Wellington Hospital - Anaesthetic Department

Until 1974 there was no secretarial/administration help for the small number of anaesthetists who worked in that department and their only office area consisted of a couple of rooms on the ramp leading to the 210 block. One room was for the Director and contained two desks and shelves for a small collection of medical books; the other room was for use by senior and junior anaesthetic staff and held only a few chairs plus a large notice board. The two rooms were separated by another office which was for the use of the Senior Orthopaedic Surgeon.
This area was close to the main operating theatre suite.
There were also three other operating theatres in use away from this main area, i.e. a theatre near the Children's Wards which was situated next to the Orthopaedic Ward (a very long inconvenient one built in WW2 for American war casualties); an ENT theatre situated on the ground floor of the 210 block; and another one for Eye Surgery, well away from the main hospital complex in an old maternity building further away in Hanson Street, Newtown - the main hospital was and still is, in Riddiford Street.

The current Director of Anaesthesia at that time was a Dr Graham Marshall, who because of the heavy load in theatres (anaesthetists were in short supply) found little time for administration. He asked the Administration Department if they could provide some help as once all anaesthetists were working in theatres during the day there was no one available to take phone calls (some urgently requiring action), attend to Department visitors, plus set up rosters etc.

I had been working as a medical secretary in medical departments there for over 20 years and so had a good knowledge and understanding of medical terminology in various specialties. As I was looking for a change, I was asked if I would like to see Dr Marshall to find out if I could help him in the matter required. I duly fronted up and he was very pleased to "take me on" because at that time he was intending to leave full time employment with the Hospital Board prior to retiring. He said that he was leaving just as soon as another person could be induced to become the new Director but so far this had been a fruitless task as the few anaesthetists available for this task were not keen to take it on. He hoped I could help with the admin work to ease the burden. I knew nothing about the practice of anaesthesia but I happily took up the challenge and started to learn what was required of me.

I knew that I needed to understand as soon as possible what was required when a surgeon needed an anaesthetist - surgical staff needed a contact person to relay their needs to an anaesthetist. At that time 2nd year house surgeons were given three monthly changes of medical duties to help them decide which area they would like to specialise in. Our departmental senior anaesthetists hoped that at least one of these when attached to our specialty would choose to return as a registrar. There had not been many takers in the past but gradually more did apply to study for their FFARACS exams which was a great relief for this area of medicine.

All the Anaesthetic Staff were very supportive in helping me learn their requirements. One in particular was a Dr Arthur Slim who, because his ENT/EYE

lists were never very long, would come in at the end of his lists and tell me how anaesthesia had evolved from the "rag & bottle" days until the present time with the advent of curare for use in paralysing for surgery; he also gave me books to read on the subject. While my initiation was going on Dr Marshall was trying desperately to get one of the senior anaesthetists to take over his position so that he could leave. After a few months he finally persuaded a Dr Bill Cochrane to take up the challenge. Dr Cochrane was a Northern Irishman who had been working in Canada as a very busy anaesthetist and had immigrated to New Zealand where he wished to spend his last ten working years leading a quiet less stressful life. After a lot of pressure from his senior colleagues, he finally agreed to take over this onerous post. He then rushed into my office (it was the one for the Director if he was ever able to use it) and this is what he said - " I've been press ganged into accepting this post but I do not wish to be bothered with the day to day running of this position so if you will agree to do that I will be very much relieved" - so I said yes and became ' IT' - the first Anaesthetic Secretary. He had only to tell me what he wanted and I put that into action. My hours were 8am to 4 pm, the early start was so that I could obtain information about theatre cases of the night before in case there would need to be any changes prior to the 8-30am start of surgery. At that time, shortage of anaesthetists was worsened because if the person on call had been working after midnight they were required to go home and not be available for work that day. This caused a great disruption as a surgical list would need to be cancelled causing upset to theatre nursing staff as well as patient and surgeon, as there would be no spare anaesthetist available to cover.

In the beginning nursing staff at that time were very annoyed about receiving any information coming from me so that Dr Cochrane had to tell the senior theatre nurse that any information coming from me was at his behest so they had to accept this new regime - it happened with the nurses at the ICU as well but gradually it was accepted that I was the one with the orders which came from the Director. At that time there was no senior specific ICU physician and the senior anaesthetist overlooked both areas. Because of that small number of senior anaesthetists, it was difficult to cover extra. emergencies so the senior Anaesthetic registrar attached to the Department (Dr Malcolm Fisher), explained to me how the rosters were to work- he said just make sure there was one registrar or house surgeon plus one senior available every night, because with our small staff load there were barely enough people available to cover this essential time.

After lunch I had to collect from the main theatre the surgical lists required for the following day and insert the name of the anaesthetist for each one- these had to be typed, photocopied and delivered to their respective wards prior to the 3pm nursing change-over.
The house surgeons of the respective surgeon operating the next day had to give this information to the theatre charge nurse before 1.30pm each day. Sometimes I had trouble getting the information on time but gradually this was accepted as the normal routine.

One incident happened which showed how important it had been for me to understand how an anaesthetic was given. Prior to the l970's all administration of

the hospital affairs, including financial, had been made in offices on the Wellington Hospital grounds. After that time all general admin offices were moved into the city and were now situated up on The Terrace. One morning while I was sitting at my desk (in the Director's room) a man appeared at the door and stated he was the Hospital Treasurer and he wished to see the Director. I told him that unfortunately during the day all anaesthetists were in theatres but perhaps I could help him. He wished to discuss our department's salary budget. It seemed to him ridiculously unnecessary to have so many anaesthetists working at the same time and so he felt our staffing ratio should be cut. I politely asked him if he knew what these doctors did in theatre and he said " yes, all they do is give one injection to each patient to put them to
sleep so are then not required to do anything until the next patient was ready for surgery, ie one person could do this job for several theatres thus having a great salary saving as less anaesthetists were needed to be employed "
I politely said I would tell him how an anaesthetic was given and how the anaesthetist was the most important person at an operation- from start to finish they were needed there in the theatre to ensure all was well as they continually administered the right amount of drugs during surgery. I explained elaborately why they had to be there all the time for the sake of the patient's life. He was horrified and said he did not need to know anything else and rapidly disappeared. It was one important time that my presence stopped a man who knew nothing about medicine from assuming a great error because he wanted to slash the hospital budget. When Dr Cochrane came back from theatre at lunchtime I told him the story and he ran around letting all the anaesthetists know how my being there had saved their salaries!

Over the next few years we gradually increased our anaesthetic staff, especially as at that time we had a number of Canadian registrar would-be anaesthetists studying for their higher degree. They came to New Zealand because here they were allowed hands-on training which they were not getting in their home country. They each came for a year then returned home to Canada very happy with their experience received here. By this time we were increasing our own senior staffing ratio once their Australasian degree was achieved because the amount and variety of surgery was increasing therefore needing more and more highly trained anaesthetists.

In this decade a new block, which contained two theatre floors, had been built at WPH but never commissioned. By 1980 it was time to do so and a new obstetric block was built supposedly having a caesarean theatre as well which would require an anaesthetist at varying times- sadly this had been poorly designed in relation to the whereabouts of that theatre so these were having to be done in the surgical theatres.
Our new Anaesthetic Department was on the 6th floor of the so-called Clinical Services Block and consisted of a suite of rooms, vis one room for the director, another for the secretary and a third was a place to hold small meetings, for a library and to be a general relaxation area with tea & coffee facilities available for odd moments in between cases. We had various medical supplier reps visiting the department now as more and more new drugs were being discovered so meetings were set up at a suitable time when our staff were available out of theatre.

An unhappy event occurred in the late l97O's - not in Wellington Hospital but in one of the private ones. Our senior anaesthetists both full & part time gave anaesthetics, outside of WPH. It was a
case of malignant hyperpyrexia which was unable to be reversed so the patient died. There are three different causes for reactions to anaesthesia;
l) the patient takes longer for the drugs to be reversed,
2) a much stronger reaction to the drugs which meant the patient must be tested to see which drug was the cause of this reaction, &
3) if the patient's temperature rises to a dangerous level, strong measures must be immediately put in place to cool them as soon as it is noted.
The last effect was reasonably uncommon at that time. An odd thing happened a month later when a young man with an arm fracture needed an anaesthetic for realignment before plastering. He was asked the usual question, have any of your family had problems with anaesthesia? - he said no & the only person he knew was sick had died recently (presumably not knowing the cause of death of this man). The anaesthetic proceeded when suddenly his temperature started rising. Luckily the anaesthetist who had performed the previous unfortunate case was in the theatre area and recognised what was happening so immediately the cold treatment was applied, therefore saving his life. The young man had had no idea that his uncle had died of this cause. From that time onward there were always enough preparations available in our theatres in case this should happen again.

Because investigating this problem was important, Dr Cressy Free, one of our senior anaesthetists, went to great trouble investigating this family and he found out the particular genetic anomaly would always cause this unfortunate reaction. It was then decided to set up an Anaesthetic Adverse Reaction Clinic so that patients with this predisposition plus others who were having difficulties recovering from anaesthetic drugs could be tested and then advised that they should wear a Medic Alert bracelet indicating the problem drug so that if future visits to a theatre were required, staff would be forewarned.
I used to make these appointments for the patients to come to the department for testing and I had some great conversations trying to persuade them why they should come for the test which would not harm them at all and could save their lives in the future. It was very hard to make some of them understand that if they not do so they could die as some were very reluctant to attend. The medical staff were very amused about the way I went about this but we had about 98% attend - I hoped I had prevented another unfortunate theatre problem.
During the 80's pain management was introduced, another part of an anaesthetist's role if they were interested in this field - the first being Dr Free. The field became larger & so more anaesthetists were required for this specialty.

Gradually many anaesthetists were required for specialised surgery which was increasing, ie heart valves, kidneys etc. so work very much increased for me as now technology was advancing at great speed. As I had reached 40 years in hospital service, having started at the age of I7 years, I took early retirement at the age of 57. I cannot say this for the historical record but I feel how fortunate I was to have had the opportunity to move about areas where today special permission must be given

& most unlikely to be granted to non-theatre personnel, ie., I was able to be inside operating theatres (gowned etc) to watch an anaesthetic being given, witness an operation in progress and the wonderful highlight of being at a Flying Doctor Base in Australia for three weeks with one of my ex anaesthetic registrars who was then Head of the Base who obtained permission for an "old colleague" from WPH to fly with him for retrievals. It was a most amazing experience to see work like that in the Outback.