DEVELOPMENT OF ANAESTHESIA IN NORTHERN IRELAND

By JOHN C. HEWITT, M.D., F.F.A.R.C.S.(Eng.), F.F.A.R.C.S.(I.),
Consultant Anaesthetist, South Belfast Hospitals,
and
JOHN W. DUNDEE, M.D., Ph.D., F.F.A.R.C.S.(Eng.), F.F.A.R.C.S.(I.),
Professor of Anaesthetics, The Queen's University of Belfast

THE Belfast Medical School has been in existence since 1835, and the University since 1845; but prior to 1908 it was a College of the Royal University of Ireland. After this date it was granted a separate Charter as the Queen's University of Belfast. The medical school has always enjoyed a good reputation, but anaesthesia as a speciality was slow to develop, and had little status prior to the 1939-45 war. After this time anaesthetists had to struggle hard to establish and maintain parity with their colleagues, and to achieve this they had to have academic qualifications at least equal to those in the major specialities.

There is little information about anaesthesia here in the nineteenth century but the following was extracted from the annual reports of the Belfast General Hospital by Dr. Maurice Brown:

1850 First mention of chloroform in Belfast General Hospital. Surgical report, Belfast General Hospital: “We are sorry also to notice an increase in another class of cases, attempted suicide, 18 of whom were admitted since our last report all of these we happily succeeded in saving. 42 surgical operations have been performed, several of them under the influence of chloroform. The facts in reference to this agent are not yet sufficiently numerous to enable us to recommend or condemn its general use. It is perhaps, however, only right that we take this opportunity of stating that it requires great caution and considerable experience to render its administration safe. The number of pupils attending...”

1851 1st April–1st September. Annual report of Belfast General Hospital: “The use of chloroform which tends so much to allay the sufferings of the patients during an operation has been more generally adopted than formerly, and with decided success, no injurious effects having, in any case, resulted from its employment in this establishment. A considerable number of students attended. An important change has been made... the light improved.”
1852 "Chloroform, we may remark, has continued to be used in almost every case of surgical operation, with the happiest effect in the alleviation of human suffering and it is very satisfactory to report that in no case has the least unpleasant result followed its use."

1853 "Chloroform has been administered to the patients, when practicable, and with most gratifying results in alleviating both mental dread and physical pain and it is our duty to put it on record that during the several years it has been in use here and in the many hundred cases to which it has been exhibited in this institution, no accident whatever or evil has followed its administration."

1854 "In all serious operations and indeed frequently in minor cases, chloroform has continued to be used with great success in relieving pain and in no case in this hospital has its use been attended with any serious or unpleasant result."

1855 "The mortality has not been 6 per cent and after 103 operations only 5 patients died, 19 of which were capital amputations with 2 deaths. This latter, it may be remarked, is as low a morality as could be presented by any hospital in the Kingdom. The exhibition of chloroform may have materially tended to produce this happy result. At all events, anaesthesia has been administered, as hitherto, without any evil result, in every case of painful operation performed, with the effect of entirely overcoming that mental stress and bodily suffering which must otherwise be endured."

These reports indicate, as Dr. Brown points out, that chloroform, one of the great medical discoveries, was not accepted in Belfast until 1852, five years after it had first been used in Edinburgh. One hopes that we would not now be so conservative.

There appear to have been two opinions on anaesthesia held by surgeons practising during the latter half of the 19th century. First, the minority view, mainly held in England but not in Scotland, that anaesthesia should be practised by specialists (or chloroformists as they were called) and the second view propounded by Joseph, First Baron Lister that "professional anaesthetists were unnecessary if a simple routine was followed during administration." In 1861 and again in 1870 and 1882 he wrote in Holmes' System of Surgery to the effect that the action of chloroform on the heart was unimportant, but its action on respiration was all important; and, in particular, respiratory obstruction was to be avoided, by strong traction on the tongue, if necessary. He continued: "The appointment of a special chloroform-giver to a hospital is not only entirely unnecessary, but has the great disadvantage of investing the administration of chloroform with an air of needless mystery, and withholding from the students the opportunity of being trained in an important duty, which any one of them may be called upon to discharge on commencing practice, and which, though certainly simple, is better performed after some practical initiation."

This is mentioned in order to suggest that this was the view held by most surgeons in the North of Ireland prior to 1939 and, we understand, in the rest of the United Kingdom, Europe and America. However, prior to the turn of the century some German and Swiss surgeons were realising the importance of skill and training in anaesthesia and were agitating for special courses of training. In 1903, Dumont of Berne wrote: "Nothing is more ridiculous than the diffidence with which the administrator of an anaesthetic accepts a subordinate role in the operation. He is just as important a personage as the operating surgeon, for the patient's life depends upon him . . ."
Here in Ulster it took nearly fifty years for the majority of surgeons to be converted to this opinion of anaesthesia. Those anaesthetists who enjoyed consultant status prior to 1953 had to have a Doctor of Medicine degree, or other higher qualification, as well as the diploma in anaesthesia. After 1953, when the F.F.A.R.C.S. (England) by examination was introduced this qualification was recognised by the Northern Ireland Hospitals Authority as the standard for consultants. In 1960 the F.F.A.R.C.S.I. was introduced and accorded equal status.

The poor reputation and status of anaesthesia was not surprising when one considers that, prior to the 1930s, methods and drugs were almost unchanged here since mid-19th century. It was usually open chloroform and ether with ethyl chloride for induction and for short procedures. The anaesthetic was not thought to be important and was given by any inexperienced doctor or student, and often by nurses outside hospital. Staff anaesthetists were few, engaged in general practice, and available for only the minority of cases. They were not always skilled and experienced.

The senior surgeons, from whom most of this information was gleaned, all agreed that morbidity and mortality were high in association with anaesthesia and surgery. Chest complications and paralytic ileus were common and, failing these, it required 48 hours for the patient to “recover from the anaesthetic”, the usual effects being vomiting and headache. Deaths on the operating table, or soon after, were common enough though coroners were easily satisfied, and legal actions rare. Occasionally a patient was sent back to bed without operation when some serious trouble developed during induction of anaesthesia. Relatives and family doctors usually asked: “How did he take the anaesthetic?” The question is sometimes still asked in rural districts and the anaesthetic is occasionally called “the chloroform”. Many of these catastrophes were caused by chloroform or its misuse: probably the other common cause was regurgitation and aspiration.

Surgeons had to shoulder responsibility for both surgery and anaesthesia, so it is not surprising that they resorted to local and nerve block techniques whenever possible. Many were short-tempered, unlike the present placid and disciplined generation. It was customary about fifty years ago, or more, for trainee surgeons to spend their first year after hospital residence giving anaesthetics; and nearly all of them had deaths on the table. Professor P. T. Crymble, a former Professor of Surgery, boasted that he was unique in this respect, having no deaths during his term; whereas his contemporaries each had at least two during their short anaesthetic careers. Many true stories are told of anaesthetic incidents, some amusing but most of them tragic. For example, Professor Macafee’s tale of the general practitioner who insisted on anaesthetising his own patient for a forceps delivery by a consultant obstetrician. The doctor had been away all afternoon at a country funeral and the obstetrician had been hoping to have the patient delivered before he came back. Unfortunately he returned slightly inebriated in time to give the anaesthetic, which he started by putting the Schimmelbusch mask on the patient’s foot as she lay in the lithotomy position. The obstetrician asked if it would not be better on the other end. He agreed and, after this not very promising start, carried on with the anaesthetic as if nothing unusual had happened. Another story, known personally to one of the authors, concerned the house surgeon who was inducing a patient with chloroform and ether mixture by open mask while
the surgeon scrubbed and looked on. Suddenly the surgeon said: “Don’t give her any more, doctor, she’s dead,” as indeed she was.

Sir Geoffrey Organe’s most interesting John Snow Lecture “Anaesthesia 1939” given to the Association of Anaesthetists in October 1969 shows, rather surprisingly, that anaesthetists and the speciality in England, and even in London, did not have very much better status than here prior to 1939. Certainly they were not accepted as members of the medical staff of teaching hospitals until a few years before the 1939-45 war.

Experiences of individual surgeons varied, but H. P. Malcolm, now retired, and in his mid-eighties, states that general anaesthesia for abdominal surgery was so unsatisfactory in the nineteen-twenties and thirties that he usually resorted to sub-costal nerve block in addition. There were, of course, some exceptions, and the first skilled anaesthetist of whom we have any knowledge was Victor George Leopold Fielden, the only specialist anaesthetist of his time in Northern Ireland. He was not a whole-time anaesthetist since he also held the appointment of Lecturer in Pharmacology and Material Medica, and did some general practice. Even now pharmacology would be regarded as a sound approach to anaesthesia. He was a remarkable man, though his standards might not now be acceptable. Born in 1866, in Plymouth, where his father was a Royal Naval Officer, Victor Fielden’s family moved to Belfast when he was 16, his father having left the Navy and joined the Board of Trade. He finished his schooling at the Royal Belfast Academical Institution, the second oldest grammar school in Belfast, having been at Heriot’s, Edinburgh, before this. He qualified as a pharmacist in 1890 and M.B. in 1892.

Some time after this he became associated with Sir William Whitla, Professor of Materia Medica and Therapeutics and a celebrated physician, assisting him in the prepartion of his first book, which became a standard work on the subject. Later, he became lecturer in the Department of Therapeutics, becoming the temporary head of the department when Whitla retired in the nineteen-twenties. It must have been a disappointment to him when he did not succeed to the Chair. However he was reputed to be an indifferent lecturer who had little control over students. Many stories are told of the pranks played on him by students many of

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**Fig. 1. Dr. Fielden in the theatre of wards 11 – 12.**

*Photograph by J. E. Morison in Summer, 1937.*
whom, just after the first war, were tough ex-soldiers and a good deal older than usual.

Fielden was a big man with rough skinned hands, attributed to having worked in operating theatres during the Listerian carbolic spray era. He obtained his M.D. with Gold Medal in 1912 for a thesis on the pharmacology of ethyl chloride. This was supported by many experiments on laboratory animals, dogs, cats, rabbits and frogs. In his preface he states: “It is an attempt to add to the limited knowledge of the action of an anaesthetic which is now largely used but whose pharmacological effects have not received much attention.” It was an exceptionally fine work, though we might not now agree with all his conclusions. As far as we know, Fielden's techniques were limited to inhalation anaesthesia. He favoured the Vernon Harcourt apparatus for chloroform and he was still using it in the early 1940s. Mr. Barry Crymble relates how he did his student anaesthetics about 1942 with the Vernon Harcourt apparatus supervised by Dr. Fielden. Prior to the first war he is said to have made and used a transportable nitrous oxide-oxygen machine for minor anaesthetics. He worked with such celebrated surgeons as Robert Campbell (brother of Sir John the obstetrician), A. B. Mitchell, Sir John Byers, Professor Thomas Sinclair, Andrew Fullerton (later Professor of Surgery) and Sir John Walton Browne. Other younger surgeons working at this time were Howard Stevenson, P. T. Crymble (later Professor), S. T. (later Sir Samuel) Irwin and Thomas Kirk. These men operated over a wide area, in different hospitals and nursing homes, and even in the patients' own houses; and Fielden often accompanied them as anaesthetist as far as the western counties of Ireland. There were few motor-cars, and those not reliable, so travel was frequently by rail, and horse-drawn car to finish the journey.

The authors remember him well during the late nineteen-thirties and early nineteen-forties, and during the war years he was still working. He was a tall bearded man of impressive appearance (fig. 1). He died in June 1946 a few days short of his eightieth birthday. He wrote and published other papers, mainly on pharmacological subjects not connected with anaesthesia.

Next in succession was Stafford Geddes who qualified M.B. in 1915 and who died in May 1969 having retired 13 years earlier. He saw many developments in anaesthesia and surgery, from the closed inhalers of Clover, Ormsby, Ombredanne and Lucas, to the Schimmelbusch mask (introduced in 1916) as well as morphia and atropine premedication. Prior to this the patient's head was turned to one side and the secretions drained from the mouth by a gauze wick. He remembered having tonsillectomy, under local analgesia, when aged 13, performed by Sir John Walton Browne.

Boyle's apparatus and the Shipway were introduced in the early nineteen-twenties and blood transfusion in the late twenties. Dr. Geddes became a whole time anaesthetist about 1925. He worked at the Royal Victoria, Ulster and Samaritan Hospitals; and he shares with Dr. Claire McGucken of the Mater Hospital the distinction of being the first whole time specialist anaesthetist in this region, and perhaps even in Ireland. He became, for his time, quite skilled and he was using Magill's endotracheal tubes for some time prior to 1930. (Geddes was one of the few subscribers to the early issues of the British Journal of Anaesthesia and his gift of them to the Anaesthetic Department was greatly appreciated).
Dr. Claire McGucken (M.B. 1923), after her house surgeon post at the Mater Hospital, spent six months as resident anaesthetist in the West Middlesex Hospital, London. Here she worked with some well known surgeons, including Rodney Maingot, and learned to use the Boyle's apparatus, the Shipway, the Clover, ethyl chloride closed inhalers, and also endotracheal anaesthesia. When she returned to Belfast she worked at the Mater as its first whole-time anaesthetist for three and a half years, from 1924 to 1928. She then married Mr. James McSparran, later a well known barrister, and retired from medical practice. She used all the techniques which she had learned in London, and the hospital acquired a Boyle's apparatus at this time. She preferred, however, when endotracheal anaesthesia was required, to allow the surgeon to insert the tube.

In the early 1920s local analgesia was widely used by surgeons. H. P. Malcolm and the late G. R. B. (Barney) Purce had probably learned these techniques during their war service. Other younger surgeons – Ian (later Sir Ian) Fraser, J. S. Loughridge and the late C. A. Calvert worked in Britain and elsewhere during the nineteen twenties and brought back and encouraged the use of new anaesthetic techniques. Tonsil dissections were done from 1927, but anaesthesia was for a number of years by insufflation through a Boyle Davis gag. Early endotracheal anaesthesia for tonsils was also by insufflation.

The year 1927 saw the introduction of rectal ether. From 1929–34 rectal bromethol (Avertin) had a spell of popularity; and Dr. John Boyd obtained his M.D. in 1933 for a thesis on its use. Some surgeons were pushing it as a complete anaesthetic and there were complications, including deaths in children. The great indication for rectal Avertin was as basal anaesthesia in surgery for toxic goitre. Prior to the discovery of thiouracil, patients with thyrotoxicosis were amongst the most serious surgical risks; and many died following operation. Avertin seemed to reduce the dangers by dampening down the post-operative “toxic” reaction which caused many of the deaths.

Dr. Olive Anderson, qualified in 1917 and still practising, relates how she stayed
for two days with a patient whose unconsciousness was prolonged due to inadvertent overdosage. Dr. Anderson worked in military hospitals in Britain from 1917–19 before returning to Belfast where she combined anaesthesia and general practice. She was sufficiently progressive and enthusiastic in the early nineteen-twenties to spend several weeks at the Westminster Hospital with Dr. (later Sir Ivan) Magill.

About 1935 J. S. Loughridge inserted radium needles under intravenous hexobarbitone. He also introduced percaine and decicaine in the early 1930s and suggested the use of Avertin in 1929 to Mr. Thomas Kirk. Spinal anaesthetics were given, usually by the surgeons, from the nineteen-twenties and perhaps earlier. Novocaine and stovaine were used, and later heavy and light percaine (later Nupercaine). There were some serious complications and deaths, and the late R. J. McConnell, surgeon at the Royal Victoria Hospital, Belfast, stated that he knew personally of two cases of permanent paraplegia following spinal analgesia. He must have thought that these resulted from errors in technique because he had no objection to using these agents in his own patients (given by one of the authors) during the period 1946–49. Spinal anaesthesia was used commonly for inguinal, perineal, and bladder operations, and in gynaecology, until 1953 when two serious post-spinal accidents were reported from England. Since then it has been little used in the province and it has now been largely replaced by extradural block.

James Wilson Heney, M.B. 1922, D.A. 1929, was visiting anaesthetist to Royal Victoria and Ophthalmic hospitals until his death, in July 1950, at the early age of 50.

George Hamilton, M.A. (T.C.D.) 1920, M.B. (Queens) 1927, D.A., was a general practitioner anaesthetist on the staff of the Royal Victoria Hospital until a short time before his death in December 1967 at the age of 80. Before qualifying in medicine he had been a Church of Ireland clergyman.

We give brief thumbnail sketches of some of the 'younger juniors'. John Boyd, qualified 1926, combined anaesthesia with general practice until the beginning of the 1939–45 war, when he became a whole time anaesthetist. He was an expert in endotracheal work and had been intubating since the mid or late 1930s. He did much paediatric work and wrote and published papers on rectal Avertin and cyclopropane. Florence McClelland, qualified in 1938, trained with Dr. John Gillies of Liverpool and Edinburgh in 1941, before returning to Belfast in early 1942. She retired from practice a few years ago, about the same time as Vida Lemon who is a native of New Zealand. James Elliott, qualified in 1938, spent 2 years as biochemist and resident anaesthetist at the Royal Victoria Hospital. He then spent eight months in Central Middlesex Hospital, London, before returning to Belfast in the spring of 1942. Fred Bereen returned from army service in 1946 having been an anaesthetist serving mainly overseas. W. M. Brown returned to Belfast in early 1946 having trained at the Westminster Hospital with Dr. (now Sir Ivan) Magill during 1944–45. He had been invalided out of the Navy. These, with John A. Macaulay of the Mater, were the first modern-trained and whole-time specialist anaesthetists and were responsible for training the post-war 'bulge' of trainees who were mainly ex-service doctors until the Department of Anaesthetics was established in 1958.

In 1946 the pattern of anaesthesia for major abdominal surgery was intravenous induction followed by nitrous oxide-oxygen and either (1) intercostal or paraverte-
bral nerve block, or low spinal sometimes for pelvic surgery, or (2) deep general anaesthesia, usually endotracheal, with ether and/or cyclopropane. If this was inadequate chloroform was often given. Cyclopropane was widely used at this time for all types of case, including thoracic, in spite of the explosion risk. Indeed for many years it continued to be the anaesthetic of choice in obstetrics. It was considered here, as elsewhere to be the anaesthetic of choice for poor risk patients. This continued popularity is interesting, in spite of its cost, and the fact that just a few years ago in the American National Halothane study it was shown to have the worst record of morbidity and mortality of any of the drugs or techniques studied. Most of us never found it completely satisfactory for major abdominal work, because it did not seem to produce as good relaxation as ether or chloroform, even when the patients had reached the stage of extreme respiratory depression and thereafter continued to be hand ventilated with a high percentage of oxygen. This was a dangerous practice from the cardiac point of view; but despite this not many cases of cardiac arrest were ever recorded.

These dangerous practices ceased when curare was widely available and accepted. Its acceptance depended partly on the demonstration that, contrary to what many predicted, the accompanying light anaesthesia did not cause shock. About this time, or soon after, the Birmingham accident surgeons showed that shock meant blood loss in the vast majority of cases. In the winter of 1946-47 curare was introduced by W. M. Brown who had seen it used experimentally in England prior to this. One of the authors (J.W.D.) started using it in Londonderry at the end of 1947. However, John A. Macaulay of the Mater got a small quantity of Introcostrin through an American serviceman and used it about two years earlier. This was a cruder and less standardised preparation which was superseded by Tubocurarine.

Many young graduates saw the potential of anaesthesia as a speciality in the immediate post-war years and, like other centres, there was a great influx of trainees. For those who elected to train in Northern Ireland the “apprentice” system was all that could be offered and some combined this with intensive courses in other centres. The majority, however, had their basic training in England and returned home for senior trainee posts. By the early 1950s all hospitals in Ulster had one or more consultants engaged solely in anaesthesia, with a standard of practice comparable to elsewhere in the United Kingdom.

If anaesthesia for general surgery was unsatisfactory prior to the 1940s it was extremely poor for dentistry. Local anaesthesia, even with a comparatively safe drug such as procaine, was sometimes not completely effective. The introduction of lignocaine (Xylocaine), a more effective as well as reasonably safe drug, was a landmark in dentistry.

General anaesthesia for dentistry, prior to the 1920s and even later, consisted of chloroform and ether, ether, or ethyl chloride; endotracheal methods were rarely used and the dangers of inhalation of debris were often not appreciated. The use of gas and air before the first war and later gas and oxygen, with throat packing, minimised one risk, but added another – that of asphyxia due to inadequate oxygen; because anaesthesia could rarely be produced without some asphyxia. These cases were almost always done upright in the dental chair and it would be impossible to assess the morbidity and mortality. This morbidity and
mortality has continued even since the last war, in spite of the use of adjuvants such as ethyl chloride (a dangerous one), trilene, halothane and intravenous agents later.

Dr. J. C. Smyth, who taught for many years in the Dental Department, and who retired about 10 years ago, claims that there were never any serious effects from general anaesthesia in the Department. The authors, however, know of some deaths and many “incidents” both inside and outside hospital. One strong young farmer was given itrous oxide by a dentist but “did not take it well” and ended up on the floor. A second attempt was made to anaesthetise him and this time he died. A surgeon friend reported that, when he was a registrar working for his F.R.C.S., he had nitrous oxide-oxygen administered by a trained anaesthetist in the dental chair for extraction of one tooth. Following this he had a 24-hour period when he was unable to concentrate properly. One can only conclude that he had had some degree of cerebral anoxia.

Even today, many general anaesthetics in the dental chair are given by comparatively untrained and unskilled doctors (or dentists). Some even act as anaesthetist and dental surgeon, which should not be acceptable. Even when the anaesthetist is trained and experienced the facilities and conditions are often below standard; and we may yet conclude that all dental anaesthetics should be endotracheal, with the patient horizontal, under conditions comparable to those enjoyed by patients in hospital.

The lack of a university teaching department was rectified by the appointment of one of the authors (J.W.D.) as Senior Lecturer in 1958. He brought to the post a large experience in teaching and research gained mostly in Liverpool (with T. Cecil Gray) and Philadelphia (in the University of Pennsylvania with R. D. Dripps and his colleagues). The effect of this appointment on the morale of the trainees and the status of the anaesthetists was very great and soon an extensive teaching programme was running in which not only the university staff but all the clinicians participated and which was well supported by senior consultants. This liaison between academic and clinical staff is still well maintained and in this respect anaesthesia has set a pattern which few specialities could emulate.

It was appropriate that one of the best known graduates of the Belfast Medical School, Dr. (now Sir) Ivan Magill should be invited to give the inaugural lecture at the opening of the new department. Magill's pioneering work on
endotracheal tubes in thoracic anaesthesia have earned him a permanent place in the annals of the history of anaesthesia. Professorial status for the speciality was achieved five years ago and this also raised the status of the anaesthetist.

Lack of laboratory space compelled the research work of the department to be largely of a clinical nature and this is reflected in the publications from Belfast. The field of intravenous anaesthesia has benefitted from the various papers on new barbiturates, propanidid, effects of drugs on arteries and veins, and the studies which have helped to elucidate the factors which influence induction complications. Premedication has also been investigated in detail, with studies of opiates, phenothiazines, anti-emetics and tranquillisers. Many colleagues have collaborated in these investigations, all of which are the result of much team work. Perhaps the nature and extent of the investigations can be judged by a recent survey of findings from 10,000 dilatation and curettage operations (Morrison, Hill and Dundee, 1968). The work of Drs. G. W. Black and L. McArdle on the peripheral vascular effects of inhalational anaesthetics has also come from Belfast, and the present Senior Lecturer in Anaesthetics – Dr. R. S. J. Clarke – has contributed appreciably to anaesthetic literature. Research has also been carried out in the Respiratory Failure Unit of the Royal Victoria Hospital (with Dr. R. C. Gray), and much work has been done in the difficult topic of relief of chronic pain.

Because of its unique position and size, with only one university department serving the whole province, there is a tendency for general teaching hospital consultant appointments to be held by those who have first worked for several years in provincial hospitals. Exceptions to this are consultants with an interest in specialised fields such as respiratory failure and intensive care, cardiac surgery and paediatrics. Contact between the consultants in the country and centre is well maintained by an active anaesthetic society (Northern Ireland Anaesthetist's Group of the British Medical Association), and by the trainees who go to work for periods of up to 2 years in these hospitals. This latter is considered to be a most valuable part of their training. Patient-contact is easier to maintain in a small provincial hospital than in a large teaching hospital complex, and anaesthetist participation in pre- and post-operative care is greater in the smaller units.

There is probably no single teaching group in Britain which, within one campus, can offer trainees such an orderly rotation between various specialities, as that of the Belfast hospitals. One of the advancements pioneered by the present Professor is a planned rotation of juniors between the various hospitals in the city. It is accepted policy that the majority of beginners (senior house officers or 1st and 2nd year residents) be located in Belfast and a small committee amicably agrees on the rotation of its 20 or so beginners. Anaesthesia has recently successfully pioneered "day release" courses for both primary and final fellowship. It would be outside the scope of this short review to describe the training programme in detail, particularly as this has been described (Dundee, 1965). Its popularity is evidenced by the many foreign graduates who train here. At the time of writing there are three Indian graduates (all with F.F.A.R.C.S. or D.A.) enrolled as Ph.D. students.

Finally, it is worth noting that anaesthesia has succeeded in breaking down political and religious barriers in this small troubled island, to an extent which is only equalled by rugby football. The Faculty of Anaesthetists of the Royal College
of Surgeons in Ireland was instituted in 1950 and the Fellowship (F.F.A.R.C.S.I.) instituted in 1961. This College is located in Dublin, yet for many in the Northern part of the country it is the "Alma Mater" as far as anaesthesia is concerned. The present authors, although both fellows of the English college, are members of the 12-strong Board of the Irish Faculty. With Dr. S. H. S. Love, one of the writers (J.W.D.) was a foundation fellow. Rather than rivalry, there is a very active cooperation between the English and Irish Faculties, but, on purely economic grounds, it is often easier for those working in Ulster to attend scientific meetings in Dublin or other parts of the Republic, than in England, Scotland or Wales. Many of the Juniors in the South have part of their training in Belfast, and relationships between the anaesthetists in the two parts of this country are excellent.

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