Portraits from Memory

26—William Anderson, OBE, FRCS (1886-1949)

JAMES HOWIE

William Anderson first caught my interest when he addressed the students' anatomical society of Aberdeen University in 1925. He came as a real live surgeon from the Royal Infirmary; and we crowded the theatre to hear him. Anatomy was not our favourite subject; all we longed for was to be clear of it and on to clinical work. Willie—no student ever knew him as Mr or William—quickly set about adjusting our perspective.

"I know my anatomy really well," he said, "because I've had to study it twice—not because I failed my second professional examination but because I had to sit the FRCS of Edinburgh in 1912 and that of London in 1923. Between 1912 and 1923 I had war surgery in France; and from that I came to realise how accurately a surgeon has to know his anatomy and how greatly it helps in examining a patient to picture what lies beneath the skin. So stick in to your anatomy or you'll not be much good when you come to my clinics two years from now."

Willie came of northeast farming stock and he had a way of inspiring confidence. A rival surgeon, who had no less anxiety or ability to serve his patients well, nevertheless had a way of scaring them instead. At one consultation a lady of my acquaintance asked him about the risks of the operation he was advising. He gave her the case-mortality rate, the failure rate of survivors, and the complete success rate. He advised her, as he advised all his patients, to check that her will was in order. The lady, not surprisingly, left him and consulted Willie Anderson. She asked him also about the risks of the operation. "Madam," he said, "it is I who will be doing your operation; and I wouldn't be advising you to have it if I were not confident of its success." She had it; and she lived happily for many years. The rival surgeon, who was a good surgeon, nevertheless but not surprisingly left Aberdeen. Willie knew his own people. He spoke their dialect and inspired confidence; and his only problem was to find time for all who wanted his highly valued services.

After the first world war he joined the Royal Infirmary staff as an anaesthetist, which was the normal route of entry. He served as an assistant to the professor of surgery until 1935 when, at last, the way was unblocked and he was put in full charge of a ward.

[Courtesy of the *Lancet*.]

A full hand

I came to know him personally when I was a medical house physician in 1930-1 because my medical ward's receiving days coincided with his; and one of my five duties was to give anaesthetics for his emergency operations. In response to one summons I kept him waiting for about 20 minutes and he made his disapproval clear. What had delayed me? I said cheerfully that I had just logged up a "five out of five"—every house physician's dream objective: to receive five urgent calls to five different places within five minutes. First, to see an emergency admission in the general medical ward, which was my first duty; second, to the gynaecology ward to deal with a bleeding abortion (a back street affair); third, to the medical outpatient emergency unit, where the police had brought in a comatose drunk; fourth, to the eye ward where a man had wandered in with a speck of metal in his cornea; and fifth, to give Willie's emergency anaesthetic. He was incredulous that such demands could fall on such young shoulders all at once; but he was also charitably amused and forgave me.

"What was the emergency admission to your medical ward?" he asked.

"That, I said, 'was not a real emergency: a lady in her 60s with chronic osteoarthritis.'"

"That *was* a real emergency," corrected Willie, "I know about it because it was I who advised her doctor to get her in as an emergency on your receiving day. She was worn out with nursing her demented senile mother of 85 and she simply had to get a rest somehow."

That was Willie all over: straight direct thought and effective action arising from a generous nature and a realistic assessment of how to solve a problem.

Realities of surgery

Abdominal surgery was his special field. In dealing with abdominal pain of uncertain causation, he never hesitated to open the abdomen because he rightly judged that the worst disaster was to "cook" an infected appendix. His incisions were as large as he judged necessary to have "a right look round for all the snags." Some critics said that his incisions were as much too large as those of his chief, Sir John Marnoch, were too small.

Willie pioneered thoracic surgery in Aberdeen with good success; and he was willing to attempt neurosurgery. The results were less successful but they prepared the way for James Learmonth's work in that specialty when he came to be professor of surgery in Aberdeen. Some said that Willie became unhappy when he realised that he had not established himself as an original writer of scientific articles and would not therefore have a chance of becoming professor, especially in the new climate which overtook Aberdeen medical school in 1930; but he and Learmonth were good colleagues and I do not think that Willie was in any way soured by being passed over.

His outpatient clinics were models that influenced all Aberdeen medical undergraduates of his period. His question to the students

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on how to deal with any surgical emergency always was: "Tell me how, in the middle of the country, you'll proceed in this case if all the roads are blocked with snow and the telephone lines are down." A good question, and one highly relevant to many Aberdeenshire winters and to dealing with emergencies in any remote part of the world. The answers made a reality of the class of operative surgery.

Willie was often confronted with patients sent to his clinic who had non-surgical problems, but whose doctors wanted them seen by Willie. He would first turn these patients over to a couple of senior students. I remember one such case where he said: "This patient has not a surgical problem. But he's from that namesake of yours in Strathdon; and he knows when a patient is ill—as this one is. So get

the answer." The patient had lymphatic leukaemia. He exhorted his students to be gentle but thorough in their clinical examinations. One lady doctor, now retired from practice, recalls how she was palpating a knee joint with one hand. Willie looked at her and said: "God gave you two hands."

I recall that at the end of one sad operation he said to his students: "When my time comes, I pray that it will not be from that cause and that I'll not be left to linger." He had his wish. Right to the end he enjoyed his shooting and his golf. He enjoyed company; and he did as much as any two ordinary men. Aged only 63, he died suddenly when attending a law case as medical referee. In James Learmonth's words he was "William Anderson; the good colleague."

Everyday Aids and Appliances

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DISABLED LIVING CENTRES

Many diseases of the locomotor system result in loss of mobility. Many neurological diseases result in impaired manipulation of objects, diminished grip, and shortened reach. Diseases of other systems also impair function. When a person's independence in self care, ability to hold down a job, or run a household is affected technical aids may help to overcome the problem.

The exact number of technical aids on the market is unknown: there may be as many as 11 000. Certainly there are 10 200 on the database of the Disabled Living Foundation. These aids vary from an eggcup with a suction base to the sophisticated environmental controls that enable the tetraplegic patient to have some control over his environment, use the telephone, and turn on the television. How is the practitioner to decide which of these is useful to his patient?

The disabled living centre can help. There are 22 of these centres (see map). Though autonomous, they liaise with one another regularly. They may be found in hospitals or in city centres; occasionally they are in purpose built buildings, usually with wheelchair access. They all have similar aims: education and the provision of information. Each has a display of technical aids and a professional, well informed staff (mainly occupational therapists and physiotherapists). Visitors are given advice on equipment, the opportunity to try it out, and information about their disability. Centres are open during normal working hours to disabled people and their helpers as well as to professionals. Referral from a doctor is not necessary, though it does help the advisory staff if information on diagnosis and prognosis is available. For instance, it may not be appropriate to recommend installation of an expensive stair lift for someone whose life expectancy is short. However, if the patient has motor neurone disease the staff may recommend appropriate aids which can be obtained without delay. A disabled visitor asking for kitchen aids will often need a full assessment in other areas—for example, of his or her ability to take a bath or use the lavatory. The staff thus organise an appointment system with sufficient time to consider each patient's needs.

There are differences in function, size of display area, and specialist advice available. But most centres include sections on bathing, incontinence, and toilet aids. The nation's bill for the

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treatment of pressure sores is huge. It could be reduced by more widespread use of low pressure beds and cushions, which lessen the pressure on ischaemic areas. Severely disabled patients who cannot move from bed to chair often rely heavily on their carers, who may