Royal College of Anaesthetists

The UK Diploma in Anaesthetics:
A world first in the path to an independent specialty

Professor J A W Wildsmith

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Professor J A W Wildsmith MD FRCA FASRA
FRCPEd FRCSEd FDSRCSEng

Professor Emeritus, University of Dundee, UK
President, History of Anaesthesia Society, 2006–8
Honorary Archivist, Royal College of Anaesthetists, 2012–15

Correspondence: wildsmithj@icloud.com

The RCoA is pleased to publish this account, and is grateful to Professor Wildsmith for his work in documenting this important period in anaesthetic history. However, any opinions expressed are those of the author and not necessarily those of the College.

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Preface

This account has its origins in the author's appointment as honorary archivist to the Royal College of Anaesthetists (RCoA) in 2012, initial exploration of the role revealing that the College possessed relatively little in the way of documentation of the years between 1948 (establishment of the Faculty of Anaesthetists) and 1982 (the move from the Royal College of Surgeons of England). This was discussed with the then president, Dr J-P van Besouw (Figure 1), and he suggested that it might be possible to search the library and archive of the Royal College of Surgeons (RCS) so that all relevant documents could be scanned to provide digital copies for our use. He approached his opposite number at Lincoln's Inn Fields to explore the possibility, and received ready agreement to the exercise which started with a search for, and identification of, the relevant documents. These were then scanned and the files transferred to portable storage media to allow uploading to a permanent home on our own system, all elements of this process receiving ready help from the RCS library and archive staff. During the initial search for documents, it became apparent that there was important, but unknown, information related to the Diploma in Anaesthetics (DA), the findings suggesting that detailed study would be appropriate. What follows is the result.

Figure 1 Dr J P Van Besouw
Used with the permission of the Royal College of Anaesthetists

That it is 13 years since the nominal starting point noted above might suggest a dilatory approach, but that would be an unkind conclusion. The processes of identifying and copying documents took a considerable amount of time, with other archival projects, notably a revamp of the 'heritage' section of the RCoA website and establishment of the 'Lives of Fellows' project, taking priority. As a result, specific search and analysis of the material for information on the DA could not begin until others took on the responsibilities of honorary archivist (Dr Anne Thornberry 2015) and editor of the 'Lives' project (Dr Alistair McKenzie 2021). I thank them and the two subsequent honorary archivists (Dr Anna-Maria Rollin 2020 and Dr Janice Fazakerly 2025) for their support, as well as that of the College's immediate past Director of Membership, Media and Development (Graham Blair) and those who were our archivists (Rosemary Sayce and, more recently, Gillie Lyons).

The real work began about five years ago in that carefree time before Covid changed so much, although 'lockdown' actually helped initially because the restrictions placed on social activity provided lots of time for the project! However, it soon caused difficulty because analysis of key material provided questions which could only be answered by return visits to the RCS to check other documents, these not becoming available until the archive was open again. Such visits were not facilitated by the author's home then being in Scotland, any benefit accruing from a return to native Gloucestershire being more than countered by the distraction produced by the move. However, the last two years have seen rapid progress and it is appropriate to thank Dr Anna-Maria Rollin again, this time for her comments on each section of new text as it emerged. The final draft was published on the College website in November 2025 to coincide with the 90th anniversary of the first DA examination held in November 1935.

Summary

The institution of the DA in 1935, the first academic marker of the development of anaesthesia as a specialty, was an important event, certainly in the British Isles (and arguably on a much wider front), and was an early triumph for the nascent Association of Anaesthetists of Great Britain and Ireland (AAGBI). The RCS and the Royal College of Physicians (RCP) in London, through the medium of their conjoint Examinations Board (EBE), were ready supporters of the proposal although it wasn't too long before the EBE's 'independent' way of working was causing difficulties. The initial high pass rates suggest that the early candidates were drawn from those actively committed to the specialty, but success rates declined during the Second World War (WW2) with much greater numbers taking the examination. Possession of the DA had become essential for recognition as a specialist in the armed services, so perhaps candidate motivation had changed, but study must have been difficult under wartime conditions, even for those still in civilian practice.

After WW2 the whole of Britain's medical profession, not just the specialty of anaesthesia, was challenged by the introduction of the National Health Service (NHS), and the AAGBI was actively involved again. Advice was received that both an academic organisation and a definitive fellowship standard examination were required to ensure consultant status in the new service, the outcome being formation of the Faculty of Anaesthetists and introduction of a two-part DA. Both were established by 1948, but the AAGBI proposals for the examinations were not followed. Unfortunately, the new format was not successful, particularly the basic science component, the first clear example of the consequences of the EBE ignoring outside views. The result was the introduction of fellowship examinations designed and controlled by the Faculty, the latter accepting the continuation of the DA to provide some screening of the general practitioner (GP) anaesthetists needed for the clinical service of the time. The DA was to revert to its earlier, one-part

structure, but the EBE reneged, without discussion, on some of the other conditions 'agreed' with the Faculty, this causing a complete breakdown in communication between the two organisations.

For almost a decade the Fellowship and DA examinations ran in parallel, the latter without any formal anaesthetic input, and its status continued to decline. Through the 1960s the Faculty tried to exert some influence, but much of the eventual change owed more to the actions of the DA examiners, nationwide developments in postgraduate education and training and, finally, the physical decline of the EBE's building. Eventually, in 1980, the Faculty obtained complete control of the DA as well as the Fellowship and embarked on several years of debate on how to incorporate both the DA and advances in knowledge (with an emphasis on intensive care and pain medicine) into the examination structure. The eventual outcome was the three-part Fellowship which allowed the possibility of acquiring the DA after success in the first part; this option lasted for another decade until more changes in postgraduate training in the late 20th century rendered the qualification obsolete. The last examination was held in 1996 with what had started as the 'jewel in the crown' of the AAGBI becoming (sadly in some ways) an anachronism. So, following on from this brief overview, a timeline and then the detail.

Timeline

1846	First successful public demonstration of general anaesthesia in Boston, USA. Its administration quickly became part of 'every doctor's' practice.
1893	In the UK the few doctors who had developed a specialist interest joined together to form the Society of Anaesthetists.
1900	The Society became the Section of Anaesthetics of the Royal Society of Medicine.
1900–14	Frederic Hewitt led pressure for formal teaching of anaesthesia.
1914–18	Experience during World War 1 showed the benefit of training in anaesthesia on patient outcome.
1919	Ivan Magill began the development of modern airway control equipment.
1931	First recorded proposal (from McKenzie in Aberdeen) for a diploma in anaesthetics, the aim being to ensure the standard of those responsible for teaching undergraduates.
1932	Magill blocked from pursuing a diploma as Honorary Secretary of Section of Anaesthetics. Association of Anaesthetists of GB&I formed with the institution of a diploma one of its first five objectives.
1934	Association AGM agreed that RCS be approached.
1935	Regulations agreed for a joint RCP and RCS diploma administered by the Examination Board in England (Conjoint Board). Main requirement of six months as a resident anaesthetist *or* evidence of administration of 1,000 anaesthetics.

First examination held in November in Examination Halls, Queen Square, London; thereafter held every May and November. The formal postnominal was DA(RCP&S).

1943 Falling pass rates led to stricter entry requirements (evidence of both appointment as a resident *and* administration of 1,000 anaesthetics), and stricter requirements again in 1947, notably 12 months of anaesthetic experience.

1947 Advice on specialty's preparation for the NHS led, in 1948, to the introduction of Faculty within the RCS, FFARCS by election and a two-part DA examination. AAGBI's suggestions for its structure were agreed informally, but not implemented.

1953 Early concerns about the two-part examination led to introduction of fellowship by examination, and reversion of the DA to one part for use as a screening examination for the GP anaesthetists needed for service coverage.

Conjoint Board imposed physician and surgeon examiners (termed the 'clinicians') for revised DA without any discussion with Faculty. This caused complete breakdown in communication between Board and Faculty, with the revised, one-part DA continuing without any external specialist input.

1962 Renewed formal contact to discuss the need for more examiners, stimulated by increase in candidate numbers, but led only to a change in role of 'clinicians'. From 1964 they remained 'in attendance', but all primary questioning was done by anaesthetists.

1966 Costs of Examination Halls were becoming a major problem; the DA fee was doubled as part of the overall response.

Examiners express concern about very poor performance of some candidates and suggest an increase in training.

Possibility of referring poor candidates for more training agreed instead, but not implemented by Conjoint Board.

1968 *More* pressure from examiners led to two recommendations from EBE: board of six examiners, anaesthetists only, and agreement to implement the earlier suggestion of an increase in training time (six to 12 months).

'Todd' Report on medical education saw little future for diplomas because of lack of specialist input to Conjoint Board, and picked out DA for particular criticism.

1969 Board of six anaesthetist examiners approved, but extension of training time to 12 months referred back to Conjoint Board – by the Dean of the Faculty of Anaesthetists.

The basic concern was that the GP training scheme allowed only six months in any one specialty as part of vocational training. Increasing DA training time would have a negative effect on supply of GP anaesthetists required for NHS service.

1970 As part of a wider attempt to obtain greater authority over its affairs, Faculty sought greater input to administration of the DA; Conjoint Board eventually ceded this *'on educational grounds'*.

1971 RCGP withdrew approval of anaesthetic experience (of any duration) as part of vocational training. This led to a decrease in GP candidates for the DA, and marked the beginning of the end of the 'GP anaesthetist'.

Proportion of successful DA candidates from overseas was now reaching 50%.

1973	Considerably revised regulations, drawn up by Faculty and including 12-month training requirement, were introduced, but not to universal approval. The basic concern was the continuation of two anaesthetic qualifications with different standards for what many would view as the same role.
1979	Continuing problems with Examination Halls, and lack of funds to deal with them, led to planning for dissolution of Conjoint Board.
1980	DA (and FFARCS) both came under direct responsibility of Faculty. Postnominal became DA(Eng) in 1981.
	Faculty Examinations Committee started review of joint structure for DA and FFARCS.
1985	Three-part fellowship introduced; DA could be awarded after passing Part 1 and completion of 12 months of approved training. Postnominal became DA(UK).
1993	Faculty replaced by fully independent Royal College of Anaesthetists, but all aspects of DA remained the same.
1995	Wide changes in postgraduate training and its structures, especially the introduction of continuous workplace assessment, spelled the end for the DA.
1996	Final part 1 Fellowship (and thus DA) examination held.

Background

The introduction and development of anaesthesia stem from its first successful public demonstration in Boston, USA, in 1846, the news spreading around the world as fast as the sailing ships of the time could carry it. Even in the most developed countries, certainly in the UK, the great majority of doctors were in general practice, with the practices of physicians and surgeons also being broadly based. As a result, the administration of general anaesthesia became a part of the practice of almost every doctor, although little, if any, time was devoted to its teaching to undergraduates. However, as the 19th century progressed a few individuals in the UK developed a special interest in its administration, their number growing until, in 1892, there were enough to support the proposal for a 'Society of Anaesthetists'.[1] Established the following year with 40 members (31 from London, nine from around the UK), its aim was to encourage the study of anaesthesia (pursued through discussions on the practical and academic aspects) and to promote *'friendly relations among members'*. All subsequent anaesthetic organisations in the UK have followed that lead; the Society, arguably the first formal step towards specialisation in the UK, also led the way in promoting better, indeed compulsory, teaching of anaesthesia to undergraduates.

After seven years the Society merged with the Royal Society of Medicine (RSM) to become its 'Section of Anaesthetics', a change bringing much advantage, although the RSM's charter restricted the Section to academic activity.[2] Individuals, notably Sir Frederick Hewitt,[3] continued to pursue the other objectives, emphasising rising mortality figures and the contrast between needing a licence to serve an alcoholic drink and the lack of restriction on the administration of anaesthetics. Hewitt's work was described in detail by Scurr in his Hewitt Lecture,[4] the published version of which all British anaesthetists should read for its insights into how the specialty evolved. However, for more detail, and access to a wealth of source material, the reader is referred to Boulton's definitive account.[2]

Regulations on the teaching of anaesthesia were adopted by the Royal Colleges, the University of London and, eventually, the General Medical Council (GMC),[2] but a draft Anaesthetics Act approved by the GMC was lost. This was unfortunate, but initially the press of other Parliamentary business predominated, and then the First World War (WW1) intervened.[4]

Fortunately, WW1 did have some positive effect on the development of anaesthesia, with bitter experience showing that proper training and the use of objectively studied methods improved outcome in injured soldiers.[5] Although these findings were slow to translate to civilian practice in a country devastated economically and socially by a dreadful war, one man, Dr (later Sir) Ivan Magill, (Figure 2) was about to change everything. Having accepted a posting to a military maxillofacial unit near London simply because it meant that he could be close to his wife, Magill invented (in essence) the airway equipment of modern inhalational anaesthesia.[7] Not only did this make reconstructive surgery of the head and neck possible, but it also produced general anaesthesia of a quality and safety unequalled previously, features of obvious benefit in every clinical situation.

Figure 2 Dr Ivan Magill
Courtesy of the Anaesthesia Heritage Centre[6]

The Diploma story: 1931–1953

The early moves

Wider application of Magill's techniques, and the advances made by others during the 1920s, did emphasise the need for formal training if the methods were to be used safely and effectively. Most medical schools took at least token notice of GMC regulations on training, but in 1931 Dr JR McKenzie of Aberdeen,[8] writing in the *British Journal of Anaesthesia* (BJA),[9] expressed concern about the quality and expertise of those delivering that training. To deal with this, he proposed institution of a diploma for '*anaesthetists for hospital and teaching posts*' to ensure '*a definite standard of knowledge of the theory and practice of anaesthetics*'. Thus, it was accepted that undergraduates would be taught to administer general anaesthesia for the very practical reason that there weren't enough specialists, a situation which would not change until long after WW2, and a point crucial to this story.

Figure 3 Dr Henry Featherstone
Courtesy of the Anaesthesia Heritage Centre

Magill was central to this development as well, proposing in 1932 (as honorary secretary of the RSM Section) the institution of a diploma, but the Society's secretary ruled that such activity was not within the remit of its charter as an academic body.[7] However, the Section's President, Dr Henry

Featherstone (Figure 3),[10] was already concerned about other matters barred from consideration, namely the financial and professional status of anaesthetists.[2] Thus, the AAGBI was formed, the 1932 Inaugural General Meeting approving five objectives, the fourth being '*to favour the establishment of a diploma in Anaesthetics*'.[11] However, a little over a year later, Council's report to the Second Annual Meeting included the statement '*It is felt, generally, that the time is not yet ripe for the introduction of a Diploma*'.[12] There is no record of the reason for this proposed delay, but it has been suggested that some established practitioners had lobbied Council, fearing that they might have to sit an examination!

Fortunately, the statement continued: '*Some of us think, however, that the advantages of having a special qualification will soon be great enough to justify its introduction*'. Clearly Magill was among '*some of us*' because the minutes of the Association's last Council meeting of 1933 record that: '*The question of a Diploma in Anaesthetics was discussed and it was resolved that Dr Magill should be asked to produce the correspondence with the Society of Apothecaries relating to this proposal*.'[13] The implication of this slightly tetchy minute is that Magill, perhaps frustrated by the negativity, had been exploring other options without reference to the rest of Council. Whatever the background, the minutes of the February 1934 Council meeting record that: '*It was resolved on the motion of Dr Magill to take steps to inaugurate a Diploma in Anaesthetics. Dr Magill, Dr Hadfield*[14] *and Dr Blomfield*[15] *were appointed to a subcommittee to report to the next Council meeting*'.[16]

Proposals agreed and pursued

Two months later the subcommittee presented Council with six paragraphs of proposals and, after discussion and amendment, it was resolved to present these to the Association's General Meeting the following month.[17] Described as a preliminary report approved by Council, the report was read and opened for discussion which resulted in

a proposal that the president should write to the president of the Royal College of Surgeons of England (RCS) with a view to setting up a Diploma in Anaesthetics.[18] A second proposal, namely that the Royal College of Surgeons in Edinburgh should also be approached, was considered, but it was decided that it was better to deal with only one organisation at a time. Thus, it was resolved to start with the RCS, offering them the subcommittee's report as the policy of the AAGBI. The RCS's positive response meant that there has been only one source of British qualifications in anaesthesia ever since. Dr Featherstone wrote, as agreed, on 8th June 1934 and, at its meeting on 12th July, the RCS Council formed a committee chaired by the President, Sir Holburt Waring (Figure 4),[19] and empowered them to meet with representatives of the Association.[20]

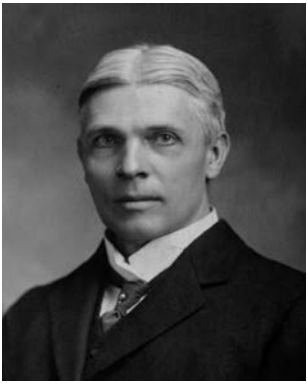

Figure 4 Sir Holburt Waring
From the Archives of the Royal College of Surgeons of England

Dr Featherstone, with the three authors of the report, met the committee on 2nd November, the outcome being that they were authorised to meet the RCS's director of examinations to establish regulations. Progress was rapid because the RCS committee, now including representatives of the RCP, agreed draft regulations on 31st December.[21] It was proposed that, like other specialist diplomas, the DA would be under the remit of the

Examining Board in England (EBE), known informally, and more widely, as the 'Conjoint Board'. This was a joint organisation of the two Royal Colleges, so the draft regulations were referred to its Management Committee (CBMC). The report included the following key regulations:

- Candidates to have either held resident appointments for 12 months, six of them in anaesthesia, in a recognised hospital,

  or

  to provide records of the personal administration of 1,000 anaesthetics (an early draft required 2,000),[2] half of them for major surgery.
- The examination to be held twice yearly (May and November) and consist of written papers, an oral and a practical demonstration.
- The syllabus to include history, anatomy, physiology, pharmacology, all types of anaesthesia and pre- and postoperative care.
- Applications to include the evidence of clinical experience and to be made at least three weeks in advance, payment of the fee becoming due after the candidate's receipt of an admission card for the examination.
- During the first year those who had, for at least 10 years, been 'visiting anaesthetists' in a hospital attached to a medical school in Britain and Ireland could apply for the diploma to be awarded 'without examination'.

The Conjoint Board takes over

Perhaps surprisingly, the CBMC '*found some difficulty in approving the regulations*' and requested a meeting with the AAGBI to discuss them.[22] At the meeting the specific problems were discussed and the solutions identified:

> *Certification of the administration of 1,000 anaesthetics*: the candidates had to provide schedules, signed by a senior member of their hospital's staff, with details of both surgical procedures and the anaesthetics administered.
>
> *The 'practical' examination*: the CBMC seems to have taken this literally, so the phrase was deleted and replaced by '*demonstration of equipment*' in the list of topics for the oral.
>
> *Award without examination*: this option was extended until 1st May 1938 and its availability was widened from Britain and Ireland (remit of the AAGBI) to British Empire (presumably the remit of the Board).

In addition, and reasonably, the regulations were rewritten in the format used for other diplomas, but the relatively minor nature of most of the changes might be thought surprising given that they had already been agreed with the RCS's director of examinations. It suggests that the real issue was demonstrating who was 'in charge', the first sign of an 'attitude' within the CBMC that was to cause difficulty later. Each of the two Royal Colleges was to nominate one examiner, the two sharing £3 of the fee (3 guineas) paid by each candidate. The revised regulations were approved on 14th March 1935, as was the suggestion that the first diet [sic] be held later in the year.[23] The announcement of this innovation was given a very positive reception by a Leader in *The Lancet*, its author recognising the importance of anaesthesia to safe, effective surgery and noting that the DA's status as an international 'first' reflected well on British anaesthetists.[24]

The DA(RCP&S) is launched

The inaugural examination for the world's first formal qualification in anaesthesia was indeed held that year (1935), in the Examination Halls, Queen Square, London (Figure 5),[25] the written paper (Figure 6) on 8th November and the orals during the following week.

Figure 5 Examination Halls, Queen Square, London
Source: Zorab and Zuck[25]

Drs Edmund Boyle[26] of St Bartholomew's Hospital and Charles Morris[27] of University College Hospital were the examiners and they passed 46 of the 54 candidates (Appendix 1).

NOVEMBER 8, 1935

From 2 to 5 P. M.

Candidates are advised to answer all the questions.

1. What do you know of
   (a) Henry Hill Hickman;
   (b) Crawford W. Long?
2. For what types of operation and patients would you recommend local anaesthesia? Give in details how you would produce local anaesthesia for a patient undergoing gastrostomy.
3. Give the points for and against spinal anaesthesia. Describe the technique that you would employ, with doses.
4. You are called to a case of intestinal obstruction with almost constant vomiting. It is decided to do an exploratory laparotomy. What will you do? Describe in detail.
5. Write a short essay on the history and present position of rectal anaesthesia and analgesia.
6. What premedication and anaesthetic would you employ in a case of bad toxic goitre?

Figure 6 First DA written question paper
Source: Zorab and Zuck[25]

The 46 included nine women, four non-UK graduates (two Australians, one each from South Africa and the Indian subcontinent) and some notable names: Parry Brown, Noel Gillespie, John Gillies, Ronald Jarman, WS McConnell and Michael Nosworthy.[28]

As planned, the examinations continued every May and November (there was little variation in this through the years), with no change in either the regulations or the examiners until Boyle stood down because of ill-health in 1939. Up to 1940, the numbers of candidates were modest (34–64 per diet, the greater ones later on), but the average pass rate (60%) was good for a postgraduate examination (Appendix 1). During this period 45 (15%) of the successful candidates were women and 26 (9%) were the products of overseas (not British or Irish) medical schools, an indicator of the DA's early international standing. The examination even influenced clinical practice, certainly in the UK. At that time, local and regional anaesthetic techniques were very much the province of the surgeons, but their inclusion in the examination syllabus promoted the attitude among candidates that '*if we have to learn about them we should use them*', and so they did![29] The DA had, to the credit of all involved (not forgetting the ready involvement of the two Royal Colleges and their Examining Board), truly started as '*the jewel in the crown of the Association*'.[2]

The very first diplomas were actually awarded earlier, but 'without examination', and included yet more notable names (Table), their total reaching 100 by the end of April 1938;[30] fittingly Magill was among them and, even more fittingly, his diploma has survived (Figure 7).

Table The first ten recipients of the DA(RCP&S) Awarded without examination, 13 June 1935.[21]

Recipient	Location	Major role(s)
AS Daly	London Hospital	Advisor to British Army during WW2
HW Featherstone	Birmingham	First President AAGBI 1932–35
CL Hewer	St Bartholomew's	Editor, 'Recent Advances' series
JBH Holroyd	Sheffield	Active undergraduate teacher
AD Marston	Guy's Hospital	First Dean of Faculty
Z Mennell	St Thomas's Hospital	President AAGBI 1938–41
AJ O'Leary	Liverpool	Founder member, BJA Board
H Sington	Great Ormond Street	Pioneer paediatric anaesthetist
GFR Smith	Liverpool	Senior roles in the Territorial Army and the Royal Army Medical Corp
WS Sykes	Leeds	Noted historian of anaesthesia


We
The President and Fellows
of The Royal College of Physicians of London
We
The President and Council
of The Royal College of Surgeons of England
have granted the
Diploma in Anaesthetics
to
Ivan Whiteside Magill
who has satisfied us of his proficiency in the subject.
In Witness whereof We the Presidents have hereunto
set our signatures
Dated this 25th day of July 1935.

Figure 7 Ivan Magill's DA Diploma
Courtesy of the Anaesthesia Heritage Centre

The formal postnominal was DA(RCP&S), thus recognising the joint Collegiate status of the EBE, but the vast majority of individuals simply placed 'DA' after their names (and always did, even when the organisation formally responsible for the award changed). Concern for those who met the standard, but had not quite been in post for 10 years, led to a variation allowing for individual assessment before the end of 1938,[31] and another 50 diplomas were awarded.[32]

However, one important individual, Robert Macintosh, who had been appointed to Oxford as the UK's first professor of anaesthesia in 1937,[33] was ineligible. He had worked previously in private practice in London and, not having held an appointment at a teaching hospital, did not meet this formal requirement. Initially (and wisely) Macintosh was given special consideration and the CBMC decided to recommend an award, but he immediately withdrew his application because of a parallel decision by the Board.[34] After his appointment to Oxford he had toured centres of excellence in the USA and, on his return, had proposed that the three individuals who had impressed him most (almost certainly including Dr Ralph Waters[35]) be awarded the DA 'without examination'.

Surprisingly, the Board claimed, '*to have no power to recommend their names for the award of the diploma*', presumably basing this bizarre decision on its remit being, as noted previously, the British Empire. Apparently, Macintosh felt that if those three weren't good enough for the award 'without examination' then neither was he.[36] He sat the examination later in the year and, as Boulton noted, '*One wonders if the candidate or the examiners were put to the greater test*'![12] A few years later Macintosh was one of those examiners (Appendix 2) and the slight to Waters was corrected when he became a very early recipient of the fellowship by election.[35]

Wartime and after

A moderate increase in candidates began in 1940 (Appendix 2), presumably due to armed services recruitment (possession of the DA was a requirement for grading as a specialist),[25] and required an expansion in the number of examiners in 1941. However, the increase in candidates was associated with a decrease in pass rates, the examiners raising their concerns with the CBMC. The issue was discussed with the AAGBI and this led to a major change in the regulations from 1st January 1943.[36] Thereafter candidates were required to provide evidence of *both* appointment as a resident in a recognised hospital and the personal administration of 1,000 anaesthetics, not one or the other as originally. This implies that they were judged, as a group, to be poorly prepared or not having the same motivation as the earlier candidates, but working under wartime conditions cannot have made study easy, even for those still in civilian practice.

Candidate numbers decreased a little after the change in the regulations, but increased markedly after the war, over 200 applying for each sitting eventually (Appendix 2), with the pass rates remaining poor apart from November 1945. That was the largest sitting (117 candidates) to that date, and it had both the highest pass rate (56%) since 1939 and the largest percentage (18%) of successful candidates from overseas – half of them Canadians. The increase in candidates continued after the war, probably due to returning servicemen seeking qualification for civilian life, and the high pass rate in November 1945 may just have been happenstance. However, it is tempting to wonder if this was a group who had gained considerable experience during WW2 (it was the first sitting after that war's end), their experience showing through in what was primarily a test of practical knowledge. The overall percentage of overseas graduates who were successful during the war period was the same (9%) as pre-war, but the proportion of successful female candidates increased by nearly half (11–16%).

Late in 1945 the AAGBI proposed to the EBE that there should be regular review of the examination's regulations, a change which would have strengthened the qualification further, but to no avail.[37] Having sought actively to discuss matters with the AAGBI two years earlier, the CBMC now declined its input, noting that their practice was to consult the examiners. There had been hints of resistance to external input previously, but this is the first definitive example of what became a significant problem later. Peacetime did bring further revision of the regulations, although the changes seem to have been driven more by the administrative effect of the increase in candidate numbers than by improving the standard. Basically, checking the growing number of lists of anaesthetics was proving too onerous for the EBE's staff, although (to be fair) the new regulations were an improvement. After 1st January 1947, details of clinical experience were no longer necessary, but a proposal first made by the CBMC in 1944, namely that candidates should acquire more experience of both anaesthesia and other work before sitting the examination, was instituted. They had to be two years qualified, have spent six months as a resident house physician or surgeon and been a resident or whole-time anaesthetist for 12 months.[38]

The NHS approaches

However, even bigger changes were on the horizon because the specialty, like all of British medicine, was preparing for the National Health Service (NHS). For anaesthesia the process began in April 1947 when Sir Alfred Webb-Johnson (Figure 8),[39] then president of the RCS and a personal friend of the AAGBI president (Dr Archibald Marston), addressed its Council.[40]

Figure 8 Sir Alfred Webb-Johnson
From the Archives of the Royal College of Surgeons of England

Crucially, he supported continuation of the wartime practice of equality of status with surgeons, but indicated that both an academic organisation and (even more urgently) an examination of higher standard were needed.[41] The benefit of obtaining other academic qualifications (eg MD, MRCP or FRCS, *in addition* to the DA) in the search for better status for anaesthetists had been made previously (in a 1941 BJA editorial),[42] but Webb-Johnson was proposing a specialty-specific examination.

In spite of developments in anaesthesia (and its organisations), the general standing of the specialty was still well below that of others. This account is primarily about the work of those who were the leaders in the field, but not all aspired to the same standards, nor were they necessarily viewed so positively, either by other healthcare professions or by the public. Consider what an Edinburgh graduate and holder of the DA who became one of South Africa's leading specialists wrote in 1939:[43] *'...still does a faint suggestion cling to the professional anaesthetist as being either lazy, doing the work for the time being only, or not having brains and ability enough to fit himself for anything else.'* The introduction of the DA had a very positive effect on the specialty's status, but there was still a long way to go.

Webb-Johnson was, in essence, making the same points as the BJA editorial, and just as well because the status of the original DA had begun to decline, even though the WW2 failure rates (around 65% – Appendix 2) suggest that the examiners were being reasonably stringent. It is disappointing that the outside perception of the qualification had deteriorated (clearly that was Webb-Johnson's view) soon after it had started so well, and in spite of changes aimed at improving it. Perhaps the real situation was that the EBE's resistance to external input, as seen with the rebuttal of AAGBI suggestions in 1945,[37] meant that the DA was not keeping pace with the specialty's needs from it.

Faculty of Anaesthetists: Two-Part DA

The result of Webb-Johnson's advice was the formation of a joint RCS/AAGBI committee which reported early in 1947 and laid out plans for a Faculty of Anaesthetists, a fellowship of that Faculty (FFARCS) and further strengthening of the DA.[44] Initially, the FFARCS was awarded by election to senior individuals only, but holders of the DA were to be eligible for membership of the Faculty. Given that the starting point for training as a consultant physician or surgeon in the NHS was expected to be the MRCP or FRCS, a qualification of equivalent standard was clearly needed for anaesthetists. Shortly thereafter, in May 1947, the AAGBI made some very complete proposals for a distinctive, two-part DA to the CMBC, their essence being as follows:[45]

> *Part 1*
> Two papers and two orals covering anatomy, physiology and pharmacology that could be taken at any time after full registration with the GMC; and
> *Part 2*
> Two papers and two orals covering the administration of anaesthetics, clinical medicine and clinical pathology (particularly its role in the assessment of patients and their level

of risk) to be taken not less than two years after qualification and with at least one year's experience of anaesthesia.

A meeting between the two organisations revised the proposal and apparently came to an agreement, but there were changes after the meeting, the eventual Part 1 owing far more to the FRCS primary than the AAGBI's proposals. Similarly, the final examination was little more than an up-rated version of the DA rather than including the more radical proposals made by the AAGBI. The CBMC's continuing resistance to outside input may have been behind the changes, but the rapid introduction of the NHS did mean that the DA needed to be changed quickly. The less radical package which was instituted might have been more palatable to the more conservative among the committee's members and so allow the rapid progress needed for the new regulations to come into force in time, which they did on 1st January 1948.[46]

The major features were as follows:

Entry

Part 1: six months as house physician or surgeon.

Part 2: two years qualified with one year as a resident or whole-time anaesthetist to a recognised hospital, such recognition becoming a Faculty responsibility with detailed criteria soon established.

Subjects

Part 1: anatomy, physiology, pharmacology and clinical pathology (the most contentious element), as relevant to both anaesthesia and analgesia.

Part 2: anaesthesia, analgesia, pre- and postoperative care and relevant clinical medicine.

Examiners

Part 1: two basic scientists (one in physiology and pharmacology, one in clinical pathology) and two anaesthetists.

Part 2: two anaesthetists and two 'clinicians' (a surgeon and physician usually took part). (This almost overt implication that anaesthetists were not considered to be 'proper' clinicians was resisted, but was ultimately accepted, presumably a pragmatic decision to speed matters. However, the consequences were to cause difficulty later and the episode does give further insight into how the specialty was still viewed at that time, even at College leve).

Fees

Six guineas for each part of the examination and five guineas completion fee for award of the diploma.

Transitional arrangement

Any candidate who had sat the DA under the earlier regulations, but failed, was exempt from Part 1; no explanation for this very generous allowance has been traced, but perhaps, once candidates were qualified to sit for the diploma, they could not become 'unqualified'. It also explains two points: first, how quite large numbers of candidates were able to sit the first two diets of the new Part 2 examination (Appendix 3b); second, that candidates who had failed under the old regulations, but were able to 'avoid' the new basic science test, may have been a factor contributing to negative views of even the new format.

The new regulations included a synopsis of the subject matter for Part 1.

Two-part DA questioned

The proportion of female and overseas graduates among the successful candidates for Part 2 increased a little over the 1948–53 period, but the key feature was that the early results of both parts were very poor (Appendices 3a and 3b) in spite of the provision of a synopsis. There is, of course, an obvious explanation for the poor early Part 2 results: many of the candidates had already failed the original (easier?) single part examination and had been excused the Part 1. Part 2 rates did increase

subsequently, but there was minimal improvement in Part 1 and, although the number of candidates increased progressively (and considerably), no diet's pass rate exceeded 30%. An external review of both November 1948 diets noted that the examination was '*conducted in a most fair and pleasant manner*', but the review's author was not impressed with candidate knowledge. Some were recorded as '*unable to answer questions which a fifth-year student could have tackled with confidence*'.[47] The Part 1 results were discussed by the Board of Faculty as early as December 1948 and, again, in June 1949 when reversion to the original DA format was considered, but an even more detailed syllabus was approved instead.

After three years with only minimal improvement, the CBMC wrote to the Part 1 examiners querying the (high) standard of the examination. The letter has not been found, but the robust responses of the Part 1 examiners are preserved with the CBMC minutes.[48] Dr Stanley Rowbotham noted, with examples, the poor preparation of candidates, defined precisely what anatomical knowledge an anaesthetist should have and, equally importantly, explained why. Dr Bernard Johnson, who had been involved in the negotiations for the two-part DA (and those discussions *were* for a fellowship standard examination), repeated the arguments quite forcefully. The two non-anaesthetist examiners were supportive of the anaesthetists, making the point that they also *had* been asked to use a fellowship standard in their marking.

Subsequently, the CBMC chairman attended a meeting of the Faculty's General Purposes Committee (FAGPC) (as an aside this was a small executive sub-group used to allow recording of important issues without its minutes having to go to RCS Council, as did those of the Faculty Board). The CBMC chair described the contents of the letter to the examiners as follows:[49]

- The EBE's diplomas were for GPs wishing additional knowledge, not potential consultants.

- The Part I failure rate (76% to this point) meant that the examination was not of the same standard as the Board's other diplomas, this being considered unsatisfactory.
- The CBMC would be willing to discuss the matter with the Faculty.

The president of the RCS was always a member of the CBMC, and the raising of such a major issue directly with the examiners, rather than through the new Faculty, seems surprising, but is consistent with the EBE's previous resistance to outside input. In addition, Webb-Johnson's time as RCS president (extended because of WW2) and thus membership of the CBMC, ended in 1948,[40] and this haughty approach makes it seem likely that his vision for the specialty was not shared by his successor.

Alternatively, one side or the other had decided that change was to be engineered. Perhaps both factors were relevant, although the frank comments made by the two sides, to say nothing of some subsequent events, suggest anything but an approach agreed between anaesthetists and surgeons. Whichever was the case, the speed of the subsequent implementation of the fellowship does suggest an 'active' process, although no documentary evidence of this is apparent. What is indisputable is that, in 1950, the CBMC had quietly noted that its members did not consider the two-part DA equivalent to the FRCS,[50] an observation which, if widely known, might have raised comment from the AAGBI about its own better proposals. That the CBMC held this poor view of the two-part DA might indicate that it had indeed engineered some change to ensure a fellowship standard examination, but it was done without the anaesthetists being given insight into why. The methodology was 'haughty' even if the (seemingly unlikely) situation was that the intention was supportive.

Johnson's response (as an examiner) did refer to '*certain political and financial disadvantages foreseen by your Committee*' when it had been suggested, at an earlier stage, that the new Faculty should inaugurate its own examination. These 'disadvantages' are not detailed, but the obvious 'political' one is that the perceived standing of an examination run by a new, inexperienced

organisation like the Faculty, would have been low (the financial issue will be considered shortly). Johnson then mentioned discussions with examiners for other diplomas who had described the knowledge of their candidates as '*pathetic*', thus openly questioning the EBE's approach to the academic standards of its products. In reporting back to the CBMC its chairman said little about the examination results (the original topic of his letter), most of his comments being about the DA's future once the Faculty had its own examination.[51] Interestingly, he reported that if a fellowship was agreed about half the Faculty Board would want the DA abolished, a view which might have saved much difficulty had it prevailed. Drs AD Marston, WA Low and V Hall attended the CBMC in January 1952 to present detailed fellowship proposals[52] and no objection was raised.

DA and Fellowship

The DA was to continue in its 1940–47 format, but set to the same standard as other diplomas under the EBE's remit, so making it an examination for GPs 'with an interest'. Given that half the Faculty Board had supported abolition, the DA's continuation might be thought surprising, but obviously other factors were balanced in its favour and, at this distance, two seem relevant:

- First, preserving the EBE's DA income might have helped retain the support of its 'parents', the two Royal Colleges, for the nascent Faculty. Detailed review of the EBE's finances is not appropriate here, but the large numbers of DA candidates do seem to have made healthy contributions, not to 'profits' for the Royal Colleges (as many thought later), but to offsetting the CBMC's considerable administrative costs. An overview obtained from looking through the records of all the diplomas does not suggest that the DA was treated, from the financial perspective at least, in any way differently to the others.
- Second, in the early 1950s there were simply not enough full-time specialists to provide an anaesthetic service, a wartime survey of civilian practice showing that '*virtually all the anaesthetists were also in*

general practice'.[53] The DA could be used to provide useful screening of this group, but having two qualifications of different standards for what the un-informed would see as the 'same' role, was controversial, remained so down the years and did cause difficulties.[54]

This situation brought seemingly contradictory positions from the FAGPC between 1949 and 1953.[55] The poor results in early Part 1 examinations had led the Board of Faculty to suggest reversion to the original DA format, but the FAGPC quashed the proposal as *'harmful to the specialty'.* By 1953 the same committee could see a supportive role for the 'future DA' in training the part-time GP. On each occasion, the main consideration must have been ensuring what had been a key component of Webb-Johnson's original advice, a fellowship standard qualification. Perhaps the difficulties with the DA were worth it as long as the standard of the definitive qualification was maintained so that consultant status within the NHS was assured. This period of the DA history seems to have been as much about guaranteeing that status as it was about the examination's standard.

Although Marston (Figure 9) and Johnson (Figure 10),[57] the first two Deans of the Faculty, achieved much else, they deserve the specialty's particular thanks for this.

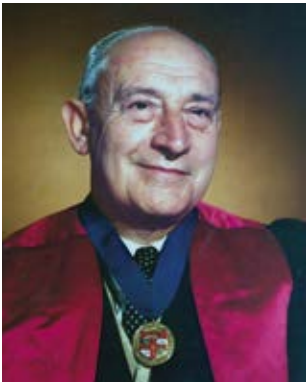

Figure 9 Dr Archibald Marston[56]

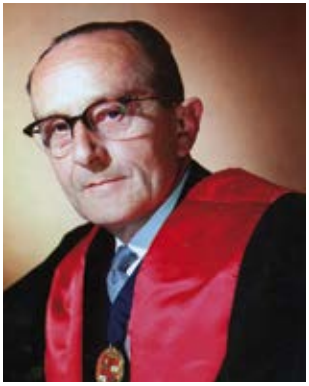

Figure 10 Dr Bernard Johnson

Used with permission from the Royal College of Anaesthetists

The Examining Board in England

The story of the DA after 1953 needs to be set in the context of what happened to the organisation administering it, the EBE having been set up to administer the joint RCP/RCS primary qualifying examination, the LRCP MRCS, in 1884.[58] This was the usual route to registration for a large proportion of medical students in England and Wales, many schools educating students, but having little or no involvement in their assessment. The CBMC comprised three fellows from each college, plus both presidents and an administrator, the secretary. The role was administration, not only of the LRCP MRCS, but also of the Examination Halls in Queen Square, London, while the examiners, sometimes appointed by outside bodies, set the papers. Today it may seem a strange system, but it worked at a time when both medical education and assessment were very different to today. Continuous assessment had not been heard of and examinations were only occasional, but very major, factual hurdles in the undergraduate medical course.

However, reviewing the CBMC's minutes from 1935 onwards while preparing this account showed that a range of issues began to stress the system, the academic ones surely driven by the explosion in medical knowledge through the 20th century. Four major matters are identified as having added progressively to the EBE's responsibilities and these were, in chronological order:

The specialist diplomas
As medicine became more specialised, the need for additional qualifications grew and the EBE was chosen to administer them, the first in 1887, and the total eventually reaching 14.

Examination Halls
The Board's responsibility for every aspect of the use, care and upkeep of a large, ageing building (its fabric needed increasing work) resulted in considerable financial pressure. The Committee also managed every aspect of the staff employed to administer the examinations.

Changes in medical education
New approaches to teaching, training and assessment for both undergraduates and postgraduates required the CBMC to respond to major public initiatives; these initiatives often challenged the very justification of its way of working.

Registration of overseas doctors
The GMC relied for some time on using the Conjoint Examination as a key part of the processes of assessing and registering increasing numbers of overseas graduates.

This list is not comprehensive, but it is more than enough to illustrate how the CMBC's administrative load grew in both depth and breadth, especially after 1950. Would a group of nine people (eight of them also busy with other duties) be made responsible today for a primary medical qualification, 14 very different postgraduate diplomas and a large building in central London? The outside consultations, and the cost of Examination Halls in particular, would seem to have distracted attention from core matters and the problems grew. Evidence of distraction is seen in gaps in examination data in the EBE's minutes for the later years reviewed here. Initially, the information (in Appendices 1, 2 and 3) was all obtained from those minutes, but from 1953 searches of other documents were needed.

The financial situation stemming from the state of examination halls was the specific, unresolvable factor which led to the final demise of the EBE, but dislike of its way of operating must have inhibited any possibility of raising funds to support it continuing. A major issue for anaesthesia, and relevant to other diplomas, was that their links with organisations *with* an interest in the subject of each diploma were poor and (as has been seen) often resisted[37]. Assessment was divorced from both training and standards of practice, with those who could provide appropriate academic oversight having no representation on the CBMC. Are these organisational factors behind not only the decline in the DA's reputation

(eventually being described as something '*given away with a packet of fags*'[25]), but also the examiners for other diplomas describing their candidates' level of knowledge as '*pathetic*'?

Subsequent issues with the DA are discussed later, and those relating to other diplomas have little place here, but three GMC-related points illustrate that it wasn't just the anaesthetists who were pressing for change:

- *1958*: the GMC engineered an external review (probably a unique event) of the Diploma in Public Health (DPH) which was found to be '*insufficient*',[59] yet no change to the curriculum seems to have been made for another decade.
- *1965*: a GMC contribution to the 'Robbins Report on Higher Education'[60] expressed the hope that the practice of bodies without teaching responsibilities awarding primary medical qualifications would '*disappear of its own accord*'. This worried the CBMC, but the presidents of both the RCP and the RCS assured the Board that their Colleges would express strong disapproval of this opinion.[61]
- *1966*: a GMC letter hoped that the DPH (a required qualification for a Medical Officer of Health) would evolve into university-delivered courses and qualifications.[62]

Examination Halls (built in 1910–11) was described as '*no longer suitable*' as early as 1964 (dry rot having been found in 1963),[63] but a subcommittee set up to explore the options quickly identified an upgrade as '*beyond finances*'.[64] The main response seems to have been to try and increase income, especially as other users (eg the Law Society) were withdrawing because of the building's inadequacies, so fees were to increase '*more in line with inflation*'.[65] Some rebuilding was planned, but was overtaken by the finding of even more defects by 1967,[66] yet nothing much seems to have happened. In 1972 a working party on the future of the hall was set up, but it was another seven years before a definitive report reached RCS Council. In that time income had been sufficient to avoid further deficits,

but there were no surpluses to fund significant work and the situation was described as '*precarious*'. Actually, the position had already been recognised as untenable, and work had begun to dismantle the whole organisation. The demise of the EBE obviously affected what happened to the DA, with other issues (including some pretty dated attitudes) also being relevant to the difficulties between the CBMC and the Faculty after 1953.

The DA story: 1953–1996

The DA to revert

Returning to 1952, the meeting between the CBMC and representatives of the Faculty in January 1952 had agreed the broad principle that the DA would revert to its original format and syllabus,[52] but not until details of the new fellowship had been settled. In December, the Faculty reported that this was the case and offered its help and advice in the reorganisation of the DA. Two representatives were invited to the next meeting of the CBMC,[68] but Dr Bernard Johnson, by then Dean of the Faculty, attended alone because his predecessor (Marston) was unwell.

The form of the examination was considered and Johnson made some general comments which were, in essence, supportive of continuing the DA. There were thought to be more than enough training places for two qualifications, with GPs, overseas doctors and even trainee anaesthetists being expected to sit the examination, which also became viewed as a useful qualification for other acute specialties. The clinical experience requirement was to be six months as resident house physician or surgeon and six months in anaesthetics in a recognised general hospital. The latter had increased from six to 12 months before introduction of the two-part version, and a reduction back to six might seem a retrograde step, but the pre-1948 examination was aimed at specialists and this one was to be at the standard of the other diplomas. So, six months it was and it was many years before the adequacy of this was even questioned.

Unfortunately, the real discussion took place after Johnson had left the meeting. The pre-1948 and the two-part exam regulations were compared and one feature from the latter retained, namely the inclusion of both a physician and a surgeon in the examination team. These examiners had been added for the second part of the two-part DA to ensure coverage of the relevant aspects of medicine and surgery, and were retained for the new fellowship. However, only anaesthetists had examined in the original DA and this change was contrary to the earlier informal agreement *'that the examination would be conducted by anaesthetists'*. The minutes record simply that Dr Johnson had mentioned this point, but the committee (without recording any explanation) felt unable to agree to it.[68] Not even in the CBMC minutes, let alone discussed with the anaesthetists, were other changes (all consequent upon having the non-anaesthetist examiners) which had been included in the revised regulations when they reached the Royal College Councils:[69]

- Only the anaesthetists would mark the three-hour written paper and there would be two 10-minute orals to ensure that every candidate was interviewed by both physician and surgeon; originally it had been one oral of 20 minutes, all on anaesthesia.
- The capitation fee for each candidate remained the same (£3), but the examination fee would increase to 10 guineas to cover the costs of having two orals instead of one and four examiners instead of two. The £3 was split (£1 15s 0d/£1 5s 0d) in favour of the anaesthetists, and provided some recognition of the greater workload, but the implications of the other consequences do not seem to have been recognised.
- The most significant of these was that the oral questioning of candidates comprised only 10 minutes on anaesthesia and a mere five minutes each on medicine and surgery.

Do these regulation changes mean that Johnson had overstated the case, was the committee reacting to his previous comments on the standard of their examinations or was the CBMC simply (as in 1935) demonstrating its

ownership? This reneging on informal agreement was, of course, a 'repeat offence', replicating what had happened with the AAGBI proposals for the two-part examination in 1947.[45,46] Whatever the reason, making these changes without discussion, and contrary to informal agreement, cannot have pleased the Board of Faculty, but it seems that its members knew nothing of them until they had been approved by both College Councils. After the Faculty's formation, the RCS's Calendar (a biannual summary of activities) noted that the Faculty made *'Recommendations to the Committee of Management regarding the regulations'* for the DA. In line with this, CBMC minutes occasionally reported that advice had been sought on a hospital's suitability for training or a candidate's qualification to sit the examination. However, the statement on the Faculty's role is absent from the 1953 and subsequent editions,[70] suggesting that the Faculty had declined to be involved or, worse (and more likely?), that it had been deemed unnecessary by Council. Intriguingly, the imposition of the 'clinician' examiners can be interpretated as a reaction to half the Faculty Board wanting the DA abolished. Could the whole episode have been a move to maintain 'outside' control of a qualification recognised as important for supporting service delivery?

The Faculty looks to other matters

The establishment of the Faculty and the FFARCS by election, in 1948, must have been a time of great optimism for those leading the specialty, with the difficulties over the two-part DA more than balanced by the introduction of the FFARCS by examination in 1953. Continuation of the DA concerned some, but the Faculty's acceptance of it having a role in screening the GPs needed for anaesthetic service provision included offering to help review the regulations. However, the CBMC's action in changing those regulations without even informing the Faculty, let alone discussing the alterations, must have been a very negative time. There is nothing about this demeaning treatment in the minutes of any Faculty group; Board of Faculty minutes had to go to RCS Council and it might

have been better to stay silent on the matter, but the FAGPC and Faculty of Anaesthetists Examination Committee (FAEC) records are equally silent. Anyone on either side who knew what was said 'off the record' is long gone, having left no known account, and it is hard not to conclude that the Faculty had been put firmly in its place – further evidence of the loss of Webb-Johnson's enlightened influence.

Either sensitivity about, or ignorance of, the episode has long continued; the Faculty had to work with the RCS, but there is no record of communication with the CBMC for nearly a decade after the episode. Scurr's Hewitt Lecture, a detailed review of the development of training and examinations, was delivered at the same time (1971) that he was (as Dean) trying to obtain more influence over the DA, but he does not mention the episode.[4] The lecture was delivered 18 years after the event, but sensitivity seems more likely than ignorance, if only because the RCS Council of the time would have been present at his lecture. Another 25 years on and another, even more wide-ranging review (Boulton's)[2] doesn't mention the event either, and this is more likely to have been due to lack of awareness because ready access to CBMC minutes made it all very clear. Back in 1953, and faced with a fait accompli, the Faculty would have been unable to change a Council decision and would have had to accept the situation and focus on what it *could* influence – the development of its own organisation to service the developing specialty.

Much of the current activity of the Royal College of Anaesthetists (RCoA) – examinations, training programmes, education, representation, etc – is in direct continuity with the Faculty's early work and there was one notable highlight: establishment of a Research Department of Anaesthetics within the RCS building.[71] All of this helped grow the status of the specialty in the UK through the 1950s and 1960s, alongside other important elements (see Boulton[2] for a full account). The AAGBI continued to be a major force, pursuing (in line with its original motivation) matters which the Faculty could not, and continuing to work in parallel on other topics. At least as

important as the organisations were the clinical and scientific developments which improved anaesthetic techniques to better facilitate surgery, produced better outcomes for patients and attracted more recruits to the specialty. The same advances also took the anaesthetist out of the operating theatre and into the intensive care area, the labour ward, the research laboratory, the preoperative assessment clinic and the pain clinic, improving lay and professional opinion further. The continued growth in the numbers of overseas graduates awarded the DA (Appendices A–H) can also be seen as a marker of the improving reputation of the specialty in the UK, although this does not mean that there weren't issues with the examination.

A DA in isolation

The difficulty resulting from the changes in the DA regulations meant that it and the Fellowship ran in parallel, with the two Colleges appointing DA examiners (with little recorded input from the Faculty) and the EBE seemingly approving hospitals for training. Presumably the list of hospitals that had already been approved by the Faculty was used initially, but for many years there is no indication of how, or even if, it was updated. The last two-part DA examinations were held in May 1953 and the first FFARCS diets the same year (primary in November, final in December). Those who had passed the Part 1 DA were exempt from the primary and all who had passed Part 2 were eligible to become FFARCS by election.

The first DA examination after reversion to a modified one-part structure, and with each candidate examined by a physician and a surgeon as well as the two anaesthetists, was also held in November 1953. From that time, the DA continued on its independent way, the only discernible change in the next decade being that the examiners fees changed from a per capita to a per diem rate (£31 10s 0d for anaesthetists and £22 10s 0d for 'clinicians') in 1959.[72] Cynics might note that this meant that the fee ratio between anaesthetists and 'clinicians' changed, from 70:30 to 60:40, to the

anaesthetists' *dis*advantage! During this period (1953–63), the numbers of candidates seen at each sitting (Appendix 4) returned to the level seen just after WW2, but with a considerable increase in pass rates (35–54%). Perhaps candidate performance had improved, but the more likely explanation is that the pass rates reflected the new standard of the examination, that of the 'GP with an interest', not the definitive specialist as previously. During this period, no trends are seen in the numbers sitting, the proportion passing or the percentages of successful candidates who were female or had graduated overseas, but both of these subgroups were larger than before. The number of graduates from the Indian subcontinent was greater than before and continued to increase subsequently, but was steady during this time.

Communication restarts

Indicators of renewed contact with the CBMC first appeared in Faculty documents in 1958:

- The FAEC minutes, which had never mentioned the DA previously, first recorded (very briefly and without any comment or explanation) the examination's results[73] and continued to do so although not consistently.
- In 1959 Professor W Mushin visited a hospital which had applied for recognition for training for both examinations, but this seems to have been a pragmatic, one-off exercise.[74]
- In 1961 the FAEC discussed whether a DA candidate had had adequate clinical training.[75]

Minor matters all, but communication had reopened and something more definitive was triggered by a CBMC discussion about the number of DA examiners in 1962.[76] The number of candidates had not decreased as expected, to some degree because of increasing numbers of overseas graduates, and the four nominated examiners had occasionally needed augmenting with locums. This led to questioning of the continuing need for the 'clinician' examiners, the CBMC chair, a surgeon, supporting doing without them, but one of the physicians was strongly against a change. It

was decided to refer the matter to the Faculty, asking for '*Observations on future appointment of examiners*'.

As a result, the CBMC chair attended a meeting of the FAEC and reported back their views: the two 10-minute orals were inadequate; the 'clinicians' were in some ways redundant; and the anaesthetists could easily ask about medicine and surgery.[77] In support of deciding what to do, a postal survey of past 'clinician' examiners was performed; it produced a range of opinions, some of them very interesting:

- The physician contributed more than the surgeon and the medical knowledge of some candidates was lamentable.
- Having only two 10-minute orals was really paying lip-service to assessment in medicine and surgery, let alone the core subject.
- One made the point (perhaps crucial to the outcome of this discussion) that it was rare to fail a candidate in medicine who did not pass in anaesthesia.
- Another noted that anaesthetists could ask relevant questions in medicine, and to a level which would improve the standard.

The outcome of subsequent consideration was that, beginning in 1964, each oral was conducted by two anaesthetists, but with a physician and surgeon 'in attendance'.[78] They would listen in and become directly involved if it was felt appropriate, the stated reason for this unusual arrangement being that it was important that the candidates knew that they could be asked about medicine and surgery. It did nothing to increase the number of examiners, the point which originally prompted the discussion, but it was some progress. However, it is tempting to wonder which group the EBE wanted the 'clinicians' to continue to monitor, candidates or examiners, this supporting the earlier speculation about control of the examination to ensure service delivery. With the new arrangement in place (1964–70), outcomes seem to have continued much as before, perhaps with a small increase in overall pass rate. More obvious were increases in

the proportions of the successful candidates who were female (now peaking at 30%) or had qualified overseas (now up to 42%) (Appendix 5).

Some definitive change

Another of the less than desirable changes made to the DA in 1953 was that the approval of hospitals for training reverted to the EBE. As already noted, it is not at all clear what process was used, but an unbound draft version of a form for this purpose does appear among the 1964 minutes. It requires information on number of hospital beds, the split between surgical specialties, the numbers of major and minor procedures and the numbers of consultant anaesthetists, together with their qualifications and weekly sessional commitments.[79] This level of detail would hardly produce an in-depth assessment of training, especially given that nothing was asked about educational facilities and activities, but it was a start. Little record of the form's use has been traced, although what was the first recorded approval of an overseas hospital for training (Galle in Ceylon, now Sri Lanka) appeared a short while later;[80] it is presumed that the form was used.

This was the period when the financial situation of Examination Halls was beginning to cause real concern and the first reaction was to raise the candidate fees, the new rate for the DA being proposed at 15 guineas.[81] However, the RCP President suggested that the increases should be more in line with inflation and so the DA fee increased to 20 guineas in 1966 – double. It wasn't too long before this led Dr HK Ashworth,[82] chair of the DA examiners, to put in a claim for an increase in *their* fees, but this was given a very robust negative,[83] the examiners probably not knowing that the extra money was for Examination Halls not them! A very different, but slightly earlier, proposal from Ashworth was given an odd response which might have had financial undertones as well, namely the EBE's desire to keep candidate numbers, and therefore fee income, up.

The examiners had found that about 5% of candidates performed so badly that further measures were needed.[84] The first EBE response was that the comments implied criticism of the candidates' teaching and that there was '*nothing*' which the CBMC could do about that, another instance of outdated attitudes. Rightly, Ashworth persisted that there *was* something, namely that the duration of the clinical experience required should increase (very poor candidates being referred for a year) or that training recognition of the individual's hospital should be withdrawn. His preferred option, candidate referral for longer training, was met with some resistance, but was eventually accepted with the proviso that the final decision would be made by the CBMC chair in discussion with the secretary. Quite how two non-anaesthetists not involved in the assessments were going to make such a decision is not recorded, and this is what suggests that the response to Ashworth was more about maintaining income than proper candidate management. In fact, the policy does not seem to have been implemented, even further support for a sarcastic interpretation of the episode, and it is no surprise that the issue was soon back on the agenda.

Ashworth's 1965 letter had made only passing reference to increasing the period of training and it is perhaps surprising that the six-month duration instituted by the CBMC in 1953 had not been challenged previously. In 1968 he wrote again,[85] this time on behalf of all the examiners, to state more stringently that six months was too short, very reasonable given the way in which anaesthesia had developed in the previous 15 years. The examiners were particularly concerned about overseas candidates who were often hampered by language difficulties and were perhaps being used in service roles in peripheral hospitals with little time to absorb teaching. As a result, Ashworth's successor, Dr SDK Stride,[86] attended the CBMC in July and several matters were discussed:[87]

- In addition to Ashworth's points, Stride felt that possession of the DA might give overseas candidates the status of 'specialist' when they returned home, but the current standing of the examination did not merit this.
- Stride agreed that the DA was still a suitable qualification for GPs with part-time hospital appointments and he noted that this potential group acquitted themselves well, perhaps a 'softer' position than Ashworth's. (There is a contradiction here in that it seems as though the DA was considered good enough for Britain, but not for overseas countries, although two important differences are perhaps relevant. First, Stride was clear in indicating that UK graduates performed better in the examination, the implication being that they were better prepared for clinical practice as well as examination performance. Second, a GP anaesthetist in the UK would, nominally at least, be under the supervision of the consultant members of the department, just as non-consultant career-grade staff were subsequently. However, those returning overseas were more likely to be working independently without any such oversight and support.)
- Asked for his views on the 'clinician' examiners, Stride thought that they served little useful purpose, felt that the current examiners would agree and said that he would like to see them replaced by more anaesthetists, again repeating an earlier proposal.

It was agreed immediately to recommend an increase in the minimum time required for training from six to 12 months, but to obtain the views of the current 'clinicians' before doing away with them. They did agree with Stride and the CBMC proposed that only anaesthetists, six of them (three from each College), would be appointed to the Board of Examiners.[88] The two recommendations went to both College Councils and the new examiner arrangements were approved (and implemented in 1970), but the one about length of training was referred back to the EBE by the RCS Council.[89] Perhaps surprisingly, the source of this referral was the Board of

Faculty in the person of its Dean who, from March 1967, had been a member of RCS Council.[90] On receiving the meeting agenda the Dean, Dr Derek Wylie (Figure 11),[91] had notice of the proposal and was able to take it to the FAEC in advance of the Council meeting. The FAEC declined to comment on the extension to 12 months because the DA was '*not within the jurisdiction of the Faculty*',[92] a decision with a strange echo of the CMBC's 1938 refusal to award the DA 'without examination' to three Americans! Subsequent events suggest that the Dean might have 'steered' the committee to this view so that he was not constrained by a decision to support the change because he did not follow the advice recorded in the minutes.

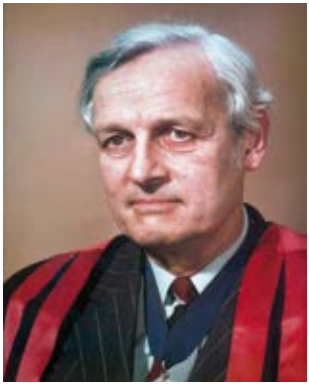

Figure 11 Dr Derek Wylie
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The FAEC felt that the opportunity should be taken to discuss the DA and its future with the CBMC because there were ongoing deliberations on a number of aspects of specialist training, notably formalisation of rotations and revision of the fellowship. The implication of this, taken with points in later minutes, is that the DA might become a defined component of specialist training, the first mention found of such a possibility. At the next FAEC meeting, Wylie reported that it had been arranged for him to attend the CBMC to discuss the DA, his colleagues further suggesting that he treat it as an exploratory meeting with no brief other than to

report matters which both the committee and the Board of Faculty had discussed.[93] However, the minutes of the Dean's CBMC attendance describe only his comments on extending the training time for the DA.[94] He understood Stride's reasons for making the proposal, but claimed that the Faculty's main focus was the continued importance of GP anaesthetists in service provision. He also noted that extending the DA clinical training time to 12 months might limit the number of training posts available for career anaesthetists. These points may have been discussed at FAEC, but they are not mentioned in its minutes and they do rather clash with the advice which *is* recorded as having been given to the Dean on what to do at the meeting with the CBMC.

The background to this issue is that the regulations of the Royal College of General Practitioners (RCGP) allowed time in hospital posts (including anaesthesia) to count towards the total duration of vocational training for general practice (GP'), but the duration of each post was limited to 6 months. There are few relevant data, but figures for 1967 are on file[95] and show that 165 of a total of 395 DA candidates were UK graduates during that year. Whether they were intending to be GPs or hospital specialists (anaesthetists or otherwise) is not known, but Stride had already noted that UK graduates acquitted themselves well in the examination. Less than half (42%) of the 1967 candidates were UK graduates, but around 55% of them were successful (Appendix 5), these figures providing some support for Stride's observation. However, the difference between UK and overseas graduates does not seem as large as the inference drawn from it regarding the possible impact of increasing DA training time on the recruitment of GP anaesthetists, and one year's data provide thin evidence for anything. Increasing the requirement beyond six months would be incompatible with RCGP regulations and have an obvious impact on recruitment, so why, the argument went, risk the possibility. Comments from the surgeons on the CBMC suggest, not surprisingly, that this had their support.

To deal with the examiners' criticisms, the CBMC suggested that very poor candidates be referred for another six months of approved training. This, of course, is exactly what had been agreed with Ashworth three years earlier and the CBMC proposing the policy anew in 1969 does confirm (disappointingly) that it had not been implemented earlier. However, Wylie considered that it might well be a practical solution which would allow formal training time to remain at six months, and he is then said to have thanked the Committee for the opportunity of '*expressing his views*'.[94] Use of 'his' may just be a reflection of the minute author's style, but the record of Wylie's comments does contrast with what is in the earlier FAEC minutes and (disappointingly) there is no mention of him raising any discussion on the DA's future. A third disappointment from this episode is that the Faculty learnt of a proposal from the DA examiners only when it reached RCS Council, indicating that, 20 years after the Faculty's establishment, there was still no formal link between it and the DA examiners. Subsequently, it became apparent that the latter were very resistant to outside input, presumably following the EBE's policy of internal discussion only,[38] and later still they were described as '*a very independent bunch*'.[96] However, the Faculty objecting to the examiners' proposal to increase the length of training[85] (made with the clearly stated aim of improving standards) cannot have helped the relationship between Faculty Board and DA examiners.

The 'Todd' Report and after

So, the CBMC had readily accepted changes to two regulations which their predecessors had instituted unilaterally in 1953 and Stride seems to have met a more amenable committee than Ashworth. The explanation seems very likely: publication of the *Royal Commission on Medical Education – the 'Todd' Report* early in 1968.[97] Its recommendations, and those from parallel initiatives, led to major changes across medicine, one distinct thread being more structured postgraduate training as a response to the increase in knowledge and the resulting need for specialisation,

since WW2. Specifically, the 'Todd' Report '*saw little or no future for the Postgraduate Diplomas*', with the DA being one of those singled out for particularly negative comment. The Board of Faculty of that time was already well in the forefront of bodies keen to 'modernise' approaches to training and assessment, and it may be more than speculative to wonder if 'Todd' was keen to help them. The readiness of the members of the CBMC to accede to changes in aspects of the regulations which they once had favoured strongly suggests that even they had recognised the need to be more responsive to others if the EBE was to continue.

Perhaps hoping to take advantage of such improved responsiveness, the pressure from the Faculty for further change increased, starting with this resolution being sent to the CBMC by RCS Council in 1969:

> '*That the Committee of Management be informed that the Board of Faculty of Anaesthetists, having reviewed the training of anaesthetists for the future now sees a clear place for the Diploma in Anaesthetics in this training pattern, and would be prepared to take over the responsibility for the Examination for the Diploma in Anaesthetics*.'[98]

That such a resolution had to go by way of the RCS Council was a consequence of the Faculty's continued 'subsidiary' position. Even in the aftermath of 'Todd' the difficulty of influencing the DA remained a specific instance of the wider struggle to gain control of the specialty's affairs. Representation on the RCS Council had only been achieved recently. In addition, the Faculty had no control over its finances; all decisions had to be ratified by Council, and the College President and two vice-presidents were still voting members of the Board.

By the time of this new resolution (1970), anaesthesia was the largest hospital-based specialty in the NHS and anaesthetists were providing 25% of the RCS's fellowship subscription income.[2] It is not surprising that the feeling was growing that being 'subsidiary' was no longer acceptable. The forwarding of the above motion by the RCS is an indicator of support from that side, but the CBMC's reaction shows that there was much more to do, the entry in the minutes recording receipt of the resolution reading as follows:

> '*After discussion, it was agreed to leave the matter on the table sine die.*'

To say that the Latin tag '*sine die*' translates as 'forget it' (or worse) may be an exaggeration, but it is very far from a positive response and is another example of the CMBC's resistance to outside input. The CBMC might have changed, but not that much!

Later in 1970 the Dean of the Faculty (now Dr Cyril Scurr, Figure 12[99] continued the pressure with slightly impatient contributions to CBMC meetings arranged to consider whether the diplomas should become registrable qualifications.[100]

Figure 12 Dr Cyril Scurr
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The minutes quote Scurr very fully, and he started by referring to:

> *'...the difficulties created in respect of certain specialist diplomas (notably the Diploma in Anaesthetics) by the situation in which the body responsible for training policies was different from the examining body.'*

His reported comments continue:

> *'The Dean of the Faculty of Anaesthetists emphasised this Faculty's disquiet at this situation and reminded the Committee of his Board's offer, recently conveyed to the Committee of Management of the Examining Board by Council, to take over responsibility for the Diploma in Anaesthetics, for which it saw a clear place in the future training pattern in anaesthesia. Possession of the Diploma entitled its holders to become members of the Faculty, and this reinforced the desirability of giving to the Faculty responsibility for the control of the examination and its training requirements.'*

The earlier motion from the RCS Council (one of the EBE's parent bodies after all) reads,[98] at the very least, as a firm request to discuss the offer and, given their growing workload, the CBMC should perhaps have been glad of an offer of some help.

The RCS flexes its muscles

The RCS Council's submission of a proposal that the Faculty take over the DA is interpreted above as showing support for the motion, but the CBMC's reaction indicates that other interpretations are possible:

- The surgeons might have been saying one thing to the Dean's face at Council, but another behind his back at CBMC.
- Were the physicians continuing to be more resistant to change?
- Was the DA income still paramount for the CBMC as a joint organisation?

However, the Faculty's efforts with the RCS must have continued behind the scenes because early in 1971 the CBMC minutes record receipt of this further 'advice' from the RCS:[101]

> *'...that it is educationally desirable that the Diploma in Anaesthetics be transferred from the aegis of the Committee of Management to that of the Faculty of Anaesthetists, to become a Diploma of the Royal College of Surgeons of England; and that the necessary steps be now taken to implement this'.*

The advice (now a very clear direction) then went on to note that this could be a precedent for other surgically related diplomas (ENT, ophthalmology and radiology), with the relevant groups' views now being sought. This surely turned the 'advice' into a very thinly veiled threat that unless a way forward was found the EBE might lose more than one diploma, the RCS's support for change to the DA being just the beginning. In the subsequent discussion the advice was still opposed by those representing the RCP who claimed that the value of the diplomas, and the justification for the EBE's existence, lay in joint Collegiate status. Clearly, the RCP *was* the more conservative half of the partnership and a way through their position was needed, because anaesthesia was leading and others were looking to follow.

The next CBMC meeting was also joined by the Faculty Dean (still Scurr) who repeated previous points and reassured the RCP representatives on the concerns which they had raised on behalf of overseas graduates and late-entry, married women GP anaesthetists.[101] The CBMC secretary, perhaps crucially, agreed that academic supervision of the DA by the Faculty would make only a marginal difference financially, obviously assuming that the CBMC would continue to administer the examination. Eventually, the CBMC *'agreed that there was an unanswerable case on educational grounds'* for a change to the DA and that discussions were to be opened with other specialties. Subsequent discussions between Faculty

and CBMC led to agreement on the ways in which various matters could be delivered *'with the advice of the Faculty'* and the following areas for its responsibility were suggested to the Colleges in 1971:[102]

- Training curriculum and syllabus for the examination;
- Recognition of training posts;
- The actual Diploma would acknowledge the Faculty;
- The Colleges to continue to consult the Faculty on Examinerships;
- The Regulations will be modified to reflect the above; and
- The arrangements to be reviewed in three years.

However, more long-lasting, to say nothing of definitive, change was given further impetus by developments in GP'.

Later roles for the DA

A little before the above events, in 1970, Dean Wylie was claiming that the Faculty *'saw a clear place* [for the DA] *in the future training pattern in anaesthesia'*, although there had been little more than suggestions that specialist trainees might sit the examination. The author started his career in anaesthesia in the same month as the relevant meeting, and his peer group (in the south-east of Scotland anyway) looked upon the DA as irrelevant, two colleagues intending to be GP anaesthetists even obtaining the FFARCS. Discussions with others of a similar vintage suggest that this position applied elsewhere, but far from everywhere; for example, of the two larger training centres in the west of Scotland, one encouraged taking the DA and the other did not.[103] Geography seems to have played a part in other ways, closeness to London influencing the ease of making the two journeys (one for the written, the other for the orals) to Examination Halls in Queen Square that were needed to sit the DA.[104]

At the time, new medical graduates were very much left to themselves to pursue early postgraduate training, and those with no clear career intention would undertake a range of specialist posts in the hope of

finding something which suited them. Those who had tried anaesthesia, and decided that it was not for them, would sit the DA simply to have something to show for the experience; others who were interested in continuing would use success as confirmation that it was the specialty for them or as a marker of later progress. Similarly, those who were committed to the specialty and had already passed the primary fellowship might take the DA as part of their preparation for the final. So, as well as being the route to sessions as a GP anaesthetist, the DA had, by 1970, also acquired a range of roles, albeit informal ones, in the production of the full-time specialist. Perhaps the Dean, in saying that the Faculty saw 'a clear place' for the DA in the future specialist training, was implying some formalisation of these functions, but there is no recorded evidence of this.

General practice lends a hand

It is very clear that the Board of Faculty was continuing to accept six months of experience as adequate preparation for part-time practice. The discrepancy between the advice which Dean Wylie was given at FAEC and the report of his attendance at CBMC suggests not only that he thought six months acceptable, but also that service needs were still a major priority. At the time in question, the author further recalls great consternation over withdrawal of recognition of experience in anaesthesia as counting towards vocational training for GP', but no mention of this was found in CBMC or Board of Faculty minutes. Enquiries of the RCGP resulted in their sharing records of what were important events with a crucial impact, begining with Dr T Hunt, chair of the CBMC, writing to the RCGP President.

The letter has not been found, but it seems that Hunt was seeking the RCGP's continued recognition of six months' experience in anaesthesia as contributing to GP training. The explanation provided (countering pressure from the DA examiners to increase the training time to 12 months) seems rather cynical at this distance given what was found in the RCGP records. A

meeting between representatives of Faculty Board and RCGP exchanged views, after which Dr JP Horder produced a position paper for the RCGP,[105] and that organisation has been kind enough to provide a copy. It records that in 1967 their Vocational Training Sub-committee had decided that anaesthesia should not be included in the list of hospital posts approved for vocational training in GP' because other specialties were more relevant. Nothing changed at the time, but, in September 1971 (just before Hunt's letter) the RCGP Education Committee, presumably a more influential group, had come to the same decision. Was it knowledge of this decision that the approach to the RCGP was really about trying to reverse?

Potential GPs, as noted earlier, had been happy to train to be part-time anaesthetists when the experience required was within their overall training requirement, but any increase in its duration would mean that it would have to become an 'add-on' component. The potential consequence of a longer training time was that few (if any) would be prepared to do so, and that did prove to be the case, the decision marking the beginning of the end of the GP anaesthetist. Both specialties were set to become full-time practices, to the long-term benefit of each in the author's opinion, given the way that medicine in general, and both disciplines in particular, were developing. Dr EV Kuenssberg replied to Dr Hunt on 22nd December 1971 and was explicit:[106]

- The duration of training in preparation for the DA was for the CBMC and the Faculty of Anaesthetists to decide.
- The RCGP Council had upheld their Education Committee's decision because other areas of experience were considered 'essential' for GP training.
- If all specialties were to adopt the 'Todd' Report proposal of longer training programmes (4–5 years), the return of anaesthetics to the list for GPs would be acceptable.

There were considerable implications for both service planning and the EBE. If potential GPs were not training in anaesthesia, they would not sit the DA and the income (thought to be around 40% of the total) from that source would be lost; this consideration perhaps explains why it was the CBMC Chair who wrote to the RCGP, not an anaesthetist. It would be nice to think that the points made in the letter from the RCGP helped the Faculty to recognise that its prime focus should be training not service and that such training needed to concentrate on providing specialists to cover the service. There is some historical sadness that it was the GPs not the specialty who precipitated the change, but the fact that it had been a RCGP decision must have made it easier to argue for increased NHS funds for more trainee and career-grade staff to cover the service in the future.

The 'new broom' sweeps further

In spite of the 'bombshell' from the GPs, the DA was to continue, with the new regulations reflecting and confirming the previous year's general principles to introduce a number of major changes:[107]

- The syllabus was widened and strengthened to include drug interactions, elementary physics of equipment (including clinical measurement), treatment of anaesthetic complications, resuscitation and emergency care.
- The examination would consist of two papers (anaesthesia and related elementary basic medical sciences; anaesthesia and related clinical medicine) and an oral.
- A minimum period of experience of 12 months in recognised posts was required to sit the examination and six months of this (and more depending on individual assessment) could be in recognised posts overseas.
- Individual consideration would be given to long service individuals to qualify on a sessional basis, but for no more than six months in total.
- Very poor candidates could still be referred for six months of further training.

- Finally, and perhaps most importantly, the wording of the DA certificate would be changed to reflect the involvement of the Faculty; the diploma would continue to be awarded jointly by the two Royal Colleges, but '*on the advice of the Faculty*'.

The new regulations were approved for implementation in 1973 and clearly reflect two important issues: anaesthesia was much more scientifically based than in 1953, and the role of the anaesthetist had widened considerably. However, not everyone was happy with this strengthening of the DA, the published views of one senior clinician perhaps reflecting the views of many who were concerned about the standing of the specialty.[108] The writer argued forcefully that the DA was '*an anachronism*', that strengthening the examination was '*harmful to the development of the specialty*' and that it risked undermining the fellowship. The earlier, lower standard DA was acknowledged as useful as a marker for those wanting relevant anaesthetic experience before working in other specialties, but on balance the argument was that it should be abolished. This view was, of course, very 'UK centric', but it was a period when the output of fully trained specialists still did not meet the demands of an expanding service and there were pressures to accept those who held only the DA, even for consultant posts.[53]

Notification of the 'stronger' syllabus certainly had an effect on the number of candidates taking the examination during 1973 (Appendix 6). An increase of 25% in those sitting the final diet under the older regulations (to 'avoid' the changes?) was followed by a decrease of 50% for the next sitting as candidates decided to revise for longer before sitting or waited to see what others reported back. Thereafter numbers continued at a level somewhat lower than previously and tended to decrease further through the rest of the decade, with the pass rates indicating that the test had become more stringent. Once the examiners were all anaesthetists, but with the earlier regulations in place, the average pass rate was 56%; subsequent to the change it was 48%. The percentage of successful

candidates who were female had plateaued at 30%, but the proportion who passed and were overseas graduates was now occasionally greater than half. The increase in overseas doctors was, in financial terms, close to compensating for the loss of potential GP anaesthetists.

The changes also resulted in a quietening in the relationship between Faculty and CBMC, the examination seeming to run to everyone's satisfaction for the next few years, although the CBMC still had its internal pressures to deal with. As the decade wore on their minutes report increasing discussions on what arrangements would succeed it, the relevant specific point being that the Faculty would take complete responsibility for the DA after December 1979. These matters were confirmed at the RCS Council meeting in April 1979,[109] leaving the Faculty with control of the DA in 1980. For another year the DA examiners continued, albeit only nominally, to report their results via the two Royal Colleges because the regulations for that year had already been established. Complete administrative responsibility was in place in 1981, with the examiners reporting directly to the Board of Faculty,[110] and the qualification becoming the Diploma in Anaesthetics of the Faculty of Anaesthetists of the Royal College of Surgeons of England. The potential full postnominal, DA(FARCSEng), was sensibly abbreviated to DA(Eng), distinguishing it from the conjoint version, but the simple 'DA' was still used by most holders.

The examination structure

At the same time as it obtained complete responsibility for the DA in 1980, and as another component of the move to greater independence, the Faculty also assumed more direct control over the fellowship examinations. This allowed the Board to explore options for a new examination structure, the proposals including, from the start, a clinically focused test appropriate to one year of approved training, a DA in everything but name. Another early suggestion was to include '*some*'

basic science in an initial examination, which would still lead to award of the DA and also provide membership of the Faculty.[110] Other aspects of basic science would be included in a final examination to be '*phased*' through training, although there is nothing on how this vague suggestion, sounding almost like a series of assessments, might be implemented.

For the time being, the DA had to continue much as it was in 1979, definitive change being limited by the FAEC being reminded (by whom is not clear, but the RCP seems likely) that the EBE had required that whoever assumed academic responsibility for the DA had responsibilities to:

- ensure that candidates who were preparing under existing regulations were not to be disadvantaged, a valid point; and
- appreciate that the existing DA was an examination which allowed overseas doctors to obtain a qualification appropriate to their own countries.

From the modern perspective, the latter requirement has less validity and reference has already been made to much earlier expressions of concern about this function of the DA.[87]

After the RCGP's removal of recognition of anaesthetic training, an increasing proportion of DA candidates were from overseas (Appendix 6) and, in 1980, the FAEC was still supporting the DA, and the experience it required, as suitable preparation for independent work.[111] Those who defend this situation speak of individuals trained in this way knowing their limitations and providing safe practice, as long as clinical support and continuing education were in place, but providing access to specialist services might have been more appropriate in the UK. The eventual outcome, certainly in terms of service provision, suggests that this has proved to be the case, but, until then, continuation of the long-standing double standard described earlier meant that the comparison with surgery was stark. Trainee surgeons from overseas took the surgical fellowship – there never was a lower status 'Diploma in Surgery' for them.

Anaesthesia was, in essence, still being considered inferior to surgery, even by the Board of Faculty and if only by default. Why did they not expect *all* overseas trainee anaesthetists to sit the FFARCS as, of course, many did?

By September 1980, the FAEC had produced a discussion paper on the future of the examinations and, interestingly, there is a clear indication that it had been produced on the committee's own initiative, not at the request of the Faculty Board.[112] Given the time it took to introduce a new structure, this minute seems to be the first indication of a wide range of views within the overlapping membership of the two groups involved, the FAEC and a subgroup, the Examination Structure Working Party. Although the memberships and oversight of these two came from the Board of Faculty, frequent changes in the individual in the chair of the FAEC perhaps reflects the level of difficulty in the discussions. The members of the Board of Faculty, having eventually won their battle with the CBMC, were now fighting each other! The discussion paper accepted that the DA would be maintained at the 1979 standard for only two years, but this presumed that the structure review would be completed in that time frame. In fact, it meant that the DA, and its regulations, would continue unchanged until two years *after* definitive agreement on a new structure had been reached, and that is what happened. The DA *could* have been changed sooner, but the focus on incorporating its elements into a revamped fellowship structure delayed any change.

The essence of the difficulty was accommodating, within a traditional two-part postgraduate examination structure, developments in the specialty as well as including 'older' material which many still considered necessary. At that time the primary FFARCS focused on the relevant basic sciences (physiology, pharmacology, physics and clinical measurement) and the final on the relevant clinical aspects (anaesthesia, medicine and surgery). Knowledge of the basics had increased, but much of the pressure for change came from those wishing to include the growing fields of intensive care medicine (ICM) and pain management (PM).[113] The details in

the conflicting FAEC minutes during 1980, 1981 and 1982 are of no direct relevance to the DA, except that the failure to agree did indeed lead to the examination continuing 'as was' for longer than it should have. It was usual to give potential candidates (and their trainers) up to two years' notice of new regulations and this meant that nothing could change while attempts at a new structure were resisted by one interest or another.

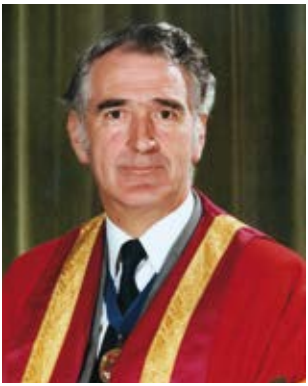

Figure 13 Professor Sir Donald Campbell
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Eventually, in September 1982, the Dean (Professor, later Sir, Donald Campbell,[114] Figure 13) expressed his concern at the three years of '*protracted and indecisive discussions*' on restructuring and required a decision by the end of the year.[115] That he then chaired the next FAEC meeting may have been happenstance, but it does suggest that he was making sure that a decision was made! That proved to be the case and the proposal for a three-part fellowship examination was presented at the first FAEC meeting of 1983:[116]

> *Part 1*
> A DA style clinical examination, but at a fellowship standard with a multiple-choice question paper (MCQP), a 'write short notes' paper and two orals;

Part 2
Physiology and pharmacology with two MCQPs and two oral assessments; and

Part 3
A clinical examination focusing on more advanced aspects of anaesthesia, ICM and PM.

This was agreed and went forward for implementation from 1st January 1985, the above discussion indicating where the main areas of disagreement had been. The essential points of conflict were in regard to including, somewhere in the structure, wider consideration of ICM and PM, as well as continued coverage of the basic sciences and the 'routine' aspects of clinical anaesthesia. The three-part fellowship was never popular, and it might have been simpler to expect trainees to sit both the DA and a two-part fellowship, but this would have continued the unhappy situation of two qualifications of different standards for activities which outsiders might deem the same. The new structure still allowed acquisition of a DA, but, because it was only one part of a three-component fellowship, it could perhaps be presented more readily as only a partial qualification.

The author was appointed as an examiner for the new Part I from 1st January 1985 and attended a briefing meeting late in 1984; much of the information presented then was useful background for the last two paragraphs.

DA(Eng) – towards the end

Thus, the DA examination continued almost 'as was', apart from the new postnominal which reflected that it was now a qualification of the Faculty, albeit one within the RCS. While the debate continued so did the examinations and their outcomes (Appendix 7) with pass rates below 50% and no change in the proportions of those passing who were female or overseas graduates. Although the FAEC can be criticised for the delay, the time was used to modernise the DA examination as much as was

possible within the framework of the existing regulations; many small, but cumulatively significant, changes were recorded in the FAEC minutes:

- From 1981 the examiners were elected in June at the same time as those for the fellowship[117] and the pool of DA examiners was expanded by adding individuals with no previous experience of this examination (Appendix 8).
- In 1982 a formal link with the DA examiners was established by their chair becoming a member of the FAEC.
- Previously there had been no limit on how often a candidate could re-sit the DA, but an initial limit of six attempts was discussed, still generous given that formal review was later required after three failures in any one part of the examination.
- Early in 1983, small working groups were set up to discuss the details of each component of the new fellowship, their brief including the need to develop common systems (eg for marking) across all parts. The group for Part 1 comprised Professor MD Vickers (chair) and Drs JA Griffiths, RD Jack and TB Boulton, with both Griffiths and Boulton having previous experience of examining for the DA (Appendix 6).
- It had already been decided that the DA would be awarded only to those who had passed the Part 1 examination and completed one year of approved training.
- In 1983, the 'introduction' of some DA examiners to fellowship-style procedures was started by their use as locums in the primary FFARCS.
- At some point (not clearly identified), a practice had been introduced of excluding from the orals candidates who had performed so badly in the papers that they would fail overall, no matter how good their oral mark. To 'sweeten the blow', a portion of the examination fee had been refunded, but this practice ceased with the demise of the independent DA.

- By 1984 the DA examination fee was £136, with payment of a completion fee of £20 required for actual award of the Diploma.

The last sitting of the free-standing examination was held in October 1984, close to 49 years after the first.

Introduction of the DA was a major step in the development of anaesthesia as a distinct medical specialty in the UK, to say nothing of leading the world in the formalisation of qualifications for anaesthetic practice. The intention of this account was not simply to record the DA's story and evolution, but to show how that story fits into the way in which the status of the specialty progressed. The excellent start of 1935 was not maintained, the low initial standing of the specialty, as seen on the wider front, perhaps being part of the problem in that progress could be obstructed by others. This is seen most specifically in the ways in which the CBMC resisted change, starting with those proposed by the AAGBI and then later by the Faculty. However, many people persisted and the changes to the examination (even before its incorporation into the fellowship) show an organisation keen to modernise and introduce new ways of working.

DA(UK), reality confirmed

With anaesthesia's academic organisation still a Faculty, the press for greater freedom of action continued, and the change of the postnominal from DA(Eng) to DA(UK), its final version, was another move away from 'subsidiarity'. When the diploma was first discussed with the membership, at the AAGBI's initial general meeting, it was suggested that an approach be made to the Edinburgh surgical college as well as the London one.[18] However, the agreed plan was to start with the RCS and the positive response meant that the qualification applied across the UK, no matter what the formal title. This final postnominal, first recorded in April 1985,[117] did at last recognise the geographical reality.

The new Part 1 was expected to be taken by those who previously had pursued either DA or primary fellowship examinations and large numbers of candidates were predicted. To cope with this, there were three Part 1 examinations (instead of two DAs) each year and there were other changes as well:

- Training abroad had long been recognised, but an annual sitting in an overseas centre was now authorised as long as a sufficient number of candidates was available.
- Those who performed badly (<20%) in the MCQP (not a feature of previous DA examinations) were to be eliminated before the orals.
- At the other extreme, a prize for the best performance (aptly named in honour of Magill) was instituted.
- After the first sitting, March 1985, the oral length was reduced to 20 minutes.

That first sitting was passed by 160 of 316 (51%) candidates, although the number referred for poor MCQP performance is not recorded. Unfortunately, that is not all that went unrecorded for 1985 (Appendix 8), there being no information on the gender or primary medical school of successful candidates. This, together with the reduction in oral length from 30 minutes to 20, suggests that running a three-part examination with three diets for one part was stretching organisational capacity. For the next 3 years information on medical school has been found, but gender was no longer recorded, probably an active decision given the sensitivities of the time. The first three overseas sittings were in Kuwait and the fourth in Baghdad, 37 of 63 candidates passing (59%) – good results; the first four recipients of the Magill Prize were Drs SS Ferguson, SSW Tan, G Hobbs and JR Thomasson.

Establishing much of what happened thereafter was made close to impossible by the loss of all FAEC minutes from November 1989 until well after the DA ceased to be awarded. Faculty minutes helped a little, but

too many reports from the FAEC were recorded as approved, but without a copy of that report being filed with the Board of Faculty minutes. The only details recorded consistently are the names of those who proceeded DA, meaning that the lists (from 1935 to 1996) are complete. In addition to paying the examination fee (£160) they paid a completion fee (£30), with only 33 of the 160 who passed the first sitting doing so at the earliest opportunity (Appendix 8), but more of them may well have obtained the diploma later. For the five years with data (1985–89) 1,107 (54%) of the 2,061 who passed the Part 1 proceeded DA, an average of 221 per annum (Appendix 8). During the last four years of the freestanding DA (1981–84), the average number passing, and therefore proceeding DA, annually was 172 (Appendix 7), so the new system had produced an increase. This is not surprising, given that some who previously had aimed only for the fellowship would have opted to acquire the DA as well.

Analysis of the other existing data from the first few years of the DA's last decade is perhaps hardly worthy of comment, but some observations are of interest. The numbers sitting the Part 1 decreased steadily, and by 28%, over the first five years (Appendix 8), the pass rate remaining at the previous DA level (45%). There was a general decrease in the number who were both successful and came from overseas, particularly the Indian subcontinent, but an increase in Australians. Really these are just tantalising glimpses, the hope being that one day the missing FAEC minutes may be found in a dusty box or on an ageing computer device, but the search for this material so far has been extensive and thorough. Other omissions from Appendix 8 are the names of the examiners. In 1984, a total of 30 were appointed to Part 1 for 1985,[118] it being expected that each person would serve in two of every three diets and that, with time, examiners would move on to Parts 2 and/or 3. Even if complete FAEC minutes had been found, identifying who served in each Part 1 might not have been possible, so the naming of examiners has been limited to those who served the free-standing examination, that is before 1985.

Faculty to Royal College

The implementation of the three-part fellowship by integration of the DA into the fellowship was one of the consequences of the Faculty obtaining greater control over its own affairs. As early as 1972, improvement in status had led RCS Council to announce that the two Faculties (the other being Dental Surgery) had achieved '*parity of status and respect with surgery*'. However, as Dr Aileen Adams (Figure 14) has described in detail,[119] final progress to anything really tangible was slow, with some difficulties explicable only in terms of (what is really quite understandable) resistance from the surgeons to acceptance of complete parity. Various options were explored, but it was 1988 before one of them had enough support to be implemented and that was the 'College of Anaesthetists', explained simply as the 'College within a College' scenario. However, the request to the Privy Council for the grant of 'Royal' status was refused because the new organisation was not completely separate constitutionally, to say nothing of physically, and it was made clear that such separation was necessary, so this was pursued.

Figure 14 Dr Aileen Adams
Used with the permission of the Royal College of Anaesthetists

Late in December 1991, a property was found (in Russell Square, London);[120] it was purchased in February 1992 and, with a new ('Royal') charter awarded on 16th May, the new premises opened on 5th

October.[121] The final 'icing on the cake' was the formal opening of the building by Her Majesty Queen Elizabeth II on 8th July 1993; anaesthesia in the UK was, at last, a fully independent specialty. The two changes in organisational status (Faculty to College, College to Royal College) made no difference to the DA because the people involved and the regulations all remained the same, as did the postnominal. The results from this period have been discussed already, and the loss of FAEC minutes probably occurred when the RCoA (its success requiring larger premises) moved on to its second home – in Red Lion Square, London.

The curtain falls

The loss of what were, at the final demise of the DA, the minutes of the Royal College of Anaesthetists' Examination Committee (RCAEC) means that there are almost no formal records of how, why or when the examination structure was changed again after another decade. However, useful information has been obtained from two 1996 sources:

- An RCoA *Newsletter* (later *Bulletin*)[122] article by the late Professor Leo Strunin (Figure 15), who was RCAEC chair at the time, provided an overview of the new examination.
- An RCoA Council minute noted that Professor Peter Hutton (Figure 16) had been appointed chair of the new primary (~DA) examination board,[123] so his memory of events was sought. He had been closely involved and has provided additional information, particularly on why the examination structure was changed.[124]

Together these two sources have enabled the following summary.

Figure 15 Professor Leo Strunin

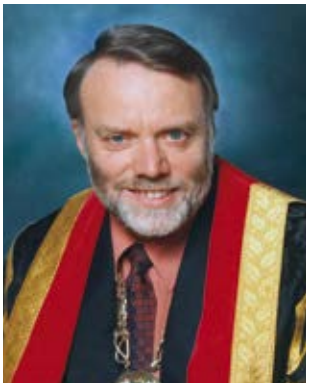

Figure 16 Professor Peter Hutton

Used with permission from the Royal College of Anaesthetists

The mid-1990s was a time when the medical profession, particularly the Royal Colleges, was under pressure from a number of directions:

- The UK Government had become very frustrated with the way some Colleges had used training approval processes, their actions causing acute disruption to several hospitals.
- There was pressure for the different specialty training programmes to be structured in similar ways.
- The UK Postgraduate Deans were taking greater control of training matters and pressing for competency-based programmes with defined steps in workplace-based assessment.
- There were individuals practising anaesthesia in the UK (often holding the DA), but with no place within the College structure.
- Medical education was being harmonized throughout Europe (this was before 'Brexit').

The interpretation is that these points would have impacted on the DA as follows:

- The RCoA's three-part examination structure and use of the DA as a 'sub-fellowship' qualification was at variance with the other Colleges.

- The need for European harmonization would make it increasingly difficult to justify having a qualification (the DA) which, at this time, was aimed primarily at those from countries far beyond the European Union.
- Anything which allowed individuals to practise anaesthesia in the UK without having any formal relationship with the RCoA was at odds with the new approaches.

However, in the present context the crucial change was that the new primary had a relatively small clinical component and this was insufficient to justify award of a qualification comparable to the DA(UK).[125] Competency-based, workplace assessment would take over the role of the DA and also mean that there was 'space' in the primary for the basic science assessment which had been one of the drivers to the three-part fellowship structure. The last Part 1 (and thus DA) examination was held in July 1996 (nearly 61 years after the first) and successful candidates had to apply for award of the DA before 31st July 1997.

Sources and statistics: changes and contradictions

The definitive sources describing the institution of the DA are the minutes of the AAGBI and RCS, and most of the subsequent story to 1980 (warts and all) is recorded fully in the minutes of the CBMC. Copies of those minutes went to both RCP and RCS Councils, but the understanding at the start of this review was that the RCP copies had been destroyed by bombing during WW2, so the RCS library and archive were the main sources for information. However, some of the detail from the period after WW2 (especially the pass lists usually found with RCS Council or CBMC records) was missing, but fortunately most of these lists were found with the post-war RCP records. It was while that material was being examined that it became apparent that there had not been any WW2 bomb damage to CBMC minutes; it was just one of those stories which simply evolve and did so long before the internet! However, three pass

lists were still missing so, more in hope than expectancy, 'SurgiCat' (the RCS archive's digital catalogue) was searched again and this resulted in the finding of the original examination ledgers. These records list every candidate, pass or fail (even noting whether they had failed previously), and would have provided complete denominator information for the analyses, but frustratingly they are closed under Data Protection Regulations. The RCS archive staff were kind enough to extract the same information as had been obtained from 'public domain' records for all the other sittings, but the complete data are there for a future researcher.

As the years went by, the Faculty and RCoA records, especially the FAEC, became more important and the disappointing loss of the latter committee's records after 1989 has stimulated a review of the College's collection policy. Fortunately, as with the documents missing at earlier times, alternative sources were found to enable production of an overview suitable for the current account. The complete set of examination results before 1985 is a tribute to those who were responsible for collecting and storing them, although compiling the appendices did challenge the author's searching and recording abilities. With their large tables of data the appendices might give an excessive indicator of their accuracy, so a few cautions should be offered.

Sometimes there were differences in the numbers noted in documents apparently recording the same information, the most extreme example being the number of passes of the November 1948 Part 1 DA. The published reports record only 12 candidates as having passed, but the CBMC minutes note 17, and the latter has been judged as the more reliable. The numerical difference is small, but the proportionate difference is large, although it barely matters in the overall scheme of things; on other occasions, the smaller differences found in much larger numbers are of even less significance. The other potential source of error was that obtaining the numbers and origins of overseas graduates required searching line by line through the pass lists, many of which are

only available tightly bound into thick volumes, a tedious process. The best efforts were made to be as accurate as possible, but mistakes can always occur so asking AN Other to do it again might produce some differences, but the impact on the 'big picture' will be minimal.

Finally, mention must be made of the two sources of information not previously accessed by the specialty. First, the author is almost certainly the first anaesthetist who has ever been able to search the CBMC minutes, a much-appreciated indicator of modern openness because they provide details of events of great impact on the specialty, but previously unknown to it. Second, the RCGP provided documents with equally revealing information on a hugely important episode, but one on which our own records, and indeed those of the CBMC, are silent. Why nothing about that episode appears in those records is a question which is unlikely ever to be answered, but it is hard not to conclude that somebody somewhere was trying to hide something, or at least keep it very quiet!

Other DAs

DA-type qualifications were instituted elsewhere.

Australasia: there were very early approaches to the Royal Australasian Colleges of Physicians and Surgeons about establishing a joint DA along similar lines to the UK one, but WW2 intervened. Subsequently, there were discussions (having a competitive element between the cities!) with the Universities of Sydney and Melbourne, a one-part DA running in Sydney from 1944 (becoming two part in 1950) until 1974, and a two-part DA (like all that University's other diplomas) in Melbourne from 1947 to 1985.[126] Both were progressively replaced as the definitive specialist qualification by the establishment of college fellowship examinations during the 1950s.

From the very first sitting, Australians had come to the UK to take the DA, initially as the only specialist anaesthetic qualification available anywhere, but they continued to come even after their own examinations were established. Much of this would have been 'medical tourism', but it is interesting that the numbers increased acutely after the Melbourne DA ended in 1985 (Appendix 8). Presumably, these doctors were seeking a qualification suitable for working in their country's more remote areas. The loss of RCAEC minutes after 1989 means that there are no further data to inform this issue, and this emphasises the importance of record retention. At the time (1996) of the final withdrawal of the DA, several Australian groups combined to address the problems of provision of anaesthesia services in Australia's more remote areas, suggesting that the DA had continued to meet a need.[127] More recently (2023), an outcome of the process has been the introduction of the 'Diploma in Rural Generalist Anaesthesia' (DRGA),[128] although 'academic correctness' has stopped medical organisations in Australia using the title 'diploma' (it is now an 'advanced certificate')![129] To avoid the problems associated with two standards of qualification, these 'remote' practitioners are trained for the role, know their limitations and are expected to continue their education. There has been mention of a parallel qualification for surgeons, but the range of operative procedures required in remote settings involves a wide range of surgical specialties,[130] so setting up a diploma presents a challenge.

South Africa: perhaps surprisingly, a fellowship examination (Part 1 1960, Part 2 1961) was instituted in South Africa by the then Faculty within the College of Physicians and Surgeons of South Africa before the diploma (1974).[131] It was introduced as a qualification for those working remotely and continues under the auspices of the College of Anaesthetists within the Colleges of Medicine of South Africa.[132] Interestingly, some centres require a pass in the examination for progression to the second level of specialist training, that is, as a registrar,[133] a far more sensible model than that followed in the UK with the introduction of the three-part fellowship.

Canada: While preparing this account an enquiry was received regarding an individual who had used a postnominal, suggesting that he had a DA obtained in one of the provinces.[134] Enquiries revealed that there never was a formal qualification offered anywhere in Canada, although a number of academic centres did organise diploma courses,[135] but not something that would entitle anyone to display a postnominal.[136]

And back in the UK: close to the time of concluding this account, an internet search on the topic produced access to a website offering a 'Diploma in Anaesthesia (DA)' from a commercial organisation, although superficially the site looks 'academic'.[137] The background to, and basis of, this has been explored and it seems to be of little substance, but the finding indicates that there is a need to 'defend' the title and postnominal from outside intrusion. This is being explored by the RCoA. Having two qualifications of different standards caused difficulty enough when they were administered by two elements (Faculty and CBMC) of the same organisation (RCS). Even the possibility of two separate organisations offering qualifications of different standards hardly bears thinking about. Modern use of the DA would confirm 'ownership' by the College, perhaps following the South African model of an award at a mid-point in training, but using continuous assessment not examination. However, the evidence suggests that the DA should never again be used to denote a subspecialist level of competency, especially in an era with considerable (and increasing) input from the UK Government into the running of the NHS.

Retrospect

In 1935 the DA was a development which made a major contribution to the development of the specialty. Later it was associated with other important events, but since withdrawal in 1996 the DA has been 'history', albeit an important and fascinating one. Final withdrawal was a consequence of outside pressure regarding changes in postgraduate training and education, just as an earlier outside pressure had had a

major effect. That, arguably, was the most important of them all, the 1971 RCGP withdrawal of recognition of anaesthetic experience as contributing to vocational training in GP'. This ended the primary role seen for the DA when it reverted to a one-part format in 1953 and was the beginning of the end for both the GP anaesthetist and the view that anaesthesia could be one part of full-time clinical practice. The specialty had grown beyond that and it was crucial to subsequent development.

It is not inappropriate to consider why withdrawal didn't come sooner, either in 1948 when fellowship by examination became the definitive qualification for specialist practice or in the 1980s when the Faculty had gained complete control over its affairs. The answer to why it didn't happen in 1948 is clear and justifiable in that it could be used to apply some screening to those who were going to be providing much of the clinical service. In 1980, although UK trainees had found their own uses for the DA, the main justification for continuation was as a service to developing countries (eg the Indian subcontinent) or those where multi-trained staff were needed to work in remote areas (eg Australia). With the benefit of hind-sight it does not seem that continuation of a qualification of a lower standard to support service in other countries was worth it, given the difficulties caused in the UK, but times and perceptions change. Perhaps some of the reason for its continuation, certainly after 1985, with its incorporation into the fellowship structure, was almost an emotional one. It was then 50 years since the DA had been such an important step in the evolution of the specialty in the UK, and those making the decisions in 1985 may have simply not wanted to 'let it go'. There was no logical reason for keeping it, but it took another decade for logic to prevail.

Tony Wildsmith, November 2025

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Abbreviations

AAGBI	Association of Anaesthetists of Great Britain and Ireland
BJA	British Journal of Anaesthesia
CBMC	Conjoint Board Management Committee
DA	Diploma in Anaesthetics
DPH	Diploma in Public Health
EBE	Examining Board in England
Faculty	Faculty of Anaesthetists of the Royal College of Surgeons of England
FAEC	Faculty of Anaesthetists' Examination Committee
FAGPC	Faculty of Anaesthetists' General Purposes Committee
FFARCS	Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons
FRCA	Fellow of the Royal College of Anaesthetists
FRCS	Fellow of the Royal College of Surgeons of England
GMC	General Medical Council
GP	General practitioner
GP'	General practice
ICM	Intensive care medicine
LRCP MRCS	Licentiate of the Royal College of Physicians of London; Member of the Royal College of Surgeons of England
MRCP	Member of the Royal College of Physicians of London
NHS	National Health Service
PM	Pain medicine
RCoA	Royal College of Anaesthetists
RCAEC	Royal College of Anaesthetists' Examination Committee
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians of London
RCS	Royal College of Surgeons of England
RSM	Royal Society of Medicine
WW1	First World War
WW2	Second World War

Appendices

Copies of the appendices may be obtained on application to: archives@rcoa.ac.uk.

Appendix 1: DA(RCP&S) 1935–1939
Examiners, total passes and details of successful candidates
https://bit.ly/DA-UK-Ap1

Appendix 2: DA(RCP&S) 1940–1947
Examiners, total passes and details of successful candidates
https://bit.ly/DA-UK-Ap2

Appendix 3a: DA(RCP&S) 1948–1953
Examiners, candidates and pass rates: Part 1
https://bit.ly/DA-UK-Ap3a

Appendix 3b: DA(RCP&S) 1948–1953
Examiners, candidates and pass rates: Part 2
https://bit.ly/DA-UK-Ap3b

Appendix 4: DA(RCP&S) 1953–1963
Examiners, total passes and details of successful candidates
https://bit.ly/DA-UK-Ap4

Appendix 5: DA(RCP&S) 1964–70
Examiners, total passes and details of successful candidates
https://bit.ly/DA-UK-Ap5

Appendix 6: Diploma in Anaesthetics DA(RCP&S) 1970–1980
Examiners, numbers sitting, number passing and details of successful candidates
https://bit.ly/DA-UK-Ap6

Appendix 7: Diploma in Anaesthetics; DA(Eng) 1981–1984
Examiners, candidate numbers, numbers and details of successful candidates
https://bit.ly/DA-UK-Ap7

Appendix 8: Diploma in Anaesthetics: 1985–1997 DA(UK)
Numbers of candidates, successful candidates, and numbers and origins of those proceeding DA
https://bit.ly/DA-UK-Ap8

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Professor J A W Wildsmith

Professor Wildsmith was born and grew up in rural Gloucestershire. Educated at the King's School in Gloucester, the Cathedral's statue of Jenner sparked an early interest in medicine and its history. Both undergraduate and postgraduate training were in Edinburgh where he was Consultant/Senior Lecturer at the Royal Infirmary before being appointed Foundation Professor in Dundee. At the College, he served two terms as an elected member of Council, gave the Hewitt Lecture, was awarded the Gold Medal and has also been Honorary Archivist. Regional anaesthesia was his main clinical and research focus, with the history of the specialty also a major interest which has continued into retirement.

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