little… perhaps because there were so many of us, one tended just a little bit to fall into the two groups, which was not ideal.

MB Talking about you landing in an interesting society there, you actually flew over at a time when that might not have been a common thing to do?

AA Well, that was accidental because I'd booked to go over from Liverpool on one of the Cunarders, but the Cunard people had a strike on. I mean after all, I was going for a year so I wanted to take a fair bit of baggage, but the Cunard strike which had started in Southampton hadn't spread to Liverpool until the day I got there when Liverpool decided to join the strike. So, they offered those of us who were in a hurry to get there to fly us over, so that was how I came to fly, and to fly to Montreal, because going to Boston which was north of New York, they said anybody who didn't mind going in through Canada, they could get us there faster. So, I flew to Montreal and took a train down from Montreal to Boston.

MB Those were the days when you came down at Shannon to make sure you had enough petrol to make the trip over to Newfoundland?

AA That's right. We went to Shannon and to Newfoundland. We stopped, I think, twice on the way.

MB But, from Montreal then you had that wonderful journey…

AA Lovely journey through New England. Beautiful. Really lovely. I mean, I fell in love with New England.

MB Was it the time of the fall?

AA No, it wasn't in the fall, it was in the spring actually. But, it was my introduction to New England and it really is very beautiful.

MB Talking of that society and getting back to that, you settled in. You lived in the hospital initially?

AA I lived in the hospital in very poor residential accommodation.

MB That was bad. And you were poorly paid as well, you said?

AA Well, I was poorly paid to begin with because I was too naive to realise that you bargained for your payment and that Beecher offered you the minimum he thought he could get away with. And being naive I said, 'Yes, alright,' and hadn't realised until I'd been there a few months that I was getting about half what the others were getting, and they said, 'Go and talk to the old man.' So, I went and talked to him and said I wasn't being paid enough - well, not just like that obviously - and without any trouble at all, he almost doubled my salary. So, you know, it was expected that you bargained. I didn't realised that.

MB And quite quickly you got out of that accommodation?

AA Well, I was approached by a most remarkable lady who was secretary to the professor of surgery, Ruth Moor Meehan(?), and she always liked to share her apartment preferably with somebody from Europe. And, of course, she'd known Ronnie Belsey who was there - I don't think she actually shared with him but, I mean, she knew him well because she knew all the surgeons who'd gone over to work with Pete Churchill who was the professor. And she had me out for dinner and we saw each other and when we realised we got on quite well together, I moved out and shared her apartment in Winchester, which is one of the suburbs.

MB Delightful suburb.

AA Very nice. Lovely.

MB So, that's where you were and that's where you stayed, very comfortably.

AA That's where I stayed. It actually gave me another opportunity. We did a bit of plotting and scheming, Ruth and I, because the first thing I discovered when I got to the States was that surgeons and anaesthetists didn't talk to each other very much and they certainly didn't mix socially and when you went into the cafeteria there were surgeons sitting around one table and anaesthetists sitting around the other table, which I thought was bad. And it was bad, you know, you work better with people if you mix with them socially than if you just see them across the anaesthetic screen.

So, I sort of got into the habit of dumping my tray down with the surgeons and got some funny looks to begin with, but after a while they realised that actually I wasn't going to bite them and that we could talk to each other. I mentioned this to Ruth and she said, 'Never thought of it because it's what I've always been used to. We will have a campaign. We will have lots of parties at which we will invite both surgeons and anaesthetists.' So, we entertained a certain amount. We always made sure we invited both and we met and we went off and we did all sorts of things, so I think I made a small contribution to what one might regard as the surgeons beginning to realise that anaesthetists were not only human, but actually people they could have some respect for.

MB Before, had that been a kind of gulf based on surgeons being slightly more elevated?

AA Well, it's a very, very long story. I mean, part of the story, of course, is the prevalence of nurse anaesthetists in North America which went back donkeys years and there are still thousands of them and there's no doubt whether you approve or not of nurse anaesthetists, there's no doubt the feeling amongst the surgeons is that if a nurse can do a job as well as a doctor, why bother with a doctor because he'll cost more and not be as bossed around as easily.

MB You found a very different health service in America. That was a culture shock?

AA Well, I think the whole way of life was a culture shock. The whole way of life was different.

MB Do you want just to put that health service into perspective for me, Aileen? I mean, what you found.

AA It wasn't the health service. I mean the hospital practice, it was different, but not sufficiently to affect me. Whether a patient paid a fee or not did really affect the way we treated them, except the private patients, we had to fill in everything we'd done in order that they could be charged for it.

MB But the non-paying patients got the kind of junior staff?

AA The non-paying patients had junior surgical staff who were not as well supervised as the surgeons in this country because they had a rather different tradition, in the sense that the surgeons in training were allocated patients, they worked them up and they decided what they were going to do and they would then get on and do it. If they wanted help, if they had a patient who was difficult or if they wanted help with the operation or if they wanted advice, it was up to them to send for the staff man to get the help, whereas the opposite applied in England. The consultant would say to his junior, 'This is a suitable case for you to do. You do it. Take that on board.' And, of course, the American system the patient's safeguard was something which I've already said we didn't have in England and that was the 'Surgical Grand Round'. The 'Grand Round', where once a week you were required to demonstrate your patient in

public and give the case history, and in public meant sixty or seventy people, everybody in the lecture theatre and patients would be…and you had to justify what you were doing. So, that was the patient's safeguard in America.

MB So, that was a severe and important test?

AA Very severe one.

MB Took a long time to catch on over here?

AA Yes, yes, it did. It took a long time. I mean, for consultant surgeons to talk to each other over here and discuss their cases took a very long time so, to that extent you're right, it was a different scene.

MB You walked into that kind of situation?

AA That's right. You had to justify what you were doing.

MB You also moved quite early, I think, to neurosurgery in a big way?

AA I'd not done a lot at Frenchay and I needed to do more and the stimulus for that was that the neurosurgeons got, I think, a rather poor service from the anaesthetists because it was regarded as very boring. It took forever to do and it was not popular with the staff men who got bored with it, so there was a saying in the department that if you upset the staff people, particularly Beecher, you'd be sentenced to neuroanaesthesia for a month. So, people were not very interested and they didn't quite know what was happening. It was slow and, as I say, they didn't realise what the problems were. So, I said, you know, I'd like to learn more about it and, of course, the surgeons welcomed that. You know, 'What are you doing and why? Tell me about this patient.'

MB So, you really began to study that area, neurology, neurophysiology?

AA That's right, and I read up whatever was written about it, which wasn't an enormous amount.

MB Did you make a contribution to that. I mean, you made amendments to surgery there?

AA Oh, I think by teaching what went on and interesting people in it, I mean, that in itself will raise the standard of anaesthesia very considerably.

MB So, that really captured you for a time?

AA It was something in which I got a little corner in for myself.

MB You felt that. When the time came to come away, I don't think you were all that happy about leaving, you were so happy with the Massachusetts General?

AA Yes, I enjoyed my time there very much and I'd explored a new country. I'd done the grand tour and spent, I suppose, about five or six weeks travelling around and, of course, a lot of British anaesthetists at that time they were a bit disenchanted with the Health Service and Beecher would make very good offers for people who wanted to stay on. As I say, a lot of the people he kept on went on to become professors. I was not quite so happy with that set-up and really wanted to come back to the UK, although I think he did make me an offer and I said, 'Well, I'd like to put that on ice.' And he said 'Don't worry, the offer will still stand. We're going to want lots of good anaesthetists for many years yet.' So, that was how I came home. I did actually go back for a second year because he offered me a more senior job.

MB But you had to come home, that obligation at Frenchay. You came back for a few months?

AA No, I didn't go back to Frenchay because I'd asked them to extend my leave and, they said quite reasonably, 'Well, a year is as much as we will extend it,' and they were quite right. I understood that.

MB So, what happened when you came back?

AA Well, I had to come back to get an immigrant visa. So, I had to come back for a while and then go back to the States.

MB And you did some locum jobs?

AA So, I did some locum jobs, yes.

MB And went back at Massachusetts?

AA And then went back to Massachusetts.

MB For more of the same?

AA No, because I went back on the staff. But again, I made it quite clear to Beecher: 'I do not want to be taken on the permanent staff. I would like to do another year with you.'

MB And you went back to the same accommodation and continued your rich social life?

AA Yes.

MB It was a rich social time?

AA Well, yes, sure. The Americans are very hospitable and very social and, you know, if you know one American they're very keen to introduce you to lots of others.

MB But they were very happy years?

AA Yes, I enjoyed it very much. I made some very good friends there and I went and worked for a while, also for just a short time, in a totally different hospital, in a small district hospital up in the wilds of New Hampshire, which was nice to do because it was a hospital with sort of one surgeon, one anaesthetist, one obstetrician, and so forth, one physician. So, that gave me a little insight into how a small hospital worked.

MB Aileen, we're coming to the end of this particular session. It's been fascinating. We will bring you to England and new adventures at the beginning of our next talk.