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AS WE WERE...

The obstetric flying squad

Professor Michael Rosen in Cardiff did not like 'chair' dental general anaesthetics or small isolated obstetric units. The latter used to be attended by emergency obstetric services (flying squads), as proposed by Professor E Farquar Murray in 1929 and started in Bellshill, Lanarkshire by H J Tomson in 1933.

These flying squad attended home deliveries in which the patients' complications made them 'so desperately ill that removal to hospital might have fatal results'. The enterprise was so successful that almost every maternity hospital introduced a flying squad capable of bringing to patients' homes obstetric aid and resuscitation by means of blood transfusion. Dr Dame Hilda Nora Lloyd was the first female president of the Royal College of Obstetricians and Gynaecologists, and in her time the squad consisted of an obstetrician, a nurse and a medical student. Equipment carried comprised a hold-all containing blankets and hot water bottles, three leather bags each containing two sterile drums of instruments, two boxes of blood, an oxygen cylinder, a light source and a tin of biscuits for personnel – the last of these because '…frequently attendance is required for long periods'.[1] A 'defence' to retain a West Berkshire service in 1977 revealed that an anaesthetist was taken on 32 (89 per cent) general practice calls and 26 (58 per cent) home calls. A paediatrician went on only two calls, both from GP units. Patient home calls were mostly for antepartum haemorrhage, and in GP units they were mostly for retained placenta.[2] Suggestions began to be made that emergency obstetric patients would fare better if they were brought immediately to hospital rather than waiting for the arrival of the flying squad. Anaesthetists Dr Chris Callendar and Professor Peter Hutton reviewed the demand on Bristol's flying squad from 1971 to 1984 and noted a reduction in anaesthetics in general practice units from 41 in 1974 to zero in 1983/1984, with only one or two at patients' homes. Retained placenta was at 84 per cent the commonest reason for a general anaesthetic.[3] The death knell of obstetric flying squads was sounded by their Royal College which in 1991 suggested replacement by a paramedical ambulance team with extended training. A commentary was written by Geoffrey Chamberlain and Malcolm Pearce.[4] Our *Bulletin* editor may wish to comment on whether they should be believed.†

Case report

Stroud Maternity hospital called our Gloucester flying squad to a case of obstructed labour with fetal distress. In the wee small hours, we assembled inside the ambulance but the paediatrician didn't turn up. Our competent Egyptian obstetric registrar asked if I could resuscitate; I'd done an obstetric job, had sucked out plenty of meconium through a Cole[5] tube (do wear a surgical face mask), and had done all these when an anaesthetic SHO and registrar. Newborns are extremely slippery. I arrived in Stroud a tad nauseous; the decision was made to perform emergency section for fetal distress. I checked their ancient Boyle's machine, found only trichloroethylene and filled the Boyle's bottle. I had used a Boyle's and Trilene when I started in Cambridge, where I discovered that it has little anaesthetic efficacy if passed through a circle absorber to the patient (it also produces the nerve poison dichloracetylene). To check the oxygen, I opened both cylinders and twiddled the white knob, but the bobbin got stuck sideways at the top above the five-litre mark and wouldn't drop down even with me thumping it. I had suxamethonium and thiopentone with me. The midwife who had come with us did the cricoid pressure, and after intubation I thought I'd better put the nitrous oxide at maximum (10 litres plus?) to give approximately a 50:50 mixture and added the Trilene. The Manley ventilator was going bananas with the high flows, so I used the Mapleson A reservoir bag to ventilate. Baby came out pdq (pretty damn quick), flat as a pancake so the midwife took it to the resuscitation table and I went to have a look. As I was completing intubation the registrar and the scrub midwife shouted for my attention. The patient was sitting up and the surgeon was shoving escaping bowel back. The midwife took over baby ventilation, I gave more suxamethonium and thiopentone and gently returned the patient to supine. Phew! The high flows had made the nitrous run out, the Trilene in the Boyle's bottle had vanished. Stability returned, we returned to Gloucester with everyone fine. I remembered that John Farman in Cambridge had told me Trilene was a great amnesic, so I, my patient, Jenson Button,[6] Patrick Viera, Trinny Woodall and Richard Hammond if gassed by this agent, hopefully forgot everything. Flying squad and Professor Rosen; RIP.

†The Editor well remembers the events leading up to the disgrace of Malcolm Pearce and the collateral damage suffered – some might say thoroughly deserved – by Geoffrey Chamberlain. Interested readers are directed to the BMJ News article at the time: bit.ly/2oQTnGX

If any fellow or member has an interest in the history of anaesthesia and the College, the College's Heritage and Archives Committee welcome any expressions of interest for new committee members.

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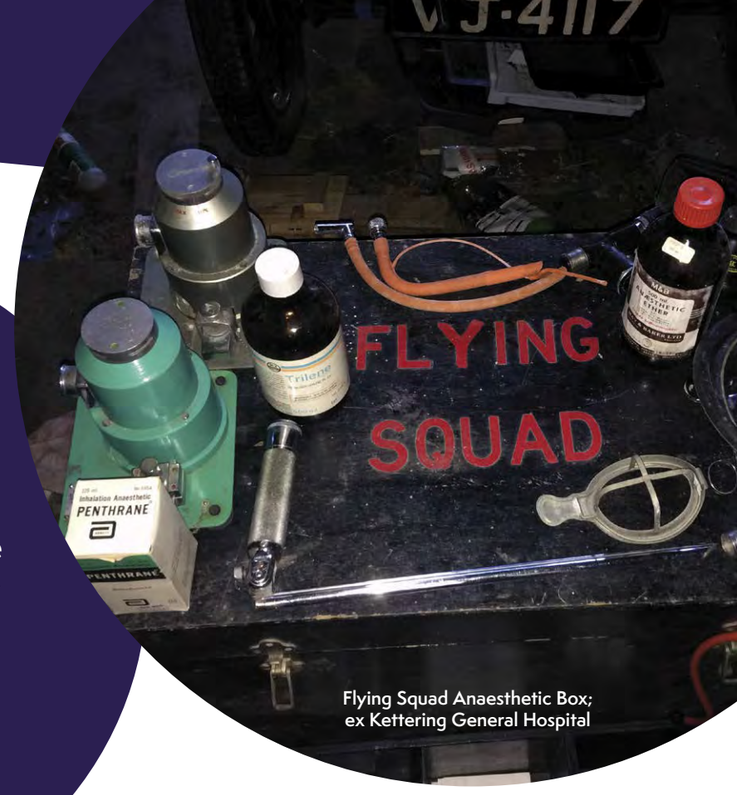

Flying Squad Anaesthetic Box; ex Kettering General Hospital

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