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Dr Derek Wylie FRCP FRCS FRCA in interview with Dr Aileen Adams
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AA Derek, you have lived throughout probably the most fascinating period of anaesthesia that we could have had in all the 150 years since it started. And what's more you have played a part in this; you've held all the, almost all the offices which were open to anaesthetists and a number of others as well, so I think you view both anaesthesia and medicine in a clear if not a unique perceptive. But I wondered if we could start right at the beginning. Could you tell me where you came from? Tell me something about your parents and your family and your upbringing?

DW Well, I had a sort of, typically what I would call a northern middle-class upbringing in a place called Huddersfield in West Yorkshire. My father was a dental surgeon and I went to private prep school and to a school called Uppingham where I didn't do very well academically. I went to a crammer and I got into Cambridge in 1938. I wasn't set upon a career in medicine, but my father was, and I did as I was told, I suppose like many boys and girls in those days you followed what your parents hoped you would do. And I must say that I thoroughly enjoyed myself at Cambridge. It was shortened by the war; I'd got a year of peace at Cambridge and a year, first year of the war. Then I went on to St Thomas' Hospital Medical School in London, arriving just after the hospital had been blitzed and bombed. And I think at that stage I really didn't begin to get interested in medicine.

AA Your father obviously had a considerable influence on you as a dental surgeon. Did you feel that if you'd gone any other way that he might have been disappointed or did you find that it was relatively easy to go on with, go ahead with what he wanted?

DW I think he would have been very disappointed. I did try not to do medicine because I wasn't very good at the examinations which we had to take in those days. But I think that fact that, as I've said earlier on, that one tended to obey one's parents and anyway it was a very good life at Cambridge before the war. I didn't do much work but he gave me a fairly reasonable allowance and I enjoyed myself. I had to work the next year to catch up.

AA Did you have brothers and sisters?

DW I had an elder sister who took up nursing and she had a very distinguished career in nursing actually, and a younger sister who still lives in that town in Yorkshire.

AA So, you went from Cambridge as you say in the early days of the war up to St Thomas' and then what happened from then on? The war had started presumably had it? I mean, how old were you at the time the war started?

DW Gosh, that's put me on the spot! I was born in 1918, so I was rather older than many of my contemporaries. I was a couple of years or a year or two ahead of them in age, because I'd taken some time to get into Cambridge. But I qualified in 1943 with the usual wartime education, pushed around doing clinical studies in various places in Surrey which was the sector that St Thomas' was responsible for during the war, and bits and pieces in London. I was fortunate; I got house jobs at St Thomas' – casualty officer, what we called resident anaesthetist, going with that post in London and then house physician. And then there was this question of going into the services. It was a pyramid. Some of you went up for another six months; some of you went into the services straightaway. I went up for another six months and another six months after that, and I was really destined to be a physician. I did my membership in what was then the old-fashioned Diploma of Anaesthetics. And I went into the RAF at the end of the war and I was a physician in the Middle East, so-called physician I have to say.

AA So it was really not until after the war that you became seriously interested in anaesthetics?

DW Yes. I'd done the anaesthetic post at St Thomas' as I've just said, but I didn't see myself as a career anaesthetist. And it was only when I got a letter from the senior anaesthetist at St Thomas' in 1946, I remember it very well, saying was I interested in a vacancy on the honorary staff at St Thomas' when I came out of the RAF… I'd never thought about it. I hadn't really had any anaesthetics experience, but I wrote back and said I was interested. I was married at that stage and had one child, I had a son, and it seemed a reasonable thing to think about, and they put me on the staff, which surprised me very much indeed.

AA Could you tell me something about what the practice of anaesthetics was like at that time? You said that St Thomas' had a post as resident anaesthetist. Now, I was a Sheffield graduate and we had no full-time anaesthetists either as honoraries or consultants or as juniors, but I think the London scene must have been rather different?

DW Well, there was a full-time resident anaesthetist. He was sometimes called a senior resident anaesthetist and I held that post, but in point of fact because of the war St Thomas' was split into various parts of Surrey. And there was no senior resident anaesthetist in London; we were left to our own devices, which was not very good. But down in the country, where most of the cold surgery was done at that time which wasn't very much anyway, that was where the post was really held and where the work was and I did that for a period of time.

AA Were you taught?

DW Not very much except by Dr Michael Nosworthy, who was always available, and he interested me in anaesthesia. At that time I wasn't a career anaesthetist, but here I learnt a great deal from him. But I learnt most of what I learnt in anaesthesia after the war and after I'd come out of the RAF back to St Thomas'.

AA What anaesthetics were you actually giving at that time? I mean, curare had come in but was not in wide use then. What were you actually giving?

DW Well, the standard of course was ether or chloroform, Evipan, hexobarbitone before thiopentone came in, and then cyclopropane, because cyclopropane was this wonderful gas which Michael Nosworthy used to demonstrate how he controlled respiration in thoracic anaesthesia for cardiac, well it was lung surgery in those days. So we used those drugs, that was really all, and nitrous oxide with oxygen.

AA Did you use spinals and locals very much?

DW Yes. I was taught how to use spinals, but not much with epidurals. Strangely enough I was taught about epidurals by a physician. He said the best way to treat low backache is to inject saline into the epidural space.

AA I didn't know it was as old as that?

DW That was true. In 1944.

AA Yes. Would it have been possible at that time to have earned your living in anaesthetics because as you say you were appointed as an honorary anaesthetist without any sort of salary?

DW Well, you did get a salary, strangely enough. At St Thomas' Hospital, the honoraries got £50 a year, about £1 a week, to come and give their services. But there was still after the war an emergency medical service, so when I came out of the RAF I did get something and you were supposed to go and find some private practice. And I'd say that as soon as the health service started, I came out of the RAF in 1947 before the health service, and when the health service started I was delighted. I got a cheque every month after that.

AA Yes. So, you were totally dependent on surgeons who were prepared to invite you to go and work with them in private hospitals, nursing homes and things like that?

DW There was virtually no private practice immediately after the war, not as far as I was concerned.

AA So, the National Health Service obviously did a great deal for the specialties that were emerging then like anaesthetics and presumably also radiology, pathology and so forth?

DW Absolutely.

AA But, at that time of course there were no, there were not very many specialists. St Thomas' and the London hospitals were perhaps unusual in having specialist anaesthetists. We had none in Sheffield certainly. We had GP anaesthetists.

DW The tradition at St Thomas' for honorary anaesthetists was before the war and their appointments were made during the war. It was for general practitioners by and large to be appointed as anaesthetists on the staff, but there was one exception at St Thomas' because the senior anaesthetist after the war who spent his wartime service

in the navy was a whole time anaesthetist. So, we had a sort of tradition of having somebody who was more interested in anaesthesia than in general practice. That was a chap called John Ryan and he was the person who wrote to me when I was in Palestine in the RAF and said was I interested in a career at St Thomas' as an anaesthetist.

AA So, you went into a new field when you took that job on? How did you adapt to that, because as you said you had rather little experience?

DW None at all. It really was a dreadful example of how teaching hospitals in those far off days appointed their staff. There were in fact two vacancies after the war and they gave the other one to a well-known anaesthetist, he died this year actually, called James Bourne who had served throughout the war and was a very erudite man as you know, Aileen. And they gave the other one to me as a young man who they thought had some prospects. So, I came back when I left the RAF with no knowledge of anaesthesia, I hadn't touched anything to do with anaesthesia for over two years, and I had to learn. And strangely enough, most of the people who were my junior – registrars and people like that – had served as anaesthetists in the army. And they were there as postgraduate registrars being paid to go for a training course at St Thomas' by people like me, well not by people like me, but I was one of those who was supposed to be training them having had no training myself virtually. I had to work very hard to pick it up.

AA I suppose that really your first claim to fame was Wylie & Churchill-Davidson?[1] Was that correct? *The* textbook which was one of the earliest books on anaesthesia and which is being re-printed over and over again and has stood the test of time ever since. Would that be correct?

DW I suppose so, yes. Actually that wasn't published, the first edition, until 1959 but of course we had the contract for it before that. For the record, I had written a previous book for the publisher, Lloyd-Luke, on pain in childbirth, which they asked me to write.[2] And after that they asked me if I would edit a book on anaesthesia as a whole, and the contract that I signed with them was also signed in the name of Dr Andrew Doughty, another well-known anaesthetist. But, I think he realised what the task was meant to be after about six months and opted out. And at that stage I was rather at a loss as to who to invite to join me and Harry Churchill-Davidson, who was then a senior registrar but just about to be appointed to the staff of St Thomas', joined me. And that was how we got together and produced that particular book.

AA Was this before or after you did the work on curare because you did, you and Harry did quite a bit of the early sort of clinical work on that, didn't you?

DW Well, Harry did a lot of work on muscle relaxants as a whole. He was really into the research field. I did some clinical investigations into a muscle relaxant called gallamine, trade name Flaxedil. I did that actually with Andrew Doughty; that was when we thought he might like to come into the book. That was our clinical research.

[1] D. Wylie, & H. Churchill-Davidson, *A practice of anaesthesia*, London: Lloyd-Luke, 1960.
[2] D. Wylie, *The practical management of pain in labour*, London: Lloyd-Luke, 1953.

There were other relaxants which various drug firms gave to us and said 'Would you like to investigate?' One was called laudanosine(?), but they were not successful and the only way we could investigate them was by giving them to ourselves and seeing what happened.

AA Of course this is one of the things which has changed enormously, isn't it, in the whole of medical practice, that when we started almost everything you did was experimental? Somebody gave you a new drug and said 'Try it out' and you did. Well, there's no way you could do that today of course, is there? Probably much for the better I should think.

DW Although I suppose if you did, you'd have a better chance of not doing any harm to anybody because the drug firms are very much more adept at producing drugs that don't have side-effects. I can remember giving the drug I have just mentioned, laudanosine[?], in very small doses – we used to give one another small doses and then increase them – to Richard Bodman who has been dead some years now but quite a well-known figure in anaesthesia. And I thought he was going to die, quite frankly. He had the most enormous reaction to the drug at a certain level of dosage. That taught me a sharp lesson. He didn't!

AA He didn't, no! After that, having learnt your anaesthesia and having settled yourself down in St Thomas', at what stage did you begin to get interested in the bigger field, in the national field? Because you went on to become involved in the Faculty and the Association and the Medical School – we'll talk about later on. But when did you start looking at that wider field and how did you get involved with it?

DW I suspect that I got involved because of the Association of Anaesthetists investigations into deaths. I was one of the four of the original committee. I remember it was chaired by a George Edwards from St George's, Pask who was professor of anaesthesia, who became professor of anaesthesia in Newcastle, and HJV Morton from Hillingdon Hospital. I was the very junior member and I think I was probably invited to join that committee because there were people on the council of the Association of Anaesthetists who knew me; influence if you like. I didn't ask for it but I was there and I learnt an enormous amount, and that was a national investigation into deaths associated with anaesthesia.

AA I suppose it was a very early form of audit, wasn't it? The obstetricians had been auditing maternal deaths for a long time, but the anaesthetists do have a very long-standing record of looking at their records?

DW I rather think the Association's investigations started before the obstetricians and gynaecologists. I'm not quite sure of the actual dates. Ours was a totally voluntary exercise and we invited anaesthetists to send it, or the heads of departments, all the deaths associated with anaesthesia and around the surgical period, the perioperative period.

AA I think it's worth commenting at this stage that anaesthesia has a, perhaps a slightly more complex organisation than some specialties. You referred to the Association of Anaesthetists but we have three bodies involved, don't we? We have

the Royal Society of Medicine – anaesthetics section, which was founded in 1906 and which in its turn gave birth to the Association of Anaesthetists because they wanted to set up an exam and the RSM was not permitted to do that. The Association started in 1932 and in fact handed on the institution of the Diploma in Anaesthetics to the Royal College of Surgeons and Physicians. But we also later, and we'll talk about this later, had a Faculty of Anaesthetists. So we have the three bodies: the anaesthetics section which is still largely for the exchange of news and views, we have the Association which has become and has all along been a fairly political sort of body, a bit like the BMA, and the Faculty which started as part of the Royal College. And you've been involved in all of these in various ways. So, your first involvement was with the Association deaths study. Where did you go from there?

DW Well, I think that one for various reasons, I don't know quite which reasons, but I was invited to lecture on the courses run by the Faculty of Anaesthetists in its early days. So like many of my contemporaries I had written a number of papers and I think that some of them were of interest to the people who were arranging these courses and I was invited to lecture on the courses. That led to my at some stage or other being asked if I would be interested in being the first – well it was the first but I didn't know that at the time – the Faculty's adviser in postgraduate studies, known as the Bernard Johnson adviser after first dean, well not the first, the second dean of the Faculty. That got me very much involved in Faculty affairs.

AA Because the Faculty started in '48 and you were then involved, what, in the early 1950s was it?

DW Well, I was involved in lecturing, yes, fairly early on but the Bernard Johnson advisership started in 1959, that was when I first did that, much later on.

AA And were you on the board of the Faculty then, or did you join it later?

DW No. I stood for the board in 1960 and got elected. I have to say that I think elections, you can call it a democratic election if you like, but the fact that one lectured and wrote papers I think gave one a bit of an edge on the people who didn't!

AA You had your name on a text-book and so forth!

DW I don't think anybody really knew anything about my capacity to be a medical politician or anything like that. I certainly didn't.

AA So, you were elected to the board then and of course by that time the examination, the Fellowship was beginning to settle down I imagine, wasn't it? Did you have much to do with the exam, setting it up or had that been done?

DW It was all set up at that time. The big, not the big issue but one of the issues when I first went on the board was to make the primary part of the examination more anaesthetic, and to get out the examiners in anatomy and physiology who were a bit esoteric in the kind of questions they asked. Certainly, the anatomists were not thought to be particularly relevant to the future of anaesthesia.

AA Well, it had been based on the surgical Fellowship, hadn't it, because that was the only example people had and of course it had to move away from that, didn't it?

DW Yes, it did.

AA So, you then moved away from anatomy and pathology into physiology and pharmacology?

DW Correct.

AA Did you examine for the primary?

DW I never examined in the primary in London. For many years I was an examiner in Dublin in their primary and then in their part two afterwards, but I never examined in London in the primary, I had enough other things to do.

AA And when did you become dean?

DW I became dean in 1967. I was vice-dean in 1965, it was a couple of years as you well remember, and I was dean for three years, 1967 to 1970.

AA And what did you feel in the time you were dean? How did you see the Faculty functioning? I mean, was it fulfilling its role within the Royal College of Surgeons or was it unable to do so because it was held back? How did you see the Faculty? The surgeons had to set it up because it was the obvious body to do it, but what had happened during that, whatever it was, eighteen years?

DW Well, I think it was, forgive me for making a correction, it was set up by the anaesthetists with the help of the surgeons. The surgeons offered a berth for the Faculty, the general feeling being that anaesthesia was more associated with surgery than with any other branch of medicine. That was the narrow view.

AA Yes. Perhaps not the right view.

DW Well, lots of people on the board of the Faculty at that time had different views about what the future should be. My view was that in an emerging speciality looking towards the future we had to have far more independence than we had at that particular time. I think that it would have been nice to think that if the then surgeons on the council were able, had been able to look ahead, what has subsequently emerged might have been somewhat different. Those of us who had some sort of say on the board of the Faculty had different views. My view was that it would have been nice if the College of Surgeons could have said 'Well, we'll have a council but that must be representative not only of surgeons but also of anaesthetists and dental surgeons' – the dental surgeons had a Faculty too. And then there would be a Faculty of Surgery, a Faculty of Anaesthetists and a Faculty of Dental Surgery. But I'm afraid that I thought that most of the surgeons, pleasant though they were and I'm sure excellent at their own particular fields of surgery, did not look forward, with one or two noticeable exceptions. They couldn't see that. They weren't going to give anything away. So, I formed the view myself that ultimately we would have to have our own college which

we now have, but I don't claim anything for that, it just happened to be my view at the time.

AA What did you feel was the status of anaesthesia and anaesthetists at the time? I mean, obviously I would agree with you that surgeons on the whole tend to be a little unimaginative about the future, but obviously we worked very closely with them. How did you feel at that time that they viewed anaesthetists and anaesthesia?

DW If you look at it, if I look at it from the point of view of my own hospital, St Thomas', there was no problem at all. This was what upset me when I became dean of the Faculty, well when I went on the board of the Faculty and met surgeons from all round the country. Quite frankly, I thought they were extraordinarily arrogant about anaesthetists as a whole, nation-wide, but I have to say that I had nothing but support from my surgical colleagues in St Thomas' from the moment I got on the staff. There'd been a war, many of them had served in the forces, and they knew the value of having somebody competent dealing with the patient as a whole rather than just a part of the patient. And, these were the people I worked with after the war. Although I didn't know much about anaesthesia when I started, they were a tremendous support, and when I got onto the board of the Faculty I realised this was not the position around the country and I think I understand why. We were at the stage then when a great many anaesthetists were not very well, weren't trained at all were not particularly good. And they were perfectly content to walk into the operation theatre and give an anaesthetic irrespective of the state of the health of the patient and walk out again and not bother about the patient any more. We were emerging, so there was, you know, a lot to be said for the surgical view that anaesthetists as a whole were not particularly able to claim recognition as specialists.

AA They were in fact, at that time they were regarding us as technicians and no more than that?

DW Yes. Some of them were.

AA Some of them. But, I'm sure you're right that one's relationship with surgeons in general was rather different from one's personal relationship with the surgeons that you were working with every day, with whom you developed very often a close relationship and one of respect.

DW I think the big problem the Faculty had was to raise the status of anaesthetists through insuring that the quality of those who practised anaesthesia was of the highest possible, that you had to train young men and women to be not only competent practitioners in the operating theatre, but to have a wider knowledge than giving an anaesthetic. Preoperative care, postoperative care leading into intensive care, all the things we take for granted now, were emerging then.

AA You were in a good position to appreciate this having started life as a physician of course, you could see the wider fields right from the beginning, because I remember at one stage…

DW I don't know that I did see the wider field. I think I was aware of the fact.

AA …I remember Cecil Gray saying at one time he felt that to be a really good anaesthetist in a teaching hospital, you should have a medical degree as well as an anaesthetic one. But of course the idea of developing the FFA was that that was not necessary, that the exam was going to be broad enough to encompass the fields you mentioned in the beginnings of intensive care and pain relief and pre and postoperative responsibility and so forth. And what did you personally feel in the time that you were dean that you'd achieved particularly?

DW I don't know that I felt that I'd achieved anything myself. I think that there was a succession of people who were able to ensure that the training system in hospitals throughout the country was improving the whole time. You recollect when you were dean of the Faculty that we had to send people to inspect departments of anaesthetics in various hospitals. Well I did a lot of that myself, but it was pretty clear to me that most of them were not very good. 'Anaesthetists in training,' in inverted commas, were being used as pairs of hands. And if you raised the standard of training too high, i.e. if you said 'If you don't train them to this high standard, you won't get the recognition of the Faculty,' then they couldn't get pairs of hands. Because they had to have, people in training had to have more time to read their books and to learn more about medicine as a whole. So, we did succeed I think in getting the standards to rise, but it's taken a very long time to get to where we are now.

AA Now, you of course involved yourself in the wider field of medicine. At what stage did you become dean of the St Thomas' Medical School?

DW Well, that was quite late on, Aileen, 1974 actually. I got involved in other things quite a long time before that I think by chance.

AA Such as?

DW A lot of the work one does sometimes, you know, somebody else who says I would be interested in doing this... Because when I was on the Board of the Faculty, I think before I became dean, I joined the council of the Royal Society of Medicine. Not the anaesthetics council, I had done that, honorary secretary I think, but the full council of the Royal Society of Medicine. And I ultimately became one of the honorary treasurers, something which I think you're doing yourself now. Then I was invited to go onto the council of the Medical Defence Union, which as you know is an organisation which looks after the interests of doctors and nurses and other medical personnel. But what isn't always understood, it looks after the interests of patients and that is what interested me. And finally, I became dean of St Thomas' Hospital in 1974.

AA Of course there seems to have been quite a long tradition of anaesthetists becoming involved in other things. You weren't the first anaesthetist to become dean of a medical school in London. And there also seems to have been a tendency for anaesthetists to become involved with education early on – I'm thinking of Patrick Shackleton – and even more recently to become managers and politicians and so forth. Do you think there is something about the practice of anaesthesia that equips you for doing these sort of jobs?

DW Well, certainly not the political side. I'm no politician myself; in fact I've always had a great distrust of politicians and of medical politicians in particular. I don't know really what it is that makes one land up holding these sorts of positions. I don't think any of the work that I've done has really had a political impact. I mean, I was never a member of the BMA set-up which is political, overtly political. No, I think it is just that perhaps your colleagues think you could do that job better than somebody else would do it. Certainly, the deanship at St Thomas', which is an elected post, of course I'd been on the staff at St Thomas' for a long time, I think that I got on fairly well with young doctors and helped to teach undergraduate students something about anaesthesia, and perhaps my colleagues thought that I would do the job reasonably well. But I did develop quite strong views about medical education, undergraduate selection in particular and medical education as well.

AA What were your views on that? Can you expand a little?

DW Well, as far as selection is concerned, I've never been convinced and I certainly wasn't at the time, that pure academic ability makes a good doctor. Not a popular theory to have. Well not a practised … not really a theory. I remember I was asked to speak at a symposium run by the General Medical Council, I don't think it was ever published, about selection as it was carried out at St Thomas' Hospital. I did a lot of homework including going to see some members of the General Medical Council who are of course responsible for undergraduate education and including one very left-wing professor in London University, a very nice lady as it turned out. And I agreed with her that the only really objective method of assessment is perhaps the results of examination, and that has its limitations, but that doesn't make you a good doctor. And you've got to be prepared to stick your neck out and say what are the other factors that make a good doctor, always assuming that the academic ability is sufficient to get through the course. And I saw every single potential doctor or student at St Thomas' over my period of deanship personally, but always with other people when we came to selecting them.

AA So, to come right up to the present day, you would go along with the General Medical Council which has now issued 'Tomorrow's doctors'[3] as a different approach to medical education. That education is not by any means the same as vocational training, perhaps we had gone too far down the line of vocational training to the neglect of education as a whole. You would…

DW Yes. Well I mean, because I did a lot of medical legal work at the Medical Defence Union before I was dean and of course while I was dean, I was well aware of the fact that many doctors were pretty good at their job as doctors, but they didn't have much idea of how to handle patients. And that's a contradiction in terms. If you are a good doctor, you have to handle patients but a lot of them were awfully arrogant and didn't like being questioned about what was going on. Perhaps they still are, I don't know, but I felt it was very important that potential doctors knew a great deal more about that side of medicine than just the purely clinical side where you learnt

[3] General Medical Council (Great Britain). Education Committee, *Tommorow's doctors: recommendations on undergraduate medical education*, London: General Medical Council, 1993.

how to listen to the heart and prescribe drugs and things like that.

AA And of course there was the very paternalistic attitude that persisted?

DW There was at the medical schools too. You were told you learnt it at the bedside because you followed these wonderful consultants walking around the wards and you saw what they did, and therefore you did what they did, you didn't have to be told that. Absolute nonsense of course, all medical students have to be told something.

AA Yes, that's right, yes. But, of course, there's a tendency to educate people into the way you are yourself and that can go on forever unless somebody thinks differently. And it seems to me that you were one of the people who was trying to think differently and approach it in a different way in the period that you were dean and were in a position to do something about it.

DW Yes. I never really got round to changing the medical curriculum in St Thomas', because you had to work within the guidelines put down by the General Medical Council. But even adding to that, there's never enough time, and we all know now that you can't train a doctor in five years of undergraduate training, it goes on the whole of your working life.

AA Yes. I think of course patients are now being much more demanding on this as well, aren't they, [than] they were, and as you were saying earlier on, you saw your role in the Medical Defence Union as defending patients as well as defending doctors?

DW Well, I think it was, at the time an enormous amount of information came to the Medical Defence Union and the other defence organisations in the United Kingdom – of course there were two others – which was not available to the doctors as a whole. We in fact started a journal, the *Medical Defence Union Journal*, to spread this information in the hope that doctors would pick up something which would be useful to them to prevent claims by patients.

AA Of course you carried on with your involvement with the Medical Defence Union long after your retirement from the NHS, didn't you? I mean, you became president of it I think. That's right, isn't it? I mean, you've been retired for some time.

DW I retired in 1979 from the Health Service and I think I left the Medical Defence Union in about 1990, finally, when I was president for about five or six years, I can't remember precisely how long. Incidentally, the Union of course is a world-wide organisation, so you were trying to also help doctors in other parts of the world.

AA The problems were similar, or were they different did you find?

DW No. In some countries there were no problems because the patients as a whole did not sue, and they didn't have a media telling them what doctors shouldn't be doing. I mean, at the moment of course the media are very intrusive.

AA Can I ask you what your views are on the present legal situation, that at the moment medical negligence cases can only be pursued within the law on the adversarial basis? Do you feel this is right or do you feel that there is something to be said for systems that some other countries have, of having independent inquiries with expert witnesses that are looking for something a little different?

DW I don't think the adversarial system whereby somebody has to say it is black or white, somebody is right, somebody is wrong, is a good one. Because a lot of medical cases are grey and between the two, and I have been an advocate of a no-fault compensation system for a long time. But, of course if you do have a no-fault compensation system you have got to also be prepared to have a panel system which penalises or does something to stop doctors who make mistakes regularly, which is the one thing which the courts are supposed do of course. But it doesn't always work that way.

AA And of course the GMC has only recently been in a position to take that on board, haven't they?

DW Yes. They didn't have the powers originally.

AA No, that's right. But they now have with their new rules.

DW Yes, that's right.

AA What did you feel from your medical legal experience, what were the problems specifically for anaesthetists? I mean, where were we going wrong mostly?

DW I think a lot of the problems related to anaesthetics, well some of them of course were a group of just bad doctors, bad doctors, doctors practising bad anaesthesia and making culpable mistakes. But I thought that perhaps not enough anaesthetists were prepared to look at the patient as a whole and foresee what might happen when they administered anaesthesia in the circumstances of surgery. They were not prepared to take a wider interest in the care of the patient and that led them to be, not just to make mistakes but to be at fault when somebody investigated why something had happened to the patient. I think that's terribly important. I mean, things have changed I am sure a lot, but there was a time as you said earlier on when the surgeons said 'This is alright, you just go ahead and give the anaesthetic.' Well, surgeons don't know all about the patient as a whole. I mean, good surgeons do, but they don't all match up to that standard, and nor do anaesthetists. Remember, there's a thing called the, the … you sign away as a patient your rights when you go into hospital and the surgeon is supposed to give a description of what he's going to do to the patient and give them some indication of what might happen. The anaesthetist is just included on the form, the consent form, saying 'And I submit myself to an anaesthetic, general or local as maybe.' I would have thought, and I have thought for a long time, that if the anaesthetist is going to do something he or she also should have to explain what the implications of that anaesthetic might be.

AA Of course America has taken this further, haven't they? You *do* have to explain exactly what you are going to do and what might go wrong, in fact perhaps in

more detail than we would feel was right because it might undermine confidence and so forth?

DW There's a very fine edge between how much and how little.

AA Could I ask you another thing? You referred to the fact that ones having inevitably to work much more in the glare of media publicity, we still do not have the profile amongst the public and the media really that we are entitled to. It's still surprising the number of patients who don't realise that we are doctors, and for example when some famous person has an operation, the surgeon is always named, the anaesthetist probably not. Do you feel that we've tended to keep too low a profile or that we've been frightened of the media? Or how do you think we should tackle this problem because we do need to raise our profile, I think?

DW It's a difficult one, isn't it, because in point of fact of course if you are a patient you go to see a surgeon, who may think that an operation is necessary and tells the patient that they have to have an operation. And that is where anaesthetists come into it. The patient doesn't see the anaesthetist in the consulting room, he probably knows he is going to have to have an anaesthetic. But when he gets, he or she gets into hospital then if the anaesthetist goes to see the patient, they should do, that's the first time the patient will be aware of it. I don't know whether publicity outside the one to one contact, patient and doctor, will ever achieve very much. Because most patients when they feel ill go and see their general practitioner and they are referred to a surgeon if that is necessary. They are never going to be referred to an anaesthetist except for the treatment of pain, something outside the surgical field. That is an area where of course the anaesthetist does have much more profile, a high profile.

AA It's always surprised me, one would have thought that many patients are more frightened of the anaesthetic than they are of the surgery. I mean, when the chips are really down, they say, you know 'I'm really scared of the anaesthetic, I'm not too bothered about the operation.' And they're scared of pain. If you look at it on the, what is almost today's yardstick, how much money are people prepared to churn in from the charities, it's hard to raise money for anaesthesia. Now one would have thought, bearing in mind our capacity for killing people which is greater than the surgeons to some extent, and our ability to relieve pain and the power of life and death, you would have appealed even to the most unimaginative. And yet it is hard to raise money for anaesthesia.

DW Yes. I suppose most of the money anyway that comes through all branches of medicine comes from institutions, doesn't it. Or the members of a particular institution like the College of Surgeons or the College of Anaesthetists, maybe they give something, but when you are looking at a wider appeal, do people put money into the hands of social charities? Cancer research and things like that.

AA Cancer, hearts and children, yes. Perhaps they don't…

DW I don't think the public as a whole put a lot of money into surgery unless there is some particular reason for doing it.

AA So, you don't think we are any different from that point of view?

DW Well, I don't quite frankly, but I do agree that we don't have a high profile with the media. Although it was quite nice to see that [in] *The Times* after the Queen Mother's hip operation, Tom Stuttaford did say he thought this was an occasion when the anaesthetist was just as important as the surgeon.

AA Well, she had had several anaesthetics at that time!

DW Well, at 95 I would be more worried about the anaesthetic than I would be about the hip replacement, quite frankly!

AA Could I just take you back to another thing that we mentioned briefly, and that is the question of the change of status from the Faculty of Anaesthetists within the Royal College of Surgeons to the independent status, firstly as a College and then ultimately as a Royal College. You were obviously very keen that this should emerge. Are you happy about the way things are going now, the way it arose and how they are going now? Are you pleased?

DW Well, not particularly about the way it arose because my original college was the College of Physicians and after the war the president of the College of Surgeons was Webb-Johnson, Lord Webb-Johnson as he became, and I thought at that time that his ideas were absolutely splendid. The College of Surgeons had these bombed-out buildings in Lincoln's Inn Fields. The College of Physicians was in Pall Mall looking… Trafalgar Square actually, Pall Mall, yes, looking to move to Regents Park, and the obstetricians and gynaecologists were looking to build in Regents Park too. So what Webb-Johnson wanted to do was to combine the whole lot in a college of medical specialities in Lincoln's Inn Fields. It didn't happen. I would have supported that completely.

AA That would have been marvellous.

DW But it didn't happen, and the anaesthetists would have been part of that. And then, as I've said already, we had the Faculty which was splendid and the surgeons were very good to help us to have that Faculty, but they wouldn't go any further which was a pity. But, if they had I think that a lot of the breakouts from surgery… And don't forget that there are colleges of ophthalmic surgeons and colleges of orthopaedic surgeons. I think that that is due to the fact that the surgeons at the time when I was on the board of the Faculty and on the College of Surgeons council could not look forward. They could not see any need for a change, which was a pity.

AA Actually, there is not a College of Orthopaedic Surgeons as yet of course.

DW I thought there was one coming up.

AA Well, it was talked about for a long time, but now that they've elected an orthopaedic surgeon as president, maybe it will be held back a bit. But you are quite right though, there are ophthalmologists, and of course all the other medical colleges, paediatricians and various other things. I mean, the tendency this last fifty years has

been for fragmentation rather than for coming together and you would regret it as I would I think. We should have come together.

DW I think we have to say that the Association of Anaesthetists and the College, but mostly the Association of Anaesthetists, has been extremely good in keeping all the potential bits of anaesthesia together under one heading. There was a great thought that some of them would have liked to break out and form their own little association, of obstetric anaesthetists and things like that, but they are all now under the same umbrella.

AA Intensive care and the Pain Society.

DW Yes.

AA Of course you were president of the Association actually again after you retired, I think, from the Health Service, weren't you?

DW Yes. A kind of fossil!

AA That's right. And there was a period where perhaps it would be fair to say the Association and the Faculty were, there was a degree of conflict between them, because the Association was leading…

DW Yes, I gather there was. I wasn't involved at that stage.

AA Well, I was to some extent and perhaps one would have liked things to have been done a little more amicably, but we survived it.

DW Yes.

AA What I would like just to do as we sort of have gone through your career, could you tell me just a little bit more about your own family? You've mentioned that you married I think early in the war. Was that when you were a student or when you were a resident?

DW I've been married 50 years this summer actually, a very happy marriage.

AA And tell me about your children and what they've been doing.

DW Oh well, I had four children. Margaret and I, my wife, had four children. My eldest son died ten years ago, which was a rather unhappy period for us. But we've got two daughters and another son who is a schoolteacher in the largest girls' school I'm told in London, the Elizabeth Garrett Anderson School in Islington. And at the great age of 41 this year, he's just married a Ghanaian lady and she's only 20, so we're going to see how that works out.

AA Is she a teacher?

DW No, she's never been in Europe before. She's married to my son. A very

happy family life. Fortunately, we've always believed in being a family as it were and see one another regularly and things like that, so we have no worries about what's happening to our children, we know by and large what's happening. Of course we worry about them, but we see them regularly. One of my daughters is married to a Spanish gentleman and lives in Spain with her children, but we are always going backwards and forwards. It's nice to have a place in Spain to go to!

AA Perhaps Spain is a good place to bring up grandchildren! I think there must be worries about bringing them up in this country.

DW My step-, my son-in-law in Spain is a theatre producer actually, so he's all round the place producing various things from pop and jazz to serious theatre.

AA Just as you've had a varied career, your family have also broken out into varied directions and none of them have gone into medicine?

DW No, no. None of them felt the least interested.

AA Does that disappoint you or not? Or doesn't it worry you at all?

DW Not particularly. I would have liked it if one of them had gone into it. It simply didn't happen and I didn't try to push them or anything like that. Two of them went to university, two of them didn't. They're rounded.

AA Yes. And the state of medicine today of course is changing enormously. Do you feel that you're, if you were still in a position to influence things, what would you do?

DW Well, I've been retired since 1979 from medicine, clinical medicine, so I can't really have a very strong opinion on it. I'm an optimist and I think the media does an enormous amount of harm to medicine by intruding and giving the wrong impression. I strongly suspect from talking to people who are still in the hospital service or in general practice – I live in the country now but I still see my ex-colleagues at St Thomas' and in fact I see the people I used to teach when they were students – and I get the impression that life is very busy but much more efficient in the hospital service. But this is a big teaching hospital and they seem to be managing all right. I really don't know. I mean, I'm not disposed to think that there is something wrong with the Health Service. It changed when I joined it in 1948 and I had very little experience before it started, but I know I was very pleased to see it start and I accepted the changes. I do recollect that my senior colleagues at St Thomas' at that time thought it was awful to have this new system imposed on them. I became dean of the Medical School at St Thomas' just when the socialist government at the time had abolished the board of governors. Our independence went. Again, we lived through it and the service didn't deteriorate or anything like that. I don't know whether the expectations of patients have changed. All the ones I've talked to in the country who have been in hospital are full of praise, quite contrary to what one might think listening and reading what's in the media. The social services are under pressure so I'm told. I've had relations and I've had friends who have been in the care of the social services, including my brother-in-law down in Hampshire fairly recently who

was nearly 90, absolutely wonderful the help he got. He never went into hospital until he actually died, he was so well looked after by people coming to the house. So, I'm not disposed to be pessimistic, but I can understand that it is very expensive nowadays.

AA And your sister of course gave you an insight into the nursing side?

DW My sister who is older than I am, she's 80 this year, she trained at King's College Hospital in London before the war. And she was matron of Manchester Royal Infirmary and she was matron of King's College Hospital at the end of her career, and I think that she knows that there have been big changes since she retired too in nursing. There have been changes. If you go into hospital now for something major, you don't stay there very long, so I don't know to what extent this makes a difference to your comfort. All I do know is that a great many things can be done to give you a better life when you leave hospital.

AA Well, I think it's very nice to talk to somebody who has had the career that you've had with all its variety and to find that at the end of it you remain an optimist in that you feel that medicine is going to continue to develop and not, as so many people think today, in a backward direction. Thank you very much, Derek.

DW Thank you.