

Harry Walker 1918-1959: an Illustration of the Mid-Twentieth Century History of Anaesthesia. Middlesbrough, Edinburgh, Burma.

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Introduction

I am writing a hybrid memoir-biography drawing on my father's life. He, Harry Walker, was one of the earlier Fellows of the Faculty of Anaesthetists and when I contacted the College I learned that he was unusual for his time in that he decided to become an anaesthetist while he was a medical student.¹ I thought a summary of his career might be of interest to the History of Anaesthesia Society. I am a physician and my account lacks detail about anaesthetic techniques but I hope it illustrates the extraordinary events that young anaesthetists lived through in the mid-twentieth century.

Medical School

Harry trained at the School of Medicine of the Royal Colleges in Edinburgh, one of the extra-mural schools set up in the nineteenth century to counter what was often seen as a stagnant and old-fashioned medical curriculum in the universities. Lectures were at Surgeons' Hall and clinical work in the Royal Infirmary. Medical teachers in Edinburgh moved seamlessly between university and hospital appointments, private practice, and extra-mural teaching. The School was absorbed into the University of Edinburgh after the Second World War.²

The School was an interesting place. The Scottish Colleges resisted the General Medical Council's proposal to restrict the intake of refugees from fascism and, as well as British students and others from the then-Dominions, the School accepted emigrés from Europe (Figure 1). There was also antisemitism in the USA and some students had been rejected by prestigious American schools despite excellent grades. Surgeons' Hall archive contains a sequence of letters home by one of these young Americans.³ A few years later, the University set up a Polish Medical School, which further increased the diversity of the Edinburgh student population.

By the time Harry joined the Royal Army Medical Corps (RAMC) in 1943, he could tell the Army that he had administered over 1,000 anaesthetics, some while he was a student. He took photographs of operations at the Royal Infirmary, carefully annotating them with the anaesthetist's and the surgeon's names (Figure 2).



Figure 1: Medical students outside Surgeons' Hall at the outset of the Second World War, September, 1939. Harry is fourth from the right wearing a trenchcoat and scarf.

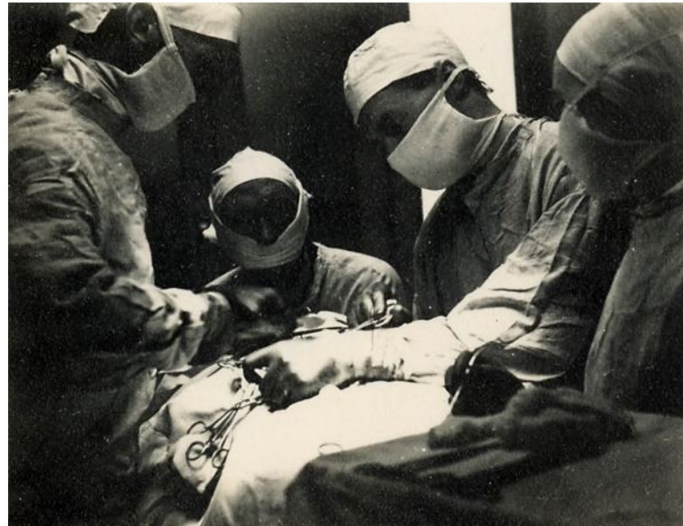
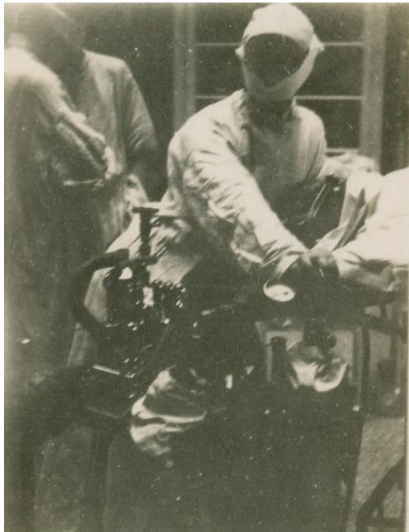


Figure 2: Two photographs of operations, Royal Infirmary, Edinburgh, 1940-41. Taken by Harry.

House Jobs

The Second World War brought stratagems to increase the supply of doctors. As well as bringing medical students like Harry in to the workforce before qualifying, women doctors were deployed in military roles they had not previously occupied, and retired and overseas doctors called up. The Colleges complained that the Army did not use doctors' expertise appropriately and as a result non-medical officers were recruited to the RAMC in administrative roles to release doctors for clinical work.⁴

Harry started his house jobs six months before he qualified, back home in Middlesbrough at the North Riding Infirmary (Figure 3a). His testimonials note his interest in anaesthesia. 'I was much impressed with his skill as an anaesthetist which was markedly superior to the average shown by a young graduate.' And, 'he shews a special aptitude in this branch of his profession'.



a



b

Figure 3. Harry Walker: a. house surgeon in the dispensary of the North Riding Infirmary, 1942; b. consultant anaesthetist in Teesside, 1949-59.

The Army

After an induction at the RAMC Number 1 Depot in Hampshire, Harry went to 190 Field Ambulance for further training, a small mobile hospital based then in Northern Ireland.⁵ In his letters from Burma he recalls Nissen huts and the Irish rain. It is unlikely that either posting provided these new Army doctors with much clinical training. The focus was on reorientating their outlook. Much of the early timetable was devoted to military law,

administration, man management and the organisation of medical services. There were physical jerks and cross-country runs. Although they were non-combatants under the Geneva Convention, doctors were expected to lead soldiers and be capable of protecting their patients, so they had lectures on such topics as reconnaissance and movement by road, learned how to operate a service rifle and the principles of camouflage, watched machine gun and other weapons demonstrations, and practised map-reading.

Before the war, civilian surgeons and anaesthetists valued their autonomy but the Army required standardisation, protocols, a restricted range of equipment, and meticulous record keeping so that patients could be handed on safely. The ethos was also different, the broad aim put starkly in *A Field Surgery Pocket Book*: ‘The main function of the medical units during battle periods is to relieve the combatant formations of the encumbrance of non-effectives by clearing them from the battle area.’⁶ 190 Field Ambulance was training for the invasion of Sicily and there are photographs in the Imperial War Museum collection showing stretcher bearers lowering a simulated casualty down a vertical Irish cliff, and doctors pretending to set up a surgical procedure in a tent (Figure 4). Buttons and boots are polished, uniform is correct, surgical gowns are crisp and white. It is all very different from the few official photographs of surgical teams at the front, the sweat-stained shirts, hurricane lamps, broken buildings, and sand, dust, and mud.



Figure 4: RAMC personnel training in Northern Ireland, August 1943. © IWM H31669.

India

After a course on Tropical Medicine in Liverpool, Harry travelled in a troopship in a Mediterranean convoy to the Suez Canal and then on to India, arriving in Bombay in December 1943 to join the Fourteenth Army under General William 'Uncle Bill' Slim. After the disastrous British defeats of 1942, with the loss of Singapore (thought to be impregnable) to the Japanese and the humiliating retreat through Burma, Slim spent time training and re-equipping his Army.⁷ Harry was posted first to 21 British General Hospital in Jhansi in Uttar Pradesh as a 'general duties medical officer' in charge of a medical ward.⁸ Cases of sickness, such as malaria, dysentery, and scrub typhus, far outnumbered battle casualties in the Burma Campaign, even with Slim's insistence on meticulous hygiene and anti-malarial prophylaxis. Lord Louis Mountbatten, the Supreme Allied Commander of South-East Asia Command wrote that 'the terrain of the South-East Asia theatre was one of the most unhealthy in the world.'⁹

An ambulance train arrived at the hospital every few days and the number of beds rose from five hundred to over a thousand. 21 British General Hospital also supported the Chindits, special forces designed to operate behind Japanese lines. The hospital commander records meetings with the Chindit Senior Medical Officer about medical screening, a dedicated ophthalmological service, advice on packing mule panniers, and setting aside one hundred beds for venereal infections caught during the Chindits' pre-deployment leave.

At last, Harry received postgraduate training in anaesthesia. The military medical authorities decided that 'battle casualties require a high degree of competence' and training centres were set up in India.¹⁰ Harry was sent further north to a hospital in Bareilly, close to the Himalayas, for February and March 1944. He was due to join a mobile surgical unit but instead was posted hundreds of miles east to 66 Indian General Hospital in Dimapur, a major railhead on the Assamese border with Burma.¹¹ The Japanese had started their 'March on Delhi' and surgeons and anaesthetists throughout north-east India were hastily seconded in April 1944 to deal with casualties evacuated from the siege of Kohima.¹²

Kohima

In Kohima, the fighting was like the worst of the trench warfare of the First World War. Three of the fourteen doctors in Kohima were killed and one wounded. Wounded men lay on stretchers in bunkers for up to two weeks and were killed or re-wounded where they lay. By the time the casualties arrived at 66 Indian General Hospital they had mortar, grenade and bullet wounds, many infected or maggot-infested, and some with gas gangrene. As well as British, Indian and West African troops, the patients included Indian non-combatant labourers, Naga tribesmen, and a small number of Japanese prisoners of war.

Mobile Surgical Units

Kohima was Harry's first experience of combat surgery. From now on he was posted to the Fifth Indian Mobile Surgical Unit (5 IMSU) as its anaesthetist and second-in-command.¹³ He joined it first in Imphal, then encircled by the Japanese, although air supplies continued. The unit was one of four MSUs on the Imphal plain. After the Japanese retreated, 5 IMSU moved through the mountainous Indo-Burmese borderland, crossed the great Manipur, Chindwin and Irrawaddy rivers, and then moved rapidly through the central Burmese plain from Mandalay to Rangoon. The unit transferred from Division to Division of the Fourteenth Army, depending on the need, usually paired with a second MSU so that they could spell each other.

MSUs had first proved their worth in the Spanish Civil War. In the Second World War, they were important in the North African desert and Italy, as well as in Burma (Figure 5). Their purpose was to stabilise battle casualties close to the fighting so that they could be safely evacuated to base hospitals. Evacuation was preferably by light plane but also by jeep or truck. Mules or stretcher-bearers were used if a section of road was muddy or otherwise non-motorable. These were small units, usually with three doctors, a surgeon, an anaesthetist, and a general duties medical officer, and about nine or ten other ranks, amongst whom the non-commissioned officers were vital, performing a variety of skilled tasks.

MSUs carried enough equipment for one hundred operations on two tables, but were not fully independent. They were co-located with a larger unit, such as a Field Ambulance (a small mobile hospital), which nursed their patients and undertook support functions such as pay and rations.¹⁴⁻¹⁶



Figure 5: Major Grace gives an anaesthetic under shellfire in an abandoned building, Lanciano, Italy, December 1944. © IWM NA10222.



Figure 6: Personnel of the Seventh Indian Mobile Surgical Unit, Arakan, Burma, 1945. Baty JA. *Surgeon in the Jungle War*. London: Kimber, 1979.



Figure 7: Inside the Fifth Indian Mobile Surgical Unit's operating tent, Ngarzun, Burma, March 1945.

There are several memoirs by surgeons who worked in mobile units but I have found none by anaesthetists. John Baty wrote about 7 IMSU, based in the Arakan coastal region of Burma (Figure 6).¹⁷ The autonomy and mobility of these units gave them a buccaneering quality and they would 'liberate' any useful item they found. Baty's MSU made creative use of bamboo and he comments that they preferred to be associated with Indian than British units because their cooking was better. Harry's MSU used part of the wing from a Japanese *Zero* fighter plane as the reflector for their operating lamp and there is one small photograph taken inside his operating tent showing the *Zero* wing and also a clock from an abandoned

house (Figure 7). Harry’s corporal stands, shirtless and in shorts, by the entrance to the tent. ‘Were shelled here’ Harry notes on the photo’s back. ‘Damage – one scraped back from jumping into a trench!’

Unsurprisingly, the work of these units was intermittent. One observer wrote that ‘during the brief periods when we *were* engaged in battle, the activity became frantic with the surgical team working flat out; wounded soldiers were treated first and then civilians [and lastly Japanese prisoners]. At other times, casualties tended to be brought in at a manageable rate.’¹⁸ A record of operations by 15 IMSU survives for the period of the ‘race to Rangoon’ and shows the wide variation in number of operations per day (Figure 8).¹⁹ When the number of battle casualties was low, the units carried out other emergency procedures such as appendectomies, circumcisions and dental extractions.

Singapore and Surabaya

The end of the war against the Japanese was a slow process with much bloody ‘mopping up’. Even after the Americans dropped atomic bombs on Hiroshima and Nagasaki on 6 and 9 August 1945, there were still large numbers of heavily armed Japanese soldiers in South-East Asia and fighting continued until the Japanese Army surrendered in September 1945. Harry’s unit rested and re-fitted in Singapore and Harry treated Allied former prisoners of the Japanese. He undertook inspection trips to prison camps for surrendered Japanese soldiers and members of the Indian National Army, who had fought with the Japanese, as well as a reconnaissance to Malaya where his unit expected to be posted.

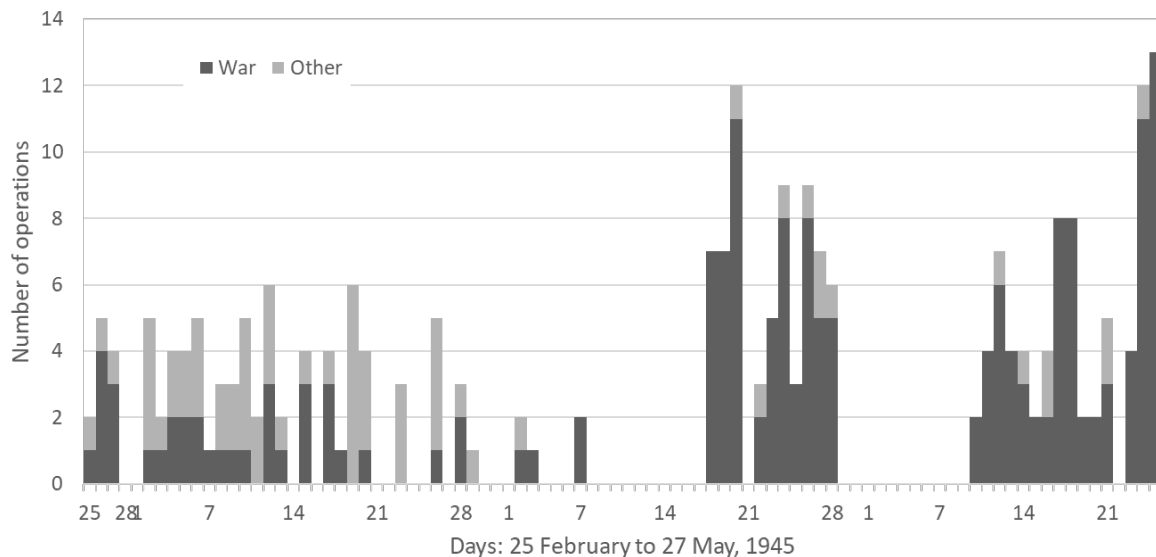


Figure 8: Daily operations by the Fifteenth Indian Mobile Surgical Unit during the ‘race to Rangoon’, 25 February to 27 May, 1945. Drawn from Wellcome Library GC/226/A5.

Instead of going to Malaya, Harry went to Java and was part of the battle of Surabaya, where Allied troops supported Dutch forces against armed irregulars during the heavy fighting for Indonesian independence. The civilian casualties disgusted him and he wrote

home with weary cynicism, that ‘It is quite simple, our method of “pacifying” a country – we merely blow the town to bits with bombs & shells & kill the inhabitants by thousands until they decide they have had enough.’ He had ‘200 odd Javanese civilians in here – legs blown off, arms missing, shot in the guts, head, everywhere – ranging from kids of 2 or 3 months to old men and women of 70 and 80.’ Presciently, he wrote that ‘we kill the Javanese, and the Javanese kill our lads and in the end it’s the Dutch who will take over the country, and Britain’s name will stink for years out here as the murderer of civilians.’

The National Health Service

Harry Walker returned to England in 1946 and was discharged from the Army in 1947. He gained some experience of peacetime anaesthesia in the military hospital at Catterick and spent six months of postgraduate study in the Section of Anaesthetics at the University of Edinburgh. This placement was part of a government scheme for doctors designed to ease the transition to civilian practice. He also spent a short time in general practice, much-needed experience after such highly focussed Army posts.

He became a resident anaesthetist in the North Riding Infirmary in 1948 at the start of the new National Health Service, and a consultant to the Teesside group of hospitals in 1949 (Figure 3b). Again, he had glowing testimonials in which the phrase ‘an excellent anaesthetist’ recurs again and again. ‘Because of his knowledge and skill in the practice of all the most modern types of anaesthetics, there is a great demand for Dr. Walker’s services in this area, where his abilities are now held in high regard by all his colleagues’ one reference says. ‘I have every confidence in him when he undertakes anaesthetics for me’ writes the senior surgeon. ‘He has the necessary disposition for an anaesthetist’ says another, without elaborating on the nature of this ‘disposition’, but other references include the phrases ‘interested and conscientious’, ‘very pleasant and stimulating colleague’, ‘most likeable personality’, ‘courteous and agreeable’, ‘full of enthusiasm for his work’, culminating in ‘in every way a first class man.’

He was an active young consultant, chairing hospital committees and supporting the British Medical Association. He had a serious interest in his specialty and bought Barbara Duncum’s important history on its publication.²⁰ He married and had three children, and rekindled his links with family and friends. He built a sailing dinghy and took a cottage in the North York moors. But he was not able to fulfil his potential, either professional or personal. He had only ten years as a consultant and died in 1959 at the age of forty of a myocardial infarction, one of the early casualties of smoking in the cohort studied by Doll and Hill.²¹

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