

Anesthesia in the 1950's at Victoria Hospital

Dr. Gordon Sellery, Professor Emeritus

During my reading of old files stored in the back drawers of the department, I came across an interesting letter written by Dr. Charles Drake, our first neurosurgeon, to Dr. Maurice Albin, a pioneer neuroanesthetist at the University of Texas. In it, he described the situation in the OR in the 1950's and the work of Dr. Ron Aitken, our first neuroanesthetist. One should remember that halothane, the first useful non explosive agent, was not on the market until 1956, there were no transducers in clinical practice and mechanical ventilators were not available in the OR. An ECG monitor was also a rarity until the 1970's.

The following is Dr. Drake's letter written in 1993. It gives a perspective on the neuroanesthetist, Dr. Ron Aitken, a member of our department until his death at age 70. The annual Aitken Lecture, that is presented by an invited physician recognized for his expertise in neurological sciences, is named after him.

Dear Maurice,

When I first came back to London in November of 1951, there was little in the way of specialized anesthesia, there being no neuro or cardiac surgery. Some anesthetists were part time in the morning and general practice in the afternoon. Using anesthetists of those days for craniotomy was an experience. Often I had to try to hold the brain in the skull while pleading with the anesthetist to listen to the chest to make sure his tube had not slipped out, kinked or gone in to obstruct a main stem bronchus, or why else was the blood black and the brain swelling out of the craniotomy? As Gillingham once said – "In the early days, anesthetists spent their time pushing the brain out of the head while now they suck it back inside". And they did not like it – it was demanding, sometimes frightening, often prolonged and boring and their income was diminished over doing frequent short easy cases. I was allowed to use the orthopedic OR in the afternoon after Jack Kennedy finished his list. I seldom finished before late evening, even into early morning hours on elective cases! having only general surgical residents as assistants, but they were very bright and good. But it was there I recognized the gift that Ron Aitken had in anesthesia; Jack had noticed it before. In those days one had to call one's anesthetist and I soon tried for Ron for every case. We got along well and he seemed to enjoy the trials of neuroanesthesia. Gradually, we became a team and he became involved in my searches for better ways to deal with aneurysm – especially hypotension in its various forms including moderate hypothermia and deeper levels under c.p. bypass with circulatory arrest, since by that time we had a good pump team.

Using moderate hypotension, I kept asking for deeper and deeper levels and he produced them – gradually, and not without concern but soon 40 MAP was routine near and at the aneurysm and even lower in critical situations. He had an uncanny instinct for the condition of the patient and how far he could go, even better I thought, than the crude measuring instruments we had in those days for intra-arterial pressures. O2 and CO2 electrolytes etc. He could tell me when to quit and I knew I should do so, if I was not committed. But I think even he was sometimes surprised how well the patients came out of it.

Later when modern equipment arrived he became a master with it, but always with his innate sense of the patient as he saw things under the drapes.

Ron had no real “academic bones”. I had to push him to write and for some reason he hated speaking from a rostrum. I think he was surprised that his one or two papers on hypotension became classics and his observation that respiratory changes in deliberate brain stem ischemia with temporary occlusion preceded B.P. or cardiac irregularities, became an issue still debated.

Despite not being a “researcher” he was a superb clinical teacher, patient, practical, with tremendous experience. He seemed to have seen everything and had simple effective approaches to difficult problems.

He was one of the first two or three Canadians who became dedicated to neuro-anesthesia and it was his influence that persuaded the likes of George Varkey, Adrian Gelb, Arthur Lam and Pirjo Manninen to follow on.

With warm best wishes,

Sincerely,

Charles G. Drake, OC, MD, FRCS(C)

This is just one example of how far we have developed as a specialty since I was a medical student in the late 1950's. Our foundations were a bit “shakey” in those days, but with the advent of clinical research we are on a solid footing. By the way, have you all made a donation to the Canadian Anesthesia Research Foundation this year?

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