A perennial plaint goes up from successive generations of resident medical officers in the larger hospitals. They complain that they are expected to give anaesthetics to the dangerously ill, the toxic and the shocked cases, whilst the visiting anaesthetists attend only for routine operations upon prepared subjects. The honorary surgical staff attend for emergency operations, but not the honorary anaesthetists, and this just at the time when the residents would most like to be relieved of anaesthetic duty.

We may reasonably consider that patients with perforated septic ulcers and with acute intestinal obstructions form a large part of the really serious cases that are surgical emergencies and that these may be taken as representative of the difficult and dangerous subjects for anaesthesia. The following figures cover periods of six months in hospitals of different type. They may help us to form a judgment of the extent to which just those very patients who most need an expert anaesthetist are deprived of his attention.

A. Provincial general hospital of 80 beds with two house surgeons:
   All anaesthetics, routine and emergency, given by house officers.

B. Suburban general hospital of 200 beds with four visiting anaesthetists and five house officers:
   Serious emergency cases—10.
   All emergency anaesthetics given by house officers.

C. London general hospital of 350 beds with five honorary anaesthetists and eleven house officers, including a resident anaesthetist:
   Serious emergency cases—36.
Anæsthetized by visiting anaesthetist—0
" " resident anaesthetist—15
" " house officers—21.

D. London general hospital of 650 beds with five honorary anaesthetists and twenty-five house officers, including a senior resident anaesthetist and four casualty officers on anaesthetic duty:

Serious emergency cases—56
Anæsthetized by visiting anaesthetists—5
" " resident anaesthetists—31
" " house officers—20

In A and B, 100 per cent; in C, 58 per cent; and in D, 36 per cent of these cases fell to the lot of the house physicians and house surgeons, whose anaesthetic experience at the beginning of their period of office was probably confined to the twenty administrations required during their training.

To have a surgeon demanding complete relaxation of an abdominal wall, when one has no idea of how deep the patient is or of how deeply he can be placed with safety, and to be vividly aware that the patient is extremely ill and may find his way to the mortuary overnight, is an experience to which no one should be subjected except in very dire emergency.

Towards the end of his engagement the house officer has learnt enough of anaesthetic administration to realize that he had been given a difficult task, before he had gained that experience from simpler cases which would have enabled him to do better work and would have saved him much distress and anxiety.

Realizing this, the houseman voices the biennial grumble in his turn. He is met with the equally periodic replies—that difficult cases provide good experience; that sick patients usually take anaesthetics very easily; that serious trouble most often occurs during simple operations upon apparently normal, healthy subjects. These answers, given with an air of experience and greater knowledge, silence the protester, though he may realize that they are inadequate. Difficulties teach, in anaesthetics as in all else, but one must walk before one attempts acrobatic dancing. Actually ill patients are easily induced, it is true; but they are equally easily knocked
out. Serious trouble occurs to the specialist anaesthetist only when it is entirely unexpected, simply because when it is expected it can usually be avoided. An administrator of experience can foresee and prevent most troubles or, at any rate, has the standing and authority to stop the operation or to refuse to give an anaesthetic at all. Now and again some completely unpredictable state of affairs arises, but for the most part the danger signals are quite definite and visible from afar. Further, a large part of the troubles of the inexpert anaesthetist may be due to his own making; he may add to the respiratory obstruction by putting in a badly adjusted airway, or may seek to stimulate a patient who is breathing shallowly by giving large blasts of oxygen.

Before the protesting junior has been able to cause any alteration in the traditional arrangements his time ends and a fresh generation succeeds. A new house officer is faced with anaesthetic duty and approaches his cases, be they for intestinal obstruction or for hallux valgus, with the same confidence or fear according to his temperament. In time he, too, finds out that he has been asked to do very difficult work with the minimum of experience.

The remedy is not hard to define but would be less easy to put into practice. Either the honorary staff of hospitals must be on call for emergency anaesthetics or else there must be two experienced residents, so that one may be always available. Surgeons have to take their turn at emergency duty and it would seem that anaesthetists should do the same. Various difficulties at once present themselves: some anaesthetists have general practices to attend; some surgeons prefer not to work with certain anaesthetists; the surgeon arranges the hour at which he will operate and fits it in with his other engagements, whilst the anaesthetist has to work at the surgeon’s time; often a decision is not made until the patient is seen by the surgeon and such decision may be against operation, in which case either the anaesthetist has been called unnecessarily, or else the theatre has to await his arrival. None of these difficulties is, however, insuperable. The main opposition will probably be from those of us who do not want to add to our duties or who prefer to avoid those cases which have a definitely high operative mortality.
It is not possible to say how far the current system works against the patient. The cases we have taken contain most of the serious ones coming to operation, and so few of them were in the hands of the visiting anaesthetists that no comparisons are possible. Three deaths on the table occurred in the series, in each case a resident anaesthetist, presumably more skilled than his resident colleagues, was giving the anaesthetic. The methods of administration were almost equally the Clover gas-ether sequence and the chloroform-ether sequence. Spinal anaesthesia and gas-oxygen were not recorded. It is well recognized that though any qualified man may operate only those with special skill and command of technique should be asked to do so save in their absolute absence. Giving anaesthetics is now a highly technical job, requiring command of many methods and instruments and familiarity with many drugs. The "rag and bottle" regime still provides the finest training and will ever be a necessary groundwork on which to build up a specialist technique. This existence of a simple method, more or less, does not mean that anyone can or should be asked to anaesthetize, especially for an emergency operation, if experienced help can be obtained. In the interests of all, save, perhaps, themselves, skilled anaesthetists should be ready to assume emergency duty in hospital as well as in private.