The emergence of anaesthesia as a specialist practice during the last decades of the nineteenth century was a peculiarly English (and mainly London-driven) phenomenon. We have seen how Snow swiftly established himself as a specialist practitioner, and after his death in 1858 this pattern was continued through the 1860s and 1870s by doctors like Henry Potter, Joseph Clover and Joseph Mills who followed his principles and method. By the 1880s, a majority of the London teaching hospitals had designated posts for administrators and it was primarily these individuals – Dudley W Buxton, Frederic Hewitt and Frederick Silk, for example – who campaigned to make the study of anaesthesia a compulsory part of medical education and who formed the first professional association of anaesthetists in 1893. By the time the jubilees of the discovery of ether and chloroform were celebrated in 1896–97, anaesthesia was a recognised specialism in England, founded on a body of knowledge and practice that was distinguished from surgery. The anaesthetist was ‘a man of science’ who had the experience to render any patient insensible to the pain of surgery, claimed Buxton in his 1897 oration. But why did specialist anaesthesia emerge, and chiefly in England?

Until the 1900s, in Scotland, most of Europe and the United States of America, anaesthetics remained under the surgeon’s control and continued to be given on a cloth or sponge. Anaesthesia was a duty performed by the surgeon in advance of the operation, or delegated to a junior member of the team – a student or nurse, for example. To explain the different trajectory taken in English practice we need to return to surgical perceptions of risk. Earlier chapters have established the surgical dislike of ether and the dominance of chloroform in Britain and we saw in Chapter 5 how, even during the 1854 crisis of confidence
In the London practice of anaesthesia, there was no return to ether. Surgeons chose to accommodate the risks of chloroform in return for its efficacy. Nevertheless, patients continued to die under chloroform and this persistent trickle of fatalities caused anaesthetic safety to remain a key issue of medical and public concern in England well into the 1900s. Although London surgeons had managed risk by practising selective anaesthesia during the 1850s, by the 1870s there were few who could contemplate performing any major operation without pain-relief. So surgeons were caught on the horns of a dilemma: they were keenly aware of the dangers of chloroform, yet were not prepared to sacrifice its ease for the safety of ether. It seems likely that surgeons were supportive of specialist anaesthesia because it provided a solution to the problem of risk. From the surgeon's point of view, specialist administration of anaesthesia diverted risk away from the surgical process itself. In the event of a fatality, it would be the doctor who gave the anaesthetic who was called to attend an inquest, not the surgeon. By supporting specialist anaesthesia, surgeons could continue to benefit from the advantages of chloroform, whilst side-stepping the responsibility of administration. This argument gains strength when we consider the different attitudes to anaesthetic risk held by surgeons elsewhere.

In Scotland, for example, chloroform was the main anaesthetic agent throughout the nineteenth century and beyond. But Scottish surgeons were adamant that their method avoided the risks of London practice. Drawing on the earlier claims of Simpson and Syme, they held to the view that chloroform killed through respiration rather than the heart: the clinical focus during an administration was upon the patient's respiration rather than the pulse. Their confidence appeared to be supported: because of different legal requirements in Scotland and England, few Scottish fatalities were publicised, whereas the majority of hospital anaesthetic deaths in England during this period were reported to the Registrar General.² For Scottish surgeons then, the use of chloroform posed no untoward risks; they perceived it as a routine task which could safely be entrusted to a student or nurse. This perception also prevailed in other parts of the world where chloroform was given on a cloth – in the southern states of America and many places in Europe, for example.

In communities where ether was the main anaesthetic – the northern states of America and a few places in Europe – there was far less fear of the risks of anaesthesia. We have seen earlier how surgeons here responded to the early chloroform fatalities by returning to ether. Certainly in Boston, this shift was driven by surgeons’ desire to avoid medical malpractice suits. Writing in 1868, Mason Warren, surgeon at