TRAINING OF ANESTHETISTS IN GREAT BRITAIN*

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It has been interesting to me, a stranger coming to the United States, to observe the difference in training and methods in the specialty of anesthesia in the United States, in Great Britain, and Europe.

ADMINISTRATION LIMITED TO PHYSICIANS

In Great Britain the specialty is mostly in the hands of men physicians—it is, of course, strictly illegal for anyone other than a registered physician to administer an anesthetic. In Kings College Hospital of the University of London, none of the anesthetic staff were women, but of course, with the increasing number of women now entering the profession, they are also entering the specialty of anesthesia, and it is becoming less rare in England to see women on the anesthetic staffs of the various hospitals. Training in anesthesia is very thorough and interesting, and students are very proud of their attachment to the anesthetic unit—membership of which is proclaimed to the world by attaching tongue forceps (which are never used) to their coats.

In the large London hospitals and training schools most of the work done is what is called in America "clinic work." To each of these hospitals is attached, as is here, a staff of physicians, surgeons, and specialists, and all their work done in these hospitals is absolutely free.

TRAINING OF STUDENTS

The students are assigned to work in groups, each group forming a unit—surgical, medical, obstetrical units, and so on.

A surgical unit consists of first, the surgeons and anesthetists equal in power and authority; second, the surgical residents; third, the house surgeons, and then the students, a group of usually four to six. On the whole, counting in the general gynecological and specialist surgery, students are eighteen months on different surgical units, and during this time all the anesthetics are given by the students, under the direct supervision of the various members of the anesthetic staff of that unit.

Service is in strict rotations from an alphabetical list hung up in the dressing rooms. As the surgeons of a unit operate at least three afternoons a week, doing from four to five major operations each afternoon, each student gives a goodly number of anesthetics during these eighteen months.

At 4:30 on the afternoons in the week (usually three) when our unit covered the casualty department, we were responsible for the minor operations performed every afternoon at that time in this department. These minor operations include removing nails, sebaceous cysts, lipomas, opening infected fingers, arms, etc. The operations are performed and the anesthetics given by the students under the supervision of the chief surgical resident, a man of some years' graduation and experience, and of the resident anesthetist.

For the short operations we gave nitrous oxid. Our duties on the anesthetic unit did not begin and end in the operating room—they began with the preoperative examinations of our patients, his preoperative medication, the subsequent administration of the anesthetic, and ended after his safe return to bed and observation of his postoperative condition. All this, as well as his behavior during anesthesia and operation, and the quality and quantity of anesthetic used were entered in the anesthetic records of the operating room.

SPECIAL INSTRUCTION

During this time we had lectures from the staff on the pharmacology, physiology, mode of action and administration of anesthetics. We were well examined in such things during our contact with our teachers in the operating room.

I may add that of course the students never gave an anesthetic except under the direct supervision of the staff. At our examinations for our university degrees we were questioned both in our written and our practical examinations on anesthesia. I remember when I took my membership of the Royal College of Surgeons of England, being very carefully examined in all of the practicals on anesthesia.

A physician who wishes to specialize in anesthesia when he has taken his degrees obtains a post in one of the hospitals as assistant resident and after six months' service is made resident anesthetist. In this way he gains further very useful experience and has as an added advantage the presence of the honorary anesthetists, as we called our staff, to help and advise him in his difficulties. He comes in contact, too, with the surgeons who, when he branches out for himself, will give him their private work to do.

ANESTHETICS USED

To the anesthetics used in Great Britain, I will refer only briefly. Chloroform is very rarely used. I saw it given a few times; each time by our chief, and the student whose turn it was stood by and watched.

Ether is mostly used in the big training hospitals. Here the patients are the very poor, the hospitals are not well off either, and gas and oxygen is comparatively expensive.

Gas and oxygen is being increasingly used, gas, oxygen, ether sequence, particularly. In our minor surgery nitrous oxid was used, and very often used alone. Everything was ready for quick operative procedure; the patient was given pure nitrous oxid until deeply cyanosed when it was stopped; the mask removed, the operation performed, and never with any fatality.

Ether is, however, the most largely used anesthetic, with gas and oxygen a good second. Ether is given by both the open and closed methods; for the latter, Glover's or Shipway's apparatus is used.

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