*Anaesthetics and the general practitioner**

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The occasional anaesthetist, like the more common occasional obstetrician, has few friends now. Anaesthetics is a fully accepted and important specialty as shown by the high reputation of British anaesthetists all over the world. There is also the sheer size of the specialty—the Royal College of General Practitioners (1973) suggests that at a district general hospital there is roughly one consultant anaesthetist to every 41,000 people. Corresponding figures for physicians and surgeons are one to 60,000, and for pathologists one to 46,000, for psychiatrists one to 45,000.

Community anaesthesia

Not surprisingly this is associated with a massive but undocumented decline in the number of general practitioners who give anaesthetics. In a North Midlands city with nearly 250 doctors on its executive council list only 17 practitioners—seven per cent—stated that they gave anaesthetics in a questionnaire to which 80 per cent had replied. None of these 17 were female and only three held the diploma of anaesthetics. The three diplomates had an average age of 35 years. The average age of the 14 practitioners without the diploma was 51 years.

The picture of the general-practitioner anaesthetist in this city may be slightly abnormal because of the presence of a medical school, but it seems clear. If we exclude the ENT anaesthetic sessions of one doctor now retired, the practitioners were responsible for two sessions of electroconvulsive therapy and all the rest were dental. Between them they did 30–35 dental anaesthetic sessions each week. There was also tremendous variation in the volume of their work. One doctor worked for 12 different dentists and another did nine sessions weekly. Most doctors did one session weekly, including one man who had been in anaesthetics for six years before entering general practice. Of the 17 doctors, five did not have intubation facilities, eight did not exclude ' at risk ' patients, four had attended an anaesthetics refresher course in the last three years, three found dental anaesthesia unsatisfying and would not commend it to their juniors, and seven found that it was not financially worthwhile.

Clinical assistants

It was thought that a small survey of the work of general-practitioner anaesthetists in the peripheral, usually smaller, towns of the region might reveal a different situation. With the help of senior consultant anaesthetists, 38 part-time general-practitioner clinical assistants in anaesthetics replied to the same questionnaire.

These 38 clinical assistants were responsible for 77 anaesthetic sessions each week. Again only three held the diploma of anaesthetics, and these three were responsible for seven of the 77 sessions. The practitioners were mostly senior men as only five of the 38 were registered after 1965; 17 did one or fewer anaesthetic sessions each week, eight did two sessions and ten did three sessions weekly. Two did only dental sessions, 26 did only general hospital sessions and ten did both. The commonest sessions were surgical, gynaecological and dental (table 1). All 38 had intubation and sucker facilities and all save three had recovery facilities.

The calibre of the help given is hinted at by the fact that 32 did not exclude ' at risk ' cases and that their consultants often mentioned that they were colleagues of exceptional value. Clearly there was often a close relationship, one consultant describing with emotion how a helpful but hard-pressed practitioner cracked under the strain of being both a good doctor and a helpful anaesthetist on call at all hours.

In their turn, 37 of the 38 practitioners found the work professionally satisfying. They were disturbed by their lack of security—they could be dismissed on short notice, perhaps after having

* Based on a paper read to the Faculty of Anaesthetists at the Royal College of Surgeons on 5 June, 1973.

TABLE 1
GENERAL-PRACTITIONER CLINICAL ASSISTANT SESSIONS

Common sessions		*Uncommon session*	
Surgical	19	Emergency	2
Gynae.	16	Eyes	2
Dental	12	On call	3
Orthopaedic	7	Other	2
ECT	4	Obstetric	0
ENT	4		

24 of the 38 practitioners did more than one type of session.

kept the local anaesthetic services going for years—and they resented being neither paid nor encouraged to assess the pre and postoperative state of their patients. Thirty-three of the 38 would recommend this work to their juniors, 25 did not find it a worthwhile financial help, and 17 had attended a refresher course in anaesthetics in the last three years.

This small sample covered clinical assistants mostly without the D.A. qualification who were anaesthetising about 325 patients weekly or about 15,000 patients a year.

Holders of the diploma in anaesthetics

Between 1962 and 1970 the diploma in anaesthetics of the Royal College of Surgeons was obtained by 2,062 doctors. Over 50 per cent of these either were living abroad or were not listed in the current *Medical Directory* and 25 per cent were employed in hospital but not in general practice. This left about 450 who were circularised of whom 263 replied. Nearly 100 of the respondents were not in general practice. Only 138 were general practitioners doing part-time anaesthetics—six per cent of those who had attained the DA qualification. Even so, these 138 doctors were anaesthetising about 830 patients in 145 weekly sessions, or over 30,000 patients a year, so it was felt that an analysis of their work and attitudes might be useful.

Twenty per cent of practitioners with the DA are not using their anaesthetic skills at all. This was due to lack of time, because of the demands of their practice, and also to lack of opportunity, but it was not possible to decide which was the major factor in such a waste of training. Three quarters of the 138 practitioners who did administer anaesthetics did more than one type of session—dental sessions, surgical, and gynaecological being again the commonest (table 2). Typically these doctors do one to three sessions weekly of one to three different types, each session lasting two to five hours. Ninety-three per cent of the doctors had intubation facilities, all had a sucker, 83 per cent had recovery facilities. Twenty-one per cent of these DA practitioners rejected at risk cases. Three quarters of these rejected 0–4 per cent of patients as unfit for anaesthetic, but about a quarter rejected as many as five to ten per cent. Twenty-nine per cent of these doctors had no colleague immediately available to help in an emergency—this compares closely with 24 per cent for the clinical assistants.

TABLE 2
GENERAL PRACTITIONERS WITH THE DIPLOMA IN ANAESTHETICS

64%	do dental sessions
64%	do surgical sessions
41%	do gynaecological sessions
11%	(each) do ECT, ENT and emergency work
8%	do obstetrics
4%	do opthalmology
3%	are on call

The DA practitioners further resembled the clinical assistants in that about half had attended an anaesthetics refresher course in the past three years, two thirds did not have anaesthetics as an undergraduate interest, two thirds did not find their anaesthetic sessions financially helpful, yet less than ten per cent found the work professionally unsatisfying.

Discussion

Although the sampling in this survey may be unsatisfactory, this background information may help the profession to reach a subtle managerial decision necessary to deal with undebatable but conflicting truths.

The anaesthetists cannot recruit indefinitely when they are already taking something like about ten per cent of the medical schools' output. Their high standards must be maintained. Yet the general practitioner is increasingly conscious of his own new role. He is not automatically delighted at an invitation to participate in less exciting areas of hospital medicine. He will not welcome a second identity as a sort of tradesman's entrance anaesthetists but only if he gets a deserved and unreserved acceptance.

Of some 62 junior anaesthetists in training, 12 thought the general-practitioner anaesthetist was valuable, 23 thought he might be of limited value at the periphery, but 27 thought there was no future role at all for him. Even allowing for the natural impatience and inexperience of young men working in well-staffed teaching centres, these opinions need consideration.

Whatever arrangements are eventually made, this small survey strongly suggests that the anaesthetics diploma is now more often taken by overseas graduates than by general-practitioner anaesthetists in Britian. An up-grading of the diploma so that it follows on 12 months ' full-time anaesthetics ' may make it more acceptable to specialists but would restrict its appeal to far fewer doctors. This would have immediate service implications and would also reduce the therapeutic and resuscitation experience so valuable to the practitioner in training. But it would fit in with the general trend for the very few highly trained practitioners to be the only ones who work in special areas of interest, since they do so at a high standard unattainable by the great majority of their colleagues.

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SMOKING IN PREGNANCY AND SUBSEQUENT CHILD DEVELOPMENT

A national sample of several thousand children has been followed longitudinally from birth. At the ages of 7 and 11 years physical and mental retardation due to smoking in pregnancy has been found, and this deficit increases with the number of cigarettes smoked after the fourth month of pregnancy. Children of mothers who smoked ten or more cigarettes a day are on average one centimeter shorter and between three and five months retarded on reading, mathematics, and general ability compared with the offspring of non-smokers, after allowing for associated social and biological factors.

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