Lost in the ether: missing perspectives within anaesthesia

Transcription of interview with Dr Penelope Boulton Hewitt

Speakers:

– Clare Gilliam (interviewer)

– Dr Penelope Boulton Hewitt

00:00

CG: *This is Clare Gilliam interviewing Doctor Penelope Boulton Hewitt on 1st November 2021. The location of the interview is the headquarters of the Association of Anaesthetists at 21 Portland Place, London, and I'm interviewing Doctor Hewitt on behalf of the Anaesthesia Heritage Centre, for the project 'Lost in the ether: missing perspectives within anaesthesia'.*

00:24

CG: *So could you just confirm for me your full name and title?*

00:29

PH: It's Doctor Penelope Boulton Hewitt.

00:32

CG: *And what is your current role?*

00:35

PH: I'm retired now. I'm still on the committee of the Medical Society near where I live, the Sutton and District Medical Society.

00:44

CG: *And before you retired, you were...?*

00:46

PH: I was Consultant Anaesthetist at Guy's Hospital. So, it became Guy's and St. Thomas' and it became Guy's, King's and St. Thomas', because... I worked at the neurosurgical unit that used to belong to Guy's, that was in the grounds of the Maudsley Hospital across the road from King's. When they reorganised the London hospitals, they decided to put it into King's rather than Guy's. So I spent a day a week there.

01:13

CG: *Ah. So we're just going to talk a little bit about your early life. In what year were you born?*

01:19

PH: 1938.

01:21

CG: *And where were you born?*

01:23

PH: My favourite reply is the front room upstairs. It was actually in the house where I'm still living, my parents' house, at Sutton- or Cheam, Sutton, Surrey.

01:33

CG: *Right. And you grew up there then presumably?*

01:36

PH: Yes. The local GP who delivered me became my godfather and used to appear every Christmas with a dolly or something to give me [laughs] And yes, after my parents died, I took it on because my elder brother had already married and got his own house. He said he'd like his share of the money, but I could have the house [laughs]. So I stayed there.

02:01

CG: *And can you tell me a bit about your family, your parents? What did they do?*

02:05

PH: My father was director of the Serum Research Institute at Carshalton, which was at that time a Medical Research Council institute. It had originally been set up by the London County Council, they used to run public health laboratories, et cetera, way back in those days. And he supervised the building of it at the beginning of World War Two, and became the Director there. But he hadn't actually got a medical qualification, he originally got a BSc in Chemistry and Physics, First Class Honours, and went on to get a PhD, D. Sc, Fellow of the Royal Institute of Chemists [Chemistry]. And so I think he was

probably quite unusual in that he was director of an institute for the MRC without actually being medically qualified. And my mother was a pharmacist, MPS [Member of the Pharmaceutical Society]. And I think they met when they were both undergraduates. And that was at what was then Battersea Polytechnic, which I think is now Surrey University, it moved down there.

03:20

CG: *And what would you say your family's economic circumstances were when you were growing up?*

03:27

PH: Reasonably comfortable, except, of course, I had an elder brother who was going to Epsom College so needed to pay fees. I went to Sutton High School, which initially was fee paying, but I was lucky enough to get- pass the eleven-plus, which meant that I got the secondary part free. At that time, although it was what was called then the Girls' Public Day School Trust - now called Girls' Day School Trust, it's now entirely private - but at that time, the secondary school part was 50% fee paying and 50% eleven-plus, which was actually a rather nice combination. I thought. Everybody merged together, you didn't sort of say, "Well, they got this" or "They can pay for that", you were all... were the same.

04:15

CG: *And what made you- well, when did you first become interested in medicine?*

04:23

PH: Difficult to say exactly. My big brother, from the age of about five, always wanted to be a doctor, for some reason or other, I don't know why, it was just sort of, "I want to be a doctor". And at school, I enjoyed doing the science subjects. I would say botanizing was my favourite occupation but I thought that botanizing was a sort of rather Victorian occupation rather than something useful and I wanted to do something useful. And I thought "Well if my brother can do medicine, I can do it. I'm just as bright as he is. I can pass the exams. If he can do it, I can".

04:55

CG: *Right. So where did you study medicine?*

04:58

PH: Guy's Hospital.

05:00

CG: *And what year did you start there?*

05:01

PH: I started in 1956. And I remember saying to my father - it sounded an awful long time, the medical course - and I said, "If I get exemption from first MB [Bachelor of Medicine] by getting all my four A-levels, and pass everything first go, I can qualify when I'm 22". And he sort of laughed and said, "If you do that, I'll buy you a car". Of course I did, so I sort of diplomatically reminded him what he'd said! [laughs]. And we came to a compromise. He paid the down payment on a hire purchase, and I paid the interest over the next three years. The only time I've ever borrowed any money, I think, apart from a mortgage [laughs].

05:46

CG: *So you did your training in four years? No...*

05:47

PH: Four years and- well, it was four years and two terms, really, because... I think we were very lucky at Guy's, we had a wonderful chap called Mr. Wallace who was the secretary to the medical school. And he just knew everything about what the students did, and how to get through things and little tips. And he said, "If you take the Conjoint Board exams, that's the Licentiate of the Royal College of Physicians and Member of the Royal College of Surgeons, it's quite helpful because you can do it in bits. So you can add them on, sort of over your sort of last year at medical school. And if you pass them all first go, you can actually qualify in March, whereas the MB doesn't finish until May. So it's good practice, it makes you revise, and you might even qualify a couple of months early". And I did. My dad got some of my fees back! [laughs]

06:44

CG: *Oh! [laughs]. So tell me about your experience of medical school.*

06:51

PH: It was alright, actually. I, erm... It was a bit intimidating to start with, thinking of what it was going to be like, because I'd been at the same school from the age of five to the age of eighteen. And suddenly travelling up to London, and having a completely new set of people that you didn't know at all, you didn't quite know what you were taking on. But it was the first year, I think they had sort of about 20 females in the year of 100 people, whereas my brother had been there five years before me, there were only sort of three or four, three or four- handful of girls in his year. So they looked very much surrounded. But we had a reasonable sized lump of the females there. I didn't notice because - you're particularly looking at the female aspect - the day I went for my medical school interview they were just purely interviewing female candidates. They'd obviously got them on a separate day from the men. And I have a feeling it was

probably because they thought if they were interviewing women, they ought to have a female on the interviewing committee, and as far as I could work out, they only had one female member of staff at Guy's Hospital, and that was a consultant venereologist who'd been appointed by London County Council rather than appointed by the hospital, but did a clinic actually in the hospital. So she probably had to turn out every time there were women on the interview list! [laughter]

08:28

CG: *In what ways do you think your experience of medical school was different to that of your male colleagues?*

08:40

PH: Not really very different. We probably didn't spend quite as much time in the bar. But we had the same access to everything and were treated the same way. We actually- when we were living-in, to do on-call, there was a building around the corner, above psychiatric outpatients, where we had our sleeping-in rooms. Whereas they were, I think, in rooms above the outpatients. So we were in a separate building then, but we did exactly the same duties, et cetera. The only thing I remember that was a little bit different was when we were on the surgical emergency admissions duty, which we actually lived-in for a week, Medical School I think had been given some endowment or other and they gave us some money to spend on catering for the week. And the idea was that in between emergencies, we would produce a meal and all the duty surgical team would come and eat this meal cooked by the students. And of course, if there were a couple of women students on, they were doing the shopping and the cooking, and we sort of said, "Hang on a moment. We're all supposed to be equal, let's make sure the men do it the next night." Big mistake, they spent practically all the money on one night's meal instead of spreading it out over the week! [laughs]. It was quite a good meal, we made our point, but they got their own back on us! [laughs]. So that was the sort of little thing, but there wasn't any real sort of discrimination or different...

10:12

CG: *Yeah, that's what I was going to ask you, did you experience any kind of discrimination?*

10:16

PH: I really can't remember any kind of discrimination, no.

10:21

CG: *That's good. So you graduated from medical school after four years, two terms. At what point did you decide to become an anaesthetist?*

10:33

PH: Good question. Strangely, I'm one of the- one of the things I did as a kid was- I was made a member of the local golf club at the age of 15. Because we actually lived right on the edge of the golf course, it was as near the first tee as the clubhouse was. I'm not quite sure why I was given that as my 15th birthday present. I don't remember ever expressing any interest in it. But I used to walk round the golf course when my parents were playing. They took it up during the war, because living there, they thought, "Well we're crazy, holidays are difficult, life's stressful, we've got this facility right on our doorstep, why don't we go and play?" and they just, the two of them, used to go out and play together. They didn't join matches, or even bother to get handicaps or anything. And I used to sometimes walk round with them, but I spent the whole time looking to see if there are any sort of wild orchids growing in the rough or anything, rather than finding their golf balls. So it may have been that they wanted me to be converted to finding their golf balls rather than botanizing. Or it may have been because they thought that a lot of- most doctors played golf. In fact, I seem to remember my father sort of saying all the doctors he knew either seemed to go sailing or play golf. And he really thought that golf was probably the better bet [laughs]. And in fact, it- playing golf was a very nice thing to do as a student and as a junior doctor and as a consultant, because it was something that the men particularly did and it was something I could do with them, without sort of invading their space.

12:12

CG: *So you became interested in becoming an anaesthetist through meeting anaesthetists?*

12:18

PH: Ah, now I remember why I started that story. There happened to be- one of the ladies who belonged to the golf club that I played with, happened to be the aunt of an anaesthetist. So I did actually hear about anaesthetists before I went to medical school. And strangely enough when we got into the clinical years, and you'd spend sort of three-month blocks attached to different specialties during your clinical years as a student, when I did my anaesthetics, one of the anaesthetists I was down to work with was Doctor Raymond Vale, who was the nephew of this lady. And he was one of the more junior consultants at the time. He was a very nice, friendly chap. He was- I think he was quite good academically, he used to do reviews for journals and he did continue to read the journals and keep himself up to date, and so on. So he was a good teacher. And he used to get me involved in actually doing hands-on things. And, you know, having in my school days tended to do sort of go to the lab with my father at the weekends and learned how to subculture bacteria at the age of about 12 and blow- do glassblowing and that sort of thing [laughs], it wouldn't be allowed nowadays I imagine! But at that time, I thought, "I don't just like the theory, I like being able to do something", and doing anaesthetics, clinically as a student, you actually had the best

of both worlds, I felt, because you had to apply your knowledge, but you actually did hands-on stuff. And you stayed with a patient until they came round and got better. If you were a physician, you went to outpatients and you told a patient what to do and wrote to their doctor. You didn't really know whether they were going to do it when they went home. You just hoped when they came back to follow-up six months later, they'd look a bit better, having taken the tablets or whatever. Whereas in anaesthetics, you could actually do it, and see it happening. It was more scientific, you know, you could give them something, see how it's working, give a bit more or take it back, and it was...

14:36

CG: *Sounds more satisfying?*

14:36

PH: It was more like science and it was more hands-on, more satisfaction to it than a lot of the specialties.

14:43

CG: *So when you'd finished at medical school, how many years- I know now it would be two years of foundation training, is that right? Was it the same then?*

14:52

PH: It's- it changed quite significantly during the course of my time as a consultant. When I first qualified you had to do six months surgery, six months medicine. Then you could start doing something specialised. After I'd done my two six months, which they called pre-registration at that time, then you get put on the medical registrar- register, if you've done that alright. The first job that came up that sounded interesting for someone at that stage was actually a job working with children, medical job at the Evelina Children's Hospital. And I thought, yeah, I wanted to do anaesthetics but I thought it would be quite nice to spend six months doing- looking after children first, because if you land up anaesthetising children, it could be quite nice.

15:44

CG: *Can you just tell me the name of the hospital again?*

15:46

PH: The Evelina Children's Hospital. It was attached to Guy's at the time, it's now amalgamated into St. Thomas'. And there's Guy's and Thomas' are merged, it's all part of the same set-up. It means it's in a different building. It was a little Victorian hospital that you had to walk to, down the road. And anyway, the interview for the children's job came up a week or two before the interview for the anaesthetics job, which was

my sort of number one interest. But luckily for me, the chap who was the hospital medical director at the time was a chap who had been- or had been, yes, before that he had been the head of the anaesthetic department. So I thought, "Well, I'll go and talk to him". So I made an appointment and went to talk to him. And I said, "Look, I'm in this position. I've got this interview coming up. But I really want to do this that comes up two weeks later. What should I do? Because I don't want to mess people around". He said, "Well go to the interview for the children's job. And when they ask you, 'What do you want to do in the long term?' just say to them, 'I'd like to do anaesthetics' and they will then know". And in fact, there was another person applying for the paediatric job, whose long-term career turned out to be a very highly respected paediatrician. He got the job, but I got the anaesthetic job.

17:10

CG: *Well, that turned out well then.*

17:11

PH: And it probably served me quite well. Because if you go to the children's job and say you want to anaesthetics, they really believe you. If you go to the anaesthetics job and say you want to do anaesthetics, they think- they might just think you're shooting a line [laughter].

17:25

PH: I went to become resident anaesthetist at Guy's. I did a year- a year's job there. And during that I did the diploma in anaesthetics, which... it doesn't really con- it doesn't give you the status of a consultant anaesthetist, it's the sort of thing that people do if they're perhaps going to become a general practitioner, but help out in the local anaesthetic department so...

17:50

CG: *I see.*

17:50

PH: It's a diploma, not a full Fellowship. And I don't think the bosses knew I'd done it because I actually did it when I was on a fortnight's holiday. And when it came to the end of the year, the head of department said- he had me into his office and said, "Well, what are you going to do now?" So reading between the lines, I thought, "Oh, he's obviously not going to offer me the one job up, the registrar-", which was at that time, the registrar post, and the- sort of the blue-eyed boys tended to get promoted within the department. I thought, "Oh. Hmm. I thought I'd done OK". But then I sort of thought, "Well, they're not- they're just not really used to women being promoted. They think you're going to sort of get married and give it up, and maybe do part-time clinics or go in for something a bit more nine-to-five than anaesthetics". But again, like several of

these things, it actually worked out to my advantage, because I sort of went home, went through the advertisements in the journals for registrar jobs in anaesthetics. And it had been a very busy job at Guy's, you had everything chucked at you, pretty well. And I thought, "Well, really, the only things I haven't done a lot of is anaesthetics for chest and heart surgery or brain surgery". So I applied for a job at the London Chest Hospital, the National Heart Hospital and the National Hospital for Nervous Diseases. And I got the job at the National Hospital for Nervous Diseases.

19:43

PH: So, I went across the river to Queen Square, lived-in there, and it was a completely different sort of set-up, a completely different set of people, all the other residents were neurologists or neurosurgeons except for one pathologist. So I was the only sort of anaesthetist on the premises, kind of thing. And it was one of the places- it had a unit called the Batten Unit, it was- which you would now call an intensive care unit, I suppose, or respiratory care unit. And it was specialised, because they'd have people like someone who'd got polio when they were out in Africa and needed to be on an- attached to an iron lung, breathing support, that sort of thing. So they were- tended to be longer term intensive care than the sort-of post-surgery intensive care that most of the general hospitals have. So you saw a lot of specialised neurological and neurosurgical patients, and you were an integral part of their treatment, if they were critically ill on the breathing side. And back in those days, there wasn't nearly the same amount of monitoring of vital functions and so on as the- as there is nowadays. So, one of the few ways you could assess whether someone's breathing was going off, you could do- look at them clinically, and listen to their chest and so forth. But they- there was a special bag that you got them to breathe in and out of, and then you took it back to the little laboratory, behind the intensive care unit, respiratory unit, and you used to measure the amount of carbon dioxide in there. And if it was building up and building up, you knew they needed a breathing machine of some sort to help them. And when they were attached to the breathing machine, there wasn't the sort of monitoring you get nowadays, you just- you had to just do the traditional feeling the pulse, taking the blood pressure, listening to the chest.

21:30

CG: *Mm. So no little bleeps and flashing lights...*

21:33

PH: No bleeps, no monitoring devices, no- nothing that tells you how much oxygen, carbon dioxide going in and out, nothing that can do the heartbeat. But during the time I was there, they actually bought a pH meter for measuring the acidity of the blood. So we were involved in setting that up, where we could actually measure whether someone's acid base balance in their blood was being maintained satisfactorily. So it was the beginning of getting things measured.

22:05

CG: *Yes. Yes. Do you think it made a lot of difference to lives being saved when things were monitored in a more scientific way?*

22:15

PH: I think probably the most important thing was which nurses were on duty. At one time, we had a lady who was a- on a- in an iron lung, who was a doctor's wife. And this is why I referred to polio out in Africa, she'd- her husband was stationed out in Africa and she got polio out there. And at night time, if there were certain nurses on, she made sure she stayed awake and if she saw anything she- that looked dodgy going on in the ward, she'd press the emergency button. So that would be- have to leap out of bed and come running over to the unit to see what was happening. Like the nurse dropping off to sleep or something [laughter]. Things could be a bit primitive at times. Others were excellent. But every so often there was a- something like that.

23:03

CG: *Yes. So just looking back, what was your experience of anaesthetist training generally? Was it a positive experience?*

23:15

PH: I think 'experience' rather than 'training' [laughs] probably was the word at that time. In more recent times, the training element of it has increased and the experience has decreased. And there's a nice balance to be had between the two. That's what one has to sort of aim at.

23:42

CG: *Yes. So your experience of being an anaesthetist, would you say on the whole has been a positive experience?*

23:50

PH Oh, yes. Rather, yes. Yep.

23:54

CG: *Why?*

23:57

PH: It enabled me to do the sort of things I wanted to do and feel useful.

24:00

CG: *Yes*

24:01

PH: And I think I achieved a reasonable standard. And after I became a consultant, I did become the tutor in anaesthetics, so I was able to help push things more towards making sure that during their first three months people were entirely supervised, so they knew exactly what they were doing, you're checking the equipment and making sure it was safe. They were going to see the patients beforehand so they knew what they were letting themselves in for. They monitored the patients during it, they saw they were properly recovered afterwards and followed them up. They went round the different sub-specialties in an organised fashion, so they hadn't landed up missing out on anything. They'd nearly all had time to do a project and write up a paper, so they knew how to look into something academically. So experienced all- anything specialist or didn't land up getting wasted.

25:04

CG: *Yes. Did you experience any barriers or discrimination during those years, due to being a woman?*

25:14

PH: I think as I alluded to before, I think probably getting promoted got delayed a bit. Because they weren't- they just weren't used to the idea. And I think some of the really nice gentlemanly chaps really thought they ought to be looking after you, rather than setting you off to do very responsible things. In the training at that time, you did the first year where you were definitely resident, then you became a registrar, where you were- some places resident, some places weren't. I in fact landed up being resident because I thought coming- rushing in at home if someone needed an emergency caesarean section or something really wasn't on. And as a senior registrar, whether you lived in or not depended on what you were- what you were covering. But... I'd landed up- when I got to senior registrar stage, I landed up being four years of senior registrar, which is really a sort of full whack. And I'd applied for some consultant jobs. Someone I- in the department I'd known for years, who was trained there before me, sort of said "Oh there's a job coming up at St. Helier Hospital in Sutton", which is near where I live. And I rather wanted to be in a teaching hospital because I like teaching. I like the academic side. So I wasn't interested in that. So I applied to St Bartholomew's, I applied at the Westminster, I applied at Oxford. And I sort of did all right at the interviews, but the jobs always went to the local chap, who was doing all right anyway, and they knew him and so... So, the head of department said, "Do you want to go to America for a year? I could probably fix something up". "Not particularly, I want to get a consultant job" [laughs]. Or, "Do you want to go to this hospital for women? Or up to Sheffield?" where one of their previous chaps had got a job. "Well, no, I really want to be in London". But, bless his heart, he helped me get soft money for a year to do a research year, and I got

a technician. During the course of that year, they appointed a senior lecturer, which is the first time we'd had an academic in the department. So the department was beginning to move from being a purely clinical one to one with an academic side.

27:42
CG: *Mm. Were there many women doing research at that point?*

27:45
PH: I don't actually know of any others at the time [laughs]. I am sure there were, in the- somewhere in the hospital, but no one that I directly knew about. But there were things I wanted to look at. We looked after a lot of post-operative patients who'd had heart surgery. And I wanted to know whether the level of ventilation and the level of gases in their blood, whether that affected the cardiac output, the pumping, how much blood has been pumped out of the heart at each beat. So in the intensive care unit, you could you do that without messing up the patient. You know, you had to get their consent beforehand that you were going to study them. But you weren't doing them any harm, and you were benefiting the knowledge, so that needed doing.

28:36
CG: *So did you publish your research?*

28:38
PH: Yep. That went into the *British Journal of Anaesthesia*. I did some psychological studies on the nurses doing the Intensive Care Nursing course which had been newly set up about that time, using Eysenck Personality Inventories got from the Maudsley Hospital, and presented that to a faculty or college symposium. And I did a follow-up of intensive care patients to see what they remembered of being in intensive care and which things really- they found most stressful and worrying, and that went into the *British Medical Journal*. So yes, it was productive. And erm...

29:29
CG: *Were there many women published in the Medical Journal?*

29:32
PH: I really don't know.

29:35
CG: *No.*

29:35
PH: I don't think there was any sex bias! [laughs]

29:40

CG: *Did you have, at that time, did you have any female role models?*

29:45

PH: Erm... not very specifically. I was quite surprised. when I went to do the Diploma in Anaesthetics, I wasn't really used to other females doing anaesthetics, and I was quite surprised that there was a significant number of- proportion of people were female that were doing the diploma. Maybe because they were only going that far in anaesthetics and not going on to be a full-time specialist. As a trainee there didn't... there weren't really any females I knew that were in more senior roles. The only female anaesthetist I'd heard of was one of the- a consultant at Great Ormond Street who anaesthetised Princess Elizabeth and Princess Margaret to have their tonsils out. So she'd been in the papers for doing that so-

30:34

CG: *Oh yes? So what was her name?*

30:35

PH: I wish I could remember! [laughs]. I'll remember it when I'm not trying to think of it, do you know what it's like? So... oh, Sheila Anderson. Sheila Anderson. Yep. So, there was her and then later on people like Aileen Adams became Dean of the Faculty of Anaesthetists. And I can't remember exactly when that was, which- oh, that was- that must have been quite a bit later on because I remember when that- when I was- became an examiner for the Fellowship, she was actually the person that sort of handed me the certificate or whatever it was-

30:44

CG: *Yes.*

31:16

PH: -at the ceremony. So that was later.

31:18

CG: *Right. So what- approximately what year was that, do you think?*

31:22

PH: 1980s? I became an examiner... er... 1986. So I'd been a consultant for 13 years. So, I think I was the first female consultant in any specialty appointed at Guy's, apart from this lady who'd been taken on from the LCC and er... because the head of department invited me around to dinner at his house and he said, "I think we've got the female- first

female consultant. You won't let me down, will you old thing?" [laughs]. He was a nice chap.

32:01

CG: *What qualities do you feel women anaesthetists bring to the specialty?*

32:08

PH: They're probably quite good at getting on with surgeons rather than having rows with them. I think a lot of women are a bit more used to multitasking than men are. So they're keeping an eye on the patient and the surgeon and the anaesthetic machine, at the same time as teaching the student or their trainee. But that may be- that may be personal bias, thinking that, but I think they're quite good at the sort of pre- and post-op chatting to the patients, and doing the pain work and the intensive care work, which is really a couple of, like, sub-specialties that have grown up during my time in anaesthetics. They didn't really exist when I started. It was really, when I started, it was purely general anaesthetics, and that was it. And then we landed up doing a lot more in the way of local anaesthetic blocks. I mean, I was put in charge of obstetric anaesthetics, so I had to do epidurals on women in labour and teach the trainees how to do them, how to care for them, teach the midwives how to look after them, what to look out for, when you need to know to come back and sort something out. And intensive care, I suppose- actually intensive care, probably the very, very first intimation of it was when I was... when I was a medical student, because one of my surgical three months was with the thoracic surgical team.

33:41

PH: And I do remember, a patient was getting breathing problems after a chest operation. And there was a lovely chap called Andrew Thornton who became the- he went out to Hong Kong and he came back as the professor in Sheffield, but he was doing a year's lectureship in the Department of Physiology. And he was the one that did a lot of breathing tests and pH tests. And I remember him wheeling a lung ventilator out from the operating theatre into the ward. So this patient who wasn't breathing very well, alone, out of theatres and post-op, was attached to a lung ventilator. And then in 1961, the year I qualified, they had a new block open at Guy's, called New Guy's House, and they actually had a recovery area attached to the operating theatres. And by the time I came back as resident anaesthetist in 1962, they had started looking after some of the heart surgery patients in there overnight, so that was like intensive care. And by the time I came back at registrar- senior registrar level, they'd converted the ward just above theatres into a surgical intensive care unit, And a bit later they made a medical one over in the medical block as well. So that all sort of grew up during the course of my professional lifetime.

35:17

CG: *Yeah.*

35:21

CG: *So we've talked about the strengths and qualities that women bring to the- well in particular to the operating theatre. How well do you think women are represented in the specialty now?*

35:35

PH: I don't know the statistics, I'm afraid.

35:38

CG: *No.*

35:38

PH: And I have a suspicion that it depends a bit where you look, because I think some of the women who got married and had families fairly early on thought they didn't want to be too competitive in teaching hospitals and tended to work out more in the country or suburban areas. But then all these things have swings and roundabouts, because I know some particularly bright very capable anaesthetists of the female of the species, with families, who once the families were growing up, they then became medical director or chairman of medical committee or had these big administrative roles and went on to the college council and things, because they'd got something in reserve that they could use.

36:31

CG: *Yes.*

36:33

PH: But I mean, on the whole, the medical schools have got just as many if not more women than men. Certainly in the dental school, they were having more women than men in the dental school. I'm not sure what the medical figures are now, I've been retired 20 years, so I'm not up to date... [laughs] You'll have to ask some of the younger ones exactly what the situation is now. But erm...

36:48

CG: *One of my questions was- again, it might not be something you can answer now. But just looking back instead, to when you were practising, were women well represented in the field of scientific research? And I think you've already answered that question by saying they really weren't, that you weren't aware of many women- ?*

37:12

PH: Oh, well, yes it- I mean, you went to the Anaesthetic Research Society, and you would see a reasonable sprinkling of women there. But, when did I join that? I can't remember. Oh, it must have been after my research year, I suppose. Yes, there were a sprinkling of them, but I don't know what proportion of all the departments were female, so as- if it was something like 20%, and then only sort of 20% of the 20% did research, there weren't going to be an awful- an awful lot. I think... I think in a way, this benefited me because - that women did go things- through things more slowly and have more time - because there were some quite bright chaps in the department who wanted to get their Fellowship, do a year or two as a senior registrar and get a consultant job, so they go straight into it at quite an early age. And then it would be rather samey from then on. But having done a bit longer, seen more specialised stuff, doing a year's research, it meant that you were much more equipped for doing research studies later on, it gave you the confidence to do it.

38:27

PH: I'm- one of the things- one of my- when I'd been to Queen Square, I then went to St. Mary's Hospital in Paddington, and they had started doing kidney transplants, one of the early places to do that. So I learned how to give anaesthetics for kidney transplants, and it obviously has quite a implication for anaesthetics, because a lot of the drugs we use are excreted through the kidneys. If you haven't got functioning kidneys, the stuff's going to build up in the body and not going to wear off or get reversed. And when I got back to Guy's, they were just about to start kidney transplant. And so I was the automatic expert, because I'd already done some at St Mary's. So I had to lecture the department on it and tell them about it. And then I discovered that at Guy's, the patients with kidney failure, renal failure, were treated with haemodialysis, the blood going round the machine and- rather than peritoneal dialysis where it's just a needle stuck in the tummy and done with clear fluid. And the patients landed up being in a lot better shape, their sort of biochemistry in their blood and so on was better. So in many ways, it was easier.

39:44

PH: And new drugs were beginning to come out, including some drugs for relaxing the muscles, which had always been a problem previously. And a new drug came out called pancuronium. And Organon was producing it. And you read the- all the pages of blurb they put out about these things and it said, "Caution in patients with renal problems". And I thought, "They're not being very specific there". So I got on to their research academic unit and sort of said, you know, "I'm anaesthetising patients with no kidneys. Can you tell me any more about this business of caution with renal failure?" and before I knew it, half of Organon descended on me, saying, "Are you going to have a look at this?" Because evidently the only way they could study what happened to pancuronium, as far as breaking down and excreting it from the body, was by radioactive labelling of it, which you could do in animals, but you weren't allowed to do in people. So they actually didn't really know what happened to it in people. So, with

these patients with no kidneys, that were having sort of preliminary things done before they had transplants, I was able to sort of say, "Right, get me a peripheral nerve stimulator on the monitoring machine so I can measure what's happening to the neuromuscular block, and I can give this drug to them, and make sure it's worn off properly before I ask them to start breathing again". And they were thrilled to bits, because we could really find out what was- what was happening.

41:24
CG: *Yeah.*

41:25
PH: Anaesthetics is good like that. Because you are actually, nowadays, you're always monitoring everything, the heartbeat, the blood pressure, the gases going in and out, et cetera, et cetera.

41:34
CG: *Right.*

41:35
PH: So you can really study what's happening. And the other thing, having spent a year at the National Hospital for Nervous Diseases, as soon as I got back to Guy's they said, "Right, do the Fridays with Mr. Murray Falconer, he hasn't got a consultant attached to his list and it's time he was looked after properly". And he was a specialist in surgery for epilepsy. And it meant that it was even more specialised than most brain surgery because when they opened up the skull to treat the patient's epilepsy, by finding the bit that was the problem and taking it out, they actually attached an electrocorticogram to their brain so they could record all the brainwaves to find out where the abnormal rhythm was coming from. And of course, as they were recording the brainwaves, this is all linked to the depth of anaesthetics and whether things are- anaesthetics are affecting the brainwaves and the depth of anaesthesia. So that was another- a nice little thing that you could record without messing anyone around, because it was being monitored anyway as part of their treatment.

42:44
CG: *Yeah.*

42:44
PH: I probably wouldn't have done any of that if I hadn't been such a long time in the more junior grades.

42:48

CG: *Yeah.*

42:49

PH: So, in the long term, it made what I did later a lot more interesting.

42:55

CG: *Yes. It sounds like you had a very broad experience, well a broad experience of a lot of specialist-*

43:01

PH: Yes. When I became president of the anaesthetic section of the Royal Society of Medicine, you had to do a presidential address. So I called it 'Jack of all Trades', because when I became a consultant, I was appointed to be in charge of obstetric anaesthetics, but I still did the neurosurgery, the brain surgery stuff, and I still did the cardiac surgery because I enjoyed doing that [laughs]. And I had to do some dental sessions because everybody at Guy's did dental sessions, because it was a dental school. So, I was doing pandoodle everything.

43:31

CG: *Which-*

43:31

PH: And it- the funny thing-

43:32

CG: *Sorry-*

43:33

PH: Just a funny story really, the- there was a lady, actually, was becoming the President of the Section of Surgery that year, Averil Mansfield, who was a cardiovascular surgeon at St. Mary's. And she called her presidential address 'Jack of all Trades'. And when we each saw the programme for the year, we thought, "They've got them muddled, given her title to me, my title to her" [laughs]. And so we spoke to each other. She had called hers 'Jack of all Trades', because her husband was called Jack. So as she's said it was a nice- that was a nice little link. And her real theme was that if you're going to become a specialist surgeon, you needed to do the general surgical Fellowship before you went into the subspecialty. So you must do general surgery because then you become the vascular surgeon or the orthopaedic surgeon or the brain surgeon or whatever. So we went to each other's presidential addresses, had dinner with each other to celebrate [laughter].

44:38

CG: *When you- you were talking about going back to Guy's and saying, "Right, we need to do this and we need to do that", was your- the experiences that you had had, were they recognised by your male colleagues?*

44:49

PH: Ah, well, I think I said during the course of my research year, they appointed a senior lecturer in anaesthetics. It was the first time we'd had an academic in the department. And a few years later, he decided he wanted to up and out and go to Australia. So that left a gap in the department and they thought, "Well, rather than appointing another senior lecturer, what we should really do is get a professor, and then we'll have a proper academic department", because with a professor, you get a senior lecturer, a lecturer, a technician, a laboratory, the full setup. So we appointed a professor, and he became the Regional Advisor for the South East region, it was the first time the College had set up regional advisors. And when they set up regional advisors, they then appointed a tutor in anaesthetics in each of the teaching centres. And knowing what I'd done, I was chosen to be the tutor, with the agreement of the clinical head of department as well, they both agreed that I'd be the one to do it. So that meant that we had a good base, you know, we had a supportive chairman of the department, a professor and a tutor, all of whom wanted to make sure that the trainees got a proper basis of academic as well as clinical training, a proper level of supervision and a proper progression through all the different specialised work.

46:28

PH: And then we set up rotations round the region, so that people- it was the same time the College was moving things forward as well. And they were dividing the postgraduate training into general professional training for the first three years, and higher professional training once people had got their Fellowship exam. So the first three years, we would have people spend their first year in the teaching hospital, so they could get a really good academic and theoretical grounding. They would then spend a year out in one of the District General Hospitals in the region, where they would get a whole load of the general work that gets chucked at everybody, you know, it has to be waded through, you know, appendixes, appendixes and fractured femurs and all the rest of the general workload that goes to all the hospitals up and down the country. Then they'd come back for the third year in the teaching hospitals, so they could then go round all the more specialised work, chests, hearts, kidney transplants, neurosurgery, et cetera, et cetera, and take their Fellowship exam. And then we would try and make sure they went to a different centre for their higher professional training, to make sure not only were they moving round the different specialties, they went to a different place, because you meet different people, have slightly different setups, different ways of running things, and you learn a lot by just working in- stepping into a different environment.

48:00

CG: *Yes. So it sounds like your experience of being a woman within the specialty was a positive one?*

48:09

PH: I think it was, yes. You know, at times you sort of felt you were being a bit held back. But then actually, it's a good thing because it's meant I've done this or I've done that or done the other. It's worked out well.

48:20

CG: *And how did patients respond to you as a woman anaesthetist? Any particular responses from patients? Were they surprised?*

48:28

PH: On the whole, I don't think so, no. I mean the only time I seem to remember really surprising a patient's relative was when I- back, all the way back when I was a House Physician, and I was in the office. This was at Lewisham General Hospital, which was a big, busy, very busy, general hospital at the time. It's now labelled as a University Hospital, but it's very much a district, busy, busy, busy. And I was in the sister's office on the medical ward, writing up some notes or something, when a patient's relative came in rather aggressively and, you know, "What's happening?" And so I looked up and he said, "Who are you anyway?" I said, " I'm Doctor Hewitt, I'm the House Physician". And he sort of stood to attention. "Oh, sorry doctor". He had thought- he thought that someone sort of sitting down in the office writing wasn't a doctor, it didn't sort of occur to him, and I had a feeling that if I'd been a male with a white coat, it probably would have occurred to him. But on the whole the patients didn't seem to- didn't seem to mind it either way.

49:30

CG: *Perhaps they looked on it positively?*

49:31

PH: Probably some of the female patients particularly did. I remember one male patient that I gave a shock to, because he was a- he was a chap from sort of a Middle Eastern background, who'd had heart surgery, and he got intractable hiccups. They just couldn't cure it. They just couldn't. They tried all the little tricks you have in the book to try and stop people having hiccups. And eventually they thought "These are so bad, I wonder if they're affecting his blood gases, you know, his oxygen and carbon dioxide. We'd better get the anaesthetic registrar on duty to come and take an arterial blood sample to see whether the blood tests all right". And as he'd had heart surgery, he'd

already had that artery there stabbed and this one cannulated. So I came up and I said, "I'm happy to take a sample from the femoral artery down here, in the thigh". And this male from the Middle East, when he had the big needle stuck in his groin by a female, immediately stopped hiccupping and never hiccupped again! [laughs]. It was very funny. I'm not sure he thought it was funny, but it worked.

49:38

CG: *It worked.*

49:39

PH: But no, they didn't, they didn't seem to mind. And in theatres - you've made me think about it, because I really sort of just got on with it at the time, but it was interesting because the nursing staff are mainly female, not entirely. And some of them you felt you got on really well with, because you were female and so were they, so you had this sort of similar outlook. And some of them, they sort of thought "Hmm, you know, she should be a nurse like us, not a doctor",

51:21

CG: *Really?*

51:22

PH: You- they didn't actually say that, but you sort of "Hmm", you know, they weren't quite sure.

51:28

CG: *I wondered whether any patients ever assumed you were a nurse. I mean, you told that story about somebody assuming you worked in an office-*

51:38

PH: I don't particularly remember that happening. I tell- the only one that- the only person that thought I was a nurse was the son of a school friend, because my mum was doing the shopping sort of locally and ran into a girl that had been in my former school, with her small boy aged about five or so I think- I should think, sort of primary school age. And Margaret said, "Oh, what's Penny doing now?" "Oh, she's a doctor, she's working at..." And the little boy piped up and said, "You mean nurse?" [laughter]

52:11

PH: Yes, well, we had a male nurse in charge of the operating theatres at the Neurosurgical Unit and he was brilliant. I think he'd learned it in the Army and everything was brilliantly organised, absolutely so- just so, you weren't going to cross him, he was very much in charge. Oh, the other- the other rather nice thing, in charge of the- this block of eight

theatres at Guy's, when I... can't remember, yes, I think it was when I'd come back as a senior registrar. The lady, the sister in charge, was someone we found quite formidable. She was nice, but she was, you know, you weren't going to cross her, she- everything was done here, there, move. You know. it was all organised. No messing around and no sloppiness. And evidently, one day a male medical student went and said to her, "I don't know where to go to do my anaesthetics. Doctor So and So isn't here, or his list's been cancelled", or something. And she said, "Oh, I don't think Doctor Hewitt's got anyone with her, you go..." "Oh," said the student, "She's a female anaesthetist, I'm not sure I can". "Go on," she said, "you'll learn just as much from her as from any of the men". And I thought- and that really made me feel good because she was someone that everybody looked up to, you know, she really ran this place meticulously. And I thought if she thinks I'm alright, I must be [laughs], really, to earn her respect, I thought was quite something. So... and the intensive care staff. I used to mix and match with them because sometimes the nursing staff on intensive care were really really busy at night time and they hadn't really got any leeway. And you- you can't leave an intensive care patient. You have to have someone next to them the whole time. And then you only got to [break?] so I said, "Oh, go on, you go and have a cuppa. I'll stay here for a bit". And you did that for them, and if they weren't too quiet in the morning, they'd bring you a boiled egg in bed because you were in the room just outside the ward.

54:13

CG: *Right.*

54:13

PH: And they'd bring you a birthday card when it's your birthday. Because, you know, you were working with them and helping them with the physiotherapy and that sort of thing. So most of them were fairly good to work with.

54:25

CG: *Good. Yeah. So just kind of summing up now. Can you tell me what was the highlight of your career?*

54:36

PH: Oooh, several things. I think... I think the things we did in Europe with the European Academy were probably quite good, because we set up an exam programme to work throughout Europe. Had to examine in French as well as English, which was quite a challenge. You had to do it in two languages, I mean French was the one I obviously did because I did O-level French at school. And Assistant Editor of the journal, the *European Journal [of Anaesthesiology]*. So that those were important things. And also getting postgraduates coming over from Thailand to do their Fellowship in this country, and I found them very good to work with because the- they had a scholarship, they

could get a scholarship from the King of Thailand that would fund them. And they would come over here for a full two years, and do their Fellowship. And so they were the- they were the bright ones, whereas quite a few of the overseas people you- that came over you feel- I think they'd come over because they weren't getting promoted in their own places. Whereas these ones, they then went back, and they became the ones that taught their junior colleagues. And they got me over to Bangkok to run a three-day programme on epidurals and obstetrics. And a lot of the sort of postgraduate training things, it's the sort of fairly junior people come, or the ones that are struggling. But when I did that, I found the people they had sent were the senior ones from each of the hospitals throughout the country. They were the ones that came to Bangkok to come to this course. And they were then going to go home to their own hospitals and spread the knowledge. And I thought, well, that's really how postgraduate teaching should be. It shouldn't be just mopping up the strays, it should be getting- making sure that everybody has this core sort of knowledge and spreads it around.

56:44
CG: *Yes.*

56:44
PH: And the other European thing that I discovered, through being on this European Academy, which the prof had got me into, was the French had set up a thing called the FEEA, the Fondation Européenne d'Enseignement en Anesthésiologie. And they were running continuing education courses in Western Europe and in Eastern Europe. And whenever they set one up in Eastern Europe, they twinned it with one of the Western European centres, who would send a group of people to Eastern Europe to make sure that they got them up to what was Western European standards. And it was fascinating seeing how all these things throughout Europe were- we'd started off in the sort of early 1980s, when I first joined this academy, everybody was coming from very different sort of training and educational and equipment and drug standards. And gradually, with the exchange of knowledge, this sort of core was coming through and the standards were being set but everyone agreed.

57:50
CG: *Yes. I see.*

57:50
PH: So those were very satisfying, I think. Oh no, gosh, the other thing I should have mentioned, when- on the Faculty here, and then the College - because it changed from being a Faculty to a College to a Royal College while I was an examiner - when I was on the final Fellowship, I was put on the clinical committee for the clinical part of the exam. And when I was first on it, you used to do the clinical examination, it was

really- it started off very similar to doing one for the final MB qualification. You know, you had some nice old patient that had been attending the hospital for years, that had got a heart murmur or something, came along and sat in the bed and- on the couch. And the candidate had to come in and take a history and examine them and say what he thought the diagnosis was and then maybe they'd take it a bit down the anaesthetic way of saying, "What problem does this have for the anaesthetist?"

59:01

PH: And while I was on the committee, the idea came in, I think it originated from the States, that really this probably wasn't the most relevant way of assessing clinical skills for anaesthetists. And there was something called an OSCE, which is- stands for Objective Structured Clinical Examination. And it meant that the- you set up an exam hall with 12 bays, 20 bays, whatever. Different patient or bit of equipment or exercise in each one of these. And if you had an actual- a patient there, it was quite possibly an actor rather than a patient. And it was something like "Mr. So and So is going to have his prostate operated on, but he's got a bit of a bad chest. Will you take a history and see how important you think it is?" And so the candidate would come in and you- as the examiner, you would watch them, you know, when they came in, did they say "Hello" nicely to the patient? Did he introduce himself, saying "I'm Doctor So and So, I'm going to be giving you your anaesthetic tomorrow and I wanted to check you out because I hear you've got a bit of a bad chest". Then he'd take the history. And the examiner would actually watch them doing it. In the past they'd just been behind curtains doing it, and then report. But this- you were actually watching it. And it was actually targeted. And this is much more like what an anaesthetist does in actual everyday practice. Because when you go up to the ward, you're not going to sit down for an hour like the house surgeon admitting a new patient, because you've got the dozen patients to go round. You'd be there all night if you did- But you have to sort of say, "Mm, that patient's a bit overweight, we'd better see if her high blood pressure's all right, and whether I can see the veins". You had a sort of focused five or ten minutes with a patient. This was much more like the structured clinical. So I landed up being Chairman of that working party when they brought it in, and supervising the first time they did the exams that way.

1:01:02

CG: *And that was something you enjoyed?*

1:01:04

PH: Very satisfying, I found it, yes, because I thought, you know, the poor old candidate stuck behind a curtain with some patient, you might get a lovely old chap who would reel off his history, boom, boom, boom, absolutely meticulous maybe. Or you might get someone who's absolutely deaf as a post, and it's very, very difficult, and they're a bit

bloody-minded. And it was really different for each candidate. Whereas this was structured in a way that it was objective, and the candidates went round all of them. And so that was satisfying.

1:01:33
CG: *Yes.*
1:01:34
CG: *So tell me about the worst moment, worst moment of your career.*

1:01:42
PH: Well, I think probably the worst moment of any anaesthetist's career is when you when have someone who actually dies on the table. Hopefully I don't think I have actually sort of killed anybody myself. But I think failed to save someone who's critical after a road accident, or after cardiac surgery, and, you know, the whole gloom dispens- descends on everybody, when you just, "They're not going to make it". Yeah. Or, similarly, in intensive care, you can have that. I think possibly the worst case was- one of the worst moments was we'd spent a long time on a long case, cardiovascular thing, in theatres at night time. Went back- took back to intensive care, attached some sort of ventilator, and this is quite a while ago. After things all seemed to have settled down, went down to theatres, got dressed in the everyday clothes instead of the theatre gear, went back up there to find them trying to resuscitate this patient, who'd collapsed. And one of the tubes had become disconnected. And no one had noticed. And at that time, they hadn't got alarms. They do now. And after spending all those hours in theatres and thinking things were all right, for that just to have happened. And there was a sister there, who should have spotted it and hadn't. So it wasn't just that the patient had died, you sort of though, "Well that sister should have noticed it, and she didn't". That's- so I went to see the hospital Superintendent and said, "You know, this has happened". She said, "Well, everybody's going to know about it. You can't sweep it under the carpet". It's tough.

1:03:24
CG: *Yeah.*

1:03:24
PH: Because you see the repercussions on the rest of the staff. Everybody, patient, relatives. That's nasty.

1:03:32
CG: *Mm. I can imagine.*

1:03:33

PH: But it's the sort of thing we're there to stop it happening again.

1:03:36
CG: *Yes.*

1:03:37
PH: So as long as people learn from it...

1:03:38
CG: *Yes. Yes.*

1:03:40
PH: And I think that is something that's come in over the years too, in that there used to be a sort of philosophy, when I started, that if anything goes wrong, you sort of don't want anyone to find out. Whereas nowadays, if anything goes wrong, you jolly well have a meeting about it, you find out why it went wrong. Should it have gone wrong? How can you prevent anything like that happening again? It's still difficult, it's still difficult, because hospitals want to protect their reputations. Everyone wants to protect their reputations.

1:04:14
CG: *Yes. Yeah.*
1:04:19
CG: *What positive changes do you think have come about for women in the field- well in medicine generally, or perhaps within the specialty of anaesthesia?*

1:04:30
PH: Well in medicine generally, I think the fact that women are going to do- study medicine. So I think it's the schools and the parents. I mean my old school, if you go back there now, you'll find about half the sixth form are going in for medicine. Whereas when I told my headmistress that I was- wanted to do medicine she was sort of "Hmm, I think I've got someone I know at the Royal Free, I wonder if I could get you in there?" I said, "Well no, I'm going to Guy's" [laughs]. And she said "What?" I said, "I've already had my interview". And they just weren't used to women doing medicine. And even when I was a registrar, senior registrar, training grade in anaesthetics, there was some of my male colleagues with young families who said, "I wouldn't want my daughter doing medicine". They didn't fancy the idea of women doing it. And yet, there were some females, younger than me, who'd got married quite early in their medical careers and got young families and they were still running this, doing that, examining... And I said, "So why do you do all that? You've got, you know, you've got your family...". "I'd be

bored if I didn't". And so, you know, the women that are capable of doing it should take it on and do it, shouldn't be pushed into it, but-

1:05:51

CG: *Yes, I was going to ask you, what would you say to young women today who were aiming for a career in medicine?*

1:05:58

PH: If you want to do it, and you don't mind working hard, go for it. But you do- I think you still probably do need to work quite hard. I think the time I did it, it was very, very difficult to be married and have a family at the same time. And I think in our department, the people that came up after me, they- the only way they could do- they had to do part-time training because the hours were so awful with the on-call that you really couldn't do it and the family. So they had to do part-time training, which I think was harder than doing full-time training. But you had to, if you'd got family. And the only way they did it, was I think three or four in a row had the same nanny, which they handed on, one to the next one when they moved on. When the nanny decided she was getting married and having a family, they came to a halt for a bit until the next one came along! [laughs]. But now I'm pleased to see that there are women with families still getting their- getting on the college council and things. It can work now. It's partly because the whole work schedule has become more civilised for everybody. We did a work study when I was a senior junior [?]. And we found that people were on- were in the hospital 109 hours a week. That's not very compatible with families.

1:07:14

CG: *No, it's not, no.*

1:07:14

PH: And even the senior trainees who aren't in- on so much, were- they're sort of 50, 60 hours a week. Now that wouldn't be accepted in any other occupation.

1:07:28

CG: *Did you- so you presumably never had a family of your own?*

1:07:31

PH: No, no. You know, I spent my teenage years wondering whether I'd have two kids or four and I landed up not getting married and having any, but there we are.

1:07:39

CG: *There we are. Do you mind me asking you if that was a conscious decision?*

1:07:42

PH: No, no. I'd have loved to have got married and had kids. But I wasn't going to get married except to the right chap, and if the right chap didn't come along, I got on with what was interesting.

1:07:50

CG: *Yes.*

1:07:51

PH: So no, I'd have... I think a proper balanced life is sensible but...

1:07:55

CG: *Yes. Looking back on your career, is there anything that you would have done differently?*

1:08:01

PH: I'd have liked to have got married and had kids as well but I think it would have been difficult to do what I did, as well as doing that.

1:08:06

CG: *It would have been a very different career, wouldn't it?*

1:08:07

PH: It would have been a different career.

1:08:08

CG: *You wouldn't have achieved all those things you achieved.*

1:08:10

PH: It would be just very interesting to do it in parallel and see which worked out more fun.

1:08:17

CG: *Well, it sounds like you've had a very interesting career, and very full and fulfilling.*

1:08:24

PH: I think I've been pretty lucky.

END