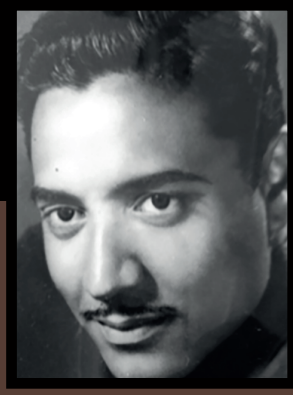
Globe Trotting and 62 Years of ENT

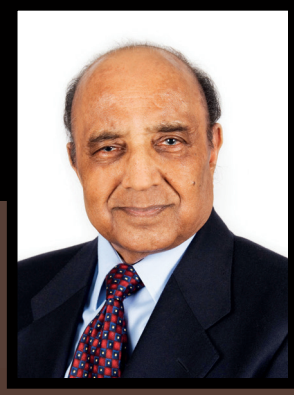
Autobiography by

Vasant Oswal

MB, MS, FRCS (Eng.), FRCS (Ed), DLO, DORL

1960 2022





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DEDICATED TO

THE PEOPLE OF CLEVELAND, ENGLAND

Whose generosity
Raised £72,000 in just six months, far exceeding the target of £40,000 to acquire

The Very First UK Laser With An Articulated Delivery Arm

for

The ENT Department at The North Riding Infirmary,
Middlesbrough, Cleveland, England
in 1982

and

TO THE STAFF OF THE INFIRMARY FOR THEIR ENTHUSIASTIC SUPPORT IN PIONEERING ITS SURGICAL USE

Table of contents

Acknowledgements	7
Foreword	9
Preface	11
Worldly arrival and growing up (1934 – 1955)	15
Medical studies in India (1955 – 1963)	39
ENT training in the sixties of UK (1963 – 1969)	61
Consultant ENT Surgeon (1970 ~)	109
The laser – a new animal (1982 – 1995)	159
You will retire someday, won't you? (1995 – ~)	245
Russia Ukraine conflict	299
The launch of the autobiography	301
Online resources	303
Curriculum Vitae	305
Special thanks	311

Acknowledgements

Many people played a vital role in making the ENT department at The North Riding Infirmary in Middlesbrough in Cleveland, England, the first and foremost in laser technology in the UK. It also established the Cleveland International Laser Course in 1983, which ran for 28 years.

The following paragraphs record their names and their role. If I have missed any through oversight, my sincere apologies.

My sincere thanks go to:

- The South Tees Health Authority who supported the proposal for acquiring the machine by public appeal.
- Mr and Mrs Pearson of Signs and Plastics who actively launched the appeal.
- The People of Cleveland, who funded the targeted appeal for £ 40,000/- in just four months. In the end, the total exceeded £ 72,000/.
- Richard Koronowski, the sales manager of Coherent (1982), who set up the CO_2 laser, the first UK laser with an articulated delivery arm.
- The 'team' of technicians and nurses, Paul Marsh, Dennis Mason, Gordon Myers, and Caroline Gowland, who spent much time out-of-hours, carrying out the experiments and video-recording them.
- John Hunton, my consultant anaesthetic colleague, who joined me in developing a set of bespoke fireproof flexible anaesthetic tubes. Also, J B Masters, instrument makers from Lancashire, who came to my theatre sessions to study first-hand and design the anaesthetic tubes and instruments for laser surgery.
- My wife Nirmal, who prepared the pig larynx and pig tongue and froze them for hands-on laser courses.
- My trainee doctors, Chawla and Zha, who helped during laser surgery.
- My medical colleagues, who referred their cases for laser surgery.
- The theatre and the ward nurses, who learnt the technology and looked after the postoperative patients.
- The speech therapist Caroline Frazer, who took personal interest and set up the Cleveland Laryngectomy Club way back in 1972. Jayne Deakin continued after the retirement of Caroline and oversaw the laser procedure to precisely locate the puncture site to use Blom singer and Provox voice prosthesis.
- Rosaleen Shine of ENT & Audioloy News, who helped to oversee the text.
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- Simon, Dries and his team, at Kugler Publications in The Netherlands, for publishing this autobiography.

I am immensely grateful to John Gibb, the administration manager, and Sister Altringham of ward four at the North Riding Infirmary for the surprise when I saw a room in the ward bearing my name 'Oswal Suite'. It is most unusual that a room is named in an NHS hospital. The Infirmary was relocated to James Cook University Hospital in 2002. A consulting room in the ENT outpatient was chosen to transfer the name; it was named 'Oswal Rhinology Lab' to reflect my work in developing Ho:YAG laser for rhinology application.

My contribution to the development of the Deenanath Mangeshkar Hospital (DMH) in my hometown Pune in India, was symbolised by naming the postgraduate training centre 'Vasant and Nirmal Oswal Postgraduate training centre'. The centre has been accredited

by the Royal College of Surgeons of England. Vasant Oswal Voice Clinic in the laryngology department is yet another honour for me. Again, I am esteemed by the generous act on the part of the administrative and medical staff of the Hospital.

As Chair of the Young Otolaryngologists Association, training the young surgeons from the old Soviet-era, I received acclaim with 'NP Simanovskii Gold Medal' for which I feel revered. I am most grateful to my late colleague Marius Plouznikov for bestowing such an honour.

There are many such awards I received from several professional bodies. However, a fellowship by-election (FRCS) by nomination, awarded to me by the Royal College of Surgeons of England, tops them all. I regard it as the ultimate epitome of my academic career. I am indebted to Paul O'Flynn, a member of the RCS Council, for the nomination.

Finally, and most importantly, many hundreds of patients trusted me to undertake surgical procedures for their ailment, a trust given in care by their most valuable possession – their self.

It has been a privilege and an honour to serve, a lifetime opportunity for us medics to do our bit to help in your hour of need and train future generations to follow in our footsteps. Thank you, one and all.

Vasant Oswal

Foreword

Paul O'Flynn

Vasant Oswal is a legend.

Born nearly ninety years ago in India, he has seen and truly observed the transformation of the social, political and professional landscape. His autobiography takes us on his journey from India as a young man to the UK, where he establishes himself as a Consultant Ear, Nose and Throat surgeon. And beyond into his 'third age'.

I started my ENT Consultant career in 1994, just as Vasant was allegedly retiring, aged sixty. If his story stopped there, it would have been impressive. However, Vasant had developed an obsessive interest in laser surgery in his NHS career, as well as gaining widely recognised editorial skills. He had also built up an immense network of friends who happened to be 'opinion leaders' in all aspects of laser surgery globally.

Although I knew of Vasant's LASER course in Middlesbrough, I did not meet him until he invited me to speak at the Laser and Voice conference in Pune in 2010. We had a terrific rapport straight away, and we went on to help DMH in Pune become the first Royal College of Surgeons of England Accredited Education Centre in India.

This book is a deeply personal account weaving through the history, opinion and observation, considered through the eyes of a highly intelligent and thoughtful man. He reflects on identity in our rapidly changing world and on lessons that should have been learnt in the last World War. There is an abundance of ENT history which will fascinate any scholar.

Vasant has not discovered the word retirement, and long may this continue.

Throughout all, Nirmal, his wife, has been his constant support, mentor and guide.

Hon Professor Paul O'Flynn FRCS England

RCS Council 2012-2022

GLOBE-TROTTING AND SIXTY-TWO YEARS OF ENT

Preface

During many casual conversations with my colleagues, friends or strangers about my life span of nearly nine decades, with sixty-two years as a medical professional, many remarked, 'You must write a biography; it will be so very interesting.' What fascinated them? The story, the story-telling style, or both?

When taking up this task, I am well-armed in writing skills, having written and edited three major medical books on lasers, having navigated *ENT & Audiology News* as the Editor-in-Chief for four years, and having been member of the Editorial Board of many peer-reviewed medical journals.

When writing a medical textbook, or an article for a journal, most of the contents follow a definitive path, well-trodden by peers! In contrast, writing an account of oneself has a different nuance. Life is a jigsaw puzzle, each piece representing a notable event. The art lies in fitting them together to make a story, an overview, a virtual reality. I hope my narrative comes up to this finesse.

While our future is unknown, the past is indelible. As I started writing, it came alive, flashing before my eyes, many a time, disturbingly. Did I live it? Did the discord of events so sternly influence my life? Yes, it most certainly did. There was no rudder. Immediate past events influenced every turn, every detail, every instance in my life.

It has been a long and tumultuous journey over nearly nine decades. When we talk about the last hundred years, it seems so long ago. Nevertheless, if one has witnessed eighty-seven years of these, everything seems like yesterday. There were roads, rough and smooth; uphill and downhill, bridges narrow and wide, turns sharp and smooth. Having manoeuvred them, what is the destination – apart from the oblivion?

The human brain is such a powerful organ. It governs our conscious existence. Each event is interpreted, configured and stored in various chronological compartments of the brain. Their recall is both instantaneous and virtual.

Each memory recall comes with hindsight, giving it an analytic ensemble and a judgemental perspective. It is now seen in the totality of the comprehensive background. You begin to understand why, how, where, and what-if. Given this new perspective, would I have done something differently? In the words of that famous French singer, Edith Piaf – 'Non, je ne regrette rien' (No, I have no regrets).

What follows is not fictional; it is *me*. Now, my *me* is being resurrected through my fingers. Enjoy reading it as much as I experienced living it!

Sections separate the contents; each section represents a significant change in chronological or professional life.

Section I covers the thirties' era. I was born in the British India, before the second world war of 1939-1945. Ironically, the third world war is in the air as I approach my twilight years. Are we so stupid that we did not learn anything from the previous two wars?

Pune is some 120 miles southeast of Mumbai. In the thirties there were no cars in Pune, no auto-rickshaws, no scooters and no buses. Apart from the ubiquitous paddle bicycles, a two-wheeled horse-drawn 'Tonga' was the only other means of transport. Late mornings and early afternoons were interspersed with hawkers selling their products or collecting items for recycling. In the sultry heat of the afternoon, the streets were mostly empty, with folks taking a siesta. Even the proverbial 'Mad dogs and Englishmen' were nowhere to be seen 'in the midday sun'. Light from tungsten bulbs filled the dark of the evenings, and the city fell into a slumber by ten or eleven.

The early forties saw the blackouts and the sirens, with a daily update of World War II broadcast on the BBC world service. For six long years, queuing for grains and kerosene (paraffin) became a way of life. I grew up to be a youth, full of energy, waiting to see my first stubbles on the lip and chin. Growing a moustache was a sign of masculinity seen in lead roles on the cinema screens, and so was cigarette smoking.

Quit India became a purpose, a goal to be conquered. The British departed in 1947, leaving behind a legacy of a nation divided by a simple line on the map drawn by Sir Cyril Radcliffe, and Pakistan was born. Millions found themselves on the wrong side of the border. A human exodus of fourteen million souls is the largest the planet has ever witnessed, with the killings, the rapes and the looting. They say history repeats itself. How true, those horrible scenes of the plight of the fleeing Ukrainians are repeated constantly on our screens.

In the early fifties, suddenly, I found myself grown up, seeking a career path. By 1960, I was a qualified doctor.

Section II and III see me climbing up my career ladder, leaving India for England for 'higher surgical studies'. After an overnight journey and a little nap, I opened my eyes and found myself in this strange land. Strange? Yes, the morning of the 11th of November 1963 was a depressing sight of a watery sun trying to peep through the smog, a shivering cold, tasteless food, and the world around me was a far cry from the life I had just left behind – a world full of hustle and bustle. I soon adapted to the new norm, the language, the culture and the society. And yes, the locals gave me a new identity: I was 'black' and then 'brown', or simply, 'a coloured person'. In the twenty-first century, some found these terms offensive. So, they gave us a more acceptable description of having 'skin of colour', which could mean all shades of black, brown, yellow and wheaty, but not white. And there were more elucidative non-skin-colour phrases: immigrant, foreigner, ethnic, Asian, Asian Indian, etc. Now, with advancing age, I am also a 'pensioner', with a free bus pass and winter fuel allowance. And to a question 'what is your gender'? I now have an option – 'prefer not to say'.

Even COVID-19 gave me yet another identity. Now I am BAME: Black, Asian and Minority Ethnic, with a risk of death from COVID-19 generally higher than white British people! And I am also elderly, which puts me in yet another category: a vulnerable age group.

As Dolly Parton sang in her beautiful voice, I am wearing 'My Coat of Many Colours', sewn by people.

Section IV takes a phenomenal turn. Instead of heading home to India, a significant event of Colonel Gaddafi deposing King Idris of Libya in 1969 sealed my destiny; I was to make England my home and weave my future, a tale you are now about to read.

Section V covers a landmark moment rarely witnessed by generations of medics. The laser – a hot laser beam used as a surgical knife. Having seen it demonstrated in a trade exhibition at a conference in Hungary, I asked the hospital authorities to get a machine for our ENT department in Middlesbrough. No one puts a hand in the pocket and dishes out £ 40,000 just for the asking, so I raised the money by public appeal. Incredibly, the £ 40,000 came in, in just four months, and the laser was installed in the theatre. We had to close the appeal at £ 72,000.

After studying the properties of the laser in a series of experimental setups, I established the parameters for using it like a surgical knife. I chose my first laser surgery patient with cancer of the tongue. Various surgical procedures followed over the ensuing months, culminating in organising the first British Conference and the very first laser course. Not in a thousand years could I have imagined that I was set on a path that would keep me busy the rest of my life and take me to the heights of an international expert and a pioneer in laser surgery in ENT. The title of this work, 'Globe Trotting', is every bit apt.

As the section ends, it is now 1995. At sixty-one, it is time to take the backstage and do what all my seniors did – retire, have a leisurely life with gardening and holidays abroad. But destiny had a different path for me. While in St Peterburg in Russia for a training commitment, a chance meeting with an Indian trainee medic led to a project to build a 1000-bedded not-for-profit hospital in my hometown Pune.

Section VI describes the establishment of the Deenanath Mangeshkar Hospital (DMH) in Pune. A brainchild of the famous Bollywood singer Lata Mangeshkar and her siblings, the first phase of 500 beds was inaugurated by the late Mr Bajpai, the Prime Minister of India, in 2003. The second phase, consisting of 500 super-speciality beds, was inaugurated by the current Prime Minister, Mr Modi. The DMH is the only Postgraduate Training Centre accredited by the Royal College of Surgeons of England (RCS) outside the UK and Eire. The laryngology department has three training posts accredited by the RCS, Eng.

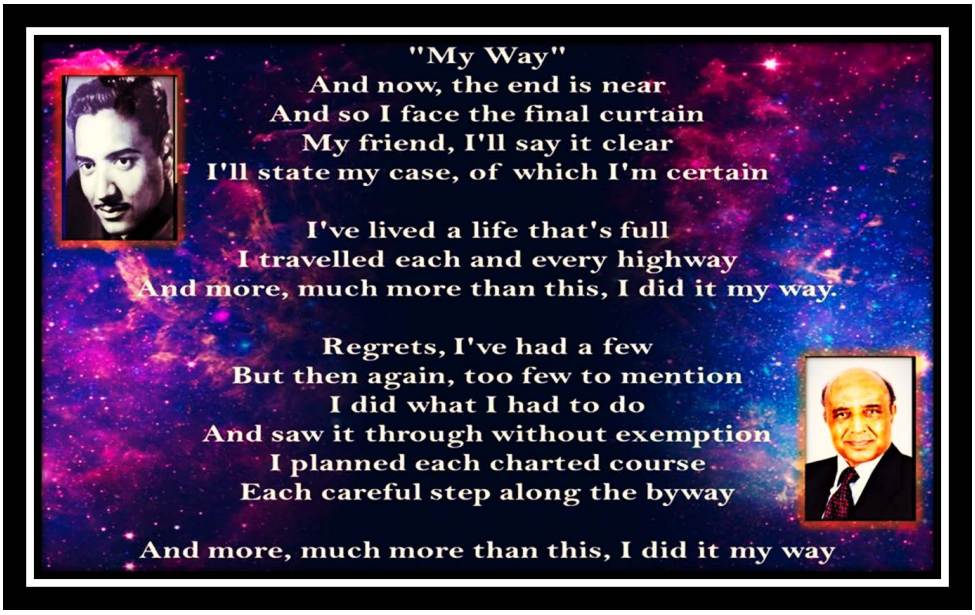
A lengthy academic career now in its sixty-second year, a reasonably healthy body, and Nirmal, my wife, looking after my earthly needs and accompanying me to all those faraway lands begs the title of section VI, 'You will retire one day, won't you…?' Yes, one day.

And what a downsize to my globe-trotting! It now spans the length and the width of my garden. It only took a little bag of protein no more than 0.1 microns thick, the SARS-CoV-2, to ground me. But it has not captured the internet, so my academic activity has not ceased; it just changed the format and transformed all those faces from 3D to 2D.

Mine has been a journey of fulfilment. It took me to many faraway places, to the heights where the Concorde flew, to the skies over the Alps, where I experienced the thrills of paragliding. I saw many cultures, met adorable people, tasted a variety of gastronomic delicacies and all this by invitations from colleagues from the five continents, the colleagues I had never met before. And a professional fulfilment of continuing to pass on some forty years of experience in Laser technology to young surgeons worldwide. As recently as March 10-15, 2022, the 2022 New York Laser Meeting, hosted by the European Medical Laser Association, honoured me with the 'Life Achievement Award'.

I hope this biography will enact my life, and you will come with me to savour all I did over those long years.

If I were to ask to put it all in a nutshell, I could not do any better than what that Ol' Blue Eyes said in a song in 1969 (Frank Sinatra, *My Way*, 1969, Reprise Records).



Section I

Worldly arrival and growing up (1934–1955)

13th September 1934

One surreal day, on the thirteenth of September, nineteen hundred thirty-four to be precise, when I opened my eyes, I found myself on a piece of land called India. No one had asked me if I wanted to be born, let alone where and why. So, what was I supposed to do? Nevertheless, like all new-borns, I did not ask any questions, closed my eyes and got on to start living life as it was in India in 1934.

As life starts, many shifting goal posts need mastering – sitting, crawling, standing upright, and then that first step, a fall, followed by another clumsy attempt with a bow-legged stand, trying to grab food with a fist to put it in the mouth, smudging the face all over.

The mouth is the most sensitive part of the baby – obviously for taking in food. In the new-born, breathing and suckling are spontaneous and independent, meaning both processes function simultaneously. Neonates are obligate nose breathers, with the mouth being used solely for sucking. This separate function of the mouth and the nose is soon lost as the baby grows. The two now must coordinate; the breathing cycle must stop precisely while swallowing, or else we will choke! There is a rare clinical condition in which both nostrils fail to canalise (bilateral choanal atresia) in the back end. It is incompatible with life in the new-born and requires immediate surgical intervention to establish nasal breathing. A two-month-old infant was brought to the A & E one night with the history of the baby going blue when given a bottle feed since that morning. Both nostrils were full of crusts at the entrance. I removed them with crocodile forceps. The infant emptied the bottle at such a speed, we all watched with great satisfaction. A cotton whisp placed at the nostrils moved with each breath, confirming no further obstruction within the nostril. The parents were very grateful. I told them to watch for further crusting and apply some Vaseline with a cotton bud to prevent it from reforming.

How does a baby find the source of food? The simple answer is it cannot. We have a dairy farm in the village. The farmer sometimes had to tend a calf born in the field in the middle of the night. Out of curiosity, I asked him, 'A newly born calf can hardly move. How does it find mother's teat'. He said, 'It cannot. Mother pushes herself nearer its mouth so that her breast rubs against its face.'

From this helpless state of early childhood, we all have to wean. In humans, the process of weaning and achieving total independence stretches to several years. Numerous conquests lie ahead. Some won independently; others need parental help, not always forthcoming.

The parental shelter is lost when the mother leaves the child in the nursery on that first day. Then, the start of schooling sets the scene where we all have to forge our future, our independent existence. In humans, the offspring has the most prolonged dependency on their parents and others, especially if they choose a professional career. Medical studies

Vasant, 1936, two year old

are one of the longest; my first salaried house job in ENT started in 1960 at 26.

Compare this with birds. In our garden in England, we have doves as our pets. After mating, the mother lays two eggs within several hours of each other. Incubation starts for both eggs simultaneously to ensure that the eggs hatch at the same time. The gestation period (sitting on the eggs) is around fourteen to sixteen days. Both parents take turns in sitting and feeding the hatched chicks. When the time comes for independent existence, some twenty days after hatching, the babies, used to being fed by the parents, are reluctant to leave the nest. The parents stop feeding, and the hunger drives chicks to tumble from the perch to the ground, searching for food. We also noticed that the mother wings her reluctant baby from the edge of the nest and makes it fall to the ground! Is there a lesson to learn for us humans?

Pune (Poona): my hometown

Pune,[1] my hometown, some 120 miles southeast of Mumbai (Bombay), is the cultural capital of Maharashtra state. It is the second-largest city in Maharashtra, after Mumbai. Historically, in the eighteenth century, it was the seat of the Prime Ministers, called 'Peshwa' of the Maratha Empire. The British called it Poona (1857–1978).

Pune has a distinction to be dubbed the 'Oxford of the East' due to several well-known educational institutions. Today, it has a burgeoning international student population, nearly half of all the international students in India study in Pune. It is also the 'Detroit of India', with a large auto-manufacturing base. It is one of the seven Indian cities to be developed as a smart city.

In 1817, the British established Pune Cantonment as a British garrison base for accommodating the British Indian Army troops. The cantonment area is known as 'camp'. The garrison included two European regiments, a mountain battery, a native cavalry and three native infantry regiments. Even now, it has the headquarters of the Indian Army's Southern Command. The National War Memorial Southern Command, which commemorates the sacrifice of soldiers of the Indian Armed Forces, is also situated in the cantonment.

My childhood in the lower-middle-class family

In the thirties and the forties of the last century, life was pretty simple. At the start of the Second World War, we were a lower-middle-class family of four children. Interestingly, the life one knows of and accepts is the life one is born in a particular family. And that norm is universal because the locality around you also lives to the same standard. And, still worse, there were shortages of most commodities since the six-year war effort took most resources.

'Pre-owned' is a fashionable modern wording for second-hand or used goods. As my brother grew out of his clothes, it was now my turn to wear them. The same happened with schoolbooks, sandals, even leftover blank pages of the exercise books. I hated anything second hand, but airing your views was pretty much against the strict discipline of our upbringing. The aversion to buying second-hand things stayed with me all my life. In England we rented a television set from the high street shop called Rediffusion. Nirmal always wanted to own a television. Philosophically, I told her: 'You don't "own" anything since, in the end, you have to leave everything behind. A philosophical viewpoint is handy when you don't have much money.

Home: a rented flat

Centrally located, we lived in a rented flat on the first floor at 1425, Shukrawar Peth, Pune. On the other side of the road, there was a stand or a resting place for bullock carts and two-wheeled horse carriages called 'Tonga'. The horses were rested and fed until the next job. Victoria coaches with four wheels and two horses were used mainly in Mumbai.

Food

I had to get up early in the morning and take a bike to fetch milk from a cowshed. I could not reach the pedal from the seat, so I had to put my leg under the horizontal bar to the other side and pedal the bike. I made tea for everyone on a primus stove. The aroma of the tea spread in all rooms, beckoning everyone for breakfast. I never smelled that aroma from the convenient tea bags or loose tea leaves. Freshly harvested vegetables and fruit came to Pune from surrounding farms very early in the morning. We were born Jains, so strictly, the food was vegetarian. After fetching the milk, it was time to go to the market some ten minutes away and buy the vegetables. I helped my mother by washing and chopping all the vegetables. Thus, my morning was packed with chores. The time soon came to get ready for school, with a tiffin carrier and a school bag. We did not have a uniform in those days. Upon returning from school, I went to the grocers and bought the supplies for the week. I also had to go to a shop where the rollers driven by the bulls going round in circles squeezed the oil from the stalks of edible plants. We ate food with our fingers and not with cutlery, the tradition that continues in most Indian homes even today.

Food contamination: typhoid from shop-bought ice cream

My mother observed strict hygiene. We always made ice cream at home in the summer months. However, once, we all had shop-made ice cream after a visit to a cinema. My brother and I got typhoid from it. It was a serious disease with potentially fatal complications due to perforation of the intestine. Since there were no antibiotics, complete bed rest and very bland food was the only management. My fever lasted 48 days and his 96 days. It was a terrible punishment to smell all the aroma of spices from the cooked food in the kitchen and not have any of it. We recovered well. Unfortunately, my cousin sister Usha, a very bright schoolgirl and another typhoid victim, succumbed to this illness in her youth.

Illnesses in the pre-antibiotic era

Apart from the common cold, mumps, measles and chickenpox, there were several other dreaded contagious diseases without specific treatment, such as pulmonary tuberculosis, typhoid, smallpox, cholera, malaria and leprosy. Vaccination was available only for smallpox. Epidemics were common, particularly after the monsoon rains. We slept under mosquito nets, hung like a canopy on the top of the bed. There were also bed bugs. We used to spray repellent powder around the bed. Vermin infestations of localities were common. Mice were a nuisance, but rats were vectors for the plague. Municipal workers would come regularly and locate holes in the walls through which they fumigated their nests. Rats were caught in traps and collected the next day for incineration. I also recall a sight of a scorpion in the kitchen. Its sting can be deadly. Domestic lizards regularly came in, creeping around the electric light which attracted insects. Our general practitioner had a 'dispensary' (GP surgery) in the same building, handy.

Clothes

We had a family tailor who came to our home with a selection of reels of material to choose from. He measured us up and tailor-made all our clothes. Ready-to-wear clothing was yet to come. Most saris were made of cotton; some were made of silk but very expensive. The shorts and trousers generally wore out after a few months of wear, with holes appearing on the bottom. We then have to take them to a tailor who would patch the worn-out area with leftover pieces of any cloth. If you have not heard Dolly Parton's famous song, 'Coat of Many Colours', listen to it, you will enjoy it. Being a lower-middle-class family meant that we got new clothes only for Diwali festivities! But it was worth a wait, to smell the tailor's shop on our new clothes!

Recycling

When they were no longer useable, my mother traded our worn-out clothes against cooking pots brought in by hawkers. They were then smartened up, patched up and sold again to someone not so affluent as us. The old newspapers were bundled up and sold to a shop by weight. Paper bags were made out of them and sold to grocery stores for packing peanuts, spices etc. There was, of course, no plastic when I was a boy. In my lifetime of eighty-odd years, I am witnessing a global drive towards recycling. We have gone back to my childhood way of living – cotton grocery bags, recycle newspapers and all that! The world goes round yet again!

Entertainment

My mother's side had a cultural and artistic taste, but there were few opportunities within the limited resources in village life. Performers of open-air dramas and musical concerts in local and Urdu languages regularly toured the towns and villages. My grandpa always took me with him. I thus developed a taste for Urdu Poetry known as Shayari, which consists of at least one couplet, and which I continue to enjoy this day. An open-air travelling cinema

also came now and again. I used to watch the cinema every time it came to the village.

In bigger towns such as Pune, public entertainment consisted of dramas played in dedicated playhouses or drama theatres. The most expensive tickets were in the front rows, with padded chairs and sofas near the stage. The cheap wooden benches were in the rear. When moving pictures or 'motion' pictures came, they repurposed the drama theatre for dual use by installing the screen.

The dramas are best seen from seats near the stage to see the performers. But the films are best viewed from a distance so that the whole screen is within your viewing angle, which is between thirty and sixty degrees. Thus, when you went to the dual-purpose drama theatre to watch a movie, you ended up sitting on wooden benches if you wanted to see the film with an optimum viewing angle!

Initially, they were aptly called motion pictures to indicate that each image was moving. Later, the name was simplified to 'movies'. The piano, playing live, provided the background music. When the soundtrack was added, the silent movies became 'talkies', and drama theatres projecting them were also called 'talkies': Minerva Talkies, Globe Talkies, Shirin Talkies and so on.

We had a His Master's Voice or HMV gramophone. It had a trumpet and a clockwork mechanism. I had to turn the handle of the key several times to wind the spring by lifting a corner of the casing so that the 'key' could go a full circle for each turn. My uncle liked listening to movie songs. We had to go to 'Ghaisas music shop' to buy celluloid discs called records and needles for the gramophone.

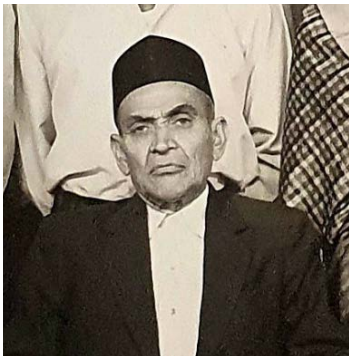
Arrival of Pushpa – home delivered (1940)

In 1940, when I was six, my sister Pushpa arrived in the front room of our flat. The mother and the baby claimed the whole of the front room and stayed there for a good six weeks, as was customary in those days. Women essentially rested in bed after the delivery. The bed had metal springs and a frame with a thin mattress; the baby slept by her side. Every day, a maid would come along and, I suppose, gave my mother and Pushpa a clean-up. Afterwards, she would light up coal in small earthenware and sprinkle some herbs, placing the pot under the bed. The whole room quickly filled with a cloud of pungent smoke. I expect this was equivalent to modern-day fumigation to kill bugs.

My first bus ride (1942)

There were no cars on the road in the town centre of Pune where we lived in the early forties, not even one! There were no motorised vehicles of any description. The only transport mode was by two-wheeled Tongas drawn by a horse and bicycles. The municipal corporation introduced a bus service on a few routes in 1942, I think. The road where we lived was on Service Route number six. It went from one end of Pune – Deccan Gymkhana – to the other end, Pune Railway Station. I do recall asking my mother that I wanted to have a ride on the bus. When the bus came, she signalled it to stop and told the conductor to give me a ride to the station but not let me get out there or anywhere else. He had to bring me back to the same spot as I was getting in, and only then let me out. My first ever ride in a motor bus!

My father: a 'Civvy' in the British Raj (Bhaijee, 1899–1986)



My father, Hansraj

My father, Hansraj Ramachandra Oswal, was born in 1899 (we addressed him as Bhaijee – literally meaning older brother). He had studied up to matriculation (the equivalent of 'O' levels). He spoke fluent English.

He was a civvy in the British army and saw action in Addis Ababa and Basra in the First World War. He never smoked or drank or raised his voice in a temper. I don't think my father took an active part in running the household since, most of his time, he had to earn a living. He would always consult my mother in most matters. She did all the work in the house. She also gave him a hand in his work as an annual supplier of fruits and vegetables to Central Mental Hospital, one of the largest mental hospitals in Asia, with close to 2000 patients in the dormitories and bedrooms. Yeravda was about six miles from our home. I often used to go with my father during the summer holidays to help him with his work. A downside of contract work is that it was annual and competitive. It would mean that the income was not steady.

My mother, my mentor: (Baai: 1910–2005)

My father Hansraj (L) and my mother Shribai

My mother (Baai) was born in 1910. She lost her mother at the age of seven and, at that tender age, had to cook for her father and two brothers. It was not a common practice in those days for women to go to school. My mother taught herself to read and write by watching and listening to the teacher who came to teach her brother at home. I am not sure when my parents got married, but I guess my mother could not have been more than sixteen years old, since the first child of the family, my sister Didi, was born in 1926, followed by the second, a boy, Madan, in 1932. I came along in 1934. After me, three more sisters were born. One died in infancy. Pushpa was born in 1940 in the front room of our small, rented accommodation and Sunita arrived rather late, in 1952.

My mother was a prolific reader. Before her afternoon nap, she unfailingly read *Sakaal*', a local newspaper in the Marathi language, and became very knowledgeable. During her visit to our home in England around 1978, I took her to Madame Tussauds wax museum in London. In the Chamber of Horrors, she felt uneasy. Nevertheless, she was able to point out and name some notorious characters of her era of the thirties onwards – such was the profundity of her knowledge despite the lack of formal schooling. My mother

Indians not allowed to use Main entrance of Dorabjee's store in the British Raj.[2]

To cater for the needs of the British admin staff, some commodities were imported from England and from other countries by a store called Dorabjee's in Pune. The owners acquired the shop in 1911 and it is still run by the family of Dorabjee. Since the store was located in the Civil Cantonment area of Pune, it was patronised by the officers of the British Army and British 'sahibs', of the Civil Service.

The British administrator of the mental hospital would give a list of items to my father who would then go to Dorabjee's shop to get them. Amongst many imported items, I recall cartons of corn flakes, digestive biscuits, cream crackers, cheeses, Cadbury chocolates, tinned and canned fruit such as pineapple and lychees, and mermaid condensed milk, Quaker oats, Ovaltine, Wooden cigar boxes and so on!

All the commodities were delivered at our home, where they were sorted out. Every so often, my parents would treat themselves and the family to the imported produce. Thus, as a child, I had savoured all that English and foreign food.

The front entrance faced the wide road in the cantonment area. However, Indians were not allowed to enter the shop from the main entrance and were also barred from the main shopping area – this was reserved for the British shoppers. I sometimes went to the store with my father. Both of us had to enter the shop from the 'goods' entrance in the street in the back of the shop, notwithstanding the fact that we brought a substantial business to them from the British administrators of the Mental Hospital.

was more intellectually gifted than I; that says something about her influence on me.

Tobacco use in any form is a known carcinogen. Even so, its consumption is universal and takes various forms. In the Indian subcontinent, some people keep a pinch of it in the buccal sulcus all day and sometimes even all night long. The ingredient increases salivation. While some of it goes into the body, the excess is spat out. To see people spitting in the streets is a common sight in India, so noticeable and repulsive. My mother also had a habit of chewing tobacco, but only at night. She gave it up in the latter years and lived up to a ripe age of 95, without any ill effects in the mouth.

Baai's peaceful demise – as gentle as her life

During one of my visits to Pune for teaching, I had finished my work in good time. Unplanned, I visited my mother that afternoon. As we were chatting away, she started feeling pain in the back along the shoulder blade on the left side. We massaged it and applied some ointment, but without any effect. Things got worse, and I decided to call help from the hospital where I was teaching. The casualty doctor examined her and said she needed to go in. After some hesitation, she agreed. She had a comfortable night. The next day, after a hearty lunch which she enjoyed, she slowly became comatose. Jay

Kelkar, the chief of the hospital, and I discussed the situation. She was suffering from multi-organ failure – not uncommon in the ageing population. We decided to hold back any intervention and let her go. At about 8 pm, the monitor stopped showing a trace. Like my father, she passed away peacefully. The morning after my mother passed away, I had an operating schedule on the first floor. For a moment, I paused. I was operating in the same building where my mother was resting in the mortuary in the basement. I felt wetness in my eyes. Finally, I composed myself and got on to my work. Everything seems weird: my scheduled Pune visit for teaching, my fortuitous unplanned visit to her that day, her admission, the decision at the very highest level to let her go, the following two days as I was working, with her lying in the mortuary and finally, her funeral. All over. The beginning of my speech at her funeral to the mourners summed up what she meant to me: 'I am celebrating the illustrious long life of my mother, not mourning her death.'

Far Shirby

When we moved to our bungalow in Upleatham Village in Yorkshire in 1982, it was named 'Far Sawrey' by the previous owners who had their honeymoon in the picturesque village of Far Sawrey in the Lake District of England. I changed it to 'Far Shirby': a synonym to my mother who was 'Far' away and whose name was 'Shirby' (Shribai).

Didi's marriage – household chores, another milestone for me

Didi gave my mother a hand with household work since my mother had to help my father receive the supplies from the market every morning. Didi got married in 1942 and went to Mumbai to her married home. I was eight years old. Now, there were only my parents, the two boys and a two-year-old baby sister Pushpa, born in 1940. My older brother Madan did not do any work in the house. So my mother would tell me – a willing donkey – to do all the housework. In later years, I asked Madan why he did not help me do work; 'I did,' was his candid reply; 'without me drinking tea, all your work in making tea would have been pointless'.

School holidays – a taste of Mumbai metropolis

Babubhai, Didi's husband, was a breath of fresh air, polished, from Mumbai, and had no close relations such as parents and brothers and sisters. He adopted our family as his own and became an 'elder junior'. We developed an alliance with him and followed him as a role model. Didi's marriage to someone from Mumbai had a direct impact on me. I got to know the metropolis of Mumbai very early in my life. I was particularly close to Didi and spent most of my school holidays with her family. Didi passed away at the age of 83 after a short illness.

Primary schooling (1938 – 1941)

I recollect that I had to walk to school alone for about fifteen minutes when I was four or five years old. We sat on the floor with a slate and chalk. Learning was in a parrot fashion, with all children cramming maths tables with the teacher. I did not have a uniform or standard school bag. Writing on paper did not exist, and we did all the learning on a slate. Primary schooling lasted for four years.

Secondary schooling (1941 – 1952) – enrolled by a mill grinder

After finishing my primary school, I wanted to go to a secondary school. But somehow, neither my mother nor my father did anything about it. One of my household duties was to get grain milled at a mill a few doors away. I asked the mill grinder if he would enrol me into a secondary school. He and I went to the 'New English School, Nana Wada', some twenty minutes' walk away. The superintendent filled out the form and asked the mill worker to sign it, assuming he was my father. He, of course, told the superintendent that I was not his son. My father came to the school to sign the application form. As it so happened, the superintendent turned out to be his teacher. He mildly told off my father for not finding the time to enrol me. Who could have imagined that, from such a non-starter beginning, I would be honoured by the Royal College of Surgeons of England in 2014, with an award of 'FRCS by election'!

Self-reliance – a way of life from being a child

Thinking back, I believe the awareness of my self-reliance came about after a particular instance. Once I got stuck with maths homework. As a growing child, one always looks up to the parents for help. My father had completed secondary school and spoke fluent English, but he could not solve it. There was no one else around who could help me. But I did not give up. I looked at the work again, and then slowly, but surely, I could unravel the question. Finally, after a while, I had an answer. I checked, and the solution was correct. That one seemingly trivial instance made me so utterly independent to this day, that self-reliance became a way of life.

My guardian angel

I must have been 'programmed' to look after myself from the tender age of seven. The urge to get educated made me find a way out and ask a mill grinder to enrol me. This self-motivated character was to be my beacon in all walks of life, in all situations. All my life, I navigated myself on my own, never asking anyone how to go about – be it choosing a career, or going to Mumbai for post-graduation in medicine, or, for that matter, going to England for higher surgical training. Finally, I decided and reached my destiny – much the same way as Frank Sinatra's inspirational number, 'I did it my way'. When I look in the mirror, I feel assured that I have a guardian angel.

Teacher in the disguise of a student

I always topped the class. A few boys were lagging. My class teacher told me to stay back after the usual hours and teach those few classmates who needed extra tuitions. I have a reputation that I talk too much and too long, lecturing others on the tiniest of the topics. I wonder if the roots of my habit go back to those early years of teaching my classmates.

Extra-curricular activities: mostly failures

I joined several extra classes. Flute playing, hockey, cricket, badminton athletics – I could not manage any. Swimming got off to a good start. But an attempt to dive from the second level went disastrously wrong, and I hit the water squarely with every part of my whole body, nearly drowning myself due to the shock and disorientation.

Typing class

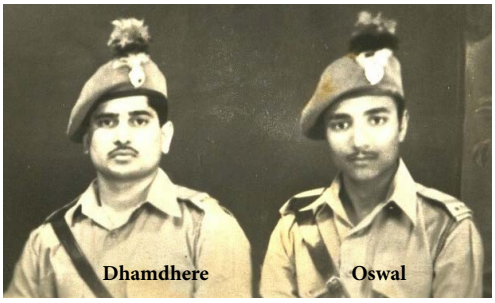
There was a typing class next to the school. It was full of girls taking lessons. The instructor told me I was too young to have enough vocabulary to be able to type! Not deterred, I went back after a couple of years and learnt touch typing with good speed and accuracy. In touch typing, eight fingers operate the middle keys. The muscle memory locates other keys without using the sense of sight. Did I know that the keyboard would be ubiquitous one day, and my typing skill would come in handy?

Riding classes – nearly decapitated

We had a Military Preparatory School in Pune. During the summer holidays, the army recruits went home. The school had riding classes for the civilians to keep the horses in top condition during the summer. I went every year for a good four years and enjoyed riding. On one occasion, I rode the trainer's beautiful horse 'Biju'. Horses sense the rider. He straight jumped the perimeter fence and sped towards the stable, which happened to be the one for ponies; it had a low roof. I would have been decapitated by the corrugated iron sheets of that low roofing had I not ducked in time.

National Cadet Core (NCC)

The National Cadet Corps[4] (NCC) in India is a voluntary organization that recruits cadets from high schools, colleges and universities all over India. It was established on 15 July 1948. The Cadets receive basic military training in small arms and parades. However, they have no obligation to enrol for active military service. The earliest age of recruitment was sixteen. I always liked a disciplined life, so I joined the NCC in 1950 when I was sixteen. After two years of secondary schooling, I continued NCC in the Fergusson College for two years, followed by four years in medical college, totalling eight years in NCC. I was promoted to the highest rank of 'Under Officer', with a cross belt and a cane.



Under Officer highest rank, NCC
U/O Dattya Dhamdhre (L) and U/O Vasant Oswal
B Medical college, Pune, India 1955

Weapons shooting

The training consisted of parades, lectures and the use of firearms. The rifle shooting took place in 'Golibar Maidan', a designated area of firing ranges in the Cantonment area of Pune. We practised with the Lee-Enfield rifle loaded with .303 British cartridges.[4] I scored high during the target practice and represented our region for competition shooting. I must have fired several hundred rounds over eight years during the training and the competition!

Chronic acoustic trauma – deafness in left year

In Dundee, where I was a registrar in ENT in 1964, I tested my hearing with a new type of audiometer, called a Békésy audiometer. It showed that I had a high tone hearing loss in my left ear. I had not been aware of any problems with my hearing. But to be sure, I tested my hearing with our audiometer in the department. Oh dear, yes, I did have hearing loss in the left ear. Years later, when I started seeing industrial workers for noise-induced hearing loss claims, I came across some shooters. Indeed, they also had hearing loss in the left ear. It was apparent that I had suffered a hearing loss in higher frequencies in my left ear during my NCC days when I had fired hundreds and hundreds of rounds of live ammunition without protection! Although a right-handed shooter pulls the trigger with the right hand, the right ear does not suffer damage since the head is bent towards the right shoulder, to see the target through the scope of the rifle, protects it. The bang therefore causes deafness in the left ear.

Summer school holidays

I spent the summer holidays with my uncle and auntie, who lived in a village called Ghodnadi, forty miles from Pune. In the latter years, I also went to Mumbai to stay with Didi. Ghodnadi[5] was a typical Indian village established around farming land and a river (Ghodnadi: a river that flows like a fast-running horse). My forefathers had migrated here from their native place in Rajasthan in the 19th century, but there are no records. The houses had low entry doors and small windows to deter easy entry by raiders. Kerosene lanterns provided lighting. They had to be dismantled and cleaned – a daily chore. Sanitation was rudimentary; women used indoor toilets whereas men went in the fields.

Travel to Ghodnadi – 40 miles in six hours by a bus!

In the forties, a couple of private operators ran the buses with wooden seats. Passengers gathered around eight o'clock in the morning at the 'bus stand' with their lunch and water since there was no schedule for departure. By afternoon, the owner/driver would judge that no more people were likely to come and herded the waiting passengers, waking some up from their afternoon nap! The bus left around 3 pm. The engine would get hot after having travelled about ten miles; the bus would stop, the cap of the radiator carefully opened to let the steam under pressure out. The cleaner topped the radiator with cold water, and the bus left for another similar stop ten miles further on. Halfway through, about twenty miles from Pune, there was a long stop for refreshment and further cooling of the engine. The forty-mile journey took a good part of five or six hours.

Apart from the passengers and their luggage, the bus also carried parcels, supplies, Royal Mail and anything else that needed transportation!

A passion for farming and gardening

Ghodnadi buzzed with people on Saturday, a market day. There were baskets of freshly picked vegetables, corn, wheat, fruit and all sorts of household commodities. Some of my distant uncles were farmers, so I had a free pass to go anywhere, which I did. That is where I developed a passion for gardening and mainly growing crops. At our home in England, I have a fair size vegetable patch.

Awakening of my youth

I used to spend my school holiday with my uncle and aunt in Ghodnadi. They did not have any children of their own, so I was a spoiled sport. One year, when I was thirteen or fourteen, I felt a sudden surge of energy from within me – as if my chest was filling, every muscle toned, my legs were springy, and my arms were pushing and thumping the walls. I felt a sudden burst of energy – testosterone must have started circulating!

There was an Indian Gym in Ghodnadi, where I did press-ups and wrestling. I went up the hill nearby, up and down, up and down and running everywhere. After a month in Ghodnadi, when I came back home in Pune, my shoulders, arms, thighs were shapely, standing proud in groups, taut as I moved my body.

I joined a gym in Pune and went there early morning at 5-30. I did Double bar, single bar, press-ups, weightlifting and Indian style wrestling. My gym activity gave me a physique, which is still apparent in my late eighties. Four or five hours of hard gardening does not make me out of breath. I have a static exercise bike and some other equipment at home for the winter months.

Summer holidays in Mumbai

I spent some three weeks of my summer holidays with Didi, who lived with her family in a Mumbai suburb called Ghatkopar. I used to go to South Mumbai, a commercial district of Mumbai, by train, wander around looking at shops, traffic and people. Even in the forties,

Mumbai, India's financial capital, was much advanced and modern compared to Pune, a sleepy town, and Ghodnadi, just a village with no electricity or running water.

The city transport in Mumbai was by red-painted buses and of course electric trams. The fare was a fraction of a penny, and the ticket gave you unlimited travel anywhere in Mumbai and part of the suburb. Pedalled bicycles were not allowed. There were wide pavements for pedestrians who were very disciplined compared to Pune. I certainly liked Mumbai, with its wide roads, tall buildings, suburban railways and the hustle and bustle, which lasted well into the evenings and past midnight.

My first encounter with the British (1939–1940)

My first encounter with the British was during the school holidays in Ghodnadi when I was a little boy of six or seven. In the heat of the Indian summer, waves after waves of red-faced soldiers passed through the village in military trucks and tanks, on foot, on gun carriages and horseback, *en route* to the Ahmednagar British garrison some seventy miles from Pune. Some soldiers came into the café for refreshments. Little did I know then that I would be a part of the British Society and responsible for taking care of the community of this Northeast corner of England, in the County of Cleveland, and the patients from the Catterick Garrison, in North Yorkshire!

The brief history of The British Raj (1858–1947)

I was born in the British Raj,[6] in British India. What is British India? Before the Indian Rebellion – the British called it Mutiny – of 1857, Indian Territory was under the British East India Company, a trading company under the charter of the British Crown. After the Rebellion was crushed by the British, the company transferred the accord to the Crown. In 1876, Queen Victoria became Empress of India by proclamation. The region under British control was called British India, which extended over almost all present-day India, Pakistan, and Bangladesh, except Goa and Kerala (Portuguese) and Pondicherry (French).

Indian Independence movement

The Indian Independence movement,[7] used two diagonally opposite forms to root out the British Administration from India. The protest involved peaceful opposition by non-cooperation, whereas the militant approach sought violence against the British rulers.

Witnessing the Civil disobedience rally personally

During the war years, Nehru, Gandhi and others, had come to Pune to urge the masses for peaceful non-cooperation. I had attended a couple of these, seeing Gandhi and Nehru in the flesh. A white cloth cap, known as the 'Gandhi cap', was worn by everyone to express solidarity with the Gandhi movement. Gandhi himself never wore the white cap, as far as I know! Congress adopted Gandhi's policy of non-violence and civil disobedience. Workers announced strikes and remained absent *en masse*. Large rallies of peaceful protests and

demonstrations were held all over the country. Nevertheless, mobs exploded bombs, flamed government buildings, disrupted electricity, and severed transport and communication lines at some places. I recall a few people symbolically burning a bus stand pole outside our home with chants of Quit India.

The Second World War (1939–1945)

The Second World War (WWII) started in 1939 and ended in 1945. During the war years, as I grew older, from a boy of five to nearly an adolescent aged eleven, I started to understand the vast expanse of the war theatre. What follows is a combination of my account of WW II, supplemented with research on the Internet and URL links.

The wind of war in Pune

India, as a part of the British dominion, was heavily involved in WWII. In Western India, Bombay Docks provided the British Naval base. Pune was the site for a large garrison in the cantonment area and an ammunition factory nearby Kirkee. Ahmednagar, 75 miles from Pune, was a base for the cavalry division. Sirens regularly sounded to impose curfew lasting for hours. Everyone had to go to any covered area in the close vicinity. Shutters came down on the shops, and the streets were deserted. Air-Raid Precaution Wardens (ARPs), wearing helmets, combed the streets to ensure there was no curfew violation. If the sirens sounded after dark, there was a total black-out. We had to cover any light bulb with an improvised black paper shade so that no light escaped onto the street. In addition, the wooden shutters of the windows had to be closed. And if anyone had not done the job correctly, there were loud orders from the ARPs: *'Black Out, Black Out'*. We had to duck under the desks in the schools to protect ourselves from falling masonry – if air raids came.

Ration cards

The introduction of rationing conserved the commodities. I had to make a weekly trip of a couple of miles on the pedal bicycle to fetch rations from the designated shop. There were long queues to obtain grains and sugar. The return trip home was even harder, the bike loaded with a weekly ration in sacks hanging from the handlebars. It must have been a challenging job for a boy of eight since I still remember it. And there was yet another trip to a different shop to obtain kerosene (paraffin) for cooking on a stove made by a manufacturer called 'Primus'.

Adults talking about the war: demonetisation of 1946

There were rumours that the Japanese were going to bomb Mumbai. Many sold their properties for whatever they could get and went into the interior of the country for safety. Black market in commodities had flourished. Some of you may be surprised to learn that Modi's demonetisation in 2016 is not unique. In 1946, the Indian administration announced the demonetisation[8] of high-value banknotes, which had conveniently hidden

the black money. Business people in India were supposed to have made huge fortunes supplying the Allied war effort and were concealing their profits from the tax department. Overnight, a high-value note became a worthless piece of paper! I recall my father had five or six high-value notes (perhaps thousand-rupee notes – a considerable sum of money in 1946). But they were a payment for the supplies to a government-run Central Mental Hospital and thus he was able to exchange them for lower value notes at the Reserve Bank of India.

All India Radio, BBC service:

We bought a radio set, 'Marconi' (Marconi, Italian inventor credited as inventor of the radio), in 1942. Every evening there was a nine o'clock news bulletin[9] on the radio presenting the latest news about the war efforts. Listening to the nine o'clock news was a ritual, and we all gathered around the set, waiting eagerly to update ourselves. I recall that the news broadcast was only in English.

British Pathé cinema newsreels

British Pathé[10] was established in London by French filmmaker Charles Pathé. It regularly produced cinema newsreels. During the war, every cinema theatre showed them before the feature film.

The Berlin Wall (1961)

President Trump's idea of building a wall between the USA and Mexico may have sounded outrageous in 2019, but the concept is not new. To begin with, there is, of course, that famous Chinese Wall.

Constructed in 1961, The Berlin Wall[11] was a concrete barrier that physically and ideologically divided Berlin into West Berlin and West Germany and East Berlin and East Germany. In 1989, a series of revolutions in Poland and Hungary led to a chain reaction in East Germany which ultimately resulted in the Wall's demise, leading to German reunification in 1990 and the dissolution of the Soviet Union in 1991. The dissolution of USSR had a direct impact on my professional life as described in section V!

Shrapnel

Upon my arrival in England in 1963, while taking a history of patients' occupation, they often told me that they were conscripts. During a routine x-ray for sinuses, I would notice the image littered with small radio-opaque fragments: shrapnel. Henry Shrapnel[12] was a British army officer. He invented an anti-personnel shell that transported a large number of bullets to the target before releasing them, to a far greater distance than rifles could fire the shots individually.

The Indian Independence Act of 1947

After the end of the war, India emerged as the world's fourth-largest industrial power. A prolonged war effort had devastated the British economy, and the British could not sustain the cost of ruling the Empire. The Indian Independence Act of 1947[13] ended the suzerainty in India. By March 1947, a new viceroy, Lord Louis Mountbatten, arrived in Delhi with a mandate to find a speedy way of bringing the British Raj to an end.

Partition of India, birth of Pakistan

Mahatma Gandhi and Jawaharlal Nehru had maintained the concept of a unitary state with a robust centre. However, some states with concentrations of the Muslim population believed that it would lead to the political dominance of the Hindus, who made up about 80% of the population. The Muslim League's 'Pakistan' resolution called for creating separate states to accommodate Indian Muslims. Communal violence in Calcutta, known as the Great Calcutta Killing, left some 4,000 people dead and a further 100,000 homeless. Lord Mountbatten announced that independence would be brought forward to August 1947, with the stipulation to create two separate states giving them no alternative. A Boundary Commission, led by the British lawyer Sir Cyril Radcliffe, drew the border for two nations: West Pakistan and East Pakistan, separated by a vast Indian territory. The critical provinces of the Punjab and Bengal were divided into two.

Suddenly, millions of Hindus and Muslims found themselves on the 'wrong side' of the border. A colossal wave of migration followed on foot, in bullock carts and trains, with Muslims heading towards Pakistan and Hindus and Sikhs in the direction of India, the communities identified by nothing more than their separate religions. An estimated 14 million people were displaced and became refugees. Inevitably, there were riots, killings, rapes, and casualties claimed by diseases in the refugee camps. An estimated two million suffered the ultimate ill fate – death.

Independence Day: 15 August 1947

At the Constituent Assembly of India on 14 August, Jawaharlal Nehru delivered the 'Tryst with Destiny' speech proclaiming India's independence.[14]

I can still hear it in my ears as I heard it then on the radio broadcast.

"Long years ago, we made a tryst with destiny, and now the time comes when we shall redeem our pledge, not wholly or in full measure, but very substantially. At the stroke of the midnight hour, when the world sleeps, India will awake to life and freedom. A moment comes, which comes but rarely in history when we step out from the old to the new when an age ends, and when the soul of a nation, long suppressed, finds utterance. It is fitting that at this solemn moment, we take the pledge of dedication to the service of India and her people and to the still larger cause of humanity."

The Dominion of India became an independent country. Official ceremonies took place in New Delhi. Nehru assumed office as the first prime minister, and the viceroy, Lord Mountbatten, continued as its first governor-general. Gandhi took no part in the official

events. Instead, he marked the day with a 24-hour fast, during which he spoke to a crowd in Calcutta, encouraging peace between Hindu and Muslim.

Gandhi assassination 1948 – perpetrator from Pune

On 30 January 1948, around five PM, radio news came about the assassination of Mahatma Gandhi. The initial rumour was that it was a Muslim who shot him dead. Muslims quickly shut their shops, they disappeared from the streets, and an eerie calm prevailed on the roads, unnerving the strongest and the mightiest.

On that very day, my cousin sister 'Jayawanta' was getting married. As the evening progressed, further news came that the assassin was from Pune. We then rushed the marriage through, knowing that there was going to be crowd trouble. And as the drama unfolded, it turned out that the assassin was Nathuram Vinayak Godse, a Brahmin and a member of the political party, the Hindu Mahasabha, and a past member of the Rastriya Swayamsevak Sangh (RSS). Godse had fired three bullets at point-blank range as Gandhi was walking with the help of some ladies to the evening prayer. They took him to his room, where he died.

Narayan Dattatray Apte was an accomplice of Godse and played a role in the assassination of Mahatma Gandhi, who they blamed as instrumental for dividing Hindu India in August 1947. On the news that Godse came from Pune, there were riots and looting. The mob targeted the houses of Brahmins, looting their shops and flaming their homes. The police lost control of the streets; the Army tanks thundered through the streets of Pune. Soldiers marched the streets with their bayonets fixed on .303 rifles in full battle fatigue. I, Babubhai, who was in Pune for the wedding, and his friend had gone out on the streets of Pune as spectators to watch the demonstrations and the burning of houses. As the army tanks roared, we all ran away, ending back home a couple of hours later. Sporadic 'cat and mouse battles' between the crowd and the Army continued through the night and for a few more days.

Pune was under curfew for a week. Later, the police made further arrests of those linked with the RSS and Hindu Mahasabha. But, eventually, law and order prevailed, and the national mourning began in earnest.

Assassin of Gandhi – my teacher's close relative

By the sheer unthinkable remote chance occurrence, Narayan Apte turned out to be the brother of the wife of my maths teacher.

Career choice

I scored first-class marks in the Matric examination (the equivalent of O-level). Now there was time to think of a career. In the fifties, there were only two career options: Medicine and Engineering. I did not doubt that I wanted to go into medicine. This career decision had been made by me when I was very young, probably eight or ten years old. I had a tummy ache, for which Baai had taken me to our family physician. He asked me what I had had to eat the night before. My mother interjected and started telling him about our

dinner. The doctor interrupted her and said, 'I did not ask you, I asked him.' To me, for the first time, there was someone else who was higher than my mother, a doctor – a role model. The incident is still fresh in my mind.

As I grew older, I watched my brother working as a businessman. No way could I have chosen to be a businessman like him. To me, the concept of buying something and then sell it to someone else at a profit was abhorrent. But, on the other hand, if I physically provided services to someone and then made a charge, it was logical and morally acceptable!

My English school teacher told us once, people whose job title contains the letter 'o' makes them more powerful than the title containing the letter 'e': Doctors, solicitors, actors – against teachers, carpenters, engineers and so on!

I could have successfully taken an Engineering career since I was good in most subjects, an all-rounder. But no! Engineers have not one but three e's, worse than teachers and carpenters, with two 'e's!

Fergusson College

I enrolled myself in Fergusson College, which had a good reputation. I chose Biology, an appropriate course for going on to medicine. First-year (FY) was the college examination. Second-year (inter-science) was a university examination, which was important since the score would impact admissions to the medical and engineering colleges.

First-class school career leading to overconfidence

I assured myself that my first-class school career meant that just a few months of studies would give me a high enough score for medical admission. I started studying seriously about three or four months before the examination. A day or two later, I was overwhelmed with the amount of study I had to do in the following three months and not only appear for the examination but also score high enough marks to go on to medicine. I realised I could not achieve that in such a short time. So, I decided to take a 'drop' – meaning I would take the examination a year later. When the examination started, all my friends duly went to the college hall. It felt so very wrong to sit at home on my own – quite depressing. But it was my own doing. Now I was classed as 'repeater'.

My parents did not say much – after all, my record was impeccable. In their eyes, I could do no wrong. But there was a 'wrong-doing' on my part. Instead of two years of college studies, I had added an extra year. That meant that my father had to support me for another twelve months and pay up additional fees.

My doxy is orthodoxy

My father was doing his duty, but I had failed him. I, of course, did not think so at that time that I had done anything wrong to anyone. All-day long, every day, we think we are right – my doxy is orthodoxy.

Years later, in the last term of my medical college studies, I was summoned by the college clerk who asked me to pay up the arrears of term fees 500/- rupees. My parents told me that there was no money to pay my fees. I was furious. I bluntly asked my father: 'If I am

doing my job of studying properly, why are you not doing your job of paying my fees?'

I do feel so sorry whenever I recall this instance. How conveniently had I forgotten my failure to study when I was in Fergusson College! Worst still, I dared to remind my father of his duty.

I came to know that Wadia College was charging half fees for repeaters. So I enrolled myself in Wadia College and sat down to study in earnest. All day long, I would sit in the library and read and read and read. Then I got all the question papers for the past five years – surprise, as you went further back in the years, the questions started repeating themselves with, maybe, a slight variation in the theme. I wrote answers to all those questions, almost as a mock examination. I checked my answers; they were more or less correct. I polished my answers, learnt them by heart, and now I was ready. Scoring high grades was no big deal for me. I recall that I enjoyed reading and learning, a passion that is keeping me alive in my present retirement days in England.

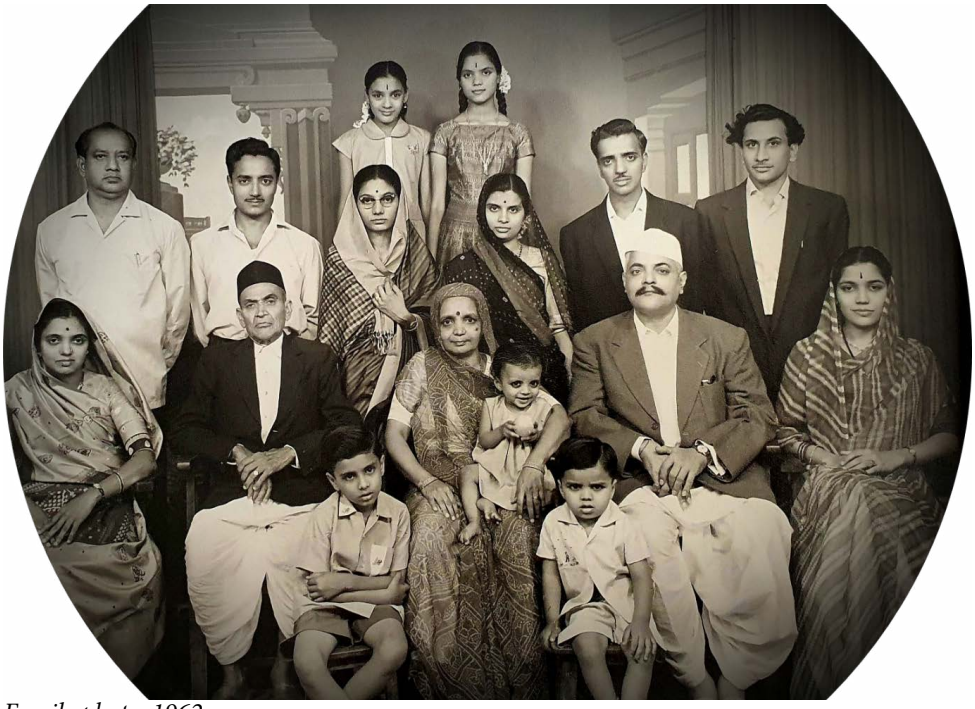
Madan, my older brother (1932)

Apart from physically fighting with him during childhood, as all boys do, I confess that I don't recall growing up with Madan as my older brother. Looking back, although the age difference was just under three years, we were two different people. Madan was intelligent but did not take studies seriously and followed the well-trodden path of a Marwari boy. He started a business by opening a wholesale grocery shop. He had a good head for business but somehow did not manage to be a successful businessman. I suppose to some, success remains illusory despite tremendous well-meaning efforts. Unfortunately, Madan was one of them. He was well liked in the community and took an active part in their matters. He passed away in 2018, after a short illness.

I have always given Madan and his family credit for doing the hard job of looking after the elderly. Towards the end, only Madan and Baai remained; others had either passed away or settled abroad, like me. Often, they used to go to a restaurant for morning breakfast and get home food delivery. Likewise, the sister and brother-in-law of Nirmal looked after Nirmal's widowed mother while her children were abroad for their studies.

Bhabhi – my brother Madan's wife: pulmonary tuberculosis

Following the tradition, Madan married in 1953 to a girl from my uncle's village, Ghodnadi, some forty miles away. Thus, I acquired a 'Bhabhi' as she was to be addressed by me. Soon after the wedding, Bhabhi caught pulmonary tuberculosis and deteriorated rapidly. There were no antibiotics. Standard treatment was total bed rest, plenty of sunshine, food rich in proteins and cough medicine. Our religion was Jainism, which meant that we were strict vegetarians - so rigid that the Jains did not even eat eggs since they could form life. A protein boost came as processed egg powder, to be taken as a drink with water. Although the thought of an egg drink was repugnant to a Jain, my mother was not staunchly orthodox, nor was she a revolutionary. She was level-headed and saw the seriousness of the situation. She insisted that Bhabhi takes the egg drink, the same as any other prescribed medicine.



Family photo, 1962
L to R
Sitting - Didi, Bhaiji, Baai, Uncle, Pushpa
Standing - Babubhai, Vasant, Nirmal, Bhabhi, Madan, Rajabhau
Standing - Sunita, Sadhana
Children - Pankaj, Sanjay, Nikhil

Consumption: pulmonary tuberculosis

Pulmonary tuberculosis was endemic in India before the antibiotic era. It was historically called consumption due to the weight loss. The airborne transmission took place via a cough or a sneeze of an infected person. Hill stations, with fresh air and sunshine, were supposed to boost the ailing body. A few months' stay in a TB sanatorium was considered an added tool to recovery. There was one such sanatorium at Panchgani, a hill resort some seventy miles away. Bhabhi pleaded not to send her there, but I insisted. A stout man carried her on his back to the street level. An ambulance took her to Panchgani sanitorium. The supportive treatment seemed to have done the trick, and she survived. Madan and Bhabhi had four children, in 1957, 1961, 1963 and 1967. During this time, I was a medical student and then a qualified doctor. I insisted that she gets sterilised to stop the constant drain on her calcium and the stress of repeated pregnancies. She, I believe, also had type 1 diabetes, which did not help. But against all odds, she survived, succumbing in the end to an acute heart attack in her sixties. She appreciated my care and concern for her and her family throughout her life. Our relationship thus counted for more than the customary kinship.

Pushpa – my younger sister (1940)

In India, until recently, women have been subject to sequential metamorphism, first in the custody of the father or brother, followed by a husband and then, in old age, their sons. This custom and practice did not allow the individuality of the female gender to develop. The dogma dictated that instead of formal schooling, they needed to learn the domestic chores of a married woman. Pushpa went to school but never got anywhere to speak off. As she got older, the custom presented its inevitable influence. Madan insisted that Pushpa gets married and started looking for a marriageable boy through his contacts in the community. I was away from home to study medicine and had minimal contact with the family.

Pushpa and her marriage (1961)

Marriages in our Marwari community in India were more a union of families than that of two young aspirants. It was usual to seek a relationship more or less on par with your own. Our financial status at that time meant that we did not carry much baggage. Pushpa lacked the sophistication of an educated girl. So, it was hard to meet an expectation of a match with families from Pune or Mumbai. The prospective groom Rajabhau came from a nearby Narayangao village. We had to borrow Rs. 7000/- (£ 7000/- in today's money) for the wedding. Pushpa got married in 1961 and went to the village to live with her husband's family. They moved to Ghodnadi to help my uncle in his restaurant business. Rajabhau was content with life as it came to him. They did not have any children. He passed away in his sixties. Pushpa now lives in a flat in Pune.

Sunita, my youngest sister (1952)

At 42, my mother gave birth to the last sibling: Sunita, in 1952. There is a difference of 18 years between myself and Sunita, and it just does not register with me many a time that she is my sister. Pushpa is! Sunita was three years old when I left home for medical studies. She was eight years old when I left Pune for my postgraduate studies. She was not much of a part of my increasingly disparate life, away from home. When I left India in 1963 for higher surgical training in England, she was still wearing children dresses. It was not until 1969 that I saw her again on my return to India. And I was still looking for that little girl in the dress, asking where she was. A fully grown 17-year-old girl in a sari came forward as Sunita. An imprint of Sunita in a dress is the only image of Sunita for me, and I am still looking for her! Sunita went to a convent school and then to college but did not complete her college degree as she got married to Arun from the USA.

It was usual in those days for the first-generation immigrants to UK and USA to seek a girl from back home since emigration was mainly of boys. They would make a journey back home once a year. Parents at home usually identified four or five marriageable girls from all over India through social contacts. The boy and the parents then would go round each location, see the girls, and if anyone met their expectation to fit in UK or USA scenario, they would accept to marry. Arun was one such boy from the USA. Through mutual contacts, Arun's family got to know our family. The customs followed, and the couple agreed to marry. The wedding had to be arranged at short notice within

days since Arun needed to return soon to his job. Therefore, the couple first registered their marriage and got the paperwork to get a passport and a visa. A religious wedding followed, after which they left India for the USA. All over - within ten days, I think. Arun had a substantial job in the Energy sector, and his doctorate from MIT assured good earning and a decent living. Neal, their son, is now a consultant anaesthetist in Chicago, and Sonia, the daughter, is in a Cloud-based company in San Francisco. She is in a relationship with an Italian-American and engaged to be married.

When her children grew up, Sunita decided to pursue her passion in health care and enrolled herself to study a college diploma course in Respiratory Therapy.

To her credit, even at the age of fifty, she completed the syllabus successfully and took up a full-time position in a nearby healthcare facility. She worked there, eventually retiring at the ripe age of 65!

Medicine – here I come

I stood second in the University amongst 2,500 students taking the examination to secure high marks and admission in the medical college! The result carved my medical career in stone. The year was 1955, that is some 67 years ago.

Medicine – here I come!

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Section II

Medical studies in India (1955–1963)

B J Medical College, Pune

Pune has always been a centre of education, dubbed 'The Oxford of the East'. The Government B.J.[1] Medical School was started in Pune in 1878 and then became a full-fledged B.J. Medical College[1] in 1946.

It ranked among the top-ten medical colleges in India for several years. It enrolled one hundred students for medical studies in 1955. Admission was strictly on merit, based on the score at Inter Science examinations (A-level equivalent).

Three Generations! Vasant Oswal – Centre, 1955; Sachin Gandhi – Right, 1983; Akshay Gandhi – Left, 2017

There were no private medical colleges in those days. So, if you did not get in – you missed the boat. There were alternatives, such as dentistry and veterinary science. But they were looked upon as colleges for those who did not make the grade for medical studies rather than another substantial health-related career. There was also an Ayurvedic college (ancient Hindu system of medicine, based on herbs). It was the last choice since most practitioners from that college practised allopathic medicine.

I was second in the qualifying Inter science examination, which assured me of admission to the medical college.

That first day in medical college (1955)

It was wonderful to put the white coat on and wrap the stethoscope around the neck to show off. There were complex studies ahead, and that first patient had not even cast as much as a shadow. But no, I was in charge, a feeling of superiority over the other fellow being perhaps? Later on in life, years of dealing with surgical patients gave me another viewpoint. In secondary schooling, our teacher once asked us what we need for living. Food? Water? Oxygen? No. We all live on hope. Hope is what I give to my patients, who in turn give me the most precious possession they have – their self and their body. Such thoughts humble me. I must do my best and not violate their faith in me. Or perhaps should it be the other way round: they deserve the best, and if I cannot fulfil that obligation, I should send them somewhere else.

The medical studies in the fifties in India

The medical course took five years; upon passing the final MBBS (Batchelor of Medicine and Batchelor of Surgery), you got registration from the Indian Medical Council, and that was it; you were a 'Doctor'. During the course, there were two university examinations, the First MBBS and the Second MBBS. Only on passing each examination, did you progress to the next stage. If you failed, you had to retake the examination after six months. Four unsuccessful attempts ended the medical career, and you had to leave your studies. At the end of five years, the final examination led to a degree – MBBS.

The 1955 batch

The intake was for one hundred applicants. But only ninety-six seats were available for allocation, strictly based on the percentage of marks achieved by the students at the Inter-Science examination. The remaining four seats were given to the students belonging to the scheduled caste. Remarkably, there were twenty-five girl students in our batch, a high number compared to other years.

First MBBS (1957)

The course started with the dissection of a cadaver to learn anatomy. In a vast and populous country such as India, there were many unclaimed bodies. After holding the body for a period required by the law, unclaimed bodies were sent to the college's anatomy department to study human anatomy. The first day of entering the anatomy hall left a recurring image of ten or twelve bodies on the dissecting tables, with a pungent odour of formalin in the air. The typical smell of anatomy hall would linger on in the nose well into the evening until one adapted to it, which took quite some time.

A human cadaver

In this era of sophisticated multimedia technology, is it right to use a cadaver to study anatomy? Should a dead body be deprived of any dignity or religious rites? Should it be shredded piecemeal in the name of learning and then discarded? And how do you discard the dissected remains of a body? The bodies are buried in the Muslim faith and cremated in the Hindu faith. It is not possible to follow these rituals with the dissected parts of an individual.

Immune to feelings?

Does working in the medical field detract you from societal norms and make you immune for feelings? I think yes, and I do not believe there is anything wrong with it. During my medical studies, I had surgery of sub-mucous resection (SMR) to correct a bent partition in my nose under local anaesthetic. When I started operating on the nose, initially, the memories of my operation came back. Unwittingly, I was going a bit 'gently'. But then I realised that I have to detach myself as a patient and behave as a technical person. That is the only way I could do the job as required. Yes, a doctor has to cross over that threshold and show professionalism – nothing less than that. It also means that if the patient is your relative, it is hard to detach yourself and do your job as a professional.

Second MBBS (1959)

The third- and fourth-year studies were hands-on, attending various clinics in medicine, surgery, orthopaedics, preventive medicine, obstetrics and gynaecology, etc. The fourth-year training covered skill acquisition such as intramuscular injections, tooth extraction, bathing the new-born, etc. At the end of the fourth year, there was a second University examination in pharmacology, preventive medicine and pathology.

Tablets were uncommon. One had to mix ingredients in water and fill a small bottle: it came to be known colloquially as a mixture. The compounder made it and 'dispensed' it in the doctor's 'dispensary' (GP surgery).

First in the second MBBS examination

I did not particularly like pharmacology and did not bother to study it. At the end of the third year, there was a college examination in pharmacology. I was last in the class, sixteen out of a hundred marks. The lady professor summoned me and told me off. I took that a bit seriously. I read the pharmacology book, front to back and back to front, several times. Now I was ready for the second MBBS examination held by the University. During the viva, there were two examiners. One of them asked me,

First in the second MBBS university examination in 1959

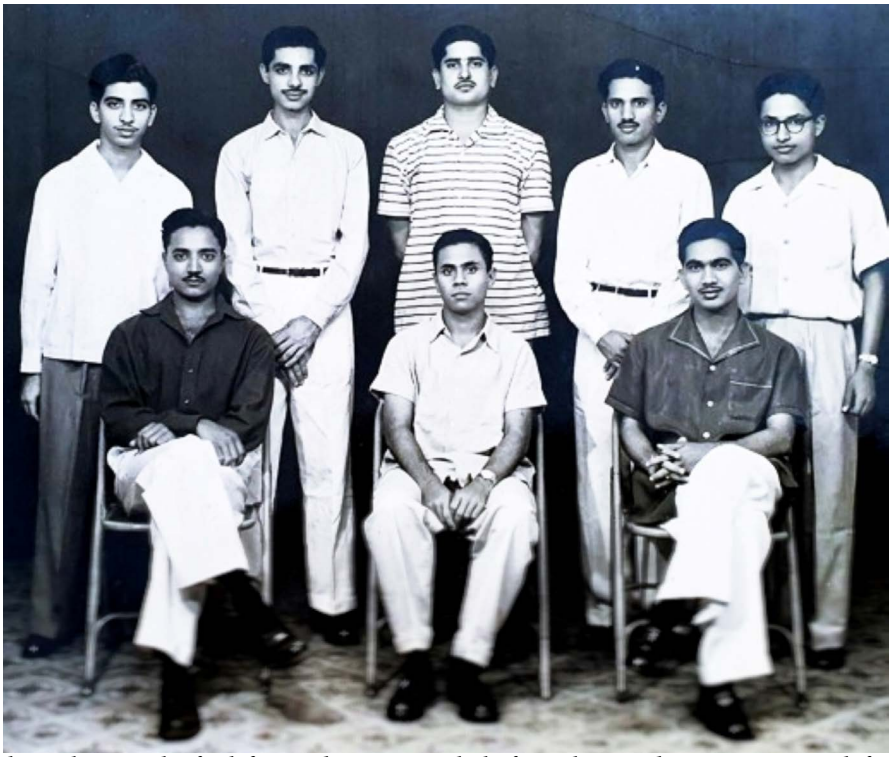
Final year M.B., B.S. 1960, Clinical Batch, B.J.M.C. Poona
Standing: R.G. Nadig, S.S. Kulkarni, R.K. Parekh, J.G. Pandit, S.R. Patil, V.R. Pai, K.B. Niphadkar
Sitting: V.H. Oswal, H. Nicholson, S.M. Kulkarni, M. Paranjpe, Y.R. Mainkar

'What are the drugs which release histamine in the body?' I knew three such drugs, one of them was folic acid. The examiner said that he did not know that folic acid released histamine in the body and asked where I read about it. I said, 'In the textbook.' He asked his co-examiner if he knew it; no, he did not either. The attending demonstrator got the book from the library. I knew where it was, on the left-hand page, right at the bottom. I showed it to the professor. I stood first in the University – in 1959. Thank you, Prof Amin, for telling me off. My name is still on the board of emeritus students in the college.

Final MBBS – from the hospital bed

At the end of the fifth year, we sat 'Final MBBS'. This examination covered all subjects in all medical studies with examinations in surgery, medicine, obs and gynae, ophthalmology, orthopaedics and everything else.

After two days into the examination, I developed a high temperature which required hospitalisation. However, I insisted that I would continue to attend the examination. I was wheeled each morning to the examination hall, was given a writer, and then back again to the ward. There were ten theory papers, followed by clinical examination and viva. I passed all of them but did not score high marks due to my illness. Now, in 1960, I was a fully qualified doctor.



Abiden Beheranwala, far left, standing; Navin Shah, far right, standing; Vasant Oswal, far left, sitting; Bashir Shaikh, far right, sitting.

My medical college friends

During my medical studies, my close friends were Bashir Shaikh, Navin Shah, Abiden Beherenwala, and Avi Badve. Incredibly, after graduation, we all went abroad for higher studies, albeit in different years and to different countries!

Bashir Shaikh

Bashir and I entered medical college in 1955 and immediately became very close friends. His father was a high-ranking police officer – Superintendent of Police. If Bashir's father was at home, Bashir did not stay out very long! He would say, 'Curfew is home!' It is unbelievable that even as grown-up medical students, we accepted strict parental control. Such was the era of the fifties and the sixties of the last century.

Bashir and I used to study together. In the evening, I would drop him off at home on my motorbike. Occasionally, Bashir would drive the bike. One day, he lost control, collided with a car and broke his wrist. We were so concerned about being told off by the parents that we made up a story about 'slipping on the staircase'. Unbeknown to us, a family contact who had witnessed the accident phoned his parents about it. Both his father and barrister brother Rafi probed us about the accident. We never budged from our 'slipping on the staircase' story, even in later life, much to the amusement of everyone! Bashir went

to Canada, qualified as Genito-urinary surgeon and settled in Toronto. One of Bashir's daughters is a qualified physician, also in Toronto.

Avinash and Asha Badve

Avinash Badve had married our classmate, Asha Gogte. Avi took up ENT, and thus we kept close contact. The couple came to England for higher studies and then returned to India. They set up their practice in the town of Nagar in the state of Maharashtra. Two of their daughters followed in their footsteps; one practising in Indore, India, with her husband, also a medic, and the other, in Hull, England as a consultant anaesthetist with her husband, a consultant neuro-surgeon.

Abiden Behrenwala

Abiden Behrenwala went back to Mumbai and established himself as a general surgeon. His two sons followed a career in medicine. One is practising in Mumbai and the other, as a consultant in England.

Navin Shah

Navin Shah is practising Genito Urinary Medicine in Washington DC, USA.

I came to England to study for FRCS, became a consultant otolaryngologist, head and neck surgeon in 1970. I achieved recognition for my pioneering laser surgery work by the Royal College of Surgeons of England. They awarded me FRCS (Eng.) by election. Although I received many awards during my career, the award of FRCS, a professional recognition stands proud above all others. Neena, our daughter, qualified as a dentist from London, and, along with her dentist husband, is practicing dentistry in England.

1955 batch - sixty years on – in 2015

Standing, from left: 4th-Vasant Oswal, sixth-Bashir Shaikh, 7th-Avi Badve
Sitting, from left: 3rd-Nirmal Oswal, 6th-Asha Badve

Dr Oswal, what next?

There was no further training by way of pre-registration – standard now in most countries. It is unnerving to think that you are now a medical doctor with a stethoscope around your neck to prove it. If you opened up your 'dispensary' as it was known in India to indicate family doctor's surgery, you would never know what your first patient would be – a simple case of a tummy upset or a full-fledged coronary. It is heartening to see the inroads made by multimedia training methods of today; the doctors now are better trained, better equipped and better placed to undertake this unparalleled position in society, to take the role of the human equivalent of the Saviour of Life.

In search of destiny - ENT

When I qualified, there was no question about going to my father and asking him to set me up as a general practitioner. There just was no money or resource by way of our property. All my smartness and high calibre brain for studies were now useless – there were no further studies unless I took a post-graduation course for the next three years. As a way out, I decided to do post-graduation, which involved taking a house officer job that paid a salary.

There was no career guidance, something which is so readily taken for granted nowadays. I decided that I liked to be called a surgeon and not a physician – too long to wait for pills and mixtures to act to see if you were on the right track! As a surgeon, you removed the bad bit and binned it, simple. General surgery – no, too much of a body to master from top to bottom. Obs and gynae – perish the thought, did not want to handle slippery new-borns.

Eyes – don't want them staring back at me. Orthopaedics – did not want to deal with only one kind of tissue, such as bones and joints. ENT seemed a clean upper end of the body, providing passage to food, air and sound. Nothing stops there like faeces and such. Yes. I did not take up ENT by design, but as a last bit of field left where I could still brandish a knife rather than a stethoscope to declare my dominance over a group of people called patients.

This is how I took up ENT as my professional career. Up to this day, in 2022, it has spanned sixty-two years. It is worth taking a bird's eye view of the changes this speciality saw since the beginning of the specialisation.

History of ENT (ear, nose and throat as a speciality)

The following few pages cover this important speciality that we take so much for granted. Ear, nose and throat – crucial parts of our body we constantly use for breathing, feeding and communication in day-to-day living. The vital part of this anatomy is the voice box or the larynx. If a disease process obstructs the larynx, we have only three minutes to remove the obstruction to avoid death.

ENT specialisation began around the 19th century when James Yearsley (1805–1869) recognised that deafness could arise from the ears, as well as from nose and throat diseases. The ear, nose and throat, commonly known as ENT,[3] were united in a single speciality at the end of the nineteenth century.

Evolution of ENT as a speciality since the fifties: a personal viewpoint

I started my medical studies in 1955, that is some sixty-seven years ago. After qualifying in 1960, I took up ENT as my speciality and started my first ENT job as SHO in Bombay Hospital, Mumbai. My long sixty years in the speciality witnessed many changes in ENT practice, driven mainly by technological advances. For example, Transoral Laser Laryngeal Surgery is now a gold standard for most laryngeal surgical procedures, including early laryngeal cancer, resulting in reduced morbidity and better surgical outcome. Other sub-specialty practices now cover otology, rhinology, paediatric otolaryngology, skull base surgery, head-and-neck surgery, sleep apnoea, voice disorders, swallowing disorders, professional voice disorders, facial aesthetic surgery and so on. However, the extent of sub-specialisation varies considerably globally due to diverse socio-economic factors and ENT surgeons' training.

The modern-day advances in ENT practice started during the fifties of the last (twentieth) century. Antibiotics controlled infections of mastoid disease. The operating microscope with fine microsurgical instruments and electric drill introduced precision surgery.

Hand in hand, surgery for cancer of the larynx declined due to the advent of fractionated deep x-ray therapy, which ensured minimum skin reaction and mucositis. Most ENT patients with cancer of ENT in the UK received radiotherapy as the first line of treatment. Only advanced and recurrent cases had surgery. Head-and-neck surgery thus took the backstage, and most ENT surgeons concentrated on otology.

Otology

During my post-graduate studies in Bombay between 1960 and 1963, ENT[6] surgeons needed the skill of a stonemason to use a chisel and gouge with a hammer for undertaking mastoid surgery, wearing a headmirrror and Bull's Eye lamp for illumination! Microscopy was rudimentary and used only by the consultants.

When I started my Senior House officer job in England in 1963, the department had a Zeiss operating microscope for ear surgery. An electric drill replaced a gouge and chisel and allowed surgery in intricate areas of the mastoid and the middle ear. Various techniques were developed to preserve hearing and reconstruct the middle ear.

Chronic discharging ear, with or without cholesteatoma, requires some form of mastoid surgery. The anatomy of the mastoid and the middle-ear structures is complicated. The intratemporal course of the facial nerve makes it vulnerable to accidental injury with unpleasant consequences for the patient in the form of facial palsy with its medico-legal overtures. Temporal bone dissections were routinely undertaken by the trainees to achieve a degree of competency in mastoid surgery, using a microscope and an electric drill.

Temporal bone dissections

During my Senior Registrar's post in Coventry in 1967, I spent my weekends dissecting temporal bones to acquaint myself with the intricate anatomy of the ear. The bones were harvested from a fresh cadaver[7] and stored in a fridge for subsequent dissections covering the various types of mastoid surgery. The specimens were readily available due to the Human Tissue Act of 1961, enacted to make 'provision with respect to the use of parts of bodies of deceased persons for therapeutic purposes and purposes of medical education and research and with respect to the circumstances in which post-mortem examinations may be carried out; and to permit the cremation of bodies removed for anatomical examination.' The changing perspective of society resulted in its repeal and replacement by the Human Tissue act 2004, making it an offence to remove any non-health-care part of the deceased without express consent etc.

Surgery for otosclerosis

The sixties saw advances in the surgical management of otosclerosis which was hitherto managed by providing hearing aids. Fenestration of the horizontal canal produced a lifelong mastoid cavity which often got infected. Rosen stapes mobilisation was short-lived and needed repeat surgery to maintain improvement in hearing. Stapedectomy with replacement prosthesis produced good long-lasting results and became a standard management, with many refinements. Stapedectomy was replaced by stapedotomy.

In the eighties, cochlear implants gave hope to many children and adults with congenital hearing deficit.

Laryngology in the seventies

In 1970, when I started working as a consultant, neck surgery for the ENT department was undertaken by the General Surgeons. They raised a strong objection to others undertaking this. Tribalism is very common in the medical world, described later. The seventies saw a resurgence of head-and-neck surgery within the ENT. The advances were mainly in various approaches for organ preservation in laryngeal cancer, retaining most of the laryngeal function. Thus, a 'surgeon' laryngologist gradually evolved into the head-and-neck surgeon.

I played a significant role in advancing the use of lasers in our speciality in the eighties, undertaking pioneering work. There is separate writing on this unique experience later in the book. The nineties saw expansion in laser applications in the oropharynx and lower airways. The carbon dioxide laser is widely used mainly for transoral laser laryngeal surgery.

Diagnosis and surgery for voice disorders

In the eighties, stroboscopy and video recording provided an accurate assessment of voice disorders. Lasers, radiofrequency and microdebriders had a positive impact on the preservation of laryngeal functions. Transoral laser surgery managed most early laryngeal cancers with curative clearance and an excellent preservation of voice. Injection and external thyroplasty gave new hopes with some spectacular results. Analysis of the quality of voice led to a greater understanding of vocal function. Some tertiary referral centres established dedicated clinics for professional voice users. Professional associations solely for laryngologists sprouted in many countries and regions. Together with Dr Sachin Gandhi from India, I took the initiative in establishing the Asia Pacific Laryngology Association (APLA: https://www.aplassoc.com/) in 2016. The first APLA conference took place from November 1-3, 2019, in Singapore, with some 355 delegates from around the world. We also developed an e-learning platform on the APLA website. My retired colleague Liam Flood played a major role in the Quiz section, and we are grateful to him.

Laryngology - an expanding subspecialty in the twenty-first century

In the past twenty-odd years, laryngology has become a subspecialty. Many countries and regions established laryngological associations. Dedicated clinics for investigations of voice and swallowing disorders, airway management, singers' clinics, etc., are appearing in large regional hospitals. Following the first APLA conference in Singapore in 2019, the second APLA conference was planned for 2020 in Manilla, Philippines. However, COVID-19 has put a damper on future conferences, the second 2020 conference in Manilla, Philippines was cancelled. As a compromise a hybrid zoom conference took place on October 1-3, 2021 in Lucknow, India, with live surgical demonstrations from India and the USA.

Rhinology in the eighties

CT-scan, endoscopes and high-resolution CT images opened up a new era in rhinology, providing a detailed analysis of the nasal cavity, especially the lateral wall and the osteo-meatal complex. David Kennedy, Heinz Stammberger and Wolfgang Draf were major proponents of modern endoscopy in sino-nasal surgery. A further extension was trans-nasal endoscopic pituitary surgery.

Skull-base surgery

Skull-base surgery is a multi-disciplinary effort that combines otolaryngology, neurosurgery, neuro-radiology, anaesthesia, intensive care medicine, and physical and rehabilitative medicine with corresponding skilled nursing care to diagnose and treat lesions of the anterior, middle and posterior base of the skull. The diseases in this location may be benign or malignant. The term 'skull-base surgery' encompasses an approach to many different conditions found in this area. Management of skull base lesions is most challenging, and it is now well established that no single-handed physician, surgeon or nurse can provide the entire range of care. The otolaryngologist now joins the neurosurgeon team, a radiologist, an intensivist, an anaesthetist, etc.

Paediatric otolaryngology

In the seventies, paediatric otolaryngology started to develop. However, specialised training or courses did not exist. Some surgeons, such as Peter Bull in Sheffield, became known as ENT surgeons interested in paediatric ENT. Now, paediatric ENT is a well-established subspecialty of ENT with dedicated departments, courses and ENT surgeons. Bob Pracey from Liverpool rightly maintained that 'children are not miniature adults; they have their peculiar anatomy and physiology which deserves special skill.'

Facioplastics

Facioplastics is now a significant sub-speciality in ENT, integrated as a part of the FRCS exam. The British Society of Facial Plastic Surgery (BSFPS) is a facial plastic surgery organisation affiliated with ENT UK. It aims to represent all ENT Surgeons who perform the many aspects of facial plastic and reconstructive surgery.

Rhinoplasty

ENT excursions into cosmetic surgery seem to be limited to rhinoplasty, bat ear correction and blepharoplasties. However, under the NHS, rhinoplasty can only be undertaken due to trauma or when treating nasal obstruction, but not cosmesis.

Current ENT status in the UK

In 2018, around 1476 ENT surgeons worked in the NHS, making them one of the most prominent surgical specialities within the NHS due to the comprehensive range of skills they cover. Although qualified as 'surgeons', on average, only 15% of the total number of patients seen by ENT surgeons will go on to surgical management.

Back to 1960: Journey to Mumbai for a job.

After qualifying in medicine, I had decided to take up ENT as my professional career. Life is not a joy ride. Because of my fever, etc., my score in ENT was low. Dr Vijay Ghate had better marks; he decided to take the only house post available in ENT and left me nowhere. In Mumbai, there were three medical colleges. I went to the first interview in J.J. Hospital in Mumbai, with a freshly ironed shirt and a tie. There were some fifty doctors in the classroom, competing for one ENT job. The admitting professor asked if there was any candidate qualified from Grant Medical College (GMC). Someone raised the hand. 'Do you want this job?' 'Yes.' The interview was over. I felt utterly hopeless. If the same would happen in all other hospitals, then I did not stand a chance. I was written off before any interview because I qualified from outside Mumbai. What was I to do next? No contact, no advice, no nothing. I was staying with my sister in Ghatkopar, a suburb of Mumbai. Each morning I went to the city and round the hospitals – no luck.

Hunger pains

I had borrowed some money from my sister, which soon ran out. I felt uneasy about asking her for any more money; they had already paid for my final term of the MBBS course. Lunchtime came, and lunchtime went – the only money I had was for the train fare to my sister's home in the evening. No lunch, no food. By evening time, I was so hungry; I started getting cramps in my stomach. The evening meal was with my sister. The next day was even worse. I had left home after breakfast to be early to look for jobs. They were long days, long days to go without enough food for a young, hungry boy. Lunchtime came and went. Hunger pains are unique, like no other kind. And worse still, only eating food can help make it better, no pills or medication! My neighbour's older son from Pune – 'Dada' - had qualified in medicine a couple of years before me and set up in Mumbai. I went to his practice to borrow some money from him for food. He said he had just started practice and had not much on him to spare. But he gave me ten rupees. I quickly went to the nearest restaurant and ordered a meal. You could buy a reasonable plate for twelve annas, equal to a three-quarters of a rupee. The food never tasted so delicious ever. As I returned

from England, some six years later, I told Dada, I owe you some money I borrowed in 1963. A faint smile on our faces said a million words.

SHO in ENT in Bombay hospital

I soon realised that there were no prospects of getting a job in the government or municipal corporation-run hospitals for a person qualified from a college outside Mumbai. Undeterred, I continued to look for a job in private hospitals. There were a few private hospitals, one of them was Bombay Hospital. They had a vacancy in ENT, but since I had qualified from Pune and not from Mumbai, they wanted a referral letter from a member of the trust board. Madan's friend Bacchubhai was in Mumbai, who knew a trustee of the hospital. Through his contact, I got the letter. I got an interview, and an offer of a job. Now, I was on the road which would take me to my next stop, some three years away. I started a house surgeon job in Bombay Hospital in 1960. At last, someone was looking after me!

My first job in ENT, Bombay Hospital, 1960

There were two units in ENT. The consultants for one team were Dr L.H. Hiranandani and N.K. Apte, and for the other were Dr R.A.F. Cooper and Dr V.A. Desai. There were two house surgeons; I was one of them. The other one was Dr Munot. We mostly looked after the wards, assisted the visiting surgeons during the operations and managed minor ENT casualties; the surgeons managed all other conditions.

Dr L.H. Hiranandani

I have much respect for Dr Hiranandani (LH, as he was affectionately known). It is not only the surgery one learnt from him. He had a dynamic personality, his words and tone inspired trust in the patients, his political skills took him all over in high places. He acquired a reputation as almost a last word in the expertise for ENT conditions. He was also shrewd and saw danger and opportunities with equal vigil.

LH was born in 1917 in the Sindh province of British India (presently in Pakistan) in a family of limited financial means. His family migrated to Mumbai in 1937. LH graduated in medicine in 1942 and passed FRCS from England soon afterwards.

My English suit

After completing my SHO time with LH, I had no further contact with him. However, I met him during the conference of the state branch of the Association of Otolaryngology of India (AOI) in Mumbai in 1972. I asked him to see my temporal bone dissections displayed in the conference exhibition, to which he replied, 'Of course, later.' However, he did notice my 'English suit' and asked me where I was working. I reminded him that I was his SHO in Bombay Hospital in 1960, and now I was a consultant in England. He invited me to his home for dinner that evening, along with all the dignitaries. I cannot recall if he did see my dissections!

At that dinner, I invited him to visit our department at the North Riding Infirmary. He said, 'Of course! I will come after the International Federation of Otorhinolaryngological Societies (IFOS) conference at Venice in Italy in 1973.'

For his visit, I had arranged a clinical meeting at the Newcastle City General Hospital. When I met him in Venice at the IFOS meeting, I gave him the details of his visit. He was surprised and asked me if I really meant to invite him! 'Many people invite me casually, and I accept, also casually. Nothing concrete comes out.' That was his style.

Clinical meeting in Newcastle, UK

Dr L.H. Hiranandani visiting the inpatient facility OSWAL SUITE at the North Riding Infirmary in England in 1988

We had a phenomenally successful clinical meeting. Of note was a patient presented by a Consultant at the General Hospital. The patient had had successful surgery for cancer of the anterior third of the tongue some twelve years previously. Now she had come with a node in the neck, which was positive, but there was no sign of local recurrence. LH asked for a glove, pushed his index finger in the patient's mouth and said, 'She has a tumour in the posterior third of the tongue.' Indeed, she had a second primary with neck metastasis.

LH was pleased with his visit, and he appreciated the clinical meeting, attended by many consultants and their staff from all over the Northern Region. He remarked: 'I obtained FRCS in the forties. I had received many awards from all over, but The English never invited me or honoured me. You made that happen, with many English consultants from all over coming to the clinical meeting.'

Our relationship progressed more than professionally. During my visit to India and his visit to England, a get together was firmly on the agenda.

One of his visits coincided with our laser course. I took him to the Infirmary to show the generosity of the staff by naming an inpatient facility in ward four, 'OSWAL SUITE', in recognition of the laser technology I brought to the Infirmary and put it on the world map!

Dr N.K. Apte

In contrast, Dr Apte was a quiet person but a brilliant academician – a common bond between us. We became a member of his family. I discussed with him many ENT topics, sometimes with much passion. Once, I was bringing him home from London. The discussion reached such a pitch that I ended up in the City Centre of Leeds, missing the road altogether! One of his passionate hobbies was to visit the Anatomy Hall and look at the skulls of unclaimed cadavers for signs of any intracranial disease that led to their death. Surprisingly, he had collected some thirty such specimens. The Royal College of Surgeons of England accepted them for display in the museum, but they never got there due to bureaucracy and the Human Tissue Act.

ENT SHO Job in Bombay Hospital – my first tonsil surgery

My job was for six months, extendible to a further six months. My monthly salary was Rs. 75/- with free lodging and boarding (in today's money, sixty years on, this is less than a British Sterling Pound a month!). In Bombay Hospital, the removal of tonsils was done by dissecting them, and adenoids were curetted with several sweeps where necessary. The surgery is done mainly on children. The anaesthetist sprayed a mask on the face with Tri-chloroethylene. Once the child was sufficiently under, he used ether via a rubber tube placed in the corner of the mouth or connected to the sidearm of the Boyle Davis mouth gag. There was no monitoring of the ether administered or the depth of anaesthesia. Sometimes children became too deeply anaesthetised – palatal twitching was the sure indication of an overdose of ether. I would then warn the anaesthetist to stop further administration. Another sign was dilated pupils.

DORL, Mumbai, 1961

The College of Physicians & Surgeons[10] (CPS) of Mumbai, an examining body established in 1912 by Surgeon General Sir H.W. Stevenson and based on Royal College of Surgeons of England, ran diploma courses in various specialities. I took a twelve-month diploma course in Otorhinolaryngology (DORL) and got my first post-graduate qualification in ENT in 1961. CPS is one of India's oldest Post-Graduate Medical Educational Institutions, empowered to confer qualifications by the Indian Medical Degree Act 1916. However, the diploma awarded was not high-ranking. Therefore, I continued to study for a Master's degree in ENT surgery.

Time to get married?

In the sixties, as per Marwari community custom, I should have been married by now and have a couple of children! But I did not and would not go that road.

There were no nightclubs and discos in Indian cities, and girls usually did not work. So there was minimal opportunity to meet a girl with prospects of finding a bride. But things have changed, there are numerous nightclubs in big cities now, and girls are working in offices and financial and government sectors. So there are opportunities to meet some

Abolition of trial by Jury: Nanavati trial for the murder of his wife's lover, Prem Ahuja[2]

During my residency at the Bombay Hospital, a sensational murder case changed the age-old 'Trial by Jury' system. Next to Bombay hospital, there was the 'Metro Cinema'. A handsome Naval Commander, Nanavati, had dropped his family at the Metro Cinema. He then collected his pistol from the Naval Base and went to the flat of his wife's lover Prem Ahuja. A verbal confrontation between the two men led to three shots, and Prem Ahuja dropped dead. Nanavati turned himself over to the Deputy Commissioner of Police. The Jury pronounced Nanavati not guilty. There was a perception that media publicity influenced the Jury to being misled. Soon after, the Government of India abolished Jury Trials in most cases except for Parsis, who still have Jury Trials for their Matrimonial Disputes. Nanavati was re-tried, found guilty, leading to a custodial sentence. Three years later, the Governor of Bombay pardoned him. Nanavati died in Toronto in 2003.

stunningly attractive girls, but alas, not for an old married man such as me! Yes, not even a rich old man. When Neena was growing to be a young girl, I teased her about marrying a rich old man so that we share the loot when he pops off. She was smart enough to exclaim – 'We?'

The voluntary community social workers introduced families of marriageable boys and girls on an entirely voluntary basis. It was usual for the community man to go to the girl's parents to inform them of the parents of a marriageable boy. By now, having a title of a doctor in Mumbai made me a very desirable commodity. And there were the good looks as well (!). People often used to say that I looked like a film star of the fifties, 'Dev Anand'.

Many potential marriage proposals came to my parents in Pune. But I had told my mother that I would not get married until I completed my Master's in 1963. My parents did not go against my wishes. To my mind, I could not earn enough money even to support myself financially in the first place, let alone an additional person. Therefore, they politely turned many proposals down.

‘I am Mahipal (1962)’- A Bollywood film star of the forties, the fifties and the sixties

I had taken up the post of Casualty officer to supplement my house surgeon’s income. My casualty work started after 6 pm. One fateful evening, as I was busy seeing casualty patients, the next ‘patient’ entered and sat. With my head down, I asked him his name: ‘I am Mahipal’. So I entered his name in the case note and asked him what the problem was. ‘No, I am not a patient; I have come to ask you to come and have dinner with us one evening.’ Just at that moment, another doctor working as a trainee, Dr Mehta, entered the room. He apologised to be late and introduced Mr Mahipal Bhandari to me. Mahipal – a film star. One of his films was running in Liberty Cinema next door to Bombay Hospital. The surname Bhandari gave away the game. It indicated that he and I came from the same community. I guessed the reason for the invitation – a marriageable daughter. Hospital food was so tasteless that an invitation to home-cooked food was very welcome, at least for one evening. We arranged a time and I went to his home.

Mala Sinha and Mahipal in ‘Riyasat’.
Mahipal, who worked with actresses like Madhubala and Meena Kumari, established himself as a hero in the mythological genre. Prakash Bhandari salutes the superstar on his birth centenary.*
**https://www.rediff.com/movies/special/mahipal-the-unsung-superstar-of-indian-cinema/20201222.htm*

Compatibility of a marrying couple

In our community, the method of assessing the compatibility of the proposed union of two people in matrimony follows an age-old practice of going back to four generations. It has a scientific basis: it prevents co-sanguineous marriages, which can result in a higher rate of malformations and abortions.

This protocol is simple. The community person makes sure that the two families do not have a common lineage going back to four generations. If the two families have conflicting descent (*e.g.*, cousins whose grand parents have the same community surname), then the matter is dropped without further ado.

Visit to Nirmal's home

The Mahipal Bhandari family lived just off Marine Drive, a posh area of Mumbai. There was a Studebaker, and a Hillman, parked in the compounds of the five-story building, 'Vijay Mahal'. I parked my motorbike, went to the fifth floor, number 22, and rang the bell. He came to the door, escorted me to the lounge. The ceiling was deep blue, star-studded, mimicking the night sky. A rug, a seating corner with a glass coffee table, a beautifully carved stallion in stone in the corner complemented the decor. He was charming, courteous and friendly, with a permanent faint smile on his face – a professional trademark, I suppose. He was good looking, with curly dark hair, a good build, a good height! OK, so far.
After the pleasantries, the two sisters came, Nirmala, the older and Sushila, younger by a couple of years. Further informal chats ensued, nothing particular to speak of. Time for dinner.

Dinner

We went to the dining room, large enough with a table for four. Large mirrors decorated the walls. Mr Mahipal directed me to a seat. Their servant Laxman served us the food and waited outside, out of our sight. As I finished a particular dish, he brought in a further helping of the same. It kept on happening. I noticed it but did not fathom out how he knew what to bring for a second helping. Later on, I worked out the secret – mirrors.

My hunch was correct. The food was delicious, way above the quality of the hospital food. It had more Northern flavour, not the Maharashtrian flavour where I was brought up. In the early forties, the family had come from Jodhpur, the father first, followed by the rest of the family in the fifties.

Mahipal, a well-known Bollywood actor of the forties, the fifties and the sixties

Mr Mahipal came to Mumbai from Jodhpur in the forties. He entered the film industry as a songwriter. He wrote the very first song that the famous playback singer Lata Mangeshkar vocalised for a movie. The acting role followed with a successful career.

Marriage into a film star's home is not an everyday experience. The fifties and sixties were Mr Mahipal's heydays, with some very successful releases such as Navrang. At one time, some six or eight different movies were running all over Mumbai, with billboards with him and his female screen partner. I used to point them out to my friends and say, 'that is my mother in law, with the father in law beside him!' So many of them and beautiful. Lucky me!

‘Please go ahead if you smoke’

After dinner, we went back to the lounge. Mr Mahipal offered me a cigarette. I was a smoker since medical college, but I never smoked in front of my parents and other elders as a mark of respect. In the forties and fifties, smoking was fashionable, symbolising masculinity and very much the ‘in’ thing. I smoked Char Minar (literally, four minarets), rather a strong and cheap brand. I recall a catchy advertisement in the cinemas: No smoking – not even Abdullah’s (another brand name)!

Benson & Hedges, an expensive brand, was waiting for me – in a silver cigarette container. I hesitated – he insisted. ‘Please go ahead if you smoke.’ It was undoubtedly unorthodox for a would-be father-in-law to offer me a cigarette. It was even more unorthodox for a potential son-in-law to accept a cigarette and smoke in his presence. But then, I thought, why not? I may never come here again if the relationship did not see the daylight for whatever reason! I was not a boy, but a grown man of twenty-seven, and it was Benson & Hedges. I took a cigarette, lit it and smoked. It was tempting to help myself a couple more and put it in my pocket for later – but I did not!

On my way out, I greeted Nirmal’s mother, standing in the entrance of one of the rooms, with folded hands; although everything went by protocol, it had an air of casualness.

The next day, I phoned Didi. I told her that I was OK with the relationship. But, nevertheless, she and Babubhai needed to make a formal visit.

They visited and OK’d. Generally, in those days, people in the film industry had a bit of a reputation for the extravaganza, drinking parties, and high living with low moral values. Madan sent feelers around in the community in Pune and found a common contact who knew us and the Mahipal family – a respectable family from the same community as we. All lights shone green.

Mahipal to visit my parents’ home in Pune

The next customary step was for Mr Mahipal to visit my parents’ home in Pune and formally invite them to visit his home and meet his daughter. But to me, a visit by Mr Mahipal to my home in Pune was more than customary. I told him that he must visit my home, since we lived in a flat, more at a lower-middle-class level. We have to share a communal toilet. He must see for himself where his daughter would live after the wedding – not in a posh area of Mumbai, in a luxurious flat, but a much-downgraded living.

When I went home the next time round at the weekend, they asked me my intentions, mainly because of me not entertaining the idea of getting hooked before M.S. I told them I was OK with the proposal, as long as marriage would take place only after my M.S., which was some two years away.

Mr Mahipal visited our home in Pune. He was recognised by people, with his large Studebaker car blocking almost half the road. A crowd gathered. I was not present during his visit. He invited my parents to visit his home in Mumbai to meet the would-be daughter-in-law. Formalities on the girl’s side were thus complete.

The next sequence: My parents' visit to Nirmal's home

I was so strongly against the crowd of people going to 'see the girl'. Some community members were seasoned uncouth, philistines, plebeian, and downright rude. They were show-offs and took pleasure in putting down the girls and girls' families. I told my family that only a limited number could visit the girl's home: my parents, Madan, Bhabhi, and my father's older brother Babaji, who was in Mumbai. Babubhai and Didi would also go. I also told them the visit was for a purpose – take a sari with them as a token to firm up the relationship. In other words, they were not going to approve or disapprove; they were going to formalise my approval. Activist, for sure, I was.

Babaji, my older uncle

Babaji was a polished person, proper and elderly, educated, and held a high position in the British Raj as Registrar of Weights and Measures to standardise them all over India. I recall when I once visited him and touched his feet as the custom, he said, 'No, now you are a doctor, we should touch your feet as our saviour.'

When Madan and the family went to get him en-route, he was in his shop, in usual day-to-day clothes. Madan told him to change into the proper attire for a visit of some importance, to a person with high status in the society – a film star. Babaji remarked: 'When I open my mouth, people no longer notice what I am wearing,' and joined in the same clothes.

He was insightful. When I went to see him before leaving for England, he had written a little note for me:

'You are going to a foreign country for higher studies. Do something different, advanced, unusual in medicine, and bring it back to India. People who live in an alien society are judged by the way they conduct themselves to the norm of society, not by their colour or creed or caste, or the way they appear, wear clothes, and follow different religions.'

If every immigrant and every host would read these words, we would have a better world today. If he was around today, I am certain that he would be very proud of me.

Back to the visit to Mr Mahipal's home: I was, by tradition, not part of the visiting party from our home. The two families followed the customs and sealed mine and Nirmal's fate. My condition of not marrying until I obtained an M.S. degree did not last long. A request came from their home that the elder uncle of Mr Mahipal was in bad shape, and it was his wish to see the very first wedding before too long. No less than a drama in the films, moral blackmail – maybe, but I succumbed. May 25, 1962 saw us joining our fates in matrimony.

The wedding (1962)

It was customary to go to the town of the bride. So the invitees – probably fifty in number, along with me and three or four of my medical friends, went to Jodhpur by train. As is customary, Mr Mahipal's family had made all the arrangements at their cost. They wanted me to dress up in a traditional knee-length coat (Sherwani), tight pyjamas, and a turban!

A Rajasthani groom

Traditional wedding in Jodhpur, Rajasthan, in 1962

We were from Pune, in the district of Maharashtra, some eight hundred miles southwest of Jodhpur. I don't know when my forefathers left our native land – Rajasthan – and migrated south. We did not have any relations of our own in Rajasthan. We had adopted Maharashtrian customs generations ago, with the language, the food, and the apparel, very much with a local flavour. The language we spoke was a mixture of Marwari and Marathi with a strong regional accent. Our everyday food was local, very different from that in native Rajasthan. We were thus Maharashtrians, all but in the name.

I had never worn a long coat, tight pyjamas, and a turban ever, not even in weddings of our community members in Pune. So, when the request came for me to wear traditional clothes for the wedding, I paused for a minute. Then I said to myself, what the heck, just for a day, think of it as a fancy dress party! So there I was, all dressed up as a Rajasthani groom, riding a horse. The procession was to go to the bride's home via a particular route, the band performing in the front, and all the invitees from Pune around me. And then a hilarious incident occurred.

Mare or stallion – 'bend over and check for yourself'

It is customary to hire a mare for the occasion, a more docile and safer horse than a stallion. One of my friends, Dr Abiden Beherenwala, jokingly asked me if I was riding a stallion or a mare – an obvious sarcasm about my gender preference. I retorted: 'Why are you asking me? Bend over a bit and check the underneath of the horse to confirm.' There was a big burst of laughter amongst the procession, including my father and close elders! I think when you are in the medical profession, your inhibitions go. You could not do your job otherwise.

The procession arrived at the venue, and all that followed was, I suppose, similar to all other weddings. We duly returned to Pune. A couple of weeks later, there was a formal reception in Mumbai so that all my in-laws' local friends could bless the newly married with good wishes.

I now had acquired a commitment – in our community, the girls did not earn their daily bread alongside the husband. Nirmal stayed in Pune and came to her parents now and again. I visited her parents' home when she was there.

Film shoots

Actors at that level have some uniqueness. For example, nothing at the film studio would happen until Mahipal arrived. As a top film star, he was in a commanding position, with everyone ready to do just what he asked for. I went to one of his shoots out of curiosity. I recall reading somewhere; never visit a restaurant kitchen. I would add film shooting – it will put you off for life! A scene, the actor is eating a banana, for example. There are ten retakes. You don't expect anyone to eat ten bananas in one go. The actor peels the banana and takes it up to his mouth, and 'cut'. Watching a movie has never been the same again unless it is incredibly engaging.

Your daughter or my wife?

Young couples start a new life with a passion for forming a unit of their own. After a week or so of married life, I asked Nirmal to change her hairstyle, which I thought would suit her better. She changed it, with all hair formed into a bun, as it is now! When we visited her father's home with Nirmal wearing the new hairstyle, he instantly remarked that the old style suited her better than this new one.

Without a moment's thought, I replied, 'she is now my wife and not your daughter.' I was twenty-eight, a surgeon – in a commanding position, same as he was in his role on the stage. Nothing in the operating theatre would happen until I arrived. I do appreciate his achievements at the top of the ladder. In the highly competitive film industry, it could not have been easy. But those who make it to the top rarely look around and appreciate others doing the same in their chosen field, and I would be the first one to admit that.

A 24/7 live-in actor

In the first couple of months after the wedding, I noticed some peculiar aspects of Mr Mahipal as a film star. The tone of his speech never varied too much. He was never angry or overly joyous. As he answered an incoming call, the same happened. Stars, who reached that level, live their role 24/7. He also directed everything and anything that happened in the house. Even clothes and jewellery and sandals were of his choice.

Mr Mahipal passed away following a coronary in his eighties.

Master of Surgery -M.S. in ENT (1963)

As a matter of principle, I never stayed at my in-laws' place, although at times, I had non-residential jobs. I continued my studies, changing my jobs as required, and sharing a room with a friend of mine, Dr Patel, by sleeping on a mattress on the floor at the J J Hospital, Grant Medical College, Bombay, India. I appeared for my MS in 1963.

I was unsuccessful at the first attempt – I knew the reason, I just had no time to study, all my time went to do my job, which was so necessary to earn my living.

The second attempt was in August 1963, and I was now Master of Surgery in ENT: MS (ENT)! I had thus completed my post-graduation studies in India. However, the uncertainty of my future never went away.

In the late eighties, John and Maureen Berry, my colleagues from England, visiting Mr Mahipal's home during a conference trip to India.

Dr V.H. Oswal, MBBS, DORL, MS (1963)- what next?

Grant Medical College, Bombay, India

Up to passing MS, there was a kind of goal which I worked towards and conquered. What next? To be a qualified surgeon with DORL and MS and write it as a postscript to my name was great. The downside of being a surgeon is that you need instruments, equipment, an operating theatre, a hospital bed, an anaesthetist, nurses and last, but not least, a patient who is willing to undergo surgery and pay for it as well. I could not go down that road. My parents could not give me financial support. I would most certainly not ask my father-in-law any favours – I was too proud, and rightly so. Nor could I get any hospital position. In the sixties in India, both private and Government hospitals had honorary positions without pay. But they were given mainly to the 'inner circle' – and I had none.

A letter from England (1963)

Just then, I got a letter from a classmate who had gone to England in 1962 – Dr Munot. The note read, 'The hospital in England where I am a senior house surgeon in ENT has asked me if any of my friends were interested in taking up a job of senior house officer (SHO) when I complete my tenure.'

I do believe in my Guardian Angel, I really do!

‘England returned’

Going to England for higher medical studies was regarded as the pinnacle of one’s career, a prestigious undertaking. The British had left India in 1947. Even then, the colonial era was very much in vogue in the fifties and the sixties. Everything English was supposed to be the best that there was. After all, they were our rulers for a good two hundred and fifty years! Old habits die hard. FRCS from the UK was well respected and assured a high position both professionally and in society. ‘England returned’ reverberated amongst the ‘locals’ as a high calibre status. Even my father-in-law said, ‘Go to England and get the FRCS’. I suppose the FRCS son-in-law imparted superior stratus even to him!

Being academically inclined and having exhausted all postgraduate examinations in India, prospects of higher studies to sit the FRCS examination in England and get more surgical experience seemed too good to miss. I wrote back to him that I could come to England and fill in the job position!

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Section III

ENT training in the sixties of UK (1963–1969)

A letter to come over for an interview – all the way to England!

A letter arrived from the North Riding Infirmary in Middlesbrough, England, inviting me to come over for an interview, and if successful, a job offer. Munot had told me that the job was for grabs – with my two post-graduate qualifications and experience in ENT under well-known professors in Mumbai who had provided me with glowing references!

Until now, I had just one aim, to pass the Master of Surgery examination. I certainly had no plans to go to England! How would I have guessed that this one letter would set my whole life on a completely unknown path? I wrote to the hospital that I was willing to go to England for an interview and sent them all the documents. It was the end of October 1963.

Ten momentous days

Within a day or two, I had a passport. Incredibly, there was no visa requirement to come to the UK from India in the sixties India since, although the British Raj had ended in 1947, India was very much a British India. dominated by the British Raj of 250 odd years.

Nirmal was still in Pune. A shop in Mumbai 'specialised' in clothes for England. Amongst other things, the owner told me to get a leather jacket. 'This will keep you warm. You can't get this quality in England.'

I sold my motorbike to buy an air ticket – a return ticket if I did not get the job! I phoned Nirmal, she immediately came to Mumbai with my parents. Nirmal's father was in Jodhpur at the time. He was due to came back to Mumbai on the 7th of November. On his arrival, he remarked: 'I heard from the driver that you are going to England?' 'Yes, I am, in three days.' In the sixties, the national airline of the UK was called BOAC – British Overseas Airways Corporation. Departure to London was on the night of the 10th of November 1963. All the preparations were over in ten days, and I was ready to board the plane to that far-away land, England, some five thousand miles away. Everyone was utterly taken aback by the pace of such a life-changing milestone.

Emotional send-off

Newspapers in Pune ran an item of me 'proceeding' to England for higher studies. There was only one airport in Mumbai, the Santacruz airport. It is still there, modernised and now used for domestic flights. It is now merged into what is called as the Chhatrapati Shivaji International Airport (CSIA). Some fifty-odd people came to the airport to see me

Send off at Santacruz Airport, Bombay, November 10, 1963.

off. Close and distant family members, neighbours, friends, everyone wanted to be part of this important event – a one-off in their lifetime and for sure, in my lifetime. They put garlands of flowers or sandalwood shavings around my neck and gave me a bouquet. A professional photographer captured the photos of my send-off against the backdrop of the British Overseas Airway Corporation (BOAC) billboard – such was the enormity of the event. I went through the immigration check with a heavy heart. I did not know when I would return and see my folks again or indeed speak to them.

Fading lights of Bombay

I had a window seat. As I saw the lights of Mumbai getting fainter and fainter and finally disappearing, there was darkness outside and inside me. I was saying goodbye to my people, home, country, everything that identified me as my 'self', and heading to an incredibly uncertain future. I must have dozed off for a while. When I opened my eyes and looked out of the window, the earth looked white. I could not fathom out whether I was looking at the snow-covered ground or clouds. I kept wandering in and out of the surrounding: seeing the faces of my people as I left them.

England, that far-away land

By today's standards, communication was almost non-existent. International calls were expensive. They had to be booked a couple of days in advance and connection took place a couple of days later. You had to make yourself available at all times to receive the connection. The standard duration was three minutes. Half the time went in sobbing, and another half in 'how are you?' The operator would ask if we wanted to continue for another three minutes. Due to excessive costs, I did not make any calls.

Airmail took up to ten days to arrive; telegram was the quickest way, taking several hours to reach the destination. The charge was per word. A man bringing the telegrams meant bad news – illnesses or deaths. The first time I spoke to the family was maybe a couple of years later when my brother phoned me to ask me to send over some medicines to one of his friends who was ill, and that particular medicine was not available in India. The doctor had to prescribe this magic potion not available locally; otherwise, how else could he rise above the locals? And of course, what is only available in England, must be good.

Arrival in England (November 11, 1963)

It was a cold, clammy, gloomy, overcast, drizzly sort of a typical November day of the sixties when the plane landed at Heathrow. What a contrast to a bright warm sunny November in Mumbai. In a matter of only a few hours, I had come a million miles away to another world which was strange, culturally so apart, and, in a way, unreal to someone who had closed his eyes just for a few hours on a plane. I did not have much money on me. The Indian Government allowed only three pounds worth of foreign exchange for travellers! Perhaps £30/- in today's (2022) value. The exchange rate was thirteen Indian Rupees to a pound sterling.

No one at Newcastle airport

I caught the second leg of my journey to my destination. There was no Teesside airport, so I landed in Newcastle. The doctor-friend who had asked me to come to England told me that he would meet me at the Newcastle airport, but he was nowhere in sight. It was now dark and also cold, wet, and generally miserable. I was exhausted. Where would I go, and how would I go?

The coach journey to Middlesbrough

I missed my folks back home; I could still hear their voices in my ears. I went to the taxi rank and asked the driver to take me to the North Riding Infirmary in Middlesbrough. Wisely, he asked me how much money I had. I showed him all of the leftover money I had on me. To his credit and honesty, he said that he would take me to a coach station where I could get a bus to go to Middlesbrough; it would be cheaper for me. He was my first contact with the honest, hard-working British of the sixties, indelibly printed on my memories. As the bus approached Middlesbrough, I was the only passenger in it. The bus driver saw me shivering in the back and told me to sit in the front and get what little warmth there was from the Engine!

My first night in England

Somewhere around the Sedgefield area, the bus pulled up at the bus stop. A familiar voice called me and told me to get out of the bus. The doctor-friend Pahade was late coming to the airport to pick me up. He realised what must have happened and followed the bus route. At last, after many hours of this rapidly changing world, I was relieved to hear a familiar voice. We went to his flat; his wife Rajani Pahade, an anaesthetist, had prepared food in anticipation. He then drove me to the Infirmary, where a room was ready for me in the doctors' quarters. I was so utterly overwhelmed by the events of the past few hours; I cannot remember when I closed my eyes that first night in England.

'The Interview'

After an eventful journey, the sleep was deep. I opened my eyes, somewhat disoriented. I was in the doctors' room at the Infirmary. The day was breaking; the clock showed 8.45 in the morning. I looked out of the window. The sun was hazy; there was no heat in the rays. On a wintry November day in the sixties, the sun could hardly manage to break through the smog. The Infirmary, then a nearly one-hundred-year-old Victorian building, did not look inviting to someone who came from a cosmopolitan and fashionable centre of the largest film industry (now ubiquitously nicknamed 'Bollywood') in the world!

My job interview was in the afternoon. The consultant, Mr Marshall, was to come at two o'clock. I waited on a bench outside the office of the hospital secretary Mr Alan Metcalf, who covered two hospitals, the Infirmary and the North Ormesby Hospital. Hilda Robson looked after day-to-day administration with a clerk working with her. Mr Marshall came in precisely at 2 pm and went into Mr Metcalf's office. Hilda Robson opened the door and asked me to go in. 'Good afternoon, Sir.' 'Good afternoon. Please take a seat.' The first remark by Mr Marshall was that I was well qualified with a Masters' degree. Dr RAF Cooper, my consultant at the Bombay Hospital in 1960, had recommended me highly. Then, after one or two more questions, Mr Marshall asked me, 'If you were offered an appointment as SHO in ENT, would you like to take it?' Not conversant with the subtleties of the British of the sixties, I was taken back momentarily, finding it a strange question for someone who has just travelled from India, only for one reason, an appointment to the ENT department. But I recovered quickly and said, 'Yes Sir.' 'Congratulations and welcome.' That was it, that was the interview!

Senior House Officer (SHO) in ENT at the Infirmary (1963)

It was not surprising that I got a job since I was the only candidate and had a bagful of postgraduate qualifications. The job was to last for a year at an *annual* salary was £ 1255/-, paid monthly in arrears. The work consisted of outpatient, operating sessions with the consultant, ward work, casualty and on-call every other day, and every other weekend – this was the norm. There were no annual holidays or study leave.

The North Riding Infirmary, Middlesbrough in the North-East England

General Medical Council of UK (GMC) registration in 1963

I was to start work as soon as I got my registration with the General Medical Council of Great Britain – a mere formality since I was a Commonwealth Citizen and did not require a visa, an employment voucher or anything else. The basic medical degree, MBBS from India, was approved by the General Medical Council (GMC) for full registration as a medical practitioner in England. Hilda Robson phoned the GMC and got confirmation of my registration over the phone. However, I could not start the work until I had the registration document. Hilda said it might take a few days for the registration to come by post. Alternatively, I could go to London personally, to the GMC office and bring the documents. I was keen to start work as soon as possible. Therefore, rather than apply for GMC registration by post and wait for it to arrive, I decided to go to London in person to get it. I borrowed some money from Dr Pahade, and the same night, took a coach from Middlesbrough back to London. I had arrived from London only a night before. And there I was, in a coach back to London just 24 hours later.

It took all night to get to London. I sat next to an old lady who had caught the bus from Sunderland. At a coach stop in Doncaster, she opened a bottle of brandy, poured some out in a cup and offered me. 'This will keep you warm.' I could not refuse her kindness. I gulped it, setting my throat, oesophagus and stomach on fire, all in one go. I couldn't get over the friendliness of the British – the taxi driver, Hilda Robson, and now a co-passenger, a stranger.

As I found years later, as you went up North from London, people were tremendously friendly, compassionate and kind. And so true, even today. Having spent nearly half a century in Yorkshire, these are 'my people, my second home'.

In London, I met a friend of a patient in Mumbai who had settled in the UK. He kindly came to take me to the office of the GMC. I filled out the necessary forms, produced all the documents of my degree etc., and paid the fees. I called in again a few hours later. By the evening, I had full registration in my hand as a practising physician in England. I thanked the friend and took a coach for a journey back to Middlesbrough, the second night in succession, on the road!

My first patient in England

The next day, I gave my registration document to Hilda and went straight to the ENT outpatient at the NHS hospital, the North Riding Infirmary to see my first patient in England! That was in November 1963. Who could have imagined that those few steps were the start of a journey which would end in my retirement in the same department in 2008, with a lifetime award of the title of Emeritus consultant Otolaryngologist and Head-and-Neck Surgeon, and name a room 'Oswal Rhinology Lab' in my honour?

Health care in the pre-1945 era

Before 1945, accessible free healthcare for the poor was piecemeal, with wide regional variations. It was provided by the 'Voluntary' hospitals staffed by physicians and surgeons who gave their time and expertise without any payment. The funding for the hospitals came from charities. The upper- and middle-class patients who could afford the personal and a higher standard of care consulted private doctors.

Creation of a universal health service

In 1945, Clement Attlee led the Labour Party to transform a welfare state into reality. A government report, written by the economist Sir William Beveridge, set out to combat the five 'great evils' of society: want, disease, ignorance, squalor, and idleness. A significant component of this was creating a universal health service, available to all and for free.

On becoming Health Minister, Aneurin Bevan (1897–1960), a prominent socialist and the son of a miner, was tasked with spearheading the creation of the first universal health care system anywhere in the world. Aneurin Bevan was born in Tredegar, a mining town in South Wales where The Tredegar Workmen's Medical Aid Society was formed in 1890 by a merger of local benevolent societies. It provided medical benefits and funeral expenses to miners, steelworkers, and their families – and later the whole community.

Members made weekly financial contributions, which collectively enabled them to employ doctors, surgeons and maintain a hospital.

Aneurin Bevan established the National Health Service (NHS) and brought the hospitals, doctors, nurses, pharmacists, opticians and dentists together under one organisation.

The National Health Service: the guiding principles

Bevan's model of the NHS project was based on his work in Tredegar. The three guiding principles for the NHS were: it must

- Universalise the best care, not simply provide a safety net for the poorest.
- Be free at the point of delivery.
- Provide service according to the need, not the ability to pay.

Under the NHS, everyone was eligible for free care. Each person signed with a specific General Practice (GP), an entry point into the system that still remains the same. General taxation and contribution to National Insurance provided the funding.

The NHS, a very British phenomenon (1948)

At the time of writing, I would have been in the NHS for sixty years. It will thus be not out of place to take stock of the NHS[1] as my eyes saw it and, hand in hand, the ups and downs of assimilation of the immigrant medics with the British from vast geographical areas of the world. So, let us start with a glimpse of the health care in the UK in 1948, the birth of the NHS.

The birth of the NHS in 1948

Britain's National Health Service came into existence on July 5, 1948. It was launched at Park Hospital in Manchester (now Trafford General Hospital). It was the first universal free health system to be available to all. Financing came from the funds from the general taxes. Bevan also admitted that it was 'the biggest single experiment in social service that the world has ever seen.'

NHS: The Good, The Bad and The Ugly, all in one

The NHS is vast.[2] It employs more than 1.5 million people.[3,4] You will be hard-pressed to find any health facility in the world where the whole population of the country is entitled to receive free health care at the point of delivery. It is even more remarkable that it is available 24/7, be it for a trivial condition or, the most complex surgery involving multiple teams of professionals.

In the NHS hospital, the consultant receives a fixed monthly salary. Thus, this built-in safeguard assures that any surgery undertaken is based on sound clinical judgment and in the patient's best interest. As a result, the quality of service is mostly consistent. However, it is hardly surprising that despite its designation as National, there are many

localities where its delivery is suboptimal due to human resources and funding shortages. Inevitably, there are waiting lists for non-urgent conditions.

Revenue and expenditure of the NHS

NHS finances come from general taxes. The allocated money can never be enough to cater for the needs of everybody from 'the cradle to the grave'. Inevitably, as in many walks of life, limited resource leads to waiting, prioritising the neediest, based on the only consideration: an individual's clinical needs.

'Stuffing doctors' mouths with gold'

Staffing of the NHS hospitals depended on the acceptance by the consultants who had a thriving private practice and could not give all their professional time to the newly established NHS. Instead, they chose to spend an odd afternoon here and a morning there, for which they received a suitable remuneration. The acceptance by the consultants was crucial to the establishment of the NHS. Still, there was much disregard towards it by the senior consultants who showed very little enthusiasm to give their time for a small reward as a remuneration. Bevan boasted that he could accomplish his goal of seeking the cooperation of the consultants 'by stuffing the doctors' mouths with gold'. He allowed consultants to continue private practice in their consulting rooms, as well as in the NHS hospitals.

Sixty years in the NHS

If someone asks me what the NHS was like in the past sixty years, the short answer would be 'My history is the history of the NHS, I am the NHS.' My career in the NHS spanned over sixty years in various grades, initially as a trainee, way back in 1963 when the NHS was fifteen years old, then a consultant, an Honorary consultant, and finally as Emeritus ENT, Head-and-Neck consultant Surgeon, a lifelong title. Even after 2008, when I gave up my clinical work, my NHS contact continued in my position as Vice President and Chairman of the Education Committee of The British Medical Laser Association.

During those sixty years, I witnessed the NHS in various shapes and forms. Moreover, having sat on many committees, at times as chairman, I must have been indirectly responsible for shaping some aspects of its development. I also undertook pioneering work in developing laser technology in ENT and trained hundreds of surgeons in their use. In a way, thus, I am the NHS! It will be apt to briefly narrate my perspective of the NHS, spanning over a long period of sixty years. The data used from the various websites are appropriately listed.

Sessional remuneration of the consultants

There were two sessions of three and a half hours a day, in the morning and in the afternoon. Payment was per session. The timing of the session was 'notional', meaning

that the consultant did not spend all three and half hours seeing patients. The clock for the session started ticking the moment the consultant left home or the private consulting rooms, whichever was nearer. Likewise, the session finished upon returning home! Thus, they received the travelling expenses, and the travelling time was included in the session and got paid.

Consultant contract in the fifties

Paid sessional work consisted of seeing patients and other work such as writing letters to the referring GP and on-call commitments. Later, training and research time also became part of the paid session. In a week, there were eleven notional sessions, two sessions each day. Monday to Friday made up for ten sessions, and the Saturday morning became the eleventh session. A full-time contract entailed payment for 11 sessions, out of which seven sessions were clinical and the rest for non-clinical work. A part-time contract entailed working for nine sessions, and the payment adjusted to 9/11th of the full-time pay.

A generous six-week fully paid annual leave was included, with a further two weeks for study leave. Then there were 52 Sundays and 52 half Saturdays. Finally, five statutory holidays for Christmas etc., completed the contract. The job was pensionable, with contributions from both the employee and an employer. In addition, widows or widowers received a lifetime pension of fifty percent of the doctor's pension. The tradition of sessional pay continues to date.

Shortage of doctors and nurses - right from the outset

The creation of the National Health Service resulted in a significant expansion of the health care facility leading to a shortfall of healthcare professionals at all levels: specialists, general practitioners, and nurses. The background of a letter for an interview I received in 1963 to take up a resident post (SHO: Senior House Officer) in the NHS thus has a historical basis.

The ENT department at the Infirmary

We had a resident Matron – Miss Hunter, whose name appeared on the hospital letterhead, alongside the name of the hospital secretary. It did not show consultant names since they were not the employees; they were the visiting consultants. The night nurses had to get the ward in tip-top condition, with patients propped up in their beds and all beds made up before the day nurses came on duty. They then handed over the charge of the ward to the day nurses.

The wards

There were four ENT wards, a male ward, a female ward, a tonsil ward on the ground floor and a children's ward on the first floor. ENT alone had seventy-eight beds! Adult tonsil

patients were kept as inpatients for five days. Mastoid patients were in for ten days, then the stitches were removed, and the patient was discharged. Terminal cancer patients stayed inpatients for months until they passed away. Ulcerated cancers had an unpleasant odour. Their beds were in the corner far from the entrance to the ward. After their use of the toilet, the odour was very offensive. One terminal patient always used the WC at night if he could manage to hold on.

Ward rounds

The day nurses had to know everything about the patients for Matron's Ward round. Then there was a resident doctor's ward round to check each patient's condition. At precisely eight-thirty, the SHOs and Matron would wait at the main door for Mr Marshall to arrive. We wished him 'Good Morning Sir'. He acknowledged with a smile. We then went towards ward one to start the consultant ward round. Ward rounds of all other wards followed. A question by the consultant to the patient 'how are you Mr Jones?' was expected to be answered: 'Very well, thank you!' It was the job of the nurses and doctors, and not the consultant's, to take care of patients' needs.

Outpatients

Patients came by appointment. SHOs saw patients for reviews in a cubicle and took them to the consultant if needed. Consultants had a large room. The audiology department carried out basic hearing tests and dispensed body-worn hearing aids.

ENT casualty

The ENT had a twenty-four-hour casualty department, where nurses saw patients and also treated them. These nurses were very knowledgeable since there might not always be an SHO in the post! Doctors on duty went to the casualty only if the patient needed admitting. ENT casualties consisted of nose bleeds, quinsy, foreign bodies in the oesophagus and acute mastoid abscesses. A blunting of the post aural groove indicates acute mastoid abscess needing urgent intervention. Acute furunculosis of the external canal also presents similarly, the only difference being, furunculosis is extremely painful! It does not need surgery. There were intra-cranial complications from mastoid infection, which required urgent surgery. The extradural abscess was drained into the mastoid cavity with ribbon gauze inserted intracranially. Foreign bodies of all sorts were inhaled or swallowed by patients, especially children, and needed urgent removal. Obstruction of the airway was another type of emergency that required a great degree of skill. There were obstructed adult cases due to cancer of the larynx, also needing immediate surgery of tracheostomy. High Dependency or Intensive Care Units (ICU) for treating seriously ill patients did not exist.

Tracheostomies in children with acute laryngo-tracheo-bronchitis

Acute infection of the larynx and trachea was seen frequently in children, and urgent tracheostomy was necessary to bypass the obstruction. Acute laryngo-tracheo-bronchitis in children was common and they were admitted to the Stockton Children's Hospital on Durham Road, ironically situated next to the cemetery. We had to take a tray from the Infirmary, consisting of all instruments necessary to undertake this extremely demanding surgery on very ill children and neonates.

If after establishing an airway via tracheostomy, a child stops breathing, giving oxygen does not help. Continuing obstruction over time results in an accumulation of carbon dioxide, which becomes the driving force for the respiratory centre. Establishing the tracheal airway washes out the accumulated CO_2. It is then necessary to restore the CO_2 concentration, and the quickest way to do that is to breathe out your expiratory air containing CO_2 into the child's tracheostomy. The spontaneous breathing of the child will be restored with this manoeuvre after your half dozen breaths into the stoma.

'Give the old boy a quarter grain of morphia'

In the Sixties, district hospitals such as the Infirmary did not always get applicants for a resident doctor post, and nurses ran the hospital.

I recall an incident when I saw a casualty patient with a bleeding nose; this was common in wintry days. Not having seen such a heavy nosebleed in the warm Indian climate, I was alarmed and decided to admit the patient. The ward sister instantly told me that admission was unnecessary: 'Give the old boy a quarter grain of morphia and send him home.' I insisted that the elderly man, still bleeding, should be admitted, and much to her displeasure, he was. Morphine is a strong respiratory depressant. It is metabolised in the liver. In the elderly, sometimes, there is a subclinical impairment of liver function. In such cases, morphine is not metabolised adequately, resulting in higher circulatory concentration, depressing respiration. Years later, when I was senior registrar, I came across a case of morphine poisoning in an elderly patient with epistaxis. He initially presented himself in the casualty department of another hospital. They packed his nose and gave I/M morphine. Upon admission, he was nearly comatose with pin-point pupils and three or four respirations a minute. A quick I/V dose of Naloxone, an antidote to morphine, restored his breathing and conscious state.

I mentioned the difficulty of admitting bleeding patients to Mr Marshall and quoted comments from the sister: 'This boy from India will not tell me how to manage a nosebleed.' Mr Marshall's reply to me was: 'Sometimes you have to learn to leave the tongue between the cheeks!' Consultants came to rely heavily upon the nursing staff, who were highly efficient, having worked in the speciality for years. On the other hand, the SHOs were mostly newly qualified graduates with no clue of managing ENT diseases which, by the nature of things, appear in dark deep-seated cavities! And there was no registrar post to fall back on either. So the experience of nurses was valuable to the newly qualified doctors, let alone the patients.

Fishbones

Friday night was busy due to fish bones getting stuck in the throat, as Fridays were 'fish days'. Traditionally, followers of the faith abstained from eating red meat on Fridays as part of a penance to mark the day of Christ's death. In the 1950s, the standard meatless Friday meal was usually macaroni and cheese, tuna noodle casserole, or fish sticks. Fish and chips was a staple diet, and the waters around the British Isles provided a bountiful harvest! Freshly fried cod and chips were bought from a corner shop, served in a parcel made of newspaper and eaten by the side of the road. A fishbone could be lodged deep in the throat (pyriform fossa), and its removal consisted of examining it with the mirror in one hand and forceps in the other hand to remove it. This procedure needed an extreme degree of dexterity since the image of the forceps is a mirror image. The forceps is moved away from the fishbone to approach it, since right is left, and left is right in a mirror image!

Operating theatres

The consultant and the senior staff operated in the main theatre. The SHO undertook a tonsil list in an adjacent small room. On alternate days, some ten pairs of tonsils were whipped out from children's throats, almost like a conveyer belt. There was a general concept that the tonsils caused many illnesses, ranging from sore throats, slow physical development, arthritis and many other general conditions! No wonder many mothers reported that 'little Billy was eating like a horse' after the tonsil operation. With today's much better understanding of the pathophysiology, the tonsil operation is performed much less frequently with very stringent criteria.

Other ENT operations were mainly mastoid infections, nasal polyps, surgery for bent septum and infection of sinuses. There was no operation for perforated eardrums or hearing disorder, otosclerosis, due to the fixation of a small bone, stapes, in the ear. Chest surgery did not exist as a separate speciality, and the ENT department undertook all examinations for the diseases of the food and air passages. The scopes typically had a small bulb with tungsten filament. The standard treatment for cancer of the throat (larynx) was X-ray therapy. The general surgeon and the assisting team from the North Ormesby hospital came to the Infirmary for surgical management. Cancer of sinuses and mouth was relatively frequent, and general surgeons carried out the operation since the speciality of oro-facial-maxillary surgery did not exist.

Residential accommodation in the Infirmary for doctors

There were three rooms with a cooking facility and a common sitting room with a television. The hospital did not charge rent for the residential doctors, who also got free food. I soon settled in my room. The two eye SHOs, Drs Mhato and Banerjee, were living in other rooms. The other ENT SHO, Dr Pahade, and his wife, an anaesthetist, lived in an accommodation for married couples.

The Canteen

I was born in a community of Jain, who are strict vegetarians. Not even eggs were allowed. Nevertheless, I used to eat eggs and also some fish at my friend's house next door – the Raje family. Indian food is highly spiced. The dinner at the Infirmary was bland with no flavour or taste. It was a three-course meal: the starter was tinned tomato soup and a roll, the main dish had soggy overcooked cauliflower, carrot, peas and mashed potatoes with some variety of red meat with sauce. The dessert was tinned pear or peach and cream, followed by tea. Sometimes, Banerjee used to cook rice and lentil with spices in doctor's quarters. It was a treat!

The lounge

In the evening we came together and watched television. The only channel was BBC, and its famous test screen came on some hours ahead of the programmes. There was news, boxing and some children programmes. The last programme was the news and the broadcast finished for the day around 9:30 pm.

Hospital married accommodation

I made enquiries if I could get an accommodation for married couples in order to ask my wife Nirmal to join me. One of the flats for married couples, attached to North Ormesby Hospital, was available. I informed Nirmal to prepare so that she could join me in a month or two.

ENT medical staff (1963)

There were two SHOs, I was one of them.

As mentioned before, there was only one consultant ENT Surgeon, Mr Marshall. Another consultant, Mr Horowitz, was appointed and started working soon after I joined the Infirmary. A clinical assistant, Dr Frank Fleming, and a few general practitioners had sessions in the theatre and outpatients. Frank was the mainstay of the hospital and well-liked by all nursing staff. He undertook most of the routine nasal surgery, endoscopies and all emergency admissions. Frank had unsuccessfully attempted FRCS several times. Mr Marshall did not let him do mastoid surgery.

Mr Marshall was a typical English consultant of the era. He wore a three-piece suit, a rose in the buttonhole, and a chain with a watch in the waistcoat. He spoke softly with a faint smile. There was no formal training for the juniors. During some of Mr. Marshall's clinics, I would be in his consulting room and observe. Likewise, there was no training in the theatre when he operated. Most of the learning was by observation.

Martin Horowitz took up a consultant post in 1964, some months after I joined. Martin was an otologist and did not do any cancer surgery. He was keen on teaching, but the hospital did not have the atmosphere of education, neither was there protected time for the doctors. The library had the latest *Journal of Laryngology and Otology*. The old copies were taken to the main library at Middlesbrough General Hospital, bound into volumes and kept on the shelves.

Swinging Sixties - a DJ of the Infirmary? You can almost hear them screaming!

Death of a child after tonsils and adenoid operation

Any unexpected death in a hospital ward is demoralising. If it concerns the death of a child, the feelings of grief are no less than those in case of a personal loss. Following is a narrative of an event that took place some fifty-five years ago. Only the main features of the event, to the best of my recollection, are presented here, without any documentary record.

A child of five or six-year-old underwent a routine T&A (tonsil and adenoid operation). A standard protocol for postoperative care included a four-hourly record of TPR (temperature, pulse and respiration). A routine postoperative ward round was unremarkable. I was sleeping in the 'on-call room' in the hospital's doctors' quarters just two minutes away from the wards. Around eight o'clock in the morning, I had an urgent call to go to the children's ward as a child had collapsed. When I arrived, the child was already dead due to aspiration of vomitus. A public enquiry by the Queen's Counsel took place to address the public concern. Our medical defence teams represented the SHO surgeon who carried out the surgery, and me. The enquiry found that the surgical and anaesthetic procedures were routine with no indication of any unusual circumstances. The postoperative instructions included a recording of temperature, pulse and respiration (TPR) every four hours. The routine postoperative ward round did not show any cause for concern for any children who had undergone T&A surgery that morning. The child had a peaceful night. When the child woke up in the morning, he was fed porridge with a spoon by a nurse, as was common. After a couple of feeds, the child suddenly vomited a large amount of stomach contents which was deep brown. Some of the contents went into the airways of the child and choked him. After a few jerky breaths, the child stopped breathing and collapsed.

The nursing record showed that during the evening, every reading showed a rising pulse rate. The trend continued throughout the night and in the early hours of the morning. A persistent rising pulse is an unmistakable sign of bleeding. The child must have started bleeding from the adenoid area sometime during the night – this is a known occurrence known as 'reactionary bleeding'.

In an awake child, any trickle of the blood from the adenoid will irritate the larynx, initiating the cough reflex, resulting in the expulsion of blood – a tell-tale sign of post-operative bleeding. If given, opioid painkillers suppress the cough reflex. Thus, the rising pulse is diagnostic of continuing oozing from T&A and a reason to examine the child's throat to assess it.

During sleep, the swallowed blood would collect in the stomach. A feed of porridge on a full stomach brought out all the contents as vomitus. His airway could not handle a large amount of vomitus, and inevitably, some of it went into the bronchi, choking him with disastrous effects.

Foreign body in the bronchus of a child

A six-year-old child with a history of choking on a piece of toy was brought in by the parents. He was struggling to breathe, with rapid respiration. It was about seven PM. My less-experienced SHO colleague and I attended to the child with oxygen administration. Dr Fleming was not contactable. We continued to phone him periodically, but he had not reached home. A good hour had passed, but again, no contact. Mr Marshall could not be reached by phone either. In those days, there were no mobile phones and people could not be contacted if they were not near the landline!

I had some experience in bronchoscopy for foreign body (FB) removal, but this being my first case in England, I was not sure about the theatre set-up, instruments, anaesthetic cover, etc. The parents were getting agitated, seeing that the child struggled to breathe, and 'the hospital was not doing anything'. I discussed the case with my SHO colleague to take the child to the theatre and carry out a bronchoscopy to remove the FB.

The child's condition was deteriorating since oxygen saturation appeared inadequate, possibly due to impaction of FB causing the lung to collapse. There were no monitoring devices, such as the pulse oximeter. If we waited for Dr Fleming, he would remove the FB successfully without any complications. But the procedure might prove hazardous due to oedema around the FB. On the other hand, if we took the child to the theatre, with our limited experience, there was a possibility that we might not be able to locate the larynx and pass the scope to the FB. Worse still, we might not be able to remove the FB, or struggling to remove FB may result in bleeding, oedema and so on. The anaesthetist also needed to undertake tubeless anaesthesia. He/she might even refuse to take on the case without an experienced surgeon. Again, I would remind the reader that the lights in the scope were tungsten bulbs, dimming, flickering and sometimes fusing at a critical time. There was no muscle relaxant. We reached a point where a balanced judgement was necessary. So, there we were: which is the lesser of the two evils? Fortunately, Dr Fleming got the message, came straight away and removed the FB successfully.

I asked Mr Marshall the following day what I should do if such incident would occur again. He said, 'If you feel your intervention would be a better option, then you should proceed.' Non-committal advice!

What can reasonably be expected of a junior doctor?

Jackson LJ, a renowned professional negligence lawyer in practice, added an interesting judgment, agreeing with Thirlwall LJ, but expanding on the issue posed by a learner doctor being the one in the firing line.[5]

Do you judge their performance by the fact that they are a learner, or that the NHS is employing them as a doctor? The classic case in the law generally is the learner driver who was judged by the standards of a competent and experienced driver. Bit unfair on them, but equally unfair on the rest of the world by whom they might be injured, as they judder or weave or speed their way in the general direction of competence. Thus, in professional negligence, as in the general law of negligence, the standard of care which the law requires is an imperfect compromise. It achieves a balance between the interests of society and fairness to the individual practitioner. It is not possible to go into any details since each case is judged on its merit. Be it suffice to say that any action of a doctor under similar circumstances, should be fully justifiable both to himself/herself and also to the judiciary as a layperson judging on the facts. A very full record, almost of the quality to be presented in the court of law, should be contemporaneously made'.

The key case on this is Wilsher v Essex AHA [1987] 1 QB 730. 'The Court of Appeal held that a hospital doctor should be judged by the standard of skill and care appropriate to the post which he/she was fulfilling, for example, the post of junior houseman in a specialised unit.'

Diploma in Otolaryngology (DLO), Royal College of Surgeons of England (1964)

During my year at the Infirmary as SHO in 1963, I sat the exam for the diploma in Laryngo-otology at the Royal College of Surgeons of England after only six months and passed it. Mr Marshall was delighted at the success achieved within a short time of my arrival in England. It was good for the hospital to have well-qualified doctors. The rest of my stay at the Infirmary passed without much change. I was now seeing new patients independently and generally advancing my surgical experience. I could have extended my SHO post to another year. Still, Mr Marshall, seeing my potential, told me to move on and get experience in as many different departments as possible before eventually returning to India. Even today, I am full of admiration for the sincerity and sense of commitment to training shown by the older generation of consultants in the era when there was no formalised stringent requirement to do so.

My first SMR (sub-mucous resection of the nasal septum)

When I passed my DLO, Mr Marshall told me that I should start doing the sub-mucous resection for bent septal bone in the nose. In my first patient for this nose surgery, the septum was particularly distorted due to previous trauma. While lifting the flap, I tore it – not of much consequence. But Mr Marshall remarked: 'Now that you have done the easiest part, do the difficult one of removing the cartilage!'

Hilarious instances in my first job in England

Today, the television, the ubiquitous internet, and the ease of travelling have shrunk the world so that we all are aware of the various people, their culture, customs, religious dogma, language, etc. But not so in the sixties; the world was a vast expanse then. Even in a country like India, the language, food, apparel, and customs are different every few hundred miles due to the country's enormous size. And here I was, I had sailed those proverbial seven seas and entered another world, completely alien, totally unreal. Little wonder that there were some hilarious instances during the first few weeks after my arrival in England.

Good evening, Sir

On the second day of my appointment, a casualty patient needed urgent theatre management. As SHO, my job was to arrange the theatre and keep it ready for the consultant to come and operate. The operation was at 7 pm. I went to the theatre promptly at half-past six to organise everything. I went in and checked that the evening nurses were getting the instrument trolley ready. As I came out of the theatre, I saw an English gentleman in a white coat approaching the theatre. I said, 'Good evening, Sir. Do you want me to ask the ward nurse to send the patient to the theatre?' He hesitated a bit and said, 'No, not yet.' So, he and I waited at the door. The next Englishman arrived in a suit and went to the changing room. Again, I asked the first gentleman if I should get the patient now. Again, he said, 'No, not yet.' And then, a few minutes later, the third Englishman arrived in a suit and went to the changing room. The first Englishman in the white coat said: 'I will get the patient.' The penny dropped – he was a porter in a white skin and a white coat! What a fool I was. But then, you must have heard the expression: 'All foreigners look the same.' Initially, at any rate!

Years later, when I became a consultant surgeon in the same hospital, he was still a porter. He mostly avoided eye contact with me.

A bruise on the neck

For tonsillectomy patients, it was usual to ask for any history of frequent bruises or any bleeding in the family. As I was giving a young eighteen-year-old a pre-op check, I noticed a bruise on her neck. Naturally, I asked her how she got that bruise. She blushed and said: 'Oh, you know doctor, it was him.' Before this incident, I had never seen a white skin with a bruise – it looked so prominent!

Haemorrhaging

Written language is so quite different from spoken language. Colloquial language is even more diverse with regional or other influences. On enquiring if there was any history of bleeding in the family while admitting a child for tonsillectomy, I frequently got the following response:

'Yes, my mother had a nosebleed.'

'How much was the blood loss?'

'Oh, a lot.'

'Had to have any transfusions?'

'No.'

So, I changed the tack:

'Do you bleed a lot when you get cuts on the body?'

'Yes.'

Ask a silly question and get a silly response.

Then I worked my way through to ask the right question to get the correct answer. Haemorrhage was the word most patients knew to mean 'real bleeding'. It was related to childbirth. Amongst women, there would be the talk of postpartum haemorrhage while attending antenatal clinics. To them, that was bleeding of any significance.

'Is there any history of haemorrhaging in the family?' always produced a correct answer: 'No.' Postpartum haemorrhage is uncommon!

I soon realised that I needed to learn the 'local' language. The best resource was the television. I watched most programmes, not so much for their contents, but as an educational tool to speak as the locals do.

The Swinging Sixties, Swinging London.

In the sixties in England, the memories of war, the London Blitz, and rationing began to find their place in the history books. Post-war austerity, which lasted through much of the 1950s, was being replaced by the recovery of the British economy. The efforts to rebuild war-torn Europe were also beginning to pay dividends. The sixties-era was dubbed 'Swinging Sixties',[6] with Swinging London as its global centre.

'Baby Boomers'

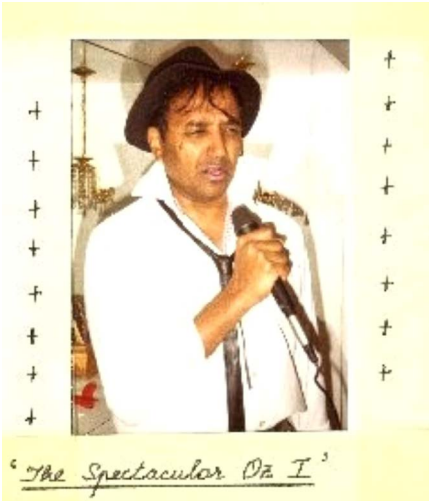
After WWII, there was a massive surge in birth rate. Children born between 1946 and 1964 are dubbed as 'Baby Boomers'. They were relatively well-off with privileges, government subsidies in post-war housing, education and increasing affluence. Many rebelled against the disciplined era of their parents and, in the seventies, became Hippies.

I arrived in England in 1963. And I was young! My memories of the swinging sixties of England are: The Beatles, Sandie Shaw, Lulu, Dusty Springfield, Cilla Black, and a weekly show of David Jacob's Juke Box Jury on BBC television. I always liked music and songs, a legacy of my mother's passion for going to cinemas in the thirties. Music has no geographical or cultural boundaries.

Ravi Shankar,[8] a composer of Hindustani classical music and one of the best-known proponents of the sitar, toured through Europe and the Americas. His association with

violinist Yehudi Menuhin and Beatles-guitarist George Harrison influenced the use of Indian instruments in pop music throughout the 1960s. The flower power epitomised freedom of expression and easy, care-free life with sexual liberation and miniskirts, which became micro-miniskirts.

In the early days of my arrival in England, one young girl patient asked me if I liked The Beatles. I said 'of course!', not appreciating the impact of their music on the young generation of England and America. In the US, they were identified as 'The British Invasion'[8] – a cultural phenomenon of the mid-1960s when rock and pop music acts from the United Kingdom and other aspects of British culture became popular in the United States.



Me, play-acting as a disc jockey!

My first Christmas in England (1963)

Within six weeks of arriving in England, I experienced the joy of the festive season, my first ever Christmas in England. Every ward had a well-decorated Christmas tree, with lots of cards hanging everywhere. It was customary for Mr Marshall to arrive about eleven in the morning and then have sherry with the Matron and the eye consultants. He then came to the ward, carved the turkey and personally served it to each patient. We then sat for ours – at least this is what should have happened, and as I gathered a couple of days later, it did happen.

But I missed it all!

In India, I grew up in the Maharashtra state, in which there was total prohibition in the late forties to prevent drunkenness, ruinous to wealth and health. I thus had no exposure to alcohol of any sort until I arrived in England. Curious about the difference between the various drinks such as whisky, brandy, gin, sherry, vodka. I decided to taste each one. I do not think I could appreciate the difference. On the other hand, it did burn my throat and oesophagus immensely as I gulped all of it in one go. As I went to another ward, I drank another variety. After finishing a visit to all four wards, I went to the outpatient and the operating theatre. I recall Mr Marshall telling my SHO colleague Dr Pahade to take me to the Doctors' residence as I was delirious and was in no position to hold myself. When eventually I woke up, some thirty-six hours later, I had missed my very first Christmas I was so much looking forward to!

Nirmal came from India – our first 'home' in England

Nirmal came to England in February 1964. I made an overnight journey to Heathrow and returned with her to our 'home' in England – a furnished hospital flat with pots and pans, dinner plates and everything else you needed for a home. Near the Infirmary, there was an Indian corner grocery shop. I had my first home-cooked meal that evening. Nirmal soon

got used to the routine. She would walk the two miles in the morning and bring lunch for me. She used to stay in the flat until I finished and then took the bus to go back to our flat.

Our first car: Standard Vanguard 8

It was now necessary to buy a car. Our first car was a used Standard 8, costing me £ 210/-. I was able to drive on my international driving permit, but I had to take a UK driving test within twelve months to get a permanent licence.

A colleague kindly gave me inside information – leave your stethoscope on the passenger seat and when the examiner comes in, take it away, saying – 'Oh, my stethoscope!' He is bound to need a doctor someday!

Completion of one year as trainee SHO

Training in medicine is incremental. To obtain experience at a more advanced level, I needed to move on to a registrar grade. The appointments committee consisted of the consultants from the ENT department and the Royal College of Surgeon's representative. The most suitable candidate for the post and not the most highly qualified candidate got the job. A registrar post had come up in Dundee Royal Infirmary, a teaching hospital in Scotland. As a rule, the overseas doctors were usually unsuccessful in getting an appointment in teaching hospitals, and I was not going to apply. Frank Fleming said, 'Let us put it this way: if you did not apply, you definitely would not get it. On the other hand, if you did apply, you may get it.'

The appointments committee awarded me a two-year contract to the Registrar post in Dundee Royal Infirmary (DRI) in Scotland. In 1964, DRI was a major teaching hospital

linked with the University of St Andrews via its medical school at University College, Dundee.

Mr Marshall gave me a pipe as a present and asked me to give up cigarette smoking. As a result, I became a pipe smoker – a habit which continued until 1982! Laser surgery results in the production of a considerable amount of smoke, which is called the plume. In the early days of laser technology, the theatre atmosphere was full of smoke since dedicated smoke evacuators did not exist. Inhaling the smoke from burning flesh all day long left me with no desire to smoke a pipe either. My nearly twenty years of smoking were over.

A sophisticated way to smoke tobacco!

Scotland - An seo thig mi a dh'Alba (here I come, Scotland! In Scottish Gaelic)

I packed all my belongings along with a fairly pregnant Nirmal in our very dodgy second-hand car and hit the road to Scotland!

I had no concept that I would be working in that part of the UK which was so very different from England.[9]

I am not sure if it is generally known in many parts of the world that the United Kingdom is a union of four nations, England, Wales and Scotland having an unmanned boundary with the adjacent part of the Kingdom and Northern Ireland being separated from all three other parts by the Irish Sea. Each nation and the demography, culture, religion, and language are distinctly different. It should not come as a surprise since a sizeable percentage of the Indians living in the North East of India is more like Chinese, Mongolians, Burmese and Japanese, not only in their ethnicity but also in their culture, religion, culinary habits, languages and so on! But in such a small country like UK, in comparison to India, what is the basis of a divided landmass integrated under the term 'United Kingdom?' A very short historical overview may help.

United Kingdom – a four-nation kingdom

In the 16th century, Henry VIII passed the Laws in Wales Acts, which incorporated Wales into the Kingdom of England. In 1707, a political union took place between the Kingdoms of England and Scotland with a new identity as Great Britain. Under England's authority, Wales became part of the Kingdom of Great Britain. In 1800, The Act of Union added the Kingdom of Ireland to create the United Kingdom of Great Britain and Ireland. In 1922, Catholic Ireland seceded to become the Irish Free State. A few days later, Northern Ireland seceded from the Free State and returned to the United Kingdom. In 1927, the United Kingdom changed its formal title to the United Kingdom of Great Britain and Northern Ireland, usually shortened to Britain and after 1945, to the United Kingdom or the UK.

I had not realised that culturally there was such a wide variation between England and Scotland.[10] For a start, I did not always understand the Scottish accents. My nurse came

from a small market town called Forfar in the county of Angus. It was amazing to hear her accent so different from Dundonian accents when you consider that the two places are only a few miles apart. And it is not only the physical distance that sets the people apart.

A coloured neighbour? No, not even a doctor!

There were reports of white people asking for a rate reduction because a black family moved in the neighbourhood, thus lowering the value of their property. We bought a house in Redcar in 1969. The neighbour told us that the previous owner who sold the house to us had the 'decency to apologise' to them for selling the house to 'a coloured family'. Nevertheless, our neighbours were 'delighted to have us as their neighbours'. Patronising? No, they were the working-class everyday folks, not polished bourgeois of the 'How Now Brown Cow' type. I, of course, came in handy when a fishbone got stuck in the throat of another neighbour's daughter.

Wheels within wheels

Most examples of prejudices have some hidden agenda. Earlier, I wrote about the ward sister questioning my decision to admit a nose bleed, with a remark: 'This boy from India is not going to tell me how to manage a nose bleed.' I reported the incident to the consultant Mr Marshall. He did not take up the issue any further with the nurse, not because she was white and I was coloured, but for the very good reason that there may not always be a resident doctor in the post, and he will have to depend on her.

Soon after this episode, Dr Fleming, a clinical assistant and not a consultant, told me to get every prescription counter signed. Having a Masters in ENT, I was taken aback somewhat to obtain the authorisation of another, less qualified doctor than I was. Frank Fleming had only a DLO (Diploma in Otorhinolaryngology). He had attempted to become a FRCS (Fellow of the Royal College of Surgeons) several times but without success. For the next few days, Frank counter-signed every prescription I wrote out. One day he called me and told me to give the prescription directly to the patient.

Later on, Frank Fleming told me why initially the behaviour of most of the hospital nurses and his attitude was against me. Apparently, on receiving my documents for the SHO job, Mr Marshall had remarked a few times that this was the first time the hospital had such a highly qualified doctor with a Master's degree in ENT, and he was looking forward to my arrival. I would be able to do some advanced surgery in the department!

As a clinical assistant, Frank Fleming had been at the Infirmary full time for years. He was, as such, de facto 'symbiotically' working with the nursing staff, almost in charge. But Mr Marshall gave him only routine work.

In the sixties, in a district hospital such as the Infirmary, it was quite possible to get a consultant post just with a diploma such as DLO. In fact, in the eye department, one of the ophthalmic consultants, had only DOph. But Mr Marshall did not support Frank Fleming's appointment as a consultant. It suited him to have someone at a lower grade, almost as a permanent SHO, look after the department and take care of all the emergencies. Mr Marshall thus never had to come to the hospital to deal with them. For the same reason, Frank got only basic surgery since advanced surgery would have made him experienced enough and eligible for a consultant appointment.

Frank then candidly told me that he was liberal and did not have prejudice to colour. What he had was 'a conduct bar and not a colour bar'. Doctors from India came from various places and had strong Indian accents, sometimes difficult to understand.

A conduct bar indeed since I am fully in agreement with him. And it reminds me of a note my oldest uncle Babaji gave me on my departure for England:

> *'People who live in an alien society are judged by the way they conduct themselves to the norm of the society, and not by their colour or creed or caste, or the way they appear, wear clothes, and follow different religion.'*

Personal experience

Personally, apart from rare occasions, I never experienced any colour bar, the obstacle to progression, appointment to consultant post, and finishing as Emeritus consultant Otolaryngologist H & N Surgeon to James Cook University Hospital in Cleveland in 2008. Not even once did I experience prejudicial remarks from my patients or my colleagues. What is more, unusually for the NHS, North Riding Infirmary staff honoured me by naming a facility after my name. Thus, for me, Frank Flemings words 'conduct bar' reverberate proud and loud, way above the diminutive expression 'colour bar'.

Dundee

Dundee is Scotland's fourth-largest city. It lies within the Eastern Central Lowlands on the north bank of the Firth of Tay, which feeds into the North Sea. Historically part of Angus, the city developed into a burgh in the late 12th century as an important east coast trading port.

Rapid expansion was brought on by the Industrial Revolution, particularly in the 19th century when Dundee was the centre of the global jute industry.

A wee mouse in Miss McLaren's sofa

We had rented a flat from the list of accommodations given to me by the hospital. There was a bedroom and a sitting room with a television. The kitchen and toilets were communal. One evening, while watching television, I felt a tickle on my behind. The wife was nowhere nearby. A little mouse was trying desperately to come out from underneath the cushion. We mentioned this to the cleaner, who promptly replied in her broad Scottish accents: 'Oh, Miss McLaren also has one in her settee!' With the baby's imminent arrival and anxious evenings watching the behind just in case there was a nest of mice, we soon moved to number 1, Rosewood Terrace, which was our home for the next three years. The landlady was ninety-three years old and mainly stayed in bed. Nirmal gave a helping hand to her visiting niece by lighting the fire etc.

The Department of Ear, Nose & Throat at Dundee Royal Infirmary (DRI)

In Scotland, Dundee Royal Infirmary (DRI) was a major teaching hospital linked with the University of St Andrews via its medical school at University College, Dundee. The ENT department first opened in 1879,[12] with Dr R. Sinclair as its first physician. Mr G.T. Guild joined as the first surgeon in 1899. A new ENT department opened in 1925, and Mr Mathers became the first to develop ENT as a teaching subject for the Medical School at University College Dundee.

Dundee ENT medical staff (1964)

When I joined the department in 1964, Alan Gibb[13] was the senior consultant. He was an otologist with a cheerful personality. Shortly after his arrival, the ENT department, affiliated with St Andrews University, was transferred to the newly founded University of Dundee. His surgical skill and enthusiasm for sharing this passion with others were outstanding. Just before I joined, Alan had been to the USA and had visited several leading otologists. He respected the juniors and taught us in the evenings by coming back to the hospital. He played golf regularly and also had established a travelling club with two other surgeons. The club visited other departments nationally and internationally for the exchange of knowledge. There were two other consultants, Mr Mitchell and Mr Mowat. Mr Mitchell did most of the routine work. He was an examiner at the Royal College of Surgeons of Edinburgh. Mr Mowat sadly became ill and passed away after some months of illness. Dr Bob Yorston was a middle-grade surgeon, in the rank of a clinical assistant, almost like Frank Fleming at the Infirmary in the sixties. He was a jolly person, always full of jokes. His presence alone was enough for everyone to laugh. He was a keen photographer and took excellent pictures with a microscope and a rudimentary camera. He was also an incredible artist and drew many valuable medical illustrations.

Registrar in ENT at Dundee Royal Infirmary in Scotland (1964)

As Registrar in ENT, I had clinical sessions and operating in Dundee Royal Infirmary. Over half of my commitments also required me to do clinics and operating in Montrose, thirty-eight miles away and St. Andrews, which was on the south side of River Tay, in Fife. In addition, there were clinics at Blair Gowrie, Forfar, Perth, and Broughty Ferry. The farthest clinic was in Pitlochry, a beautiful town some forty-five miles away. I went there once a month. Following is a brief description of some of my work as Registrar in Dundee.

Guillotine tonsillectomy

As described earlier, removal of tonsils involved using a guillotine method. There were eight children on each operating list. Registrars would start a list at 9 AM. Immediately after removal of the tonsils, adenoids were curetted. Surgery on all children was completed by 10 AM before the consultant came for the main operating list. If the tonsil list ran a little bit late, some consultants were visibly displeased! The postoperative bleeding rate

With medical secretary Wilma, Dundee Royal Infirmary (1964 – 1967)

following guillotine tonsillectomy was similar to the dissection method. There is no doubt that the guillotine method was much quicker than the dissection method.

Operating at peripheral hospitals

Apart from the most obvious complication of postoperative bleeding following Ts&As, I came across two further unusual instances while operating at the peripheral hospital.

Peritonsillar abscess

An adult patient presented with a huge peritonsillar abscess that was nearly going to burst. The anaesthetist induced him and opened the mouth to pass the oral tube. He unwittingly punctured the peritonsillar abscess with his tube. A massive amount of pus came out and filled the oral cavity. I immediately turned the patient on the side and let the pus flow out of his mouth. I then cleared his mouth with suction. Operation over! Most disasters happen at induction and recovery from the anaesthetic, much like most plane crashes happen at take-off or landing.[29] These are critical times. I always hung around the anaesthetic and the recovery rooms during my entire career, not in the surgeons' room sipping coffee.

Out of interest, one of the most famous cases of tonsil as the seat of a severe infection is that of the first president of the United States, George Washington, who fell ill in Mount Vernon, Virginia, suffering from a peritonsillar abscess, causing dyspnoea. Three doctors assisted him. The newest one, Elisha C. Dick, recommended a tracheostomy to improve

his breathing. However, the other two doctors' opinions prevailed. They had preferred traditional methods for treatment, such as bleeding the infection. The president died that night, December 14, 1799.

Vanishing anaesthetic tube

Nasal intubation for Ts&As is very useful since the tube is out of the way. A very accommodating anaesthetist always did nasal intubation. One day, he could not pass the tube at the first attempt. He attempted a few times, thinking that the patient had huge adenoids, but the tube refused to go further. He had over-extended the patient's head while advancing the tube in the nasopharynx. The tube tore the posterior wall of the nasopharynx and went into the prevertebral space! During further attempts, the tube followed the easiest route and ended in the prevertebral space. Oral intubation solved the problem. The torn posterior wall healed quickly without any treatment.

'Surgeon' in a peripheral hospital

I gained invaluable experience in surgery when operating unsupervised many miles away without the reassuring presence of the consultant. The general practitioners looked after the old cottage hospitals. So to have a surgeon visiting to do the list was a big event. And who was the surgeon – me. Yes, that day when I was operating, they had 'a surgeon' in the hospital. A casualty came in with a wound on the head. The GP could not control bleeding, so they summoned the surgeon's help, yes, me! The vein had retracted under the cut, continuing to bleed copiously. I lifted the flap, located the vein and tied it. There was a general air of appreciation around. 'Thank God the surgeon happened to be in the hospital!' I felt ten feet tall.

Bleeding after Ts&As in St Andrews

St Andrews[14] is a small town across the Tay River from Dundee, on the east coast of Fife. The town is home to the University of St Andrews, the third oldest university in the English-speaking world and the oldest in Scotland.

St Andrews is also known worldwide as the 'home of golf' because The Royal and Ancient Golf Club of St Andrews, founded in 1754, exercised legislative authority over the game worldwide (except in the United States and Mexico) until 2004. It is the most frequent venue for The Open Championship, the oldest of golf's four major championships. Several of its courses are amongst the finest in the world.

The town's name goes after the apostle Saint Andrew. There has been an important church in St Andrews since at least 747 AD.

Before the NHS, many small hospitals served local communities admirably. The hospital Matron was highly efficient in caring for most emergencies and minor procedures. Tonsil and adenoid surgery was considered minor. As such, many private consultants carried out Ts&As in these hospitals. And, of course, the majority of Ts&As procedures were uneventful.

However, when things go wrong, they go wrong disastrously due to the vicinity of the

airway. You then need expertise, such as an experienced anaesthetist, competent surgeon and dedicated theatre staff. The most dreaded complication is postoperative bleeding. One such episode occurred while I was registrar at DRI.

In 1964, there was a clinic and a tonsil list once a week in St Andrews' cottage hospital. But there was no road bridge to St Andrews; the present Tay Bridge did not exist. A passenger and vehicle ferry service operated across the River Tay between Craig Pier, Dundee and Newport-on-Tay in Fife. The registrars alternated the weekly lists in the cottage hospital in St Andrews, using the ferry service to cross the River. The GP practice in the town provided postoperative care.

One night, I received a phone call from Mr Gibb, my consultant, that a child who had tonsils and adenoids removed earlier that day in St Andrews had started to bleed, and I should go over and sort it out. I asked the GP covering the postoperative care to send blood for grouping and cross-matching. He said, 'I had not done a venepuncture since my student days, and I did not see any prospect of getting any blood out since all the veins had collapsed.' He was not confident to do anything since there was a good chance that any intervention might push the child over to a catastrophe.

A dash of 55 miles to save a life

The ferry was not running since the tide was low, and it was night. I needed to go via the town of Bridge of Earn, where there was a bridge over the river to the south bank. The total distance from Dundee to St Andrew's via the bridge was fifty-five miles. And oh, I needed to take the anaesthetist from Dundee since there was no anaesthetist in St Andrews. It was snowing hard. We discussed if we should call out a helicopter from RAF Leuchars and decided against, on account of the inclement weather. It was 1.30 AM by the time I got to the hospital. The child was in shock, ashen and moribund, but the bleeding had stopped. The anaesthetist and I put up a drip, took blood and sent it to Kirkcaldy in Fife, some twenty miles away, for grouping and cross match. The blood for transfusion arrived at 5 AM. By 6 AM, the face started to get a pale shade of pink, and all of us took a sigh of relief. I took the child to the theatre, cleared a clot from the postnasal space and inserted a postnasal pack. I needed to take the child to Dundee by ambulance.

Ambulance with blue flashing light and siren

We sent a message to hold the first ferry service of the high tide. An ambulance with a flashing blue light was waiting outside, in anticipation. When the phone call came for the first departure, we took the child by ambulance to the ferry. The nurses were waiting at the entrance of the DRI. The child was rushed away to the ward.

A very long and arduous night had passed; it was 9 in the morning. I straight went to do the clinic after a very welcome breakfast a nurse had kindly prepared for me. A tragedy was a whisker away. We learnt a lesson, stopped operating in St Andrews until the completion of the Tay Bridge, with twenty-four-hour access to a peripheral hospital. If some cases needed a priority operation, I slept in the cottage hospital for the night. A VIP treatment was on the plate, with Matron personally overseeing the serving of freshly baked cakes, scones, cream, jam, sumptuous dinner and a full English breakfast in the morning. After all, the surgeon was staying overnight in the hospital.

Hogmanay (1964)

In Scotland, Christmas is very quiet because the Church of Scotland – a Presbyterian church – never placed much emphasis on the Christmas festival. Christmas Day only became a public holiday in 1958, and Boxing Day, in 1974. The New Year's Eve festivity, Hogmanay, is the last day of the year (New Year's Eve), followed by celebrations well into the wee hours of the New Year's Day (January 1). Hogmanay is by far the largest festival in Scotland during the festive season.

We went to the town square, where the Hogmanay was in full swing. An old man nearby saw us shivering and very kindly opened his flask and gave us tea, and before we managed to put the cup to our lips, he drowned a generous helping of scotch in it. I drank it to make sure he was not offended. One sip of it, and Nirmal was feeling sick. With the baby nearly due, I thought we better smartly make our way back home.

Neena on the way

At about 9.30 PM on March 28, 1965, Nirmal told me that the baby was on the way. I asked her a couple of questions and said that there were many hours ahead, and I would take her to the hospital the next day when I went to do my operating list. I went back to my reading medical books for FRCS and fell asleep. The following day, when I woke up, I realised that Nirmal had spent all night with repeated labour pains, with no helping hand from anyone. Back home, she would have gone to her mother, delivered the baby under the vigilant eye of the experienced close relatives, and returned with the baby a good couple of months after the delivery. Such was the isolation in a foreign country.

The arrival of Neena (1965)

A baby girl was born at 1.25 AM on March 30, 1965, and both mother and baby were fine. However, I did not know about this until the following day. When asked why nobody informed me immediately, the nurse replied, we have a note here 'not to disturb you at night' – my way to be oblivious to the labour pains and the labour? Neena did bring some money with her. Having been born in the financial year 1963-64, I got a full year's tax relief for a family of three! Women were routinely asking for induction of their labour if they approached 5th April with no prospect of natural birth on this side of the financial year!!

The next few days were busy. While meeting my work commitments, I had to go shopping to get everything on the shopping list for Nirmal and the baby. Once, being in a hurry, I straight went to M & S and, at the counter, read out the list to the young female assistant, starting with an open-fronted bra. She blushed and quickly said, 'give it to me'.

Duty before family commitment

On the fifth day, Nirmal and the baby (Neena) could go home. I had arranged to take them home in the afternoon, after my morning clinic. However, a phone call from Mr Gibb told me to go to Blair Gowrie to do the clinic that afternoon as the consultant covering that clinic was not well. Those were the days of 'There's not to reason why, there's but to do or die' (Alfred Lord Tennyson). So I phoned the maternity ward, told the nurse that Nirmal and the baby could not go home as planned, and they needed to stay another day in the hospital, a far cry from the paternal leave of this era for the baby's arrival and time off afterwards.

Wedding of Nirmal's sister Sushila in India (1965)

When Neena was about ten weeks old, a message came from India that Nirmal's younger sister Sushila's wedding was to take place in June 1965. Nirmal wanted to go to the wedding, but she could not take Neena with her. In those days, travelling was a huge undertaking, particularly with luggage and a baby.

Five doors away, there was a Scottish family, Bridget and Andy. One of their children (Pauline) was of similar age as Neena, and thus we got to know them quite well. One day, as I was washing my car, the wee Bridget, a bit older than Pauline, came to me and asked me if my mother had allowed me to play outside! A happy age, a pity that children have to grow.

Neena

I told Nirmal that a baby of three months old wants a feed, a wash and a sleep. If she were to go to India, the baby would hardly know about it. Neena was bottle-fed, so that was not a problem. Bridget was quite happy to look after Neena for a couple of weeks. Moreover, I would bring Neena home at the weekend and look after her then. Everything seemed allright. So, Nirmal attended the wedding and returned within a couple of weeks. In India, people were quite surprised that she had left a little girl and dared to travel to India for a wedding!

FRCS

FRCS (Fellow of Royal College of Surgeons) is a postgraduate diploma in Surgery, granted by the four Royal Colleges in the UK and Ireland: London, Edinburgh, Glasgow and Dublin. The examination was in two parts: primary and final. Primary FRCS covered the basic sciences and final FRCS the clinical.

Primary FRCS

Due to the pressure of work, studying for primary FRCS was patchy. There was no study leave. There were only two registrars, so being on call was frequent. Most doctors from South East Asia had a high failure rate at both primary and final FRCS. My first two unsuc-

cessful attempts were at Edinburgh and Dublin, respectively.

Some regulars were seasoned. They took every examination in rotation: London, Edinburgh, Glasgow and Dublin. One of them used to point to a couple of stones on the wall at the examination hall, claiming he had paid for them through his many failed attempts!

'Oh! I thought it was physiology today….'

I recall one hilarious occasion during one of those visits to take examinations. One doctor had failed quite a few times and took examinations as 'just another something to do that day'. We were taking the primary at Glasgow. A seasoned candidate came to know that Mr McKenzie was an examiner in anatomy in Glasgow. He had encountered Mr McKenzie a few times in different centres and thought that Mr McKenzie had some grudge against him and would fail him. So there he went to the anatomy viva. When he came back, he bragged about how he got the better of Mr McKenzie this time.

'Oh, not you again.'

'Yes, it is me. How are you, Mr McKenzie?'

'OK. Let's get on with it.'

'Then he gave me a humerus and asked me: "What is this?"

'I took it in my hand, looked at it, turned it upside down and sideways and gave it back to him, replying, "I don't know."'

'You mean to say you come for primary FRCS and you don't know that this bone is a humerus?'

'Is it? No, I don't know. I was going to read anatomy this evening. I thought it was physiology this morning.'

Two unsuccessful attempts.

I failed at two attempts. I was not going to go attempting the primary until I passed. I knew of a friend who had passed the examination only when he did not take any job and studied full-time.

One afternoon, I was on my way to the cottage hospital in St Andrews to do the list. As I was passing St Andrews University, I thought that if I got a job in the academic surroundings as a demonstrator, I might stand a better chance of passing the primary. Also, I knew that the demonstrator job was light, and thus I would get ample time to study. The downside was the pay. I would have to take a substantial cut in my salary. I stopped at the University and asked if they had a job as a demonstrator in anatomy. They said they did not, but there was a job available in physiology. Yes indeed, there was, and they were happy for me to take it

Demonstrator in physiology, St Andrews University, Scotland

I got back home, and I told Nirmal that I planned to take up the job as a demonstrator in physiology to give the primary my best shot. The pay would be much less, and therefore, we would have to sell the car. I would go to St Andrew's by train. And should I still fail, we

would pack up and go home. She was taken back with the suddenness of all this. The next day I put in my resignation. Mr Gibb was on holiday. I told him of my plans when he got back. He was momentarily surprised but said, 'If you think that is the best for you, then OK.'

The staff consisted of two demonstrators, a couple of lecturers and the head, Professor in physiology. Both medical, as well as BSc students were enrolled. Medical students got their first MBBS in anatomy and physiology. They were then free to apply anywhere in the country for their clinical years! Indeed, as expected, there was a lot of time to study. I had to give a couple of lectures a week to the BSc students doing biosciences. The rest of the time was all for me. No calls, no weekends. I had my own office. I went to the University every day at nine in the morning, spent all day studying and got back in the evening. I was doing a lot of studying!

The coffee break was for a good half an hour or more. We all gathered in the Professor's office and discussed various aspects of teaching physiology in general. The atmosphere was very casual and friendly. My assumption that an academic surrounding would benefit me in my studies was way out of the mark! In the early days, I happened to ask the Professor about the pathways for the eighth cranial nerve. He said, 'What the hell does it matter as long as you can hear?'

I passed Primary FRCS at the third attempt at Glasgow in 1967.

A Senior Registrar job in Coventry

The Senior Registrar position was the highest trainee grade. On completion of training, doctors were eligible to be appointed to consultant positions. Although the SR appointment required a postgraduate qualification of FRCS, it was not an absolute necessity. In fact, in the late sixties, one could get a consultant job with only DLO, a much lower postgraduate qualification.

Although I had only primary FRCS, I decided to apply for a Senior Registrar (SR) job, which would give me a lot more experience since Senior Registrar is one rank below the consultant.

A Senior Registrar job came up in Coventry, in the Midlands. To my surprise, I got a letter for an interview. There were three other candidates, all with final FRCS.

The interview

At the Regional HQ in Birmingham, there were twelve members in the appointments committee. I was now thirty-three years old, a mature person and an experienced surgeon. Furthermore, my job in Dundee required me to operate in peripheral hospitals without any consultant back-up. It gave me an excellent opportunity to build confidence, much like a consultant who is independently responsible for the care of his patients. During the interview, I was relaxed, answering questions with confidence.

It is essential to enquire about the extent of experience on offer. The appointment of a trainee doctor is two-way traffic. The Committee must assess that the prospective candidate has adequate experience and ability to support the departmental commitment. Equally, the appointee must also know that the department has on offer what he or she needs to make progress. The appointment is symbiotic, meeting the requirements of both parties.

I asked Mr Roland, the department head, if I would get a chance to perform mastoid surgery. He said 'yes'.

Have I an English daughter?

A member of the Committee remarked:

'So, you have an Indian wife and a two-year old English daughter'.

I was quick to correct him:

'No, I have a Scottish daughter. She was made by India, packed in England and delivered in Scotland. She is already saying: "There is too much frrroth on my beeeya maaan".

The whole room burst into a loud laughter. He turned towards one of the members and said:

'My apology, Mr McDonald.'

'Apology accepted!'

And there came another round of laughter, and I got the job! I asked if I could start a bit later since my final FRCS examination was imminent. They accepted without any comments.

Senior Registrar

Although I had started my SR job with just the primary FRCS examination, I was introduced everywhere as Mr Oswal. I felt a bit uneasy and told Mr Roland that I was still a 'doctor'. He said, 'You will soon be Mr!' He was right.

Final FRCS (1967)

While working as Senior Registrar, I attempted the final FRCS – unsuccessfully. My first unsuccessful attempt at the final FRCS was due to the lack of a measuring tape for measuring the circumference of a thigh of a man who had some neurological condition. An ENT Surgeon going round with a measuring tape? To measure the circumference of the neck – perhaps, but certainly not that of the thigh!

The FRCS in 1967 was in General Surgery, it did not exist in ENT. Therefore, you chose ENT as a special subject while taking the general FRCS. My FRCS is general surgery FRCS, so if I decided to do abdominal Surgery after my FRCS, I was 'qualified' to operate.

General surgery FRCS

From the start of my medical career after obtaining an MBBS, all my jobs were in ENT. I had not done any jobs in general surgery, whereas Final FRCS was a general surgery FRCS. So I needed to sit down and read general surgery and attend some general surgical clinics. I then attempted the final FRCS in Edinburgh in 1967.

Now I am Mr Oswal, FRCS (1967)

Success!. During the successful attempt, there was a case of bladder infection or something. 'Have I done a PR (finger examination of the back passage)?' Be honest and say NO. 'Why not?' Tell a lie: 'Registrar told me not to, since it was uncomfortable for the patient'.

There is a knack for passing examinations. To my mind, any question such as the findings of a PR examination was irrelevant since, as an ENT surgeon, I was never going to do a PR!

Why are surgeons addressed as Mr / Mrs and not as doctors?

Training in Medicine:
Historically, in the Middle Ages, *physicians* had to get formal university training to get a degree in medicine before entering practice. It gave them to the title of 'Doctor of Medicine' or Doctor.

Training in Surgery:
Until the mid-19th century, there was no formal training for ***surgeons***; they usually acquired surgical skills by serving as an apprentice to a surgeon.

After 1745, the Surgeons' Company conducted examinations. After 1800, The Royal College of Surgeons took over this task. When successful, an award was a diploma and not a degree. Therefore, they could not call themselves 'Doctor' and stayed instead with the title 'Mr'.

Outside London and in the large cities, the surgeon served as an apprentice like any tradesman, but did not necessarily attend any examination. Today, all surgeons have to take examinations to be able to practice as surgeons. However, the tradition of a surgeon referred to as Mr/Miss/Ms/Mrs has continued, meaning that in effect, a person starts as Mr/Miss/Ms/Mrs, becomes a Dr and then goes back to being a Mr/Miss/Ms/Mrs again!

Modern-day surgical experience requires advanced and detailed knowledge and technical skills in the chosen speciality, usually identified by an anatomical region, *e.g.*, ear, nose and throat; ophthalmology; neurosurgery etc. The speciality name is also on a tissue type, *e.g.*, orthopaedics, or age group, *e.g.*, paediatric surgery. A general FRCS examination from each Royal College is now with the Intercollegiate FRCS. As of 2019, the Royal Colleges held specialist examinations in as many as ten surgical specialities and General Surgery in two parts.

What is the difference between a GP and a specialist? The GP knows a little about the lot, whereas the specialist knows a lot about a little!

Coventry

Coventry,[19] the ninth-largest city, is in the West Midlands in England. It is nineteen miles from Birmingham. It is also the most central city in England, being only eleven miles (18 km) south-southwest of the geographical centre of England in Leicestershire.

The ENT department in Coventry

There were three consultants, Mr Roland, Mr Waldeck and Mr Rice and a full-time clinical assistant. Two SHOs, a registrar and a senior registrar, worked in the trainee grades. The outpatient services were at Coventry and Warwickshire Hospital and the inpatients at Gulson Hospital. There were peripheral clinics at Rugby, Nuneaton and Keresley. The latter two also had operating lists. As a senior registrar, I had a lot more responsibility in the department. My operating was at an advanced level. In addition to the routine nasal and pharyngeal surgery, I was performing mastoids and stapedectomies independently. I was the first assistant to Mr Roland in all H & N surgery, at times, doing the surgery independently. Peter Roland came to rely on me heavily to look after all patients, including his private ones.

My several postgraduate diplomas and degrees had one unforeseen benefit. The theory gets read so many times. And, if one fails an examination or two, then there is an added benefit of consolidating your knowledge by reading books yet again! I had seven revisions: once for DORL, once for DLO, twice for MS, and three for FRCS. The upshot of this was some advanced clinical acumen, described below.

Some interesting clinical cases

I correctly diagnosed a rare case of Frontal Lobe abscess secondary to frontal sinus infection with classical symptoms of headache, loss of orientation and confusion.

Once, following private Oesophagoscopy, a patient developed tachycardia, rapid breathing and surgical emphysema. I could not contact Mr Roland since he had not reached home yet. I went ahead and arranged for a chest x-ray and a thoracic surgeon's opinion. Mr Roland appreciated my initiative.

A patient presented with an enlarged lymph node in the posterior triangle of the neck. A 'blind' biopsy of nasopharyngeal tissue confirmed squamous cell carcinoma. Another patient had repeated oral infections. The registrar who saw him missed Ca of the floor of the mouth. It is not unusual for ENT surgeons to reach for a tongue depressor and put it in the patient's mouth. The tongue and the depressor hide the pathology of the floor of the mouth. The correct way to start the examination of all areas of the oral cavity is visual, without the depressor.

Likewise, insertion of the nasal speculum hides the carcinoma of the nasal vestibule underneath. Everting the nostrils and examining the vestibule will clinch the diagnosis. If missed, the patient will present again with pain due to infiltration of the cartilage. An alar collapse causing nasal obstruction is similarly missed due to insertion of the speculum.

Suppose an anatomically successful septal surgery fails to improve the patient's symptoms of nasal obstruction as expected. In that case, there may be a mulberry posterior end of the inferior turbinate obstructing the posterior nasal cavity. When endoscopes were not yet invented, shrinking the mucosa with a decongestant would show an enlarged posterior end of the turbinate.

Acute loss of voice during warming up session - an actor's nightmare

Mr Norman Punt, an ENT surgeon, practising in London, had a particular interest in the singing voice. I had attended one of his lectures on the topic of the singing voice. He had designed a laryngeal syringe with a curved cannula to spray the vocal folds with Benadryl, a vasoconstrictor.

In the Belgrade theatre in Coventry, one evening, a singer was due to perform. During the warming up session, he suddenly lost his voice and came to the ENT department. I remembered Mr Punt's lecture. I sprayed his vocal cords with Lignocaine anaesthetic solution. After a few minutes, he recovered his voice. He was most grateful for saving his performance. He sent me two complimentary tickets in the front row!

In the Proceedings of Royal Society of Medicine (1968), Mr Punt writes:

'It is often said that any local treatment can have only a brief effect and is therefore not worthwhile. This is only occasionally true. If the artist can have a single performance made vocally easier for him, then the larynx may have sufficient chance to recover; alternatively, treatment may be repeated daily until the performer is able to rest – perhaps up to Saturday, after which he may be able to be silent until Monday evening.'

I think with today's knowledge, the condition would be diagnosed as muscle tension dysphonia, perhaps.

The Belgrade theatre acquired its name in recognition and thanks for a gift of timber from the Yugoslavian (today Serbian) capital city of Belgrade (Coventry's official sister city), used to extensively construct the auditorium.

A wedding ring – not too tight, not too loose!

In the sixties, in a stapedectomy procedure, a fat-and-wire prosthesis replaced the Stapes. A question often arose as to how tight the loop around the Incus should be? Too tight, and the process would suffer avascular necrosis. Too loose, and the sound vibrations would not be transmitted.

The sound advice was 'It should be like a wedding ring – tight enough to work but loose enough to come out if it did not work'.

In 1968, there were many cases of deafness due to otosclerosis. They wore hearing aids to help them hear better. When the stapedectomy procedure came along, there was a large caseload. As a senior registrar, I was doing three stapedectomies a week with fat-and-wire-prosthesis. A stainless steel mould had studs on the surface. You take some fat from the ear lobe, tie a steel wire knot on it, then wind it around the studs – it produced a shape of the prosthesis which looked like a question mark: ?. The hook end went around the long process of Incus, and the fat at the other end sat in the oval window. The surgery was under local anaesthetic. The hearing was tested preoperatively by asking the patient to repeat numbers voiced by the surgeon at a distance measured in feet. The same test, repeated at the end of the surgery, showed the successful outcome instantly – the patient sometimes shouting, 'Yes, I can hear now.' This time, the patient was able to hear from many feet away. A thrill for both the patient and the surgeon, no need to wait for the audiometry!

Academic activity

I have always been academically minded. There is so much to learn, with eyes and ears open! I attended quite a few lectures at the clinical meetings of the Midland Institute of Laryngology and the Royal Society of Medicine (RSM) proceedings in London. Mr Roland regularly attended the RSM day for ENT. I also went with him many times, enriching my knowledge with many advances in ENT through attending these Lectures.

Lectures on vertigo to aircraft industry personnel

I gave a talk on vertigo to aircraft industry personnel. Space technology and supersonic flights were making news in the sixties, so obviously, sensory illusions experienced by pilots were topics of interest.

Military tank testing

A manager of the tank testing facility consulted the department for advice on the noise level. A tank struck a two-foot thick wall to test the crumple zone on the tank. The testing made a deafening bang. I gave them information on ear protectors available at that time. I also advised periodic monitoring of the hearing levels of workers within a specific range.

You are the greatest in Rhinoplasty

A surgeon from the US said about rhinoplasty: 'I ask the patient why he or she chose me for the surgery. If the patient says, "Doc, you are the greatest," watch it, he / she is a potential trouble maker, you may end up with a law suit on your hands. On the other hand, if the patient says he / she has seen the result of a friend's Rhinoplasty you had done – that's great.' Many of his patients had an unstable relationship, and they put it down to the looks, ending up having all sorts of facial cosmetic surgery. None of that, of course, mended their disturbed relationship.

Temporal bone dissections – 'I am not a potato-and-onion man'

Every Saturday morning, I dissected temporal bones. One day, Nirmal said that I should go out shopping with her and Neena. 'The doctor on the first floor, his wife and little girl always do the shopping for vegetables and groceries together.' I told her: 'I am not a potato-and-onion man. We will go together if we need to buy big ticket items such as fridge or furniture. I need to do dissections to learn mastoid surgery.' Unlike many other professions, a career in medicine is usually hard on the family. I acknowledged Nirmal's help in all the books I have written and edited. Recently, in one of the conferences, I confirmed her contributions to my career by showing a slide of her wearing five different saris and posing for a photo: 'It is usually said that behind every successful man, there is a woman. I have all five of them'.

Sacrifices to study for post-graduation

I don't think people realise what sacrifices a doctor or a surgeon has to make to gain the knowledge and surgical experience and then pass examinations. When Neena was a child, I really could not play with her or take her for a walk – things other fathers usually do while raising a family. And even when an appointment to a substantive post comes along, the workload and responsibility are enormous, compared to many other professions.

I pay the same taxes as you do

A colonial relic, a consultant anaesthetist who came to do our list, had a chip on his shoulder. He once remarked to me that, as compared to India, I must make a load of money here. 'Yes,' I said, 'I would – if only I did not have to pay taxes the same as you do and buy the goods in the shops at the same price as you do.'

He also had a grudge against Mr Roland, who was of a different faith. Once I was waiting in the changing room with my regular clothes still on. Mr Roland asked if the anaesthetist was there yet. I said, 'No.' He told me to get changed so that he would know that we were waiting for him and not the other way round!

Condescending attitude to others

A young female nurse inadvertently entered the male surgeon's changing room, apologised for the error, and went straight out. The anaesthetist said to her, 'Come in dear, if you have not seen it before, there is something worthwhile to see. And if you have seen it before, there is nothing new to startle you.' These days, he will be castigated for such language.

All done, time to go home

I had no other plans on hand after I passed my M.S. in 1963. I came to England because I was academically minded; I wanted to continue further studies and get more surgical experience. Coming to England fulfilled both my goals. I also gained valuable surgical and clinical experience at the highest possible trainee level – Senior Registrar, a post with a workload almost at a consultant level. The maximum tenure was for four years.

Neena was getting older, and soon her schooling would assume a vital commitment in our lives. Time to settle somewhere to start my independent practice.

It had been over five years since I had left India. I was yearning to see my family and friends again. Nirmal was also keen to visit her family. A short visit to India would also give me an insight into starting my practice either in Pune or Mumbai. During Neena's Easter break, we all went to India. We were returning to India after a foreign trip – still a significant event. Moreover, I had also obtained the well-respected qualification of FRCS, with surgical experience in England.

Huge reception at Mumbai's Santa Cruz International Airport

First visit to India in 1969, after six years in the UK

There were at least fifty people – my family, Nirmal's family, neighbours, friends – everyone wanted to be part of this big event. As per tradition in India, several people had brought garlands for us to put around our neck, a traditional welcome. After a long five years of being away, the reunion was emotional. I wanted to meet my close family individually, my parents, brother, family, sisters and their families, my in-laws, and their family.

Neena's first ever experience of India at the age of four

From Dr Oswal, MBBS (1960) to Mr. Oswal, MB, MS, FRCS, DLO, DORL (1969)

Did I ever think of what a child of four would think of a land, its people, the culture, the language - so very different from what she was used to in England? No, I did not. At the airport, they all wanted to see the new arrival - Neena. Our little four-year-old was utterly overwhelmed. My brother lovingly picked her up – she told him: 'Put me down, put me down.' He could not understand her 'British' accent and asked me what she was saying!

During a train journey, as more people came in, Neena had to move closer to us.

'Dad, I am being squashed, I haven't got enough room.'

'Neena there are lots of people in India, so we have to share seats.'

'Oh, OK.'

'Oh, look dad, the cow in the road. She should be in the field.'

Her Grandpa had a complimentary remark for us. 'Every child coming to our home just goes everywhere and touches everything.

For the first time ever, I have seen a child sitting happily with her sketchbook. And when we give her something to eat, she first looks at you to know if she should accept it.'

In India, out of affection, everyone wanted to give Neena something to eat. She would always look at us. We would say to them , 'She would not take anything from anyone; we are not used to it.' My agenda about Neena eating was more practical: spicy food, hygiene, tummy upset, miss the flight back, etc.

Where is my youngest sister Sunita?

When I left India in 1963, Sunita, my youngest sister, was a little girl of about eleven years old, in a dress. That image of hers had frozen in my mind forever. 'Where is Sunita?' I asked. A grown-up girl, fully clad in a sari, came forward. I ignored her, still looking for that Sunita of 1963. She got upset and tears came to her eyes – they told me that that *was* Sunita. Time plays tricks on you. I now have two Sunita's – that child in the dress I still want to see, and the other in a sari whom I have to accept as Sunita.

Nirmal's father had arranged a little get together at his home. In a fair-size room, we all sat down for refreshments. Everyone was eager to hear all about England.

Language difficulty in reverse!

When we came to England, I must have been still speaking in Hindi with Nirmal, although we both really cannot recall that with any degree of certainty. When Neena was born, we gradually and seamlessly slipped into English as our first language. Nirmal was not vocal to start with, but she slowly got fluent in English. Since Nirmal learnt English as a spoken language in England rather than a curriculum in schools in India as I did, her English sounds more 'local' than mine!

So when we returned to India after a long stay of five years in England, we found it impossible to find words in Hindi or any other local language we spoke before coming to England. I continued in English to tell them about England, my father translating it into the local language after every sentence. I felt so embarrassed, but I could not help it. It took me three or four days to hold a conversation partly in the local language.

During the British Raj, speaking in English was a sign of higher placement in society. It also had a tinge of showmanship. Some of my relatives thought I was deliberately speaking in English to make an impression – a foreigner returned, belonging to the upper echelon of the society!

What is England like?

A Wiki definition of England is apt:

> 'The welfare state of the United Kingdom comprises expenditures by the government of the United Kingdom intended to improve health, education, employment and social security. The UK system has been classified as a liberal welfare state system.'

In the sixties, today's globalisation was not even a conceptual term. The nations were separated by 'seven seas', at least metaphorically, and there was very little knowledge of the world at the grassroots level of the communities of India. Literacy and the knowledge base were very low.

In the late sixties, television was not a common household item in India. Daily transmission began in 1965 as a part of All India Radio (AIR). Television service was later extended to Bombay and Amritsar in 1972. Up until 1975, only seven Indian cities had television services. Travelling abroad was limited to business people or rich people. Some of my distant relatives came from remote villages, so they were even less knowledgeable of the world outside!

The British left India in 1947. However, even some twenty years later, in 1969, the colonial rule remained permeated into everyday life in India. For them, a first-hand impression of England from someone like me was much more interesting than newspaper edits written by a reporter.

The following is the gist of many questions and statements during that first day.

- Do they grow rice there?
  No, it is too cold. Only wheat, barley and oat are grown.
- Do they grow chilli there?
  No, again, too cold. Cauliflower, cabbage, carrot, peas, tomatoes, potatoes, and onion are grown in summer. Vegetables are boiled and eaten bland.
- A bunch of coriander costs an equivalent of 100 rupees in England.
  Oh God, so expensive, here in India, it is only a few Rupees.
- What do people do?
  State and local authorities employ many hundreds of thousands. Others have businesses, shops, farming, etc.
- All education is compulsory and free (yes, even university education was free in those days, I did not have to pay any university fees for Neena's dental terms in 1984-89, in the University College, London). So is all medical help. There is unemployment benefit, sickness benefit, maternity allowance, housing allowance, state pension on retirement. It is a welfare state.
- There is no bribery or black market.
- It rains anytime, any day, all year-round. The sunshine is irregular since clouds come anytime and cover the sun. Smoke comes out of chimneys from fires for heating homes and further blocks the sunlight. It is called smog.
- It is freezing in winter, with snow falling anytime.
- In winter, it gets dark at four o'clock in the afternoon – the day breaks at 8.30 or 9.00 in the morning. But in the summer months, there is daylight up to ten in the evening. The day breaks at 4.30 in the morning.
- The hilarious information was that it is usual to have a bath on Thursday evening; all clothes are washed, dried and ironed, ready for the weekend. The wage was weekly and not monthly, and so on.

I recall an amusing example of how little knowledge there was in India about the rest of the world. After a short business trip to England, a person returning to India told his friends that everyone in England speaks English, everyone is so highly educated. Of course, in India, speaking in English was a sign of education at a high level!

I also think that the bigger the country, the less the knowledge of other countries amongst the general population. The day-to-day domestic news of local interest is so relevant that there is hardly any mention of world affairs on populist television shows.

During my recent visit to India in January 2019, a significant number of people had not even heard of 'Brexit', let alone know about the intricacies of ongoing negotiations. (I think many of us here don't know either!) And the US lump all the non-US world into one phrase, ROW – Rest of the World!

Return to Pune, my hometown

It was exciting to return to my home – a flat in a dilapidated building. But it was home; it was heaven. I met up with some classmates – medical and non-medical. The holiday was only for three weeks, so I decided to get on with making enquiries about instruments, equipment, and a rental place to start my consulting, a hospital to operate and so on. Further consideration was whether it was going to be Mumbai or Pune.

Nirmal's father had three flats in Mumbai, which he rented out. He had very kindly allocated one of his flats for us when we returned to India for good. However, I was determined not to accept his generosity; it was against my grain to take any favours, gratuities, short term loans, gifts or whatever.

Potential patients

Patient referral to a specialist was by the general practitioners (GP). They also came directly, but only to established surgeons of some standing. I have been away for five years, so I did not know even one GP who would send me ENT patients!!

Instruments and equipment

A supplier showed me the range of locally made instruments. They lacked the quality I was used to in England. Some fine instruments for mastoid surgery and stapedectomy were just not available locally. The drill and the operating microscope had to be imported with hefty import duty.

Hospital attachments were few and far apart. They were honorary, and the 'inner circle' of surgeons got them, not an outsider like me. Moreover, there was an air of hostility on account of my foreign postgraduate qualification. And annoyingly, my MS batch mates were well-settled and had a five-year head start behind them, with property, family and a car or two.

Thus, I found myself totally overrun and at a disadvantage of having a foreign qualification, a very English daughter and a wife who was beginning to adopt the English culture. If, on the other hand, India still would have been under British rule, or soon after the British had left, I would have received much respect for my high achievement and status as a foreign-trained surgeon. Worse still, I had no hope of getting any financial help from my parents, and I would never accept any help from Nirmal's father.

The three weeks passed very quickly, the holiday was over, and now it was time to return to England to resume my senior registrar duties in Coventry.

Back to Coventry

Having taken stock of the situation in Mumbai and Pune about settling back in India, I analysed that there would be some minimum requirements to make a start.

- I needed to buy some fine micro-instruments like the ones I used in England.
- I also needed to acquire a decent operating microscope from Zeiss. There were some refurbished models I could buy at a reasonable price.

- I would also need some capital to sustain a family of three in a metropolis city such as Mumbai, which was not cheap. The alternative was Pune – perhaps.

Resource for finance

In the sixties in the UK, the trainee grades' salary was minuscule. It was sufficient for a family like ours to live on, but one could not save significant money to generate capital.

The health service in the Middle East and North African (MENA) countries started expanding on the strength of their oil revenues. However, having no structured base, their governments looked to the Western Countries for expertise in the health sector.

Advertisement for recruiting an ENT specialist for Libya

I came across an advertisement for the recruitment of an ENT specialist for the Kingdom of Libya. The salary was at least four times the SR salary in England, and it was tax-free. In addition, housing, schooling, travelling and many other benefits were also generous.

The financial reward was thus substantial. I worked out that in two years, I would be able to buy all the equipment and instruments to start a private practice in India. After considerable pondering, I decided to apply for the job. It was May 1969.

Kingdom of Libya

In the mid-20th century, the Ottomans, the Italians, and the British were still fighting over this land.

In World War II, Idris allied with the British to try and end Italian occupation with their North African Campaign. It helped the British defeat Italy and Germany in Africa in 1943. In 1949, the British were instrumental in enabling Idris to announce the independent Emirate of Cyrenaica. Later, he was also elected Emir of Tripolitania. Libyan unification followed. In December 1951, Idris proclaimed the United Libya Kingdom,[20] naming himself as the King. The country lacked resources, and poverty, disease and illiteracy were endemic. Idris closed deals with Britain and the US, allowing them to build military bases in Libya. In return, they provided funding to modernise the Kingdom.

Libya granted multiple concessions to Esso, Mobil, Texas Gulf, and others,[21] resulting in significant oil discoveries by 1959. On the back of oil revenue, Libya prospered in the sixties.

The offer of an appointment as an ENT specialist in Libya

Within a few days of my application, I received a letter from the Libyan Government, offering me the appointment. At last, I had some direction to finance my private practice in India. I told Nirmal that Libya is no place for family life; they should go to India. I would join them in a couple of years after I completed the necessary purchases. I replied to the Libyan Government, accepting the appointment.

Next, I put a resignation in for my SR job in May 1969. The notice period was three

Kingdom of Libya
MINISTRY OF HEALTH

المملكة الليبية
وزارة الصحة

4th May 1969 التاريخ

P.O. Box No. 204
Tripoli, Libya ملف رقم

Dr. V.N.Oswal, M.S. F.R.C.S., D.L.O., D.O.R.L.
Whitley Hospital
London Road
Coventry
England

Dear Dr. Oswal,

I acknowledge your application for employment with this Ministry, and after having seen your qualifications I am pleased to offer you the post of E.N.T. Specialist at an annual salary of £L2,400 on a two year renewable contract. You will also receive a housing allowance each month, plus a furniture allowance amounting to three months basic salary for a married person, or half this amount for a single person.

If our offer is agreeable to you please inform us by cable in order to send you the appropriate air ticket from London to Tripoli. Also, kindly let us know if your wife and child will be travelling with you so that we may send them air tickets too.

Full employment proceedings will be carried out on your arrival in Libya, including the signing of your contract. Will you also advise us by cable of the exact date and time of your arrival in order to arrange your reception.

Yours sincerely,

ABDULMONEM GHARIANI
Undersecretary
for Administrative Affairs

AG/AT/vpr.

months. The effective date would thus be the end of August. I had some holidays so that I would go to Libya in the first week of September.

When we came to England in 1963, we had a couple of suitcases and cabin baggage. Some six years later, in 1969, our household collection required ten wooden crates. These were stored in a warehouse and were ready to be shipped after Nirmal had gone back and settled. Nirmal and Neena left for India in August 1969.

Visa for Libya

I needed to get a visa for Libya since I had an Indian passport. So I travelled to London on Monday September 1, 1969 to reach the Embassy by early afternoon. At the Embassy entrance, an armed London Bobby (police officer) was guarding the Embassy. He asked me why I wanted to go into the Embassy. I told him that I had come to get a Visa and showed him my letter of appointment. He said, 'Don't you know, there has been a coup last night and the King has been deposed?' I told him: 'No, I don't. What happens to my appointment?' He said, 'Go in and ask them.'

I went in and showed some people in the room my appointment letter and asked them if they would give me a visa. I distinctly remember a remark by one of them: 'We don't even know if we have our own jobs, let alone any authority to give you a visa.'

King Idris (L) and Col Gadafi

Colonel Gaddafi ousted King Idris in a Coup d'état

It transpired that overnight, in a bloodless coup d'état, a twenty-seven-year old Libyan Army Colonel, Muammar Gaddafi, had ousted King Idris I of Libya.[22] A group of twelve young officers had formed the Revolutionary Command Council that implemented an end to the Monarchy. At the time of the coup, the King was in Turkey for medical treatment. King Idris's nephew, Crown Prince Hassan el-Rida, announced his 'voluntary abdication' from serving as the 'acting monarch'.

I left the Embassy and made my way back to Coventry. The speed with which the events were unfolding was staggering. A well-paid job on which I had planned my future had overnight disappeared into thin air. I had no job in Coventry any longer since I had resigned three months ago. Nirmal and Neena were in India, and all our belongings were in the warehouse.

It was reminiscent of my few days in 1960, when I left home in Pune looking for a house job in Mumbai, but without any success. A doctor without a job in India in 1960, and again, a doctor without a job in England in 1969. If my luck was playing jokes with me, it was not funny.

Can I have my SR job back, please?

The next day, I phoned the Birmingham Regional Authority and told them what had happened and asked if I could continue as SR for a few more months until I got myself sorted out. They were very sympathetic to my predicament. However, they could not extend my job since it was advertised. The Secretary of the Authority said, 'The only way you can be appointed to the SR post will be to interview you again with all the other applicants. And I can tell you that you will not be successful. The job is a trainee post, and you already have been trained for the past two years.'

A moment later, he said, 'But let me phone around and see if there are any long-term suitable jobs for you.' A few hours later, I received a phone call: 'They want a locum consultant for six months in Newport in Wales. Would you be interested?'

Locum consultant for six months in Wales

The ENT department in Royal Gwent Hospital in Newport had two consultants. One of them had a split contract with Cardiff. With my postgraduate qualifications, I was well received. The job was pretty routine, with some clinics, some operating and on-call rota.

I also had to go to another hospital to do a tonsil list. I cannot recall the hospital's name with any certainty, but it could have been County Hospital, some ten miles away, at Pontypool. I remember that the theatre was in a stand-alone building, with wards in another building. Both buildings were single-story, with a Victorian-era look.

Two children were laid on the trolley with their heads sticking out of the blanket at each end. Two porters, one at each end, wheeled the trolley to the theatre. The distance was no more than, say, forty feet. They were similarly wheeled back for recovery from the operation. If it was raining, the porters would have umbrellas covering the children completely.

At the main hospital, I did mastoids and nasal surgery.

Nirmal and Neena back to England

I wrote to Nirmal to tell her what had happened. Unbelievably, they had been in India for no more than four weeks before they were on the way back to England.

We found a rented accommodation in a small village called Blackwood, about fifteen miles from Newport.

Have you thought about staying in this country as a consultant?

The consultants in the department were very friendly. They appreciated the experience I had at an advanced level of Senior Registrar. One day, the Senior consultant asked me: 'If you have as yet no concrete plans for yourself back home, have you thought about staying in this country and apply for a consultant job?' He opened the British Medical Journal (BMJ) and looked at the job advertisements. There were two jobs in that issue, one at Weymouth and the other, coincidentally, at Middlesbrough! 'Middlesbrough,' he said. 'It is an industrial area, a lot of disease there, you will do well. In Weymouth, there are mostly the pensioners and old people. You will end up fitting hearing aids!'

Appointment as ENT consultant (1969)

The Middlesbrough consultant position was at the North Riding Infirmary, the same hospital where I had started my first job as Senior House Officer (SHO) on arrival from India in 1963! The vacancy could have been anywhere in the UK. But no, it was in Middlesbrough. Equally, the Middlesbrough job could have been advertised a month earlier or a month later. But no, it was in the issue that the consultant in Wales opened the BMJ to look up a job for me. What a coincidence!

My interview was at the Newcastle Regional Health Authority. There were three other candidates. The two consultants, Martin Horowitz and Frank Fleming from the Infirmary were on the appointments committee. Of course, when I was SHO there in

1963, Martin had just been appointed as consultant, and Frank was Clinical Assistant. Frank had passed his FRCS examination in the late sixties and was now a consultant.

The interview was pretty routine, nothing remarkable! They asked me if I had visited the hospital before the interview – as was customary. But I had not; I would have felt uneasy if my visit would have seemed like soliciting them. So, no. I had not visited but had enquired from some of my friends who were there recently. I was aware of the progress the department has made since my days there.

They offered me the appointment, and I accepted it. So, as luck would have it, there I was, I came to England to a house job in the backwater of England called Middlesbrough in 1963. And again, I was going to be a consultant in the same backwater of England.

After the interview, both Martin and Frank congratulated me. Then, Martin said, 'Neither of us does head-and-neck surgery. Would you take it up?' Shell-shocked, without a thought, I said 'Yes.' In the sixties and the seventies, only a handful of ENT surgeons performed neck surgery; most departments sent the patients to general surgeons. But, as I came to know later on, Martin Horowitz wanted to make the ENT department at the Infirmary 'self-sufficient'. I give him great credit for this foresight. As an otologist, he established one of the most modern audiology departments in the country.

A king in exile?

On November 11, 1963, I entered the Infirmary as a candidate for a House Officer job. On April 1, 1970, I entered the Infirmary again, this time as consultant ENT Surgeon, something which could happen only in a storybook!

If the British have any issues with me, then 'Blame Colonel Gaddafi. He deposed two kings, one from Libya and the other from India!' So, I am not an immigrant here; I am a 'King in exile'.

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Section IV

Consultant ENT Surgeon (1970 ~)

ENT consultants in the UK in the seventies

In 1970, when I was appointed to the ENT consultant position at the North Riding Infirmary in Middlesbrough, there were only 350 consultant ENT posts in the UK. An appointment was competitive, and it was quite an achievement to be a consultant for an overseas graduate like me. In fact, in 1970, there were only three ENT consultants of Indian Origin in the whole of the UK, and I was one of them!

Consultant contract in the 1970s

Historically, the foundation of the NHS in 1948 was very much dependent on the consultants with private practice agreeing to give some of their time to the NHS hospitals. A half-day work, consisting of three and a half hours, was counted as one session. The clock started ticking when the consultant left his home or his practice, whichever was closer and ended on return. Thus, the travelling time was counted as part of the session. Moreover, we also submitted a monthly claim form for the mileage allowance, which covered the notional cost of fuel and the maintenance of the car. The pay was based on a sessional remuneration and was paid pro rota according to the choice of contract.

Then there were some sessions called 'notional sessions' for the non-patient-contact work of a consultant – dictating letters to the GPs, training the doctors and nurses, and being on-call and so on. So, in effect, this meant that the clinical sessions, where one has patient contact, were six for a part-time nine-session contract or seven for a full-time eleven-session contract.

As a self-employed person, the consultant was free to do the work as he/she saw appropriate. Most part-time consultants doubled up all their 'notional' session work during the regular outpatient clinic and did not come to the hospital for any of the notional sessions! Instead, they would undertake private work. Although all this was within the contractual terms and perfectly within the contractual obligation, nurses, porters, and technicians saw it as the consultants 'making a bomb' in their private clinic while also getting paid by the NHS. Therein lays the basis for the industrial action of the full-time staff supported by their unions, described later.

As independent contractors, they had to pay for and provide indemnity cover against any litigation arising from their NHS work. The Medical Protection Society and Medical Defence Union were the two prominent players in the field of the indemnity cover. All other staff, including the trainee doctors, were covered by the NHS, since they were 'the employees' and not the contractors.

Malpractice cases and compensation awards increased substantially in the eighties, and the annual premium for indemnity cover rose sharply. Following much discussion with the profession, the NHS took over the indemnity – Crown Indemnity. However,

it provided a cover only for any *clinical* issues. The consultants were still advised to get private indemnity for any disputes or complaints against the NHS and any private work they did in the NHS hospitals.

Part-time vs. full-time contract

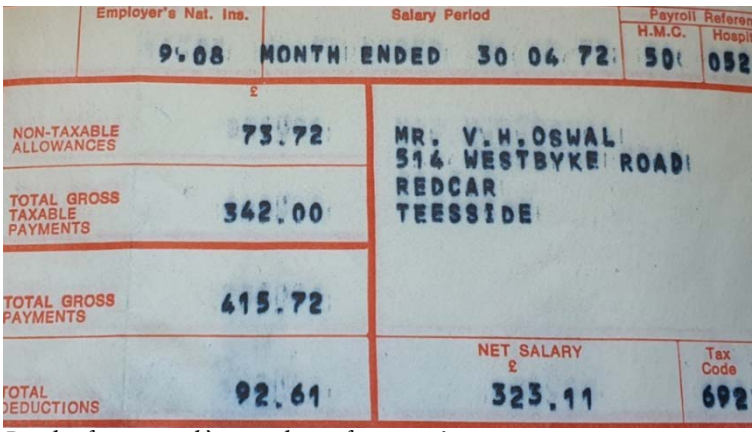
I opted for a part-time 9/11 contract. I still wonder why I chose a part-time contract. I think the sequence of wording has something to do with it. The Regional Administration Secretary asked me if I wanted a part-time or a full-time contract. So, I said 'part-time'. If he had asked me 'full-time or part-time', I am sure I would have said 'Full time'! As mentioned earlier, my Libya job turned out to be a non-event, and thus I wanted to fill in two years somewhere before returning to India, so, part-time or full-time was irrelevant.

It was also unprofessional for the consultant to take money personally. The private patient would pay the fees to the secretary or receive an invoice by post. A consultant's private consulting room was amongst the very few places where you got the services without paying for it on the spot.

Advertising of private practice was not allowed. A telephone book entry was limited to the name followed by only one professional qualification. The nameplate on the consulting room also had to be of a specified size to deter potential advertising.

Later in life, a part-time contract turned out to be a blessing for me; I gave up the private practice in the late eighties and used the free time for the development of laser technology.

Consultant salary in 1970



Payslip for a month's net salary of £323.11!

My annual salary was £2800 with automatic five annual increments. IIn 1972, it rose to nearly £4104 with a travelling allowance of £73.72 as the payslip shows.

After all deductions, I got £323 per month. It seems minuscule by today's standard. But the following example shows its buying power!

The half a crown coin was substantial money for everyday use. It was worth two and a half shillings, or twelve and half a penny in today's money! In 2021, a ten-pound note is probably

a day-to-day denomination, equal to (new) 1000 pence. A small hut at the Port Clarence end of the transporter bridge sold cigarettes, etc. Half a crown bought me a packet of ten Woodbine cigarettes (yes, I used to smoke, having started smoking as a medical student in 1955, was fashionable in American movies, an image of masculinity), the evening paper, a cupatee, and some change to buy a ticket for the bridge! I was a happy man just with that!

Before taking up my job, it was necessary to find somewhere to live. The consultant contract stipulated that I must live within ten road miles of the Infirmary to ensure that the out-of-hours patients (Casualty, now known as Accident and Emergency or A&E) were seen within a reasonable time. I made enquiries about getting a mortgage from Lloyds Bank, where I had opened an account. My NHS employment as a consultant made a fair bet for the bank to lend me the money. In theory, I could 'raise' 95% of the property's value as a loan. However, the maximum mortgage from the bank was 80%. Fifteen percent was to be covered by the insurance company for which I had to obtain insurance on our lives and pay monthly premiums, in addition to the mortgage repayment. The remaining 5% had to be paid in cash. Another condition for securing a mortgage was that the property's value must not exceed two and a half times my annual income.

Our first house: A link-detached dwelling for £ 4250 in 1970

A link-detached two-bedroom dormer house, valued at £ 4,250/-, situated on the outskirts of the coastal town of Redcar, nine miles away from the Infirmary, met all the above criteria.

From the bedroom window, we had a 'beautiful view' of the cooling towers of the ICI in Wilton village. The prevailing wind was westerly, so the emission went away from us towards the northeast most of the time. However, on still days, the emission was vertical, and there was a distinct chemical stench in the air. Sometimes furiously burning waste gases from the flare stacks chimneys lit the whole area up brightly.

The seller was a salesman in a carpet shop. So, fortunately, the carpets were of reasonable quality. However, apart from the carpets, the whole house was bare; everything was taken away, including the light bulbs – a norm for that era of the economy.

Since we never had any plans to live in England, we had nothing on us which could qualify as suitable for day to day living. In the beginning, we bought only the bare necessities – thinking back, they were kitchen and bathroom items – Baloo's 'Bear' necessities. Yeah.

Home-made furnishing

Most of the items we bought were by instalment (pay the purchase price in a certain number of agreed instalments). Curtain materials came. Nirmal and I made curtains, put up rails and draped them. Beds came for our and Neena's rooms. We ordered the sofa. For six weeks, we sat on the carpet in the evenings!

It was customary to rent a television. A miserable looking gas fire could not even warm itself, let alone all three of us. So, we sat as close to it as possible. I fitted the tube lights in the lounge to get enough light at a reasonable energy consumption of 40 watts per tube.

There was no wallpaper, so we painted the walls. Reading DIY books, we partly tiled the bathroom and kitchen. In the kitchen, I started tiling from the floor up. I found that the wall needed more tiles as I went up. Of course, the walls were not square. No walls ever are, only people who build them are!

Later on, I asked a paviour a quotation to pave the small garden in the back. I bought the flagstones of my choice and also sand and cement from builders' merchant to save money. When I came home from work, I found the paving flagstones were askew, with grouting lines getting wider and wider as you looked at them from the building line. I really could not see myself coming home every evening and not looking at that shoddy work. When I pointed it out to the paviour, he said 'your ruddy garden is skew-whiff'. I told him that I would pay him the hourly wage for however long it would take to lay them straight, but I wanted them straight. Some hours later, magically, all the grouting looked straight, even after a couple of glasses of wine.

The garage leaked when it rained. So, I got hold of a roofer. He said it was best to come when it is raining and locate the ingress of water. It rained; he found the leak, and on a dry, sunny day, repaired it. I duly paid the costs. It remained dry and sunny for the next few days. But then it rained, and the water came in again. I phoned him, but he said he was busy for the next couple of months and could not come. I got another roofer who felted the whole roof. It cost a lot of money, but then, it did stop the leak.

We had no furniture in the lounge or the bedrooms. I started reading a DIY book on how to make furniture. I bought tools and 8 x 4-foot (8 b 4, as it is called in the trade) melamine-faced 'Conti Furniture Boards'. I cut lengths with a jigsaw, made rectangular

Home-built coffee table for Neena's birthday party

boxlike structures screwed together, and put the shelves inside for storage. Then I cut a triangular shape piece, and screwed in three legs and voilà, there was a nice coffee table.

I fixed a towel rail in a slope of the roof of the dormer house for hangers. Then I fixed tracks and a made-up fascia with sliding doors – suddenly, there was a wardrobe. A luke-warm iron run over the self-adhesive edging tape imparted a finished look to all the furniture. Who said to be poor is no fun? Indeed, it is about your attitude to life, not the money.

Job description

I had clinical and operating commitments at two hospitals. The main hospital was at Middlesbrough, The North Riding Infirmary, and the other was at St. Hilda's Hospital in Hartlepool, seventeen miles from the Infirmary.

Town of Middlesbrough

Middlesbrough[4] is a large post-industrial town in North Yorkshire on the south bank of River Tees, northeast England. It was founded in 1830. The Iron and Steel industry dominated the River Tees area since Iron production started in Middlesbrough during the 1840s. Imperial Chemical Industries (ICI) also dominated the town in the last century, employing nearly 16,000 workers. Teesport is the third-largest port in the United Kingdom, handling fifty million tonnes of domestic and international cargo per year.

Middlesbrough is noteworthy for its Transporter Bridge,[5] and as a birthplace of Captain James Cook[6] (1728-1779), the famous British explorer.

The transporter bridge During my early days as a consultant, I sometimes used the transporter bridge (currently out of action for essential repairs) to return from Hartlepool. Built in 1911, it spans the River Tees between Middlesbrough and Port Clarence. It carries a segment of A178 Middlesbrough to Hartlepool roadway across the River Tees. The Gondola platform of the bridge is slung from a tall span by wires. When it was operating, it was the longest working transporter bridge globally, ferrying nine cars and pedestrians on its Gondola in 90 seconds. With its 850 feet (260 m) length and 225 feet (69 m) height, it dominates the geography of the area and remains an iconic symbol of Teesside's engineering and industrial heritage.

Captain James Cook was born in the village of Marton in Middlesbrough. He made the first recorded European contact with the eastern coastline of Australia and the Hawaiian Islands and the first recorded circumnavigation of New Zealand. To commemorate the explorer, the new 1000-bedded University Hospital was named James Cook University Hospital, where I worked as a Consultant ENT Surgeon.

Hartlepool

Hartlepool[7] is a small industrial town on the Northeast coast of England. It was founded in the 7th century. In the latter part of the 19th century, the industrialisation and shipbuilding industry made it a strategic target for the Imperial German Navy at the beginning of the First World War.

The ENT services in Cleveland

My base was at the North Riding Infirmary with outpatients, inpatients, departments of radiology, audiology, speech therapy and a pharmacy. There were three consultants, including me. Martin Horowitz and Frank Fleming worked only at the Infirmary, whereas I covered both the Infirmary and St. Hilda's ENT department in Hartlepool for outpatients and inpatients. In addition, the on-call consultant provided ENT casualty cover to both hospitals. Attending a casualty in Hartlepool required me to travel a sixty-miles round trip from home when I was on call. In later years, if a call came in the middle of the night, I used to get a taxi so that I could snatch a sleep of forty-five minutes before I got to Hartlepool.

ENT department at the Infirmary

The Infirmary was housed in a majestic Victorian building right in the centre of the town. The inpatients were in four wards: male, female, children, and tonsil ward with a bed complement of seventy-eight! A twin theatre suite with recovery provided the operating facility. Other accommodation was a library, a mortuary, and administrative offices. Mr Marshall, the consultant under whom I had my first job in England as a Senior House Officer, had retired and, sadly, died soon after, becoming yet another statistic of the day that doctors who work up to the age of sixty-five have their longevity limited to just two more years. Martin Horowitz was Administrative in Charge; a title later changed to a less imposing Liaison Consultant. Frank Fleming was promoted to the consultant post following his success at the FRCS examination. The third post was created to manage the increased workload due to technological advances such as surgery for deafness in adults due to otosclerosis and fluid in the middle ear (secretory otitis media). A registrar appointment was also added.

ENT department in Hartlepool

The ENT department was at St Hilda's Hospital, in the older part of Hartlepool known as The Headlands. The junior doctor support in ENT consisted of one registrar sent from the Infirmary and one resident senior house officer (SHO), but the SHO post frequently remained unfilled. House surgeons of the other specialities then provided the cover for the ward.

Dr John Berry, the general practitioner in the town, had considerable experience in tonsils and adenoid (Ts & As) surgery and undertook two lists a week. He also did submucous resection of the septum (SMR). In addition, he had outpatient clinics in ENT alongside mine.

One day senior registrar, next day consultant

An extensive experience I gained during all my trainee years was reflected when I became a consultant surgeon. One day I was senior registrar, the next day, I was a consultant – just a change of the title. I did advanced ENT surgery, including Head-and-Neck,

mastoids, and stapes surgery. During the first week of my appointment to the consultant post, I was performing a maxillectomy in a peripheral hospital at Hartlepool for cancer of the maxilla!

Car for Nirmal

Although her father had a Hillman, a Studebaker, and a chauffeur back home, he never allowed Nirmal or her sister Sushila to drive. It proved to be such a handicap when we settled in England. It was now necessary that Nirmal had a car so that I did not have to ferry her around. Moreover, once I left home in the morning, I was many miles away and could not help her with shopping. I gave her some driving lessons during the weekend. She took a few more from the driving school and got her drivers licence. My job involved a fair bit of driving, covering Middlesbrough and Hartlepool. We therefore decided that Nirmal should start using my Ford Cortina, which I had bought in Scotland, and I get another one for myself. The Cortina was six years old and would be ideal for local journeys. I bought a new Volvo for £ 1250.

Schooling for Neena

There were two schools nearby, a Catholic School and a Public School. Catholic schools[8] are distinct from their public-school counterparts in focusing on the development of individuals as practitioners of the Catholic faith. With the creation of the Church of England in the Elizabethan Religious settlements of 1558-63, the establishment of Catholic schools in UK and the Continent of Europe encountered various struggles. Anti-Catholicism in this period encouraged Catholics to create modern Catholic education systems to preserve their traditions.

The Catholic School told us that Neena would have to follow and attend all religious classes in keeping with this ethos. Religion has never been on our menu ever. Nirmal and I were born Jains, but never practised while in India. In England, we would say we are Hindus – to make it easier for others to write a more familiar word! I practised my religion at the Infirmary, all day, every day. That is where *my* God lived.

Thus, whereas we were not following even our own religion, we would certainly not be dictated by the Catholic school that Neena would have to follow Catholicism just to get enrolled. A child's tender age is hardly adept at choosing which God to worship. She could, of course, get confirmed when she reached an age of majority if she so wished. We enrolled her in the public junior school and, when she finished schooling locally, into the private Teesside Girls' High School for the secondary education. It also had a sixth form so that Neena could do her 'A' levels for university admission. The school was in Eggles-cliffe, about fifteen miles away. Neena had to be dropped off at Redcar Railway station to get a train to school.

Car wash for 20p

Car wash machines were not common. The cost per wash was 20p – not cheap on my meagre salary. So, I used to wash my car on the driveway. Neena usually gave me a hand.

As she got older, she did most of the washing, for which I gave her 20p, the same as the car wash machine, and asked her to save it in a piggy bank. The cost of the wash went up to 25p. Neena immediately asked for 25p. I said, 'If you want my business, do it for 20p or lose it to the machine wash. They provide me with water and soap without extra charge, whereas you will be using my water and my soap.'

One day she asked me if she could have £ 3/- to go on a school trip to Edinburgh. I told her I would give her £ 2/- and that she should take £ 1/- from her piggy bank to make up the cost. For two days, there was no mention of the Edinburgh trip. Then she agreed. Cruel? No. After all, she had her earnings saved in the piggy bank – just as mine, in Lloyds bank!

When she got a bit older, she bought herself soap of her choice – Imperial Leather – with her own money and told us it was 'her' soap. It had a rather nice smell, and I used it every day for a shower. The tablet got smaller in days. She suspected and pressed her hair in it as a marker. I got the message. So, I removed the hair gingerly, used the other side, and pressed the hair back again, exactly. I also volunteered to tell her a commercial secret that the company had a special ingredient, which made it evaporate quickly to increase their sales and make more profit. Now, to pay her 20p per car wash was a bargain for me.

Nirmal to earn money

Logically, Nirmal also should be earning. She was, of course, not qualified to take a clerical or secretarial job. All that she could do was cook Indian food at home. I came up with an idea of her making pakora – cauliflower, potato, and onion, dipped in spicy batter and fried. She said she could do it after Neena went to school. We found a corner shop that was ready to have a go at selling them.

Assembly of Biro ballpoint pen (BIC)

One day the owner asked her if she would put the tube containing the ink and the plastic holder together and make disposable ballpoint pens. Each day all of us made several hundreds and made some money.

Avon calling

The Avon brand[10] goes back more than 120 years when David H McConnell, an American door-to-door salesman, started giving scent bottles away with his books as a sales incentive. He soon realised that it was the perfume and not the books his female customers craved for! In 1886, McConnell founded the California Perfume Company, hiring women to sell fragrances door-to-door. The California Perfume Company was renamed Avon back in 1939 as he was visiting Stratford-upon-Avon and falling for its beauty.

The first British Avon ladies took to ringing doorbells with their Avon bags twenty years later. The iconic 'Ding Dong' advertising campaign was launched in 1954 with the Avon representative pressing the doorbell, which chimed the two-tone, 'ding-dong', rhyming with a voice-over 'Avon calling'! Nirmal was asked if she would become an

'Avon calling' salesperson and earn some money in the afternoon and evenings. The offer was way above assembling biros for pennies. She did an excellent job of it and indirectly became very knowledgeable about perfume, lipsticks, and such. She was also asked to take part in fashion shows, showing off the graceful Indian wear, the sari!

Nirmal showing off an Indian attire, a sari, during an 'Avon evening'

Nursery teacher

One day, the head teacher of the nursery where Neena went when she was little, phoned Nirmal and said that she had a couple of newcomers who were Asian and if she would like to help in the nursery, a few hours a day. This was, of course, a paid job. Nirmal was very happy to do something different and useful for the community. She stayed in that nursery for a good fourteen years. Years later, Nirmal used to bump into former pupils in our town, which always resulted in nice chats. Incredibly, only a couple of years ago, while taking a domestic flight, the flight attendant said to her, 'Hello, you were my teacher in the nursery school in Redcar when I was little.' It meant that Nirmal had not changed even now that she was older by a good forty years! Women usually retain their features well into their sixties and seventies; men don't. They go bald and, generally, look quite different.

Nirmal, a nursery teacher

Teaching, of course, is two-way traffic. Nirmal also learnt a lot about the communities, children, customs, manners, which boosted her confidence. Eventually, she started helping me in Cleveland International Courses and took over all the responsibility. I was delighted that through a combined effort by both her and me, she established her own identity and persona, mixing with wives and partners of the faculty and delegates, attending many international conferences and courses, all over the world.

Pasha – an Alsatian puppy during the medical studies in India

In India, having a pet is not common. Perhaps there are too many people as it is, and there is no room for animals. However, there are plenty of stray dogs. Dog bites are a regular occurrence. When I was a casualty officer in St Georges Hospital in Mumbai, one of my duties was to work in a regular morning session on weekdays for rabies vaccination. The vaccine came in a large ampoule, containing ten doses. Dog-bite patients coming in during the weekend were told to come back on a regular Monday session since opening an ampoule containing ten doses for one patient would go to waste if not used immediately. A patient once remarked, 'Doctor, can you tell the dogs not to bite on weekends?'

As a boy, I always wanted a dog – contrary to the Indian social norms. But we did not have enough room in our communal flat. When I moved out to my room nearer the medical college, I acquired an Alsatian puppy! I named him Pasha and kept him outside, near my room, in a basket. In the morning, I found that he made a mess in the middle of the night. I put the alarm on to wake me up at five am to take him for the walkies. But he had already emptied himself before my alarm woke me up. I set the alarm for an earlier time – this went on. It did not matter if I had set the alarm for one am; he would have emptied himself before that!

We never bonded ourselves since I was mostly out to the college. One day I found that he had just gone.

Years later, my friend Bashir and I saw a thin stray Alsatian dog and we called him: 'Pasha, come here.' And he came! We had found him, fully grown. We decided that it was not right to keep him and gave him to Bashir's family butcher. He grew beautifully with all that meat. We used to visit often and stroke him, spending some time there.

'We want a dog, we want a dog'

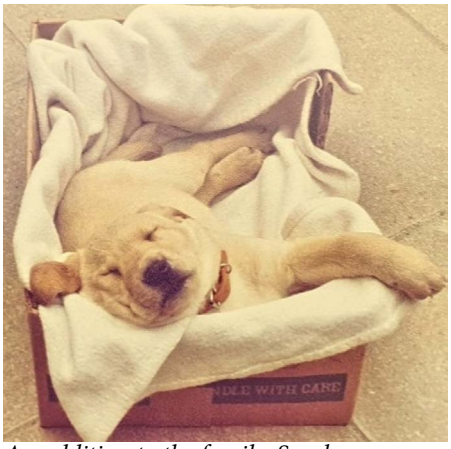
Within a couple of years of taking up the consultant job and our own house, I told Nirmal we wanted to get a dog. Nirmal said no, dogs bite – still the conceptually Indian way of thinking. I told her our dog would not bite us. A persistent 'no' continued. Then I planted an idea in Neena's head, and it took hold. Many of her school friends had pets of one kind or another. Now there were two out of three who wanted a dog. But Nirmal's objection continued unabated. One day, Neena brought in the news that one of her friend's mum-dog produced a litter of ten puppies – Labrador, and we could have one. That was it. A majority vote gave an ultimatum to Nirmal – if you still say no, then it is you or the dog. We two want a dog, so you will have to find somewhere else to live – in the garden shed perhaps.

Sandy

We all went to see the litter. This pup just came to us, and that was it – Sandy was in the car, in a little cardboard box.

With Neena and I being away every day, Nirmal had to look after him. How can you not pick up this little ball of wool in your hand? Before long, Sandy became Nirmal's pet – another child – looking after him, feeding him and telling him to behave himself.

I bought a few books on training a dog – even a police dog. He grew quickly and, in a year, was an obedient and therefore, a lovable pet, not a nuisance. Just like children, dogs also have to be raised.



An addition to the family, Sandy

Pets and the Covid-19 era of 2020

Having had to stay in our home for the past eighteen months, an urge to get a puppy came in waves. Nirmal, who was very much against having a dog in the seventies, mentioned it a few times without prompting! And I must say, now that I am spending so much time in the garden, I could do with a company. But with us in the wrong age group, we need to look after ourselves and not commit to a young pup. A news item appears regularly of pets acquired for company during the lockdown are now being abandoned, or taken to a rescue centre, or worse still, the pets are suffering emotionally for being left alone most days.

ENT services in the seventies under Northeast Regional Authority jurisdiction

When I took up the consultant position at the Infirmary in the seventies, there was only one Regional undergraduate teaching hospital, the Royal Victoria Infirmary (RVI), in Newcastle. The head of the department was Desmond Dawes. Another hospital, Newcastle General Hospital, also had an ENT department run by Ivor Frew and Charles Diamond. It did not take part in undergraduate training. The smaller towns had district hospitals that provided ENT service.

District Hospitals

Northern Regional Health Authority jurisdiction extended coast to coast. Middlesbrough, Hartlepool, Darlington, Sunderland, South Shields, Carlisle, and Barrow-on-Furness provided ENT services at the 'district' level. The ENT consultants in the district hospitals did not always have higher surgical training with FRCS, but

'Did YOU chew this pot?'
'No, it was Neena. Throw it in the bin, no good now'.

'Extended family?' No, our own family

'Sandy, watch fish'. Fish in the pond is fascinating for all, including the dog!

some experience and a diploma in Laryngo-otology (DLO). They provided a basic ENT service such as removing tonsils and adenoids, nasal polypi, cleaning discharging ears with suction (suction clearance), removing foreign bodies from the nose, air, and food passages, etc. The resident doctors in these departments were at the level of senior house officers (SHO). The Royal Colleges approved only some such posts for taking the DLO/FRCS examinations.

In 1963, when I arrived in Middlesbrough as SHO, Bob Marshall with FRCS did otology; Frank Fleming, a clinical assistant with DLO, did all the basic ENT surgery and took calls. Martin Horowitz, with FRCS, was appointed just at the tail-end of my SHO job in 1963. Martin was also an Otologist. There were just two resident posts in ENT. They provided a 24-hour emergency cover, ward work and some operating such as a tonsil list.

Things were not much different in 1970, when I joined the Infirmary as a consultant. Martin Horwitz had established himself as an otologist. Frank Fleming, although now in the consultant grade, continued to do much the same routine work as he did when he was a clinical assistant. When Bob Marshall retired, Ramu Tiwari was appointed to replace him. Thus, there were three consultants in 1968: Mr Horowitz, Mr Fleming, and Mr Tiwari. Mr Tiwari covered both the Middlesbrough and Hartlepool departments.

The changing pattern of the ENT workload in the sixties and the seventies

During my postgraduate trainee years in the sixties and early years as consultant in the seventies, the ENT practice witnessed a few significant changes due to technological advances. The major change was the operating microscope which replaced the binocular loupe. A later addition of the beam splitter to the operating microscope allowed an additional viewing tube for the assistant as well as a camera attachment for photography. The single tube was later replaced with a binocular attachment, providing a real-time view to the trainee, with surgeon's orientation of the operating field.

Gouge, chisel and hammer for mastoid surgery were replaced with a pulley-operated dental drill and later, a stable electric dental burr and air drills and the suction-irrigation system.

Schwartze radical mastoidectomy was phased out with a more conservative surgery of tympanoplasty and canal-up, canal-down mastoid surgery. Surgery for deafness was possible with myringoplasty, reconstruction of the ossicular chain and stapes mobilisation and later, stapedectomy for otosclerosis. Grommet insertion treated secretory otitis media, common in children. We made our own grommets with Armstrong's vinyl tubing and a scalpel knife heated on a spirit lamp!

In the seventies, we also acquired a wall-mounted microscope for the outpatients. A cheap version with a wobbling arm had to be replaced with a sturdy, more expensive one. You get what you pay for!

Introduction of Fractionated Radiotherapy reduced morbidity and became the first-line management of head-and-neck malignancy. All suspicious oral and laryngeal lesions were biopsied for malignancy, and positive cases were referred to the radiotherapy department at the North Ormesby Hospital. Patients needing bronchoscopy and esophagoscopy for foreign bodies and malignant lesions also came to the ENT department. On the other hand, there was not much change in the intranasal surgical procedures. Caldwell Luc and intranasal ethmoidectomy with curettes treated chronic sinusitis cases.

Referral of H&N cancer to general surgeons for surgical management

In common with most ENT departments in the country, the Infirmary did not undertake head-and-neck surgery. Frank Fleming biopsied failed or recurrent cases. Positive reports were considered either for surgery or for palliation since further radiotherapy was not an option. All cases needing surgical management of H&N cancer were referred to the general surgeons at the North Ormesby Hospital. Sometimes, if their theatre was not available, they came over to the Infirmary to operate.

Terminal cases

There was no hospice. Terminal cases were admitted for palliative treatment in a far corner of the ward. Terminal patients helped nurses; they washed, dried, and powdered rubber gloves for reuse in the theatre where they were sterilised. Disposable gloves and disposable syringes were yet to be invented and marketed. The history of disposable gloves[12] is interesting. The first disposable latex medical gloves were manufactured in 1964 by Ansell. They based the production on the technique for making condoms. All disposable gloves were variously powdered over the years to facilitate wearing them. However, powders were incriminated for granuloma formation and scarring, and their use was banned as recently as 2016.

Head-and-neck surgery at the Infirmary (1968)

Ramu was a general surgeon but moved to ENT. Thus, he was well-trained both in ENT H&N surgery for various conditions. I knew Ramu as a registrar in neurosurgery in Bombay Hospital in India when I was an SHO in ENT in 1960! Ramu started to do some H&N surgery at the Infirmary. Martin Horowitz was an otologist by training. Frank Fleming also did not tackle H&N cases.

Objection by general surgeons to ENT surgeons undertaking H&N cancer surgery

Ramu Tiwari started to do H&N surgery at the Infirmary around 1968. The general surgeons immediately raised their objection that H&N surgery is their field of surgery, and the ENT must refer such cases to them. It led to acrimony between ENT and general surgeons who considered H&N surgery undertaken by the ENT surgeons as an encroachment on their territory (of H&N).

Tribalism, based on anatomical regions, is very prevalent in the medical field. Perhaps, these days, most of it is driven by money in private practice. But in the old days, money was not the issue since most patients were NHS patients. Nevertheless, the surgeons' objection reached a fever pitch when Mr Tiwari did a private thyroid surgery. This and some other issues unsettled him, and he resigned.

After my successful interview for the consultant position, I was asked by Martin Horowitz and Frank Fleming if I would undertake H&N surgery for the whole department

since they were 'not interested'. Shell-shocked from having just been appointed as the consultant, I unwittingly accepted. Of course, they did not inform me about the strong objection by the surgeons. Even so, it would have made no difference.

My Head and Neck surgery training

There was no dedicated training module in the H&N surgery for the master's degree in Mumbai or the fellowship examination in England in the sixties. However, I was exposed to the H&N surgery during my training for the master's degree in Mumbai since the ENT consultants routinely undertook H&N surgery as part of their workload. Moreover, my first year as House Surgeon was under Dr LH Hiranandani, who operated exclusively on H&N patients. And he was known for his adept surgical hand.

Furthermore, part of the MS syllabus consisted of a practical examination during which the candidate was given an H&N surgical procedure to perform on the cadaver. My practical examination was external carotid ligation. In India, oral cavity cancer is common due to tobacco chewing, and many patients require extensive excisions. Surgeons routinely undertook external carotid ligation as a prophylaxis to reduce the incidence of postoperative bleeding.

In 1963, when I joined the ENT department at the Infirmary as a house officer, Bob Marshall, the ENT consultant, did only otology. Frank Fleming biopsied suspected cancer patients and referred them to the general surgeons at the North Ormesby Hospital for surgical management.

There was no exposure or training in the H&N surgery in Dundee either, where I worked as a registrar for two years, mainly with Alan Gibb, an otologist. Interestingly, Arnold Maran joined the department in Dundee soon after I had left in1966. After training in ear, nose and throat surgery in Edinburgh, Arnold had further training as a head and neck surgeon in the United States and returned to a consultant post in Dundee. This story shows us the lack of H&N surgical training even in a renowned centre such as Edinburgh. Arnold soon moved to Edinburgh, where he was awarded a personal chair in otorhinolaryngology by the University of Edinburgh. He established head and neck surgery training courses in collaboration with Professor Philip Stell of Liverpool. By this time, I was senior registrar in Coventry.

There, Mr Peter Roland did all the H&N surgery. As a senior registrar, I was the first assistant and also got to do some H&N surgery independently.

The lack of H&N surgery as an integral part of the ENT surgery until much later was perhaps due to the introduction of the operating microscope, which widened the scope of the surgical management of ear diseases. Improvement in radiotherapy for cancer led to it as the first line of management.

ENT as a speciality in FRCS did not exist when I took my examination in 1967. The Colleges awarded FRCS in general surgery. Therefore, my FRCS from Edinburgh in 1967 was in general surgery. Consequently, a qualified general surgeon could operate upon any part of the body he or she was competent with.

However, there is no doubt that although physiologically integrated, the ENT and the neck, each anatomical area presents a complex structure with its peculiarity and need dedicated training. Any ENT surgeon may have to tackle an accident and emergency case (A&E case), which requires some experience in H&N surgery. Exposure to H&N surgery during the training is thus desirable, as a summary of the following cases would show.

Cut-throat emergency

Soon after taking up the consultant appointment, as I was operating at the St. Hilda's Hospital in Hartlepool, I had a frantic phone call from the Infirmary that a patient with suicidal cutthroat injury was bleeding furiously in the theatre. One of my colleagues, who was on call could not control the bleeding. I was in the middle of an operation and asked one of the nurses to tell him that I would come over the moment I finished operating. In the meantime, he should press the bleeding spot with a finger and don't remove it until I get there. During the next fifteen minutes, calls continued, saying that the bleeding continued despite pressing the bleeder.

The cut-throat wound is not an anatomical incision. It is deep on the left side of the neck in a right-handed person, but it becomes shallow and irregular as it comes to the right side. Major vessels are never damaged since the taut sternomastoid muscles protect them as the person extends the neck during the suicide attempt.

As soon as I arrived, I put on gloves and went straight to the operating table. I converted the wound into an anatomical incision and identified the landmarks. The bleeding was from one of the superior thyroid artery branches, but the bleeder had retracted quite a bit under the skin and was actively bleeding, forming a pulsating pool of blood.

The cut vessels retract. Lifting the edge of the cut skin would show them. I ligated it, and the bleeding stopped. Then I scrubbed up and finished the surgery by stitching the incision.

Intractable epistaxis in a thirteen-year-old boy

A thirteen-year boy reported with epistaxis following a cricket ball injury to the side of the nose. A routine packing with ribbon gauze stemmed the bleeding but oozing continued through the dressing. My on-call consultant colleague took the child to the theatre to pack the nose under a general anaesthetic. Copious bleeding continued despite several attempts to pack the nose tightly. Another consultant colleague also joined him, but both could not manage to control the bleeding. I was in the outpatient. They called me to help them.

Examination showed pulsating bleeder in the high up in the anterior ethmoidal area. With a history of cricket ball injury on the side of the nose, I suspected the origin of pulsating bleeding from the anterior ethmoidal artery. I opened up the area lateral to the inner canthus and retracted the orbital contents; there it was, a torn anterior ethmoid artery amongst the fractured ethmoidal cells. By retracting the orbital contents further, I was able to see its course from the ophthalmic artery, but just. I asked for a stapler to staple it nearer the orbital end, but the NRI did not have a stapler. I got a diathermy needle, sucked the blood out continuously and placed the tip of the needle on the anterior ethmoidal aperture. The access was extremely limited, and any movement to press the pedal would move my instruments, so I asked my colleague to step on the pedal. The blood charred, but the bleeding continued. I repositioned my suction tip and continued the diathermy burn. After a few seconds, the bleeding stopped.

I asked him to continue pressing the pedal for a few more seconds and saw the char extending deeper into the ethmoidal cells. I gently removed the instruments, placed a gelfoam pack and stitched up. I removed all the packs. The bleeding had stopped.

Anterior and the posterior ethmoidal arteries arise from the ophthalmic artery, enter their respective foramina and supply the mucosa of the upper ethmoidal cells. They then turn superiorly, enter the cranium through the cribriform plate and supply the dura. If the torn vessel retracts intracranially and continues to bleed, it results in extradural (epidural) haematoma, a serious and potentially fatal complication.

Failed tracheostomy

A ten-year-old boy woke up with breathlessness and was brought by ambulance to the Infirmary. My on-call colleague decided to do an emergency tracheostomy. He was still operating on the boy when I arrived for my morning list. I asked if he wanted me to come in. The boy was intubated. I took over, got to his trachea and inserted a tube in. The child's breathing did not improve. I asked the anaesthetist if he had any difficulty in intubation – no, ruling out upper airway obstruction.

The obstruction was obviously in the lower airways. Asthma causes expiratory stridor, whereas inhalation of FB or vomitus causes inspiratory stridor. A subglottic or a tracheal lesion causes both inspiratory and expiratory stridor. The breathing was generally shallow in this child, without any expiratory or inspiratory stridor.

The Collapse of the lung – as a medical student in 1955 in India, I had seen a 'therapeutic' collapse of the lung in pulmonary tuberculosis cases. There were no antibiotics. Rest in bed, and supportive treatment was all that was available. Resting the lung by crushing the phrenic nerve was one other treatment. The patients typically had shallow breathing after the phrenic crush.

I asked the anaesthetist to listen to the child's breathing sounds. They were absent on one side. I diagnosed lung collapse due to rupture of a bulla - spontaneous pneumothorax. A portable x-ray machine wheeled to the theatre confirmed the diagnosis. We transferred the boy to another hospital to aspirate the air via a tube thoracostomy since we had no such facility or indeed expertise to manage the case at the NRI.

Loss of two lives following a tracheostomy

Acute epiglottitis was common in the sixties and the seventies. A pregnant woman was admitted to another hospital following a successful tracheostomy in the casualty. Unfortunately, half-asleep in the middle of the night, the patient tried to pull out the tracheostomy tube. It got displaced and could not be reinserted by the night staff or the resident medical staff. Two lives were lost. A displaced tracheostomy tube either comes out of the trachea completely or slips into the pre-tracheal space. Any failed attempts to reintroduce it results in a false passage in the pre-tracheal space.

Some surgeons stitch the flange of the tube to the skin to secure it firmly – drastic? No, not if it can save lives in a peripheral hospital in that era. Whichever method is practised, it must be one hundred per cent secure; there are no shortcuts to this life-saving bypass to breathing. We used to have an instrument 'tracheal dilator', much like a Killian speculum. The blades separated the soft tissue, providing a view of the opening in the trachea. A short Killian speculum can also be used for retracting the soft tissue. More importantly, all the resident ENT staff should receive training in replacing the tracheostomy tube, should it be accidentally dislodged or displaced.

Curare intubation in an obstructed patient

Following a fire on board an Egyptian cargo ship in Hartlepool docks, a few men developed laryngeal oedema due to inhalation of hot smoke. One of the crew had severe obstruction. I had a clinic there on that day. I took the patient to the theatre. The anaesthetist gave him curare and attempted intubation. He failed; there was gross oedema in the supraglottic area. The 'trache' tray was laid out, but the blade for the knife was doubly wrapped. The patient's face became pale with a bluish tinge. I asked the nurse to give me the knife – she asked me what size blade – any, I said. I did a 'stab' tracheostomy. Being head and neck surgeon, I got the tube in within thirty seconds and connected it to the machine. The colour of the blood turned from dark blue to pink. The patient passed away due to renal failure the next day. I went to his PM. My tracheostomy was in the exact place where I would put it during an elective tracheostomy.

I firmly believe that irrespective of their chosen subspeciality in ENT, everyone should be exposed to some H&N surgical experience during their training.

I had H&N surgical exposure during my trainee days in Mumbai and England. I put it to use by undertaking management of a wide range of H&N pathology.

The general surgeons' objections reached professional and statutory bodies

The general surgeons' objections continued. Advice as to what surgery ENT surgeons should undertake was sought from various professional and statutory bodies. The Royal Colleges advised that the FRCS was general, and it was up to the individual surgeon to undertake whatever surgery he or she was comfortable with. The General Medical Council (GMC) advised that their registration is more concerned with the basic medical qualification than the postgraduate qualification. The defence societies advised that their remit is to defend the doctors when things go wrong rather than tell them what surgery they can do.

Having exhausted all avenues for their irrational objection, the surgeons went quiet. Martin Horowitz advised me to go easy and not have any mishaps which would result in the renewal of the topic – good advice considering the extent of the opposition. In our department, at least, the H&N surgery became an integral part of the ENT surgery way back in 1970 – for which a full credit goes to Martin Horowitz, who envisioned a self-sufficient ENT department with I developing the H&N and him, the otology/audiology side of it. Frank was a valuable colleague to take extra calls when Martin and I went to the Royal Society of Medicine (RSM) meetings in London.

My role in establishing the Head and Neck Surgery as an integral part of the ENT surgery, some fifty years ago

I believe I played a significant role some fifty years ago in establishing Head and Neck Surgery as an integral part of the ENT training in the UK, and the history will record it alongside the pioneering work in laser technology for ENT surgery; covered in other sections!

The following is a summary.

- I had H&N surgical exposure during my trainee days in Mumbai and England. Following my appointment as an ENT consultant in 1970, I put it to use by undertaking surgery for a wide range of H&N pathology.
- I strongly resisted the objection of the general surgeons that the ENT surgeons must not undertake the H&N surgery and successfully argued with the GMC, the Royal Colleges and the Defence organisations who did not support the objections of the general surgeons.
- As you would read later, I established a 'Team approach to Laryngeal Cancer', a forerunner of the present-day multi-disciplinary team (MDT) approach, in 1970. It won 'the best entry in the world' award during the Centennial Conference on Laryngeal Cancer in Toronto in 1974.
- My article on 'The setting up of a Head and Neck service in a peripheral ENT unit' was published in a book titled ' Cancer of the Head and Neck' published in 1973.
- Scottish senior registrar to be trained in Middlesbrough in England: The specialist advisory committee, established to oversee the teaching for the trainee doctors, visited the ENT departments countrywide. They noted that the learning in Dundee Royal Infirmary lacked H&N surgery. They had seen our department and were aware of a wide range of H&N surgery I did in Middlesbrough. They advised Dundee that there were no other ENT departments available for H&N surgery placement in Scotland. Therefore, their senior registrar should spend the last two years of training in our department in Middlesbrough.

Blind biopsy

For an enlarged suspicious lymph node in the posterior triangle, it was customary to take a 'blind' biopsy of the postnasal tissue to rule out the primary lesion. During one postgraduate meeting, the neurosurgeon talked about skull base surgery. He showed us how close the intracranial course of the internal carotid artery was, and it could be damaged while taking a 'blind' biopsy. To him, 'blind' meant inserting a punch forceps and biting a tissue without seeing it, not realising that the 'blind' refers to 'obscure, primary due to lack of local symptoms', rather than visually blind!

Dominance of the teaching hospitals over the district hospitals

There was a regional ENT committee that met at the RVI every six months. Desmond Dawes, the senior ENT consultant from the RVI, chaired it. All the consultants in the region attended it. I sensed some hostility towards me because of the advanced work I was doing in Middlesbrough, including H&N.

Why don't you send him to Newcastle?

In Hartlepool, a consultant anaesthetist asked me to see his registrar, who had developed sudden unilateral deafness following mumps, a well-documented complication. I explained to him that this was a known complication, irreversible, with no treatment. I

received a phone call from his consultant.

'Why don't you send him to Newcastle?'

'I don't need to, but you can, if you want to'.

In Newcastle, a registrar and not a consultant saw him. Steroids were prescribed – but did not do anything for his deafness.

'I usually go to Newcastle'

A patient was referred to me privately for treatment of nasal polypi.

'My doctor usually sends me to Newcastle every time they grow back.'

I was appointed a consultant surgeon to serve the people in Cleveland. And my people in Cleveland do not need to go anywhere else to get the best there is; they will get it here on their doorstep. Hardly did I know that such an opportunity was in the waiting, laser technology, as you will read later.

A visit from regional adviser, Mr Desmond Dawes

I received a memo from the region that the chair of the Committee, Mr Desmond Dawes, a well-respected otologist, would visit the Hartlepool clinic for inspection. During his visit, the hospital secretary and the matron were in attendance; such was the dominance of the regional departments on the peripheral hospitals. The tour lasted an hour and a half; everything was scrutinised. At the end of his visit, Mr Dawes remarked: 'You do quite advanced work in a small hospital like this. And you have a full-time secretary to the department. whereas I have to share my secretary at the RVI with another consultant.' Without any thought, I replied, 'Why don't you take up this job and I take up yours?' Innocence is a blessing. Desmond was a giant, a regional adviser, and I, a little fellow in a very peripheral hospital in Hartlepool, so peripheral, that any further and you are in the North Sea, literally! Nothing more came out of that visit.

Expansion of the Middlesbrough ENT Department in the seventies

Soon after I came to Middlesbrough as a consultant in 1970, despite the political upheaval of the early seventies, Martin and I discussed how to develop the department to a standard where it could be considered a centre for higher surgical training, which involved establishing a senior registrar (SR) post. There was no template for developing a department. I thought of visiting ENT departments abroad to acquire some knowledge, and an opportunity soon came my way. During one such conference, I recall meeting a professor from Tromsø, Norway. He invited me to visit his department. Tromsø is the Northernmost University in the world. Apart from visiting Tromsø, I also visited departments in Oslo, Helsinki, and Stockholm. These visits were worthwhile. Audiology was much more advanced in the Scandinavian countries. I suggested that Martin upgrades our audiology department, which he took on board and established one of the most advanced facilities in the country.

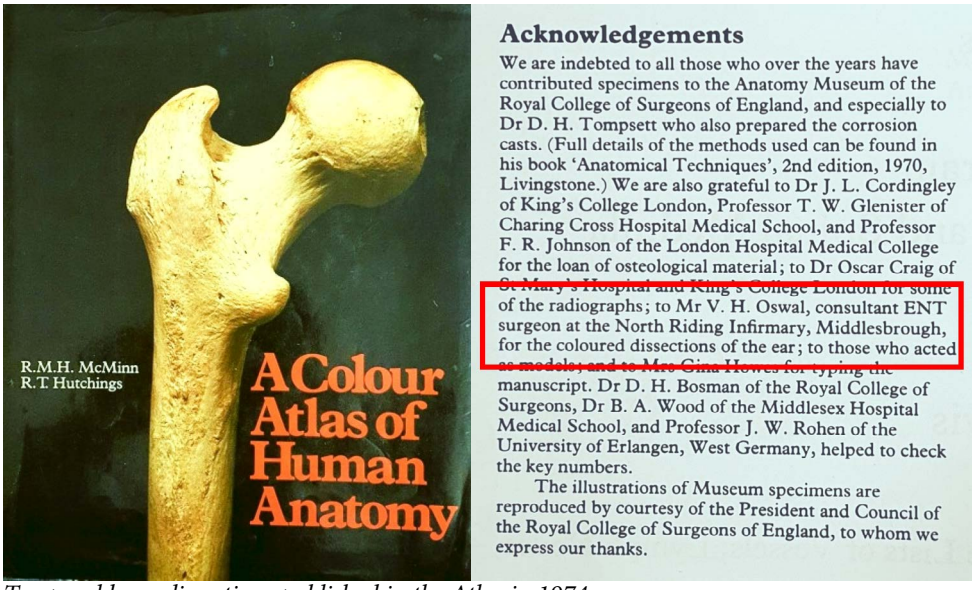
Senior registrar post

Since I was doing all the H&N Surgery, I charted out the training programme for the proposed SR post. Every Wednesday, the SR would be with me in the theatre during my whole-day operating list for major H&N excisions, sometimes extending well into the evening. His remaining time would be spread out with Martin, and various other sub-departments such as audiology, paediatric audiology, allergy clinic, joint H&N clinic, secondment to the plastic surgery, neurosurgery, chest surgery and paediatric departments at other hospitals in Middlesbrough.

Temporal bone lab

One specific requirement for the SR post was the availability of the temporal bone lab.[13] A small room adjacent to the lecture room was available. We bought a refrigerator, an outpatient grade microscope, and some other equipment. Unlike today, temporal bones were readily available from the department of pathology and forensic medicine. The trainee would undertake the various surgical procedures on the same bone in sequence to optimise its use, such as cortical mastoidectomy, radical mastoidectomy, exposure of the facial nerve course, the semicircular canals, etc. At the end of each step, Martin or I would check the dissection.

Publication of the temporal bone dissections



Temporal bone dissections published in the Atlas in 1974

I had been dissecting temporal bones since my days as senior registrar. It almost became a hobby and I continued dissecting them after taking up the consultant job. The harvested specimens were washed in soapy water, immersed in formalin for a couple of

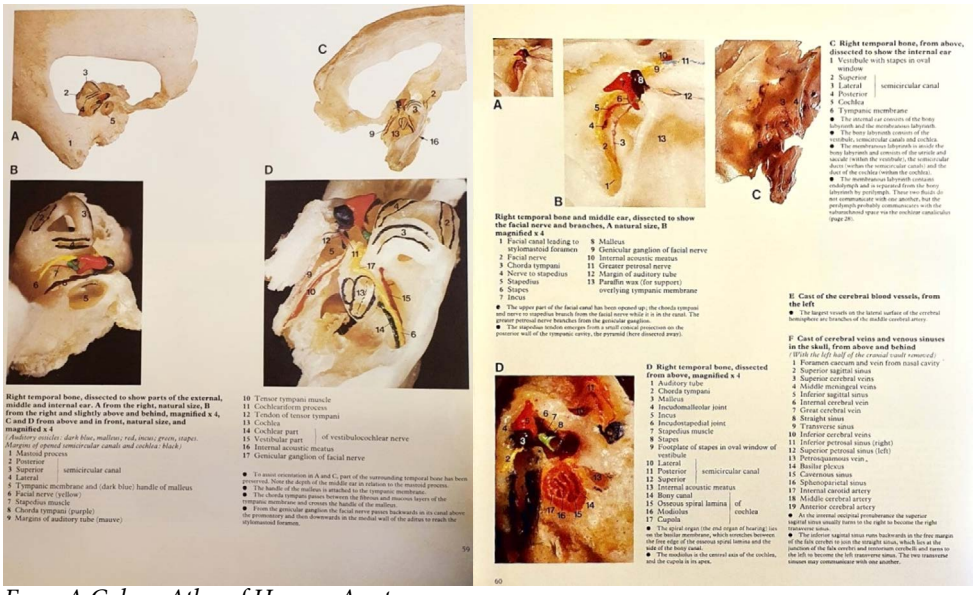
days, then in 20% hydrogen peroxide and finally in water for a few days. I then removed the overlying bone of the mastoid and the middle ear and continued the dissection until I reached the petrous apex.

The dissection in continuity demonstrated the three-dimensional relationship of all the intricate structures that make up the anatomy of the ear, along with facial nerve and chorda tympani. I then coloured the exposed structures with various colours for easy identification.

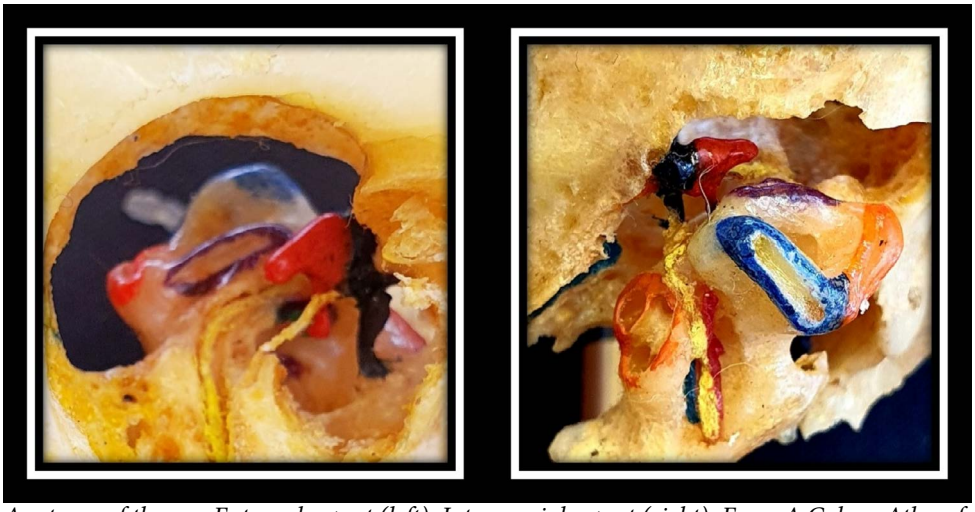
Prof McMinn of the Royal College of Surgeons of England, who had seen some of my dissected temporal bones displayed in Wellcome museum, wrote to me that he would like to publish them in his book *Colour Atlas of Human Anatomy*. He was even prepared to come to Redcar to take them all! I was due to go to the RSM meeting in a few days, and I wrote to him that I would bring them to him. He was delighted.

The specimens are in the Wellcome Museum, mounted in a plastic mould with a built-in magnifier lens. It is gratifying to know that many generations of ENT surgeons have learnt and would, in the future, learn about the anatomy of the ear from these specimens to ensure that they know their way round in this complex structure of hearing. Maurice Hawthorne, one of our newly-appointed consultants, was pleasantly surprised to know that they were my specimens he learnt from, while studying for FRCS.

The new Anatomy and Pathology Study Centre, which replaces the Wellcome Museum of Anatomy and Pathology, will open in early 2022.



From A Colour Atlas of Human Anatomy



Anatomy of the ear. External aspect (left). Intracranial aspect (right). From A Colour Atlas of Human Anatomy .

New department of audiology and rehabilitation

Until the early seventies, the standard instrument for testing hearing was a pure-tone audiometer. The audiometrician presented a series of sounds at set frequencies in increasing intensity. A response from the patient recorded a threshold of his/her hearing. The test is subjective since it depended on the patient responding upon hearing the tone and therefore lacked accuracy.

Objective audiometry is based on physical, acoustic or electrophysiologic measurements. It does not depend on the cooperation or subjective responses of the subject and thus gives a more reliable reading of the patient's hearing threshold.

Some universities introduced courses in audiology, leading to a BSc degree. We contacted Prof Body, the head of the physics department at Newcastle University. He was delighted to collaborate, since our proposal opened up a new opportunity for the physicist to work in the health sector. He had one postgraduate student, Philip Newall, who was doing MSc in audiology. Prof Body suggested that his department offered Philip a clinical placement to work with us and fund any equipment necessary to undertake audiometry and research for a PhD.

The existing audiology room was certainly not adequate to modernise the audiology facility. The finances to extend the outpatient to build a new audiology department came from the district's administration, without much hassle!

Sir and Lady Ewing

Sir Alexander and Lady Irene Ewing from Manchester were pioneers in developing paediatric audiology since the early twentieth century, influencing professionals worldwide on identifying and managing childhood deafness and the education of deaf children. We invited Sir and Lady Ewing to inaugurate the new audiology and rehabilitation department and named it after them. Dr Devlin, the school medical officer, came

from the local educational authority to run a weekly clinic for children with hearing loss. Philip started a course for the audiometricians' training, with new staff taking examinations as audiology technicians. Ours was the first department of this kind in the Northern Regional Health Authority hospitals.

Senior registrar Rotation between Dundee and Middlesbrough

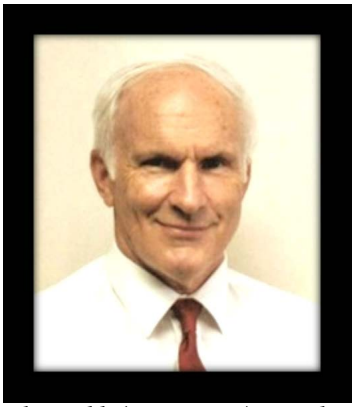
Specialist Advisory Committees (SAC) were established in the late sixties or early seventies to play a vital role in developing and improving postgraduate surgical training in the UK and Ireland. Each SAC worked to ensure that training programmes cover all aspects essential to train someone to the level of a consultant. Their visit to Dundee highlighted the lack of training of the senior registrar in the Head and Neck surgery.

The SAC had already visited us in Middlesbrough and were aware of the extensive Head and Neck surgery I was doing in large numbers. They told Alan Gibb that their SR must split his appointment with the two years in Dundee, and two years in Middlesbrough, to ensure adequate exposure to all aspects of ENT surgery.

There was much opposition from Alan Gibb to the rotation. 'Scotland is capable of training all its doctors without having to cross the border' - some board members of the appointments committee openly told us. The SAC told the Dundee department that they would lose their senior registrar post if they did not rotate.

When I was in a trainee post of registrar in Dundee in 1964, I could have hardly imagined that one day, I would return to Dundee as a consultant to discuss with Alan Gibb a rotation of Dundee senior registrar to Middlesbrough to complete the training in the Head & Neck surgery! Martin Horowitz and I travelled to Dundee for a meeting with Alan Gibb. As a consultant colleague, I was addressing him as 'Alan', as the custom dictated. He probed into the figures, asking me how come I treated so many H&N patients considering that Middlesbrough is a small town. I appraised him of my extensive drainage area due to a lack of ENT surgeons undertaking H&N surgery in many hospitals in the Cleveland catchment area and beyond. After considerable deliberations, he agreed to the rotation, on the condition that the interviews would take place in Dundee and the SR would spend the first two years of a four-year rotation in Dundee.

This was a blessing in disguise for us. It meant that when the trainee started the Infirmary arm of the rotation, he had already been trained at a higher surgical level in Dundee for two years. The doctors received removal expenses from the appointing authority when they took up a new post. Since the SR appointment was not a new appointment in the case of rotation, the Northern Regional Authority refused to pay removal expenses to the SR to take up the post in Middlesbrough. Equally, the Dundee board was also adamant that they would not pay removal expenses for the doctor who was leaving! Following further talks, both boards agreed to share the costs on a 50:50 basis! The rotation continued for several years until a local rotation within the Northern Regional Health Authority hospitals was established.



Alan Gibb (1919–2020), Dundee

Rehabilitation of the deaf: A link-up with the Hartlepool Social Services[14]

It is common knowledge that as we get older, the hearing acuity goes down. The NHS offers free hearing aids to help such patients. Patients come after a GP referral. After examining the ears to rule out any other pathology, the audiology department supplies the hearing aid free of charge. Any repairs or replacements are also free.

Age-related hearing loss, compensated merely by amplification with an aid, does not solve the patient's problems. The amplification increases the volume, and the person may 'hear' the sound and still not comprehend the spoken words due to another effect known as recruitment.[15] The frustrated patients, who expected the aid to restore a 'normal' hearing, gave up using the aid, which was then stored safely in a drawer.

There are many additional measures the patient can take to achieve maximum benefit from the aid. The volume is set at a comfortable level. The speaker should be in a well-lit area so that the patient can watch lip movements and gestures, and speak at an average or slightly increased loudness, but not shout as many people did before. In a restaurant, the hard-of-hearing person should sit against the wall to minimise the background noise.

In short, some counselling is necessary for a few days. Unfortunately, this critical aspect of rehabilitation is not always possible in the audiology department, due to the volume of work.

During one of the clinics in Hartlepool, a patient with multiple disabilities came in for a hearing aid. The person who was accompanying him seemed pretty knowledgeable about many aspects of deafness. It transpired that he was one Mr Ron Davis, Welfare Officer for the Deaf, employed by the local authority. His work involved helping people with hearing impairment, supporting them in challenging situations such as dealing with the social services, the police, court appearances, etc. These people were severely deaf and used sign language as their mode of communication. Mr Davis would interpret their sign language.

I asked him if he would provide counselling support to our patients. His enthusiastic response led to establishing a joint rehabilitation programme between the ENT department and the social services department, in a purpose-built room displaying various hearing aids. Mr Davis initiated the rehabilitation of every patient fitted with a hearing aid. Also, he assessed the need for continuing rehabilitation at home, which he then undertook with the help of the voluntary attendance service, to follow up the patient with home visits. The results of the study showed a substantial benefit of such a link-up.

'I can hear Redcar races'

During one of the clinics, a patient with an aid said to me:

'I can hear the Redcar Races commentary.'

He was a war pensioner, and apart from deafness, he also suffered from several vague ailments. Some might have been real, but I always thought he overplayed them to get more pensions.

When he told me about the Redcar Races, about thirty miles away, I thought he was at it again, concocting yet another symptom worth a few more quid. Just at that time, Mr Davis happened to enter the room. This patient was well-known to him.

'How are you?'

'Do you know, I can hear Redcar races in my ear.'

Mr Davis realised what was happening. He had just installed a loop in his room to demonstrate how the hearing aid could pick up a wireless signal from a radio set at home. Someone nearby actually listened to the Redcar Races on the radio. The signal was picked by the loop and then by the patient's hearing aid, which must have been on T setting (for transmission)!

Exponential increase in referral of malignant disease in ENT

Since only a handful of ENT centres in the country undertook cancer surgery for ENT cases, the patients and their families had to travel long distances and spend many days in the hospital until the healing was complete. With the establishment of H&N surgery at the Infirmary, our referral rate increased. The catchment area also extended to North Yorkshire, County Durham, Scarborough, Darlington, Catterick Garrison, Hartlepool, Stockton and East Cleveland, covering a population of well over a million. I had to give up all otology and rhinology surgery to cope with this workload. As mentioned earlier, we clocked nearly one major excision a week for a full forty weeks in a year, at times forgoing my full holiday entitlement. I carried out laryngectomy, maxillectomy, external ethmoidectomy, excision if oral-pharyngeal cancer, radical neck dissections etc. There were also many benign lesions, such as carotid body tumour, branchial cysts, salivary gland tumours, parapharyngeal tumours, etc.

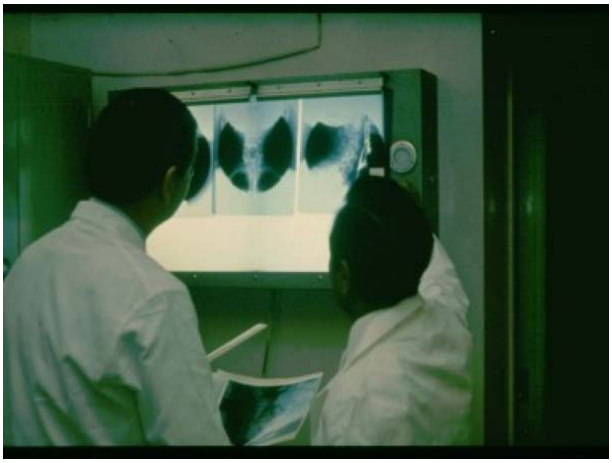
Cancer of the oral cavity

Oro-facial-maxillary surgery as a separate speciality did not exist. All benign and malignant diseases came to me by direct referral from GPs or the dental department at the Middlesbrough General Hospital. There were two consultant dentists with basic and postgraduate dental qualifications but not a 'medical' qualification which would entitle them to a rank of a 'doctor'. Their training did not cover diseases of the oral cavity, including cancer of the tongue or floor of the mouth. Importantly, if the patient died during the oral surgery, they were not qualified to sign the death certificate since only a 'doctor' was qualified to state the cause of death and sign the certificate. Their training was limited to dentistry; they were dentists and not doctors. I undertook partial and total glossectomy, hemimandibulectomy, tonsils cancer, and all benign diseases of the oral cavity.

The most extensive operation by far, was the COMMANDO operation or COMMANDO[16] procedure – **COM**-bined **MA**-ndibulectomy and **N**-eck **D**-issection **O**-peration for malignancy of the tongue. Lasting for over six hours, it comprised glossectomy (partial or total removal of the tongue), hemimandibulectomy (removal of part of the lower jaw), and block dissection of the cervical nodes.

Joint ENT and radiotherapy clinic

I established a joint clinic, attended by a team consisting of the ENT surgeon, a radiologist, a radiotherapist and pathologists. A discussion of various strategies offered the best possible management, tailor-made for a particular patient.



Nigel Robson (L) and Vasant Oswal in a joint cancer clinic

The establishment of a dedicated protocol for the management of the laryngeal cancer

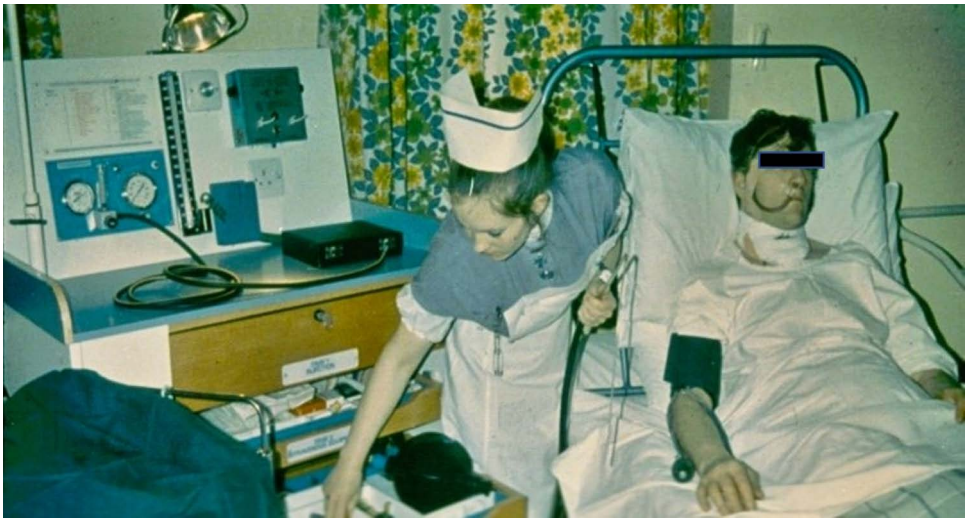
Initially, the patient is seen in the joint clinic and discussion takes place to offer the best management tailor-made for that particular stage of the disease process. The treatment for most cases was by radiation. Those cases which failed to respond, and other patients with advanced cancer needed surgical removal of the larynx. This surgery is known as total laryngectomy.

Total laryngectomy: a life-changing operation

When the larynx or the voice box is removed, the continuity between the lungs and the mouth is lost. The breathing tube (trachea) is brought out to the surface of the neck and stitched to the skin. The patient has a 'hole' in the neck – a tracheostomy – through which he/she breathes in and out. Since the air from the lungs cannot reach the mouth, the patient cannot speak.

Laryngectomy thus has a devastating effect on the patient's day to day living as well as long-term consequences. It may not be possible to continue a job, which would be financially disastrous for the patient and his/her family. He/she will have to learn an alternative way of speaking, known as oesophageal voice. Since the breathing is now through the tracheostomy opening, the filtering function of the nose is no longer available. The outside air goes directly into the lungs, resulting in bouts of cough and production of excess discharge. Taking a shower was out of the question since the water droplets entering the tracheostomy would precipitate a violent bout of coughing to expel the water.

It is thus clear that these patients need substantial postoperative rehabilitation to manage their life after laryngectomy.



Patient after laryngectomy needs care by nurses trained at an advanced level

Team concept for the management of laryngeal cancer

The term rehabilitation was more often used to indicate retraining after bony injury following trauma. However, a broader concept of a need to rehabilitate following a life-changing surgery such as laryngectomy did not exist.

I believe that it is the surgeon's responsibility to establish a protocol of rehabilitation of laryngectomy patients in the context of the overall management of a disease entity rather than a one-off episode of surgery. The management strategy should put the patient back in the community as close to his original way of life as possible. Total rehabilitation involves addressing all these issues and not just the loss of speech. This philosophy led me to develop a *pre-operative* protocol while the patient still could vocalise.

Pre-operative protocol

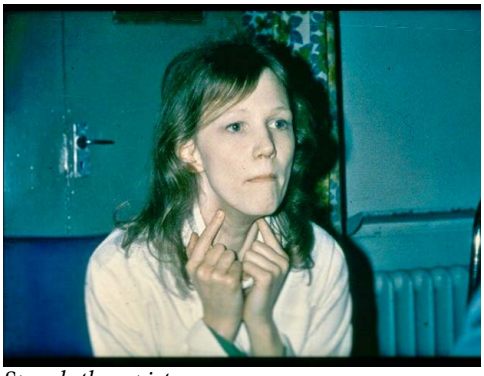
The speech therapist and the physiotherapist provided technical guidance to achieve an optimum result. Letters to the general practitioner ensured that the patient would get informed help, such as a visit by the community nurses, as required.

Cleveland Laryngectomy Club

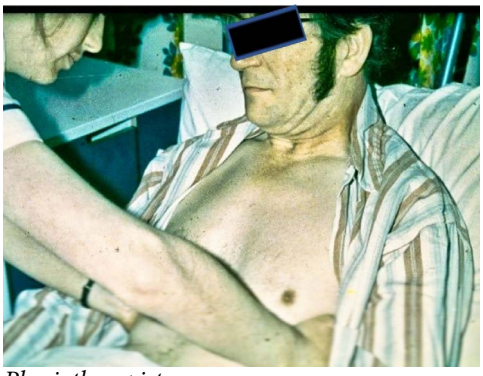
Self-help groups are now commonplace. However, in the seventies, the concept did not exist. I established Cleveland Laryngectomy Club in 1972.

The objective was to bring together laryngectomy patients to exchange experiences of their real-life post-laryngectomy situation amongst each other. They also got moral support to help them realise that they were not the only ones to experience this unfortunate episode in their life. A further advantage was that quite a few of them volunteered to visit the ward to meet any patient who was to undergo a laryngectomy.

The family and the friends receive counselling about life after a laryngectomy.



Speech therapist



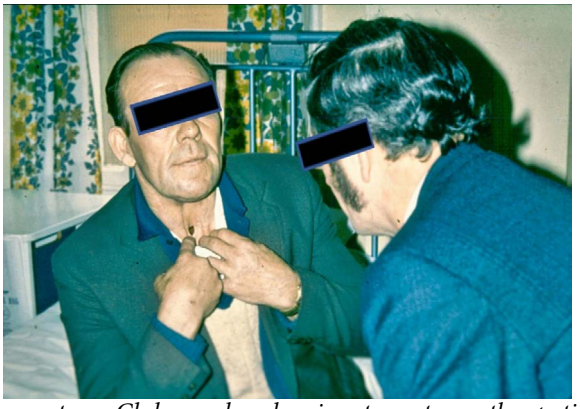
Physiotherapist

The family and friends also found this protocol of much help to understand their vital role in patient care. The speech therapists played a significant role in making the club an enormously successful enterprise. On her retirement, another passionate speech therapist, took over the club. With the closure of the Infirmary, the members decided to disband the old club and resurrect the idea in some other way when we settled ourselves at the new site at James Cook University Hospital (JCUH).

Contact is also made with the works manager and redeployment officer to ensure, wherever possible, to find alternative work more appropriate for someone without speech and with a tracheostoma for breathing.

The police and the ambulance service personnel were trained to give mouth to neck and not mouth to mouth breathing to a laryngectomy patient in an emergency.

Cleveland Laryngectomy Club - 1972, Vasant Oswal sitting, second from the right



The Cleveland Laryngectomy Club member showing stoma to another patient who is about to have his larynx removed

Liaison with the works manager and the redeployment officer via GP

A married woman who lives in Teesside is one of twenty people from this area who has undergone the operation. She is a member of the Cleveland Laryngectomy Club, formed by the people who have had the "Hawkins' surgery." They meet occasionally for discussions, talks, film shows and visits. Here she describes her thoughts and feelings about the operation and having to learn how to speak again.

"I HAD the operation two years ago. A week before, the surgeon and my own doctor explained it to me. But I didn't properly grasp what was happening. It really hit me after the operation that I would have to learn to speak again.

I knew no-one could do this for me. I'd have to do it myself.

A man who had had the operation several years before came to see me in hospital. I thought it was marvellous when I heard how he could talk. He had a good voice.

This is the great thing about this hospital and the club. Everybody connected with it is so encouraging. I've never heard complaints from any of the people who've had the operation.

The nursing staff support you and the surgeons and consultants are marvellous. You get great encouragement from other people who have had the operation, and you see the results with them.

I find my voice is getting better now. I relax and just talk, but if I start to think about working on it properly, my voice just goes.

I use my chest muscles to help me speak rather than my stomach muscles, as I am meant to do. I develop my speech, then, with my tongue and teeth and the muscles in my mouth.

I used to give a lot of talks and I was a good speaker.

The thing that's helped me most of all is the club. This is really marvellous, because you meet people like yourself. I have never heard one person grumble. They're all most cheerful.

At the club I would like a talk on Jack Hawkins and his operation. I think he was wonderful. He tried so hard.

I wasn't frightened when I came for the operation. My biggest shock was when I went home. It was like when you go home from hospital with a baby you have to take things on from there, by yourself.

My first thought after the operation was that I was glad I'd got through.

I was very fortunate. I have a good family and some very good friends. I went shopping two days after I got home. I went straight back into my life.

I haven't set any target for my voice returning. I take it day by day.

A nice thing, I find, is that people say to me in shops, 'You have a bad cold. Have you lost your voice?'

That's the biggest compliment. They think I've just got a sore throat.

I can't converse at cocktail parties because of the background noise, but I can speak on the telephone, even long-distance.

After the operation my daughter rang me about three times a week and forced me to speak long-distance to her.

And when the family had all gone out I used to get a newspaper and force myself to read out loud.

It was terrible to begin with because I was thinking in my own voice, as I knew it before, and monitoring my old voice.

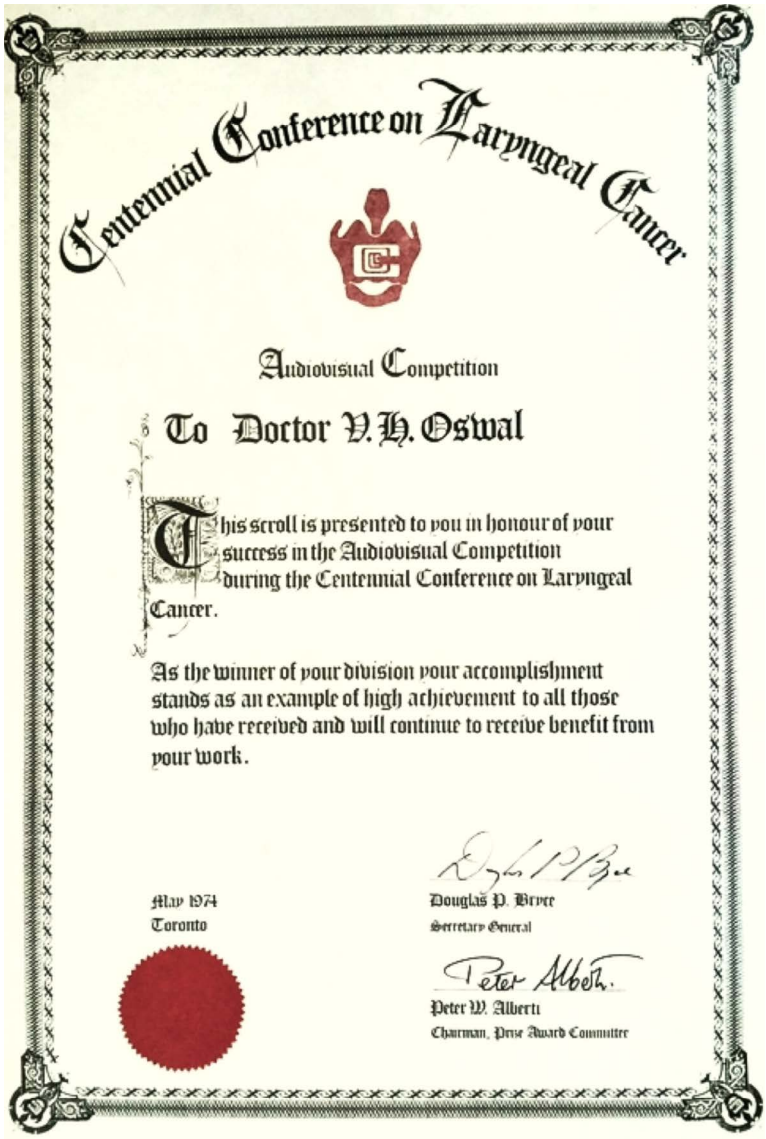
Now I am working on trying to get some cadence into my voice."

'The thing that has really helped most of all is the club'

Tape-slide programme on the 'Team Concept of Laryngeal Cancer'

The photography department of Newcastle University made a tape slide programme on this topic. It involved making slides and recording commentary on the audiotape to play with each slide. An audible and electronic signal, incorporated at an appropriate place in the commentary recorded on the audiotape, changed the slide automatically, thus encouraging self-learning. The concept of total care was titled: 'Team Concept of Laryngeal Cancer'.

Team Concept in Laryngeal Cancer – International Award



Centennial Conference on Laryngeal Cancer

Audiovisual Competition

To Doctor V.H. Oswal

This scroll is presented to you in honour of your success in the Audiovisual Competition during the Centennial Conference on Laryngeal Cancer.

As the winner of your division your accomplishment stands as an example of high achievement to all those who have received and will continue to receive benefit from your work.

May 1974
Toronto

Douglas P. Bryce
Secretary General

Peter W. Alberti
Chairman, Prize Award Committee

Scroll awarded at Centennial Conference on Laryngeal Cancer, Toronto 1974

Centennial Conference on Laryngeal Cancer, Toronto 1974

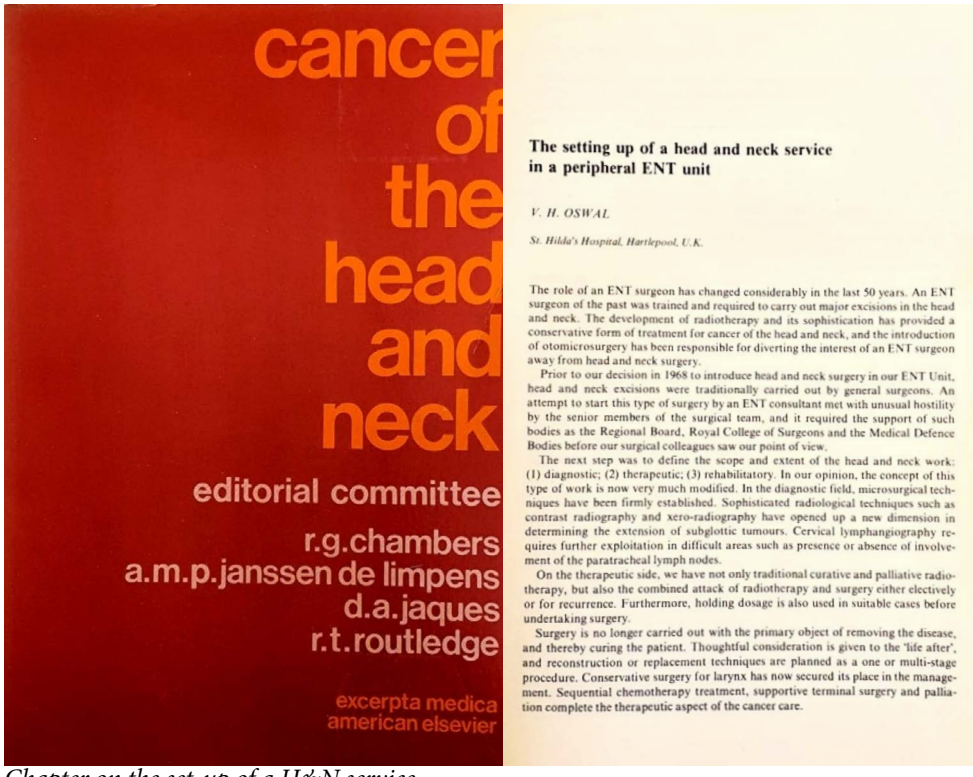
The first total laryngectomy was performed in 1873 by Billroth, who removed the entire larynx and left the patient with a pharyngo-cutaneous fistula.[17] The Centennial Conference on Laryngeal Cancer took place in Toronto, Canada, in 1974 to mark one hundred years of laryngectomy. It was on a global scale, attended by over seven hundred delegates from all over the world. I presented the tape-slide programme at this conference. The entry received much acclaim and was judged the best entry globally. I was awarded a scroll.

YouTube: 'Team Approach for Cancer of Larynx. A 1972 Award Winning Concept by Mr Oswal'

The tape slide programme entitled 'Team Approach for Cancer of Larynx. A 1972 Award Winning Concept by Mr Oswal' is now on YouTube.[18]

Establishment of a H&N Service in a peripheral ENT Unit

A comprehensive strategy – an establishment of a team to manage patients suffering from H&N cancer was published in the following book published in 1975.

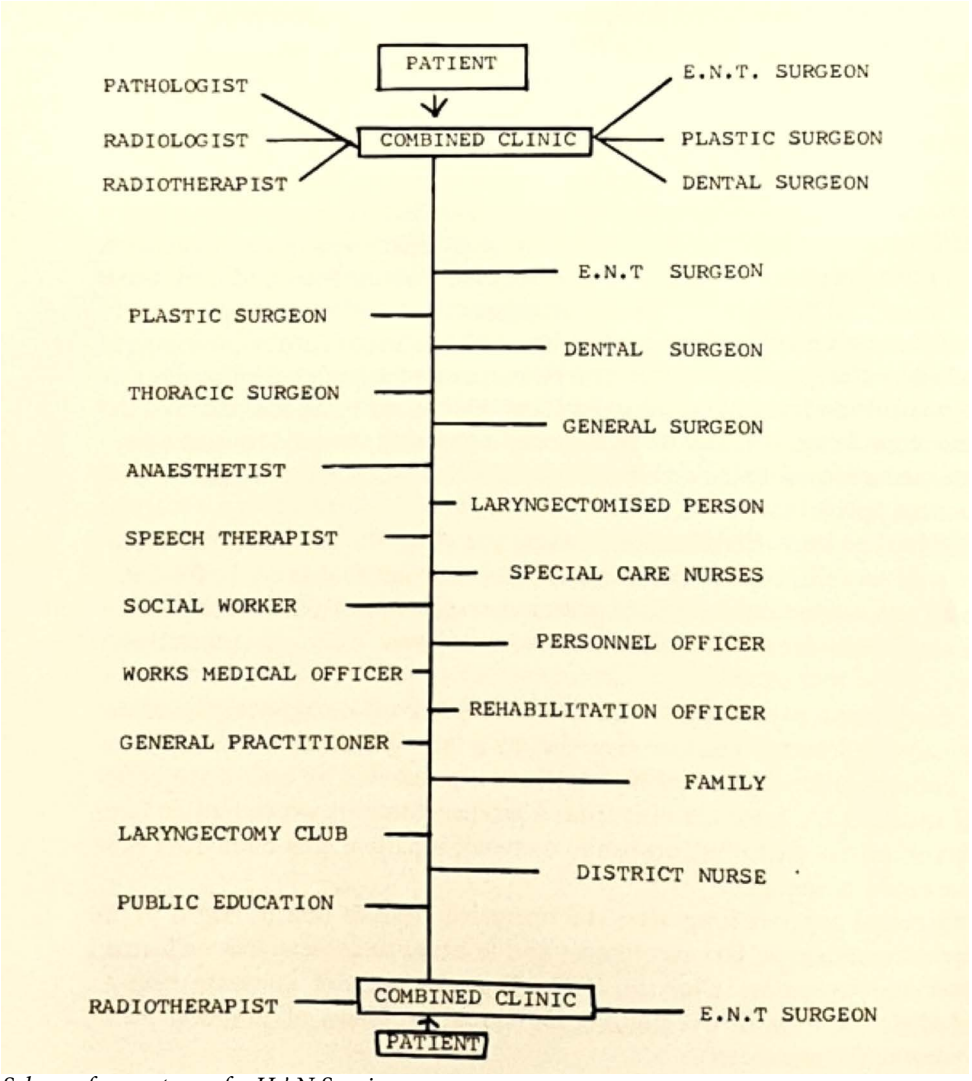


Chapter on the set-up of a H&N service

This concept of involving diverse expertise is now called 'Multidisciplinary team (MDT)'. The thought humbles me that I had proposed an idea and established it way back in 1973!

Oesophageal voice

Oesophageal voice production requires that the patient swallows a gulp of air to initiate voice production. This delay branded a laryngectomee as a deaf person who apparently did not understand what was said to him or her and needed repeating of the sentence. It is also necessary to continue to swallow the air periodically during speaking. Therefore, there is a lack of fluency of speech.



Scheme for a set-up of a H&N Service

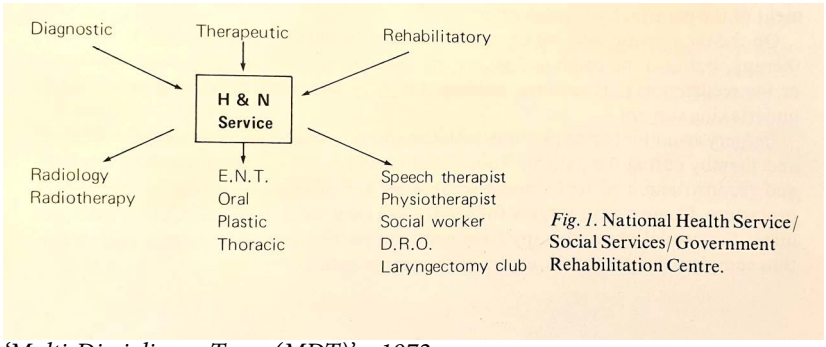


Fig. 1. National Health Service / Social Services / Government Rehabilitation Centre.

'Multi-Disciplinary Team (MDT)' – 1972

Learning how to talk again...

The patient is Mr. Thomas Lupton, aged 58, of Colburn, Catterick Camp. The operation he has undergone will alter his life dramatically. The people gathered by the bedside are specialist nurses who will help him through the post-operative period. They are, left to right: Sister Gillian Charlton; Theatre Sister Margaret Owen; Chief Nursing Officer Mr. Geoffrey Lythgoe; Nurse Silvia Gwillam; Nurse Dorothy McGee; Theatre Sister Elsie Pickering. JOHN McLEOD reports below on the operation and the experts involved in a highly-specialised field.

THE death of Jack Hawkins had particular meaning for 20 people who live in Teesside — for they have all had the same operation as the late actor.

Their operations for removal of the larynx, or voice-box,

surgeons described this Jack Hawkins operation:

"We expose the larynx, or voice-box and then remove it. We reconstruct the food channel which lies immediately behind the voice-box and creat an opening in the throat through which the patient will breathe all his

area is stitched up. The patient is fed through a tube for about two weeks, until the healing is complete."

After the operation the patient faces the greatest challenge: learning to speak again.

□ □ □

Oesophageal voice

George's delight speaks for itself

Plastic valves restore lost voice to dad

HE'S SHOUTING for joy! After nine years of suffering in silence, George Crossen has his voice back.

Thanks to a revolutionary operation at Middlesbrough's North Riding Infirmary and two plastic valves, throat cancer patient George can today have his say again.

And the New Marske dad delivered the implant's verdict of success by saying: "It is absolutely marvellous."

A year ago he had his voice box removed and for nine years before, he had vitually no voice at all. Now the retired construction

Story by: FELICITY STEWART
Picture by: TERRY REED

superintendent is coming over louder and clearer than ever. The gift of near perfect speech came from the first operation of its kind in the Northern region, where the special valves were inserted in his throat to replace his larynx.

And today father-of two George, 52, of Highcliffe Grove, said: "Now I can shout at the dog, speak to people and communicate with my daughter Susan in Canada on the 'phone without any problems whatsoever.

"People just think that I've got a bit of a cold or have been singing too much! But I'm better now than I have been for years."

Ear, nose and throat consultant

• George Crossen — singing the praises of the valve which has restored his voice

Vasant Oswal decided to go ahead with the operation at the Infirmary in April after seeing it performed in Miami, America last year.

He said today: "The results are excellent. They speak for themselves. We have done the first operation and it has been so successful we will be continuing to do this operation."

Blom-Singer duck-bill prosthesis

Blom-Singer and Povox prostheses for voice rehabilitation after laryngectomy

In 1980, a device, the 'Blom-Singer® Duckbill prosthesis',[19] solved the problem. When placed in the tracheo-oesophageal wall, it directed the airflow from the lungs into the oesophagus via a valve. I met both Blom and Singer, at an IFOS conference in

Miami, in 1985. In 1990, the first Provox® voice prosthesis, manufactured by Atos Medical, was introduced. Several variations provided valuable refinements. Our department was a leader in the Northern Region to introduce voice prostheses for our laryngectomy patients.

A laryngectomy patient from Potash mines

A 36-year-old man (I will call him Smith – not his real name) from the Cleveland Potash Mines in East Cleveland underwent a laryngectomy. He was a face worker, working at the rock face, blasting, cutting, and removing the rock. The works' medical doctor found him a job on the surface, dust-free, in broad daylight with sunshine. However, Smith insisted that he should go back as a face-worker.

The works' doctor turned it down on safety grounds, but Smith persisted that he wanted his old job back. The doctor was very sympathetic. Nevertheless, he could not risk sending Smith back to be face-worker. In the end, the doctor asked me if Smith could go back to his original work. Northeast England had many mines, and I knew a bit about coal mines which are damp, dusty and dirty, most unsuitable for someone with a tracheostoma. But the mine at Boulby was a potash mine, the only one in the area. The doctor said it was not dusty and invited me to visit it and see it first-hand.

Boulby potash mine

In 1939, potash was discovered in Aislaby in North Yorkshire when drilling for oil. The mine is just southeast of the village of Boulby.[20] Potash or potassium chloride is an agricultural fertiliser. The rock salt is extracted as a by-product and used across the region as a de-icing agent on roads in wintry conditions.

The mining shaft goes deeper to the Rock-salt layer. Here, the rock-salt bed is dug out to make permanent roadways. At 1,400 metres (4,600 ft.) deep, the Boulby potash mine is the second deepest mine of any kind in Europe. I met the works' doctor, the foreman and Smith at the site, and after putting on appropriate gear, we went down to the mine.[22] It certainly felt like ages in the lift, travelling back over 220 million years in geological time! The mine is ventilated by blowing fresh air down the man-riding shaft.

To the rock-face!

Incredibly, the mine was comfortably warm, dry and dust-free. So, the next question was, why is it dust-free? There were colossal extractor fans, so efficient that I did not even need to wear a mask. My conversation with the foreman went like this:

'How far does the roadway go?'

'We are already under the North Sea. We continue going further until the performance of the extractor fan reaches its limit.'

'Do you abandon the mine then?'

'No, we start another roadway in a different direction.'

'Why are these timber pillars in the roadways?'

'To support the roof.'

'Does the roof come down?'

'Yes, only by inches, now and again. We inspect it every few hours.'

'What do you do then?'

'We start digging towards the floor of the roadway. That keeps the distance between the roof and the floor constant at the operational level.'

We came back to the pit-bottom.

'What happens if there is an accident?'

'Every miner carries a whistle. If a miner blows the whistle, everyone comes to the designated area.'

So, we got to the first match point – Smith, with a laryngectomy, would not be able to blow his whistle if there was an emergency. But, in his oesophageal voice, Smith said,

'I can blow the whistle louder than any man.'

He grabbed a whistle, put the mouthpiece on his tracheostoma and blew. It was indeed deafening. There was no dead space – the wind came directly from the lungs.

'OK, what happens next?'

'We all wear an oxygen mask and help the injured man.'

'Why do you wear an oxygen mask?'

'In case there is a fire, we don't want to inhale smoke. We then lift up the injured man and put him on the stretcher.'

So, we got to the second match point:

'An oxygen mask is totally useless for you, Mr Smith.'

'But I can hold the mask on my stoma'.

Then the foreman intervened:

'But it may not be as tight a fit as a mask on the mouth, since it is properly shaped for use there. Moreover, you would then have only one hand free to help the injured man, whereas there is a legal requirement that both your hands must be free.'

When we got to the surface, I asked the doctor, what is so much about the face working that Smith wants to go back, away from the daylight and fresh air? Is it the money?

'No, Mr Oswal, it is like a community down there, same as in the village street. Even their children want to go down the mine when they grow up.'

I was so sorry for Smith that I had to turn down his passion for life. But I was richer for the experience.

The seventies – a decade of turbulence

Most of the '70s era was turbulent in many walks of life due to a variety of factors. It was a decade of social unrest, the Yom Kippur war, fuel shortage, strikes and a three-day working week to conserve fuel. Intervention by Health Secretary Barbara Castle against the private practice by the consultants led to the first-ever work to rule by us. We did no more than the minimum required in the contract. Thus, we cancelled the last patient on the operating list if the surgery was expected to go beyond 5.30 pm - the end of the sessional contracted time.

The following few paragraphs describe how it had a direct effect on my hospital work.

Era of unrest in the NHS

In any organisation, the team consists of heterogeneous skill levels, and it requires teamwork to run it smoothly. Thus, no worker's job can be regarded as superfluous and paid for in a low wage structure. Historically, low-skill jobs were always poorly remunerated. For example, in the NHS, the ancillary staff – porters, laundry workers, catering staff and so on – received a very poor wage for their important work, even though of low skill.

Nobody dishes out the money just for the asking, and NHS was no exception. The Government's own Department of Employment warned in 1972 that 'The Service got on for so long due to the goodwill of its employees.' Moreover, successive government reports had found these jobs to be among the worst-paid in the country. However, local government staff received a pay rise, whereas the NHS workers did not get any.

I do not doubt that staff at all levels in the NHS are driven by dedication and compassion towards ill patients. And Government of every colour knows this.

Unfortunately, the negotiations between the unions and the authorities broke up several times. Then, the only possibility left for the unions was to call out a strike. 'One-Out-All-Out'. But for many, it was a 'bridge too far'. Therefore, unions agreed to a campaign of selective strikes involving overtime bans and 'working to rule': doing no more than the minimum specified on one's contract. The working to rule lasted six weeks and caused widespread havoc.

The unions achieved a watershed moment within the NHS. Ancillary workers had proved they were intrinsic to the function of the NHS – and without them, wards and even hospitals would close.

A successful financial reward also gave them a new identity. The ancillary staff had found a new power – strong enough to shut the facility down – 'One out, all out!' became a catchphrase of the strike era.

Nurses were next to strike: they received a great deal of sympathy from the public resulting in the pay rise they had asked for.

The subsequent dispute was very different: the newly-empowered nurses and ancillary staff complained that the private patients increased their workload. Increase in the workload? How? The same operating slot is taken up either by the NHS or by the private patient. But significantly, only the consultants received extra money without bringing a fair share of it to the team.

Historically, the problem was that the consultants had been allowed to admit private patients on NHS premises – a source of income and one of the key concessions won by the senior doctors from Aneurin Bevan in 1948. And the hospitals also earned money and liked PP to some degree. The concession was necessary then, but was it right to continue the archaic arrangements in the seventies? I sincerely believe that everyone in the team should get a proportionate share from the income generated from the private patients. If implemented, you would not come across instances such as my experience of a child, having received pre-medication, who could not have surgery as a private patient.

The social discontent of the 1970s

The seventies are considered a decade of social unrest affecting every walk of life. In the NHS, staff at every level took part in the industrial action. It made them aware of

the potential power they had of disrupting the normal working of the hospital. Some interesting instances are worth noting.

Ancillary staff demanded extra money for being on call

Staff: 'When does on-call time start?'
Admin: 'Seven o'clock when you reach home.'
Staff: 'No, six o'clock when we leave the hospital.'
Staff: 'When does the extra money end?'
Admin: 'By midnight, you would be in your bed by then anyway.'
Staff: 'It is none of your business where I would be at midnight. On-call money would continue until we are on normal duty the next day. And if we are called out, we want double the money.'

Similar examples were seen in other industries. Is, for instance, the miner's shower time included in the work time?

In an extreme example, a story went round about a factory worker suing the factory for injuries sustained in a road traffic accident. How? He would not have been on that road at that time of the day had he not been going to the factory – and thus, the factory was liable for his injuries. It transpired that he had only a third-party insurance cover!

UK miners' strike (1972)

The miners' strike of 1972[23] was about wages. It started on January 9 in the thick of winter and quickly spread nationally. The striking miners sent 'flying pickets' to other industrial sites to persuade workers to strike in solidarity with the miners. They also stopped strike-breakers from entering the workplace. The real problem came when workers came from outside the area to man the essential services. Workers in the other industries supported the miners' strike. Railway workers refused to transport coal, the operators in the power stations declined to handle the coal to generate power.

Portable generators from Catterick Garrison for the Infirmary

On February 9, 1972, the weather turned bitterly cold, and the electricity boards reduced the voltage across the entire national grid. Power shortages emerged. The Central Electricity Generating Board announced power cuts starting from February 16, 1972. Many homes and businesses were without electricity for up to nine hours a day. A rolling blackout shut down the supply over different parts of the distribution grid. The Government imposed a three-day week, some 1.2 million workers were laid off.

North Riding Infirmary was affected by the power cuts. The Electricity Board, of course, would not cut power to the hospitals. But this was not logistically possible since any particular building from the block could not be isolated to maintain the supply. We geared our activity to take place outside the blackout times, severely curtailing outpatients and operations. But some services, such as casualty and emergency surgery, had to be maintained. Portable generators from Catterick Garrison were summoned and connected to the essential supplies.

The strike ended on February 28, 1972, when the miners accepted an improved pay offer from the Heath Government. We learnt a lesson and made provision with in-house generators for any future disruptions.

Coincidentally, in October 1973, the Arab states launched a surprise attack on Israel. The war in the Middle East quadrupled oil prices. Arab countries reduced supplies to the West. With the cost of coal rising and stocks dwindling, Britain's miners rejected a pay increase and voted for a national strike. On November 12, both the miners and the electricity workers began an overtime ban.

State of Emergency – a curb on the use of power and fuel

On November 13, 1973, Prime Minister Edward Heath declared a state of emergency and issued several orders to curb power and fuel use.[24] He

- banned the use of electricity for floodlighting, advertising and for the heating of shops, offices, and restaurants;
- imposed a 50 mph speed limit on all roads;
- reduced heating of offices and commercial premises to 63F (17°C);
- had selected street lighting turned off;
- had television broadcasters shut down the programmes;
- had most pubs closed at 10.30 pm each evening.

The Yom Kippur War (1973)

The Yom Kippur War was fought from October 6th to 25th, 1973, by a coalition of Arab states led by Egypt and Syria against Israel. The 1973 oil crisis began when the Organisation of Arab Petroleum Exporting Countries (OPEC), led by Saudi Arabia, declared an oil embargo. The embargo was targeted at nations supporting Israel during the Yom Kippur War. The ban caused an oil crisis, or 'shock', with many short- and long-term effects on global politics and economy. The Post Office began to issue petrol coupons to car owners. Food shops were exempt from the restriction.

Petrol coupons for the consultants

The Newcastle Regional Health Authority issued coupons to the consultants employed by the Authority. They had records of monthly travelling claims by the consultants for reimbursing the travel expenses. The average of the past three months of travel claims formed the basis for allocating the coupons. Coupons came in the post. However, the strike ended before the stocks depleted to enforce rationing.

I had always bought fuel from the same filling station, so I was a 'regular' customer. As a reward for loyalty, the owner gave priority to regular customers. Thus, when the stock was limited, I got fuel as a regular customer, but not as a doctor needed the car to save lives.

Ambulance services

A restriction on the use of ambulances came into force to save fuel. While in a clinic in Hartlepool, I had a call from a GP about a patient needing a home visit. The patient experienced a gradual difficulty swallowing. However, for the past two days, he had complete obstruction and he could not even drink water, resulting in dehydration. The patient lived only a few streets away from my home, so I told the GP that I would see him in the evening on my way home.

When I saw him, he was severely dehydrated and certainly needed urgent intravenous fluids. I phoned for the ambulance to take him to the hospital. The controller asked me when the GP requested a home visit. 'In the morning', I said. He said, 'We can only pick up home emergencies which have been requested by a doctor in the past two hours. All other cases are not emergency cases.'

The household did not have a car. Taxi service was also problematic and cost money. The relatives asked the neighbours, but they said they needed to go to work with whatever fuel they had. I was also in the same position – with limited fuel.

In the end, we found someone down the road who took him to the Infirmary. And I went home to have that well-deserved dinner.

Turn down that thermostat

The order came to turn down the thermostats in the hospital, apart from the wards and the theatres, to 17°C. While treating outpatients, we wrapped ourselves in warm clothes. However, when I started the day seeing the patients at a clinic in Hartlepool, my fingers and hands started getting cold. At 17°C, the stainless-steel instruments were also cold. The patients did not complain since the cold instruments were tolerable for a short contact. But for me, I was handling them continuously, patient after patient.

We asked the hospital secretary if we could turn up the thermostat in the clinic; he apologised and refused the request since the Government order was for 17°C.

In the clinic, we had a hot plate to keep the coffee warm. There was no restriction to use it. So, we plugged it in, laid out all the instruments and continued the clinic, with instruments comfortably warmed on the hot plate. Two can play the game!

A large proportion of the population in the UK in the seventies was war-hardened. Life during the war years must have been ten times worse than what was happening in the seventies. There were no ill feelings against the striking miners, or, for that matter, the war in the Middle East.

A snoring policeman

The police in Cleveland had a private insurance cover for hospital treatment. A burly looking large policeman walked into my rooms with a complaint of nasal obstruction and snoring. Being a policeman, he might have had punches on his nose in the line of duty, I thought.

'Since how long have you had the breathing obstruction?'

'Oh, for a few years.'

'So, what makes you come to me for it now?'

'Well, seven of us are on duty to watch the striking miners to keep control. We sit in a police van on the bridge crossing the A19. By lunch time lasses bring sandwiches and tea and coffee. I have a few. and then I can't keep awake. My mates complain I snore too loud and disturb their sleep! So, they nudge me to wake me up, but I can't stay awake. So, they said I must get my nose sorted out.'
'So, who are the lasses? Your wife and her friends?'
'No, they are the wives of the striking miners; they are our neighbours and take turn in bringing sandwiches.'
'So, there are no ill feelings?'
'No. They know we have to do our job, same as their husbands have to go on pickets. We are all a close-knit community. Government can't break us up.'

Dark nights – baby boom

With no late-night television, people went back to doing the things they used to do before television came into their lives. Nine months after the blackout winter, there was a baby boom. The three-day week also enabled families to spend more time together. It will be interesting to see if we have another baby boom due to the covid lockdowns and working from home when the stats come out!

A loud bang at the Infirmary in the middle of the night

The night staff heard a loud bang one night and rushed to see what had happened. A roof of one of the ophthalmic wards on the first floor had come down. The ward was empty due to NHS strikes. The metal frames of the beds were twisted under the weight of the collapsed roof. If there is any good that comes out of the NHS strike, this was it; 'thank God for the strike; there were no patients'.

The Infirmary was ageing, and we kept patching it up. To conserve the heat, we built a false ceiling. The main corridor started to tilt and needed urgent attention. The support was strengthened, and the floorboards were replaced.

When I came back to the Infirmary as a consultant in 1970, there were some seventeen hospitals dotted around the county of Cleveland. A large central hospital with thousand beds to serve the modern needs was planned – the current James Cook University Hospital, in Marton. It was built in phases. The Infirmary was last to move to the new site in 2002.

The ultimate driver of the NHS – the consultant, but who controls the consultants?

Right from the inception of the NHS, the consultant remained the ultimate driver of the system, in whatever way it delivers health care to the nation. This was especially so in the sixties, when I was SHO. As mentioned elsewhere, the consultants were the 'visiting' doctors. The trainee doctors and the matron had to wait at the front door to receive the consultant and go round the wards. After all, it was their goodwill to work for the NHS, which ensured its launch. The 'Medical' staff committee ran the hospital affairs. The hospital manager was 'in attendance' and followed the committee's decisions on all matters. But when things

go wrong at the consultant level, who controls the consultants? Fortunately, there are not many such instances, and the system works by and large. Nevertheless, it has its downside, as my following experience in the seventies will show. It also describes the evolving role of the GMC as the ultimate controlling body of doctors.

Pre-GMC regulation of the medical profession in the UK

Before the GMC,[25] nineteen bodies regulated the UK medical profession, each having its criteria for competence. The 1841 Census estimated that a third of all practicing as doctors in England were unqualified.

General Medical Council – 1858

The General Medical Council (GMC), as a legal body, was established in 1858 for overseeing Medical Education and also to maintain a register of qualified doctors. It also published a pharmacopoeia. In 1860, Richard Organ was the first 'doctor' to be removed from the register for being unqualified. In 1899, the council held its first hearing with a doctor facing a 'drunkenness' conviction.

When I came to England in 1963, the GMC's role was to ensure that the doctor was suitably qualified to be listed as a GMC-registered practitioner. The procedure involved presenting a certificate of the basic qualification of MBBS from listed educational establishments in several Commonwealth and other countries. Once registered, the GMC never came into the doctor's professional life ever again!

The Three Wise Men (and/or women)

In the '70s era of the NHS, the consultant body formed a small committee of seniors, 'The Three Wise Men and/or Women'.[26] Its task was to investigate concerns about a doctor at an informal meeting. It would then advise the hospital management or the regional health authority if any supportive measures or sanctions are required to correct the doctor's behaviour (clinical or otherwise).

Medics are human beings, no more, no less than anyone else. They are subject to the same pressures in life as most others, and the solution they find cannot be 'out of the ordinary'.

Along with one other medic, I became involved in corrective measures of one of the medics, X, who unfortunately found an easy escape in the bottle (of alcohol). A long period of impasse followed as to how best to handle the situation. A culture of 'look after one of your own' was very much prevalent, and nothing more than glances and raised eyebrows were in evidence. Nobody dared confront X, ask direct questions, and solve the problem, which demoralised the hospital staff.

The Infirmary was like a small family, caring not only for the patients but also for fellow workers at all levels. Since it was isolated from the mainstream general hospital, the matter remained 'local'. However, after serious discussion with my co-medics, we double-checked the work to ensure nothing significant was missed. We also covered the on-call rota. Annual holidays meant being on call every single day and night for a couple of weeks or more.

We appointed a locum doctor who ran clinics and performed tonsils and adenoids surgery. Once, he could not manage to control postoperative bleeding. I had to rush in the middle of the night. The child had been inhaling the blood which clotted in his airway like a cast of the tracheobronchial tree. I at once stopped all cold surgery both in Hartlepool and in Middlesbrough. We were in a serious situation. If an emergency arose in Middlesbrough while I was operating in Hartlepool, it would have remained unattended until I could get back to Middlesbrough. Covering singlehanded two hospitals some seventeen miles apart twenty-four hours a day for a good two or three weeks was asking for trouble. I also cancelled routine clinics and emergency cover in Hartlepool. The patients had to go to the Infirmary.

Everyone, including the administration, was aware of the dire situation we were in, but such was the power of the grade; no one in admin dared say anything or take any action.

Inevitably, things went from bad to worse. In ENT, there is very close bodily contact with the patient. Some patients mentioned to the nurses the smell of alcohol on X's breath, even during the morning clinic. A staggering walk, slurred speech, slow reaction time, impaired memory, and several attempts to open the car door meant that the time had come to do something more.

The hospital morale hit rock bottom. Nobody likes to witness the downfall of a professional person due to a disregard or lack of sympathy.

One day the critical point was reached. While examining a patient, X could not balance and hit the corner of a desk with the forehead. A hospital admission followed; the blood sample was sent to be checked for alcohol, and the Three Wise Men summoned. X was sent on enforced leave to dry out.

Today, the onus of reporting and further action is on the colleagues. If they fail to do so, they will be answerable for their failure to act, and themselves face disciplinary proceedings. Reassuringly, the unfortunate doctor will not be ostracised but instead given support so that he/she can return to work if and when the matter resolves. For this, I congratulate the system.

Work to rule by the consultants

Barbara Castle, the Secretary of State for Health and Social Services, proposed a new consultant contract that would curtail private practice in the NHS hospitals. The ancillary staff also supported the government policy since consultants, using the NHS staff, the NHS time and equipment, charged the private patients and bumped up their earning. Although the NHS did charge the private patient for using the NHS facility, the staff did not receive extra money for private surgery and postoperative care.

The consultants called off the action when Barbara Castle agreed that the consultants opting out for part-time NHS contracts could continue the private practice.

Later that year, consultants again took action when Ms Castle proposed plans to phase out private work from the NHS hospitals. The British Medical Association urged consultants to limit their work to emergencies only (but to care for those already in their wards).[30] I felt it to be entirely wrong not to do clinics, but had to abide by the BMA stance. The action was suspended after the government's legal expert, Lord Goodman, produced proposals to hand the issue over to an independent board.

Growing vegetables – a by-product of the industrial action by the consultants

The consultants worked to rule and suspended all 'goodwill activities' between January and April of 1975.[31] I used my time to read a series of gardening books, *Be Your Own Doctor*. I read them as if I were going to take an examination. Neena was eleven years old. At the end of each chapter, I asked her to test me with questions. Such a smile and pleasure showed on her face when I was wrong. 'WWRRrong!' And then she read out the correct answer.

In contrast to commercial growers, if you grow vegetables for fun, there is a likelihood of hit or miss, and that is all part of the learning process. After my retirement, I took up growing vegetables as a serious undertaking. Germination is a critical time. Many factors influence the process: the compost, the depth of seed planting, the moisture and the temperature. If you get any of them wrong, germination fails, and there is no harvest. On top of it, I have come to believe firmly that the seeds have some other mechanism that determines germination success. I have often encountered that the germination has failed even though all of the conditions mentioned above were in place.

Of course, you can go to the supermarket and buy what you need. But that is not the point. Growing your own food is a challenge, and I have always lived for overcoming challenges! If you have made an error such as planting too soon or watering either too much or too little, and the crop fails, it takes one full year to correct your mistake. And then the following year, you make some other error, and again, no crop. After about five years or so of getting the things just right, we can grow our vegetables successfully to the extent that we hardly need to buy any from the supermarket for a good many months. What is for dinner? Whatever is ready for harvesting in the garden. The taste and flavour of freshly-harvested produce are something you have to experience first-hand to appreciate. And as a bonus, we know that farmyard manure and our recycled kitchen and garden wastes give all the goodness back to the soil. Thank you, Barbara Castle!

Half-way house – a recipe for 'Clash of Civilisations'!

The current (*i.e.*, in the year 2021) ideological division between the free-for-all NHS and the private health-care system is the worst of both worlds. Following a routine colonoscopy for polyps at a private hospital, I developed symptoms of peritonitis, a potentially fatal condition. In line with most such hospitals in the country, the private hospital had no facility to accept emergencies, and I had to go to the NHS A&E. After four hours of waiting, a bed became available, but no doctor came to see me for hours. A hundred miles away, my dentist daughter was concerned about the delay and told me to tell the nurses I have severe pain – eight out of ten on a scale of one to ten. When I did that, it did not produce a doctor in a hurry; instead, a couple of Panadol and a glass of water arrived. As a medical student, I recalled the teaching of 1955, not to give analgesic to an acute abdomen lest it masks the symptoms and leads doctors into oblivion. Perhaps that teaching is now outdated. Lying in bed helplessly, I felt my time had arrived to say goodbye in my hospital where I had served for thirty odd years. But, of course, the body is quite resilient and does not give up so easily. After another five hours of wait, doctors, who had been busy operating, came to see me and started intravenous antibiotics. So, I lived to tell the tale, until another time, that is.

Can you put your hand on your heart and tell me?

Health service undergoes frequent reorganisation. For example, school clinics, previously run by the Education Authority, came under the NHS. One day, I had a call from Area Medical Officer. He asked me some details about the clinics and suddenly, out of the blue, said: 'Can you put your hand on heart and tell me that you spend three and a half hours at the clinic?' I instantly said, 'My conscience is not open for probing by anybody,' and walked out. But, of course, he would not know that I went well over my contracted hours most days.

Tongue sandwiches during total glossectomy

Most of the cancer surgeries took the whole day. The sandwiches would come around lunchtime from the canteen, and we would take a break at an opportune moment as per the progress of the case. One day there were no sandwiches. A new canteen supervisor wanted to know 'who was going to pay for them'. Now here we were, in our full theatre gear, discussing if someone's functioning eye should also come out during maxillectomy for an extensive carcinoma to achieve a complete clearance, being bothered about paying for the sandwiches before we got them. I picked up the phone in a rage and called the hospital manager. The sandwiches arrived.

The following week, we did get sandwiches without asking for them. However, there was one snag. They were tongue sandwiches. Most of the morning, we were holding the patient's tongue in our hand and excising cancer that arose in it. And now for lunch? Tongue sandwiches. Perish the thought. On a similar note, there were no biscuits during the operating list when we took a coffee break. The reason: it was now 11.40, and 'nearly time for lunch' at 13.00. We could have biscuits with coffee if the break would be at 11 am. I wished that some bureaucrat was on the table, halfway through the surgery, and I am enjoying those biscuits precisely at 11 am. Cruel? OK, forget it. Did you really think I would do such a thing?

No slot for 1 pm appointment

I always called the patients for suction clearance of the ear canal during lunchtime since they do need extra time. However, a recently installed computerised system would not book a patient for me at 1.10 pm. 'Mr Oswal, one to two pm is lunchtime, and only emergency patients can be scheduled in that time slot.' A double whammy? I must not see patients between one and two pm. And the computer will only accept the patient's names as emergency booking since an emergency, by definition, cannot be booked in advance. Computers, robots are logical devices. When logic is required for a task, they outperform the human brain. But currently, they do not work illogically. Artificial Intelligence (AI) should do the trick of thinking illogically. Time will tell, but logically, I will not be around. Illogically I may live to a ripe old age of two hundred. In the end, we agreed to cheat the computer and ask the patient to come, without an appointment slip, every two months during the lunch break!

I recall a conversation with a colleague: 'What do you do during the lunchtime?' 'Well, have lunch, I suppose.'

Only three patients in the afternoon clinic? Why?

During an afternoon clinic at the Infirmary in the mid-seventies, I had only three patients booked for the whole afternoon. There was a shortage of clerks in the records office. A couple of them were on maternity leave, one or two on holiday and one or two on sick leave – an unusual combination of factors.

There were such shortages in the past, but they always appointed a temp (temporary staff). I phoned the hospital administration secretary and asked why there were no temps.

'We have no money to employ them.'

I was furious. Here I am, taking a consultant salary, nurses are getting their wage, we have a waiting list for the patient to get a clinic appointment and all that a waste, just for a few bobs' worth of a temp? I phoned the Chairman of the Authority. She came to see me in the clinic.

'What is the problem?'

I explained, still boiling with a temper and frustration about not having money to employ temps.

'Yes, true. We are approaching the end of the financial year and we have overspent already'.

'I feel guilty, sitting here and not working. I did not take this job just to sit around, I took this job up to help people, to see them, to operate on them if need be.'

'Oh yes, I understand your viewpoint as well, but everyone is doing their job conscientiously, and that includes the admin staff. But I will see what I can do.'

The next day there were temps, and the clinics went back to normal. But, of course, NHS will always be underfunded and overspent; that is in the nature of the beast we have nurtured as our national institution.

Whose needs are a priority? A child who cannot breathe for want of an injection costing £ 1.8 million, or mine, needing a few pounds for a temp so that I can see all those patients waiting for an appointment? If there was an answer, you would not be reading this.

Life is not a joy ride. At every step of the way, there are obstacles. Some you succeed in overcoming, others you give up. But I am not the one who would give up easily. As you will read further on, when I wanted to develop new technology, a surgical laser, I did not take no for an answer. I went public, raised the money by donations and got the laser – the first in the UK for airway management.

Laser surgery – an esoteric practice?

I had been doing some School Clinics at the Child Health Centre in Hartlepool, run by the Education Authority and thus outside the NHS contract. When I needed more time to develop laser technology in the eighties, I asked our clinical assistant to take over these clinics. The hospital secretary became suspicious of my actions and started asking my secretary to give him a count of private patients I had admitted in the past five years. When my secretary mentioned this to me, I was livid. I wrote a letter to him along the following lines:

'You were completely out of order to put my secretary in a position to spy on me and watch my private patient activity. For your information, I have given up school clinics to get more time to develop laser technology'.

He wrote back, 'You are giving up clinical work for esoteric practice.'

I was hurt. I wrote back: 'I am developing laser technology for treating cancer patients in the NHS. Obviously, you know very little about me and my intentions. To educate you, I am going to send you one letter every day, giving you all the information you need about me, in the hope that you will change your opinion about my NHS practice, my private practice, and my esoteric practice.'

I started the letter with all my medical qualifications, which took fifteen years of hard study. And the work I had put into developing the Infirmary during the seventies and so on. Then the evenings and the weekends, I spent collecting funds via a public appeal. And finally, a description of how the laser technology will save a patient from undergoing a mutilating operation of removing the voice box. After four days, I received a letter apologising for inquiring into my private practice and asking me not to write any more letters. I do not hold any ill-feeling against the hospital secretary. He was following the ways of the world he lived in; it was not my world.

So, this episode takes us nicely to a significant part of my academic career in the next section, Section V, 'Pioneering work on Lasers in Otolaryngology, H&N surgery'.

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Section V

The laser – a new animal (1982 – 1995)

What is surgery?

Surgery is the branch of medicine that deals with physically manipulating a bodily structure to diagnose, prevent, or cure an ailment. Ambroise Paré,[1] a 16th-century French surgeon, stated that to perform surgery is, 'To eliminate that which is superfluous, restore that which has been dislocated, separate that which has been united, join that which has been divided and repair the defects of nature.' Since antiquity, we developed surgical techniques when we learned to make and handle tools. Each subsequent modification or a new method was more sophisticated than the previous one.

For undertaking a surgical procedure, we need instruments. Every surgical instrument is a specially designed tool or device for performing specific actions of carrying out desired effects during surgery or operation, such as providing access and viewing tissue and modifying it or excising it.

Surgical instrumentation dates back to the pre-historic period.[2] Trephines for performing round craniotomies have been found in several Neolithic sites. In Antiquity, many instruments were manufactured from bronze, iron and silver. They are still very well preserved in several medical museums around the world. The impetus for further development of instruments gathered pace with the discovery of anaesthesia and surgical asepsis, allowing safe exploration of body cavities, viz., the skull, the thorax and the abdomen. Advances in these fields have transformed surgery into a scientific discipline capable of successfully treating many diseases and conditions. New materials, such as stainless steel, chrome, titanium, and vanadium, marked another significant advance in manufacturing precision instruments.

I had been doing extensive H&N surgery since the early 1970s for patients from a wide catchment area in and around our county of Cleveland. Excision surgery for H&N cancer is an anatomical dissection, preserving vital structures while taking the diseased portion out. The first ten, twenty procedures make you feel great, to have carried out major surgery successfully. The next ten, twenty patients will make you aware that variations in the technique are sometimes necessary. After a while, you develop an almost automated routine that does not require highly focused effort. The theatre nurse, sister Milburn, and other nurses, had also learnt my way of working and put the right instrument in my hand without asking or indicating. However, she would also know a critical stage of the operation which needed focused attention.

Some years on, I was told by the theatre staff that when I needed to concentrate for some stages of the operation, such as dissecting cancer from major blood vessels, I would start whistling. Everyone took a cue from the whistling and maintained silence in the theatre. Once that critical stage was over, sister would tell the staff nurse, 'Put the kettle on,' and everyone relaxed, ready for a break. The senior registrar (SR), a senior trainee doctor, always assisted me as part of the training. He/she would be given some steps of the operation to

perform while I took the role of assisting.

Sometimes, when the SR was on holiday, a registrar and Dr Udi Kumar, a permanent staff member, would assist me. Once, as Udi was advancing an artery clip to clamp a bleeding vessel, it looked as if he would miss the vessel and damage some other tissue nearby. I said to him, 'Watch where your clip is going, Udi.' He replied, 'It's OK, Mr Oswal.' And he caught the bleeder successfully. We then realised that he was holding the clip in his left hand. Udi Kumar was a left-hander[3].

Udi Kumar and his wife Ann

Most people are born with a dominant right hand, known as a right lateral bias. The world around us is distinctly right biased: it is almost impossible for a right-handed person to use everyday scissors with the left hand. In surgery, most instruments are designed for right-handed surgeons. Instruments designed specifically for left-handed surgeons are available. But our theatre set-up, in common with most theatre set-ups, did not have them. They are visually difficult to separate after autoclaving; they also add to the expenses. Fortunately, Kumar was ambidextrous, and thus, apart from approaching tissues in an awkward direction, he was comfortable with right-handed instruments.

Laser surgery – a paradigm shift and a rudderless tool

Lasers[4] brought about a completely different kind of technology in the form of a beam, shown on the tissue from a distance. When activated, the beam cuts the tissue and, in the process, seals off the blood vessels, rendering the operation almost bloodless – a paradigm shift indeed.[5] The introduction of lasers represented a truly novel way of undertaking surgery. It required a new skill acquisition by the surgeons.

The first time I came across the laser machine was in one of the conferences in the USA where it was on display. It was a Ruby laser.[6] The prototype was about ten feet long; there was a 'beam stop' at one end. It interrupted the beam resulting in the formation of a circular spot. Years went by. The next time I saw the laser again was in 1981 at the IFOS (International Federation of Otolaryngological Societies) Conference in Budapest, Hungary. It was now a commercial model for use in clinical practice.

The CO_2 laser was one of the earliest gas lasers invented by Kumar Patel of Bell Labs in 1964[7] and remains one of the most useful types of lasers. Interestingly, Kumar Patel was

born in Baramati, a town in India, only a couple of hundred miles from Pune, where I come from. In the late fifties, Patel received a Bachelor of Engineering (B.E.) degree from the Government College of Engineering, the University of Pune, India. I received a Batchelor of Medicine and a Batchelor of Surgery (MBBS) degree from Government Medical College, the University of Pune, in 1960. I did much pioneering work in its clinical applications. Kumar invented the CO_2 laser, and I developed its clinical use[8,9,10.11] – both receiving undergraduate training from the University of Pune, more or less at the same time, in the fifties – what a coincidence! However, we have not met or had any contact.

The next few pages cover my very early involvement in this paradigm shift[7] in surgical instrumentation – from raising money by public appeal to acquiring the machine and teaching myself its use for surgery on the mouth and the airways. My pioneering work in the surgical use of lasers in the UK brought me into prominence, both nationally and internationally – such an event rarely occurs in one's professional life, leading to publications of the three books on lasers and globetrotting for teaching courses and conferences.

No money in the NHS budget to buy the machine.

I received a quote £ 40,000/- from the laser company 'Coherent' and forwarded it to the admin office in another hospital. It was a princely sum indeed. Weeks passed by, but there was no response.

The bug in my head

One lunchtime, I happened to go to a shop, 'Plastic Signs', to get some signs for my private consulting room. While waiting, I mentioned to Mrs Pearson, the shop owner, my frustrations in getting the NHS funding for the laser machine, the most advanced technology for ENT surgery. I told her all about the laser and how it would help patients. I noticed that she was listening intently with much interest. Finally, I told her that I was thinking of raising the money by public appeal.

While doing the afternoon clinic at the Infirmary the same day, I received a phone call that she and her husband, Mr Pearson, would like to talk to me about the public appeal. I spent a good twenty minutes with them explaining everything. They said they did fundraise for many noble causes and had a team taking on a particular activity each year. They would very much like to get involved in this project as their next endeavour.

However, to launch an appeal, they needed a letter from the hospital authorities that they did not have the money to buy it. I wrote to the admin people again. This time, they responded to say they would include the requisition in the 'forward planning'. What chance did a peripheral small district hospital stand to get the ultra-modern equipment when it was not being used by any reputable centres of excellence around the country?

In the end, I wrote to them that I would go to the Evening Gazette and make people aware that they would not get the modern hi-tech treatment for their ailment because of a shortage of funds. The strategy worked, and I got the letter! Mr and Mrs Pearson were delighted.

Fundraising philosophy

Nevertheless, I passionately believed that the Government should provide all the necessary money to ensure that people get the best. I did not have to 'beg, steal or borrow'. But every story has an alternative viewpoint. Once I was in an admin meeting at the hospital where I met the chief bureaucrat. I aired my disappointment for not getting the money from the hospital and having to go public for the appeal. He said, 'Oh no, it is a good thing to get the local communities involved; they get to feel that the facility is theirs rather than some distant organisation from another planet meeting their health needs – much better!' I have to admit that there is some truth in what the admin chief said. The fundraising appeal to acquire laser technology for a small Eye and ENT hospital in Middlesbrough in the Northeast of England brought a sense of purpose for everyone in the hospital. It injected vitality into the mundane day-to-day routine. Bed push events were organised with enthusiasm never seen before. As the donation continued to mount exponentially, there was a palpable exuberance amongst the staff: domestics, cleaners, porters, nurses, admins, everyone. When it comes to supporting a cause for our beloved national institution, the National Health Service, the outpouring of affection has no boundaries.

Within a couple of months, the fundraising movement took off. I had to go to many events such as the ladies' evenings and explain these hitherto never heard of 'Magic Rays', which offered bloodless surgery. Good, but yet another angle to fundraising was even more appealing.

Where was the nearest one? Paris? New York? Maybe, but I could not imagine any of my patients travelling to that faraway Yankee land to get the nodule out to improve the voice. London? Yes, London was planning to get one – I was told to let slip that 'secret' now and again – most palatable.

'No, Cleveland people are not travelling to London for their treatment. We want it right here, on our doorstep, in our hospital.' 'And rightly so,' I nodded in agreement with myself!


EVENING GAZETTE, Thursday, September 2, 1982

MINERS DIG DEEP - IN THEIR POCKETS: Regulars at the Miners Arms in Skelton gave a big cash injection to the North Riding Infirmary Laser Appeal in September 1982. The drinkers, who raised almost £1,600 through a string of charity events, handed over a cheque for £1,587.09 to hospital consultant Mr Vasant Oswal (second from left). Also pictured are Malcolm Peacock, Hilda Robson, Chris Neil, Miners Arms licensee Keith Grainger, Edmund Pearson and Alan Lawson from Vaux Breweries - but our original caption does not say exactly who was who.

Fundraising

The fundraising activity reached a frenzy in a short two to three months. The money also started pouring in, mainly from the collection boxes from pubs across Cleveland – £ 3000/- a week at one stage. When a pint of something is bought at the counter in a pub, the change goes into the collection box – the next best thing after the Sunday service to ensure

a place in this earthly heaven. Two hospital clerks took two full days to count all the coins and deposit the collection in a building society account.

There are two instances during the fund raising worth a mention.

Master Butchers dinner evening: 'You take the best bit out; I leave the best bit in'

I had to go to many places to receive a big replica cheque handed over to me with a photo opportunity for all. One such event is worth mentioning. I was invited to the Master Butchers' Association to receive a donation of £ 500/- which was to be presented during their annual dinner evening. I was surprised by how formal that occasion turned out to be. Firstly, we all had allocated places, secondly, there was a welcome tune, and thirdly, the top table party entered with us all rising. The President wore a chain of office. When they were seated, the President nodded, and we all sat down. The dinner and the wine were high class, the Chateaubriand just melted in the mouth. Then, before the coffee, there were speeches. I was invited to go to the top table, and the President handed over the cheque with a few words. Now it was my turn to give a thank-you speech. Not having been forewarned, I had not prepared it. Sometimes, the best addresses are the ones that come instinctively. And this was one of them.

'All evening, I was wondering why I felt so homely amongst you lot, and after some reflection, I realised why. It is the common platform. We belong to the same profession. You use the knife skilfully, and so do we. The only difference is that you take the best meat out, and I leave the best bit in.'

There was thunderous applause of the appreciation. Then there was the toast to the Queen, the various dignitaries and all the ladies. 'To the ladies', and all the men stood up with their glasses raised above the head.

'Mr Oswal, just get that laser, I don't need a receipt'

And there was another episode, I recall. I was buying some plants for the garden in our usual nursery. As I paid the money, it went in the till. The owner then put his hand in the pocket and gave me a ten-pound note. 'This is for your laser appeal.' I was taken aback; I said, 'I don't have a receipt book on me.' He said – 'Mr Oswal, just get that laser, I don't need a receipt.' These were touching moments savoured forever. I can still see that Mr Thompson.

Forty thousand Pounds in four months

Within four months, there was enough money to pay for the laser in full – yes, all £ 40,000/-. The machine was on its way from the States. The company arranged a date to deliver it. There was a lot of razzmatazz since it was the first laser machine in the country, specifically for laryngobronchoscopy. A special coupler came with the machine – a bronchoscope adapter that would take laser energy to the lower airway (tracheo-bronchus) to destroy the cancer growth or a stricture obstructing the airway.

The Coherent CO_2 Laser model 400 in the UK*

The first Coherent laser model 400 introduced for the UK market was the laser head. It was attached rigidly to the operating microscope, and the target had to be positioned in the path of the beam- a cumbersome piece of equipment, where the patient has to be moved to it!

The CO_2 Laser model 450, with an articulated arm

The Coherent exhibited their new CO_2 laser model, 450, at the Budapest IFOS conference. It had an articulated arm with two elbow joints for angular mobility. One end of the arm was attached to the laser head. The beam travelled through the arm and exited at the other end.

Accessory systems connected to this end focused the beam precisely on the target. A handpiece delivered it to the oral cavity, a micromanipulator attached to the operating microscope, to the larynx. And the bronchoscope coupler took it to the trachea and bronchi.

When I tried the 450 model at the conference, I was able to strike an apple precisely and also move the beam (and not the apple) to etch my name on the apple. That is when I decided that I must get one for our ENT department in England.

The CO_2 Laser with an articulated arm, the first in the UK*

The generosity of the people of Cleveland allowed me to get the new Coherent 450 model with all its accessories within a short four months of launching the appeal. It was the first in the UK, a truly 'state of the art' technology, a game-changer in the centuries-old cold steel instrumentation. A ray of a beam cutting the tissue and, at the same time, sealing the blood vessels – a bloodless surgery!

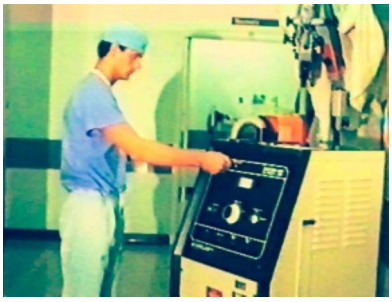
The stand-alone laser machine was to going make the theatre overcrowded. The Technicians from the Coherent detached the head from the laser console and mounted the laser head and it's articulating arm directly onto our new, very stable, Zeiss microscope. This unique arrangement gave me the ability to move the microscope and the laser as a single unit.

Self-learning: bench experiments

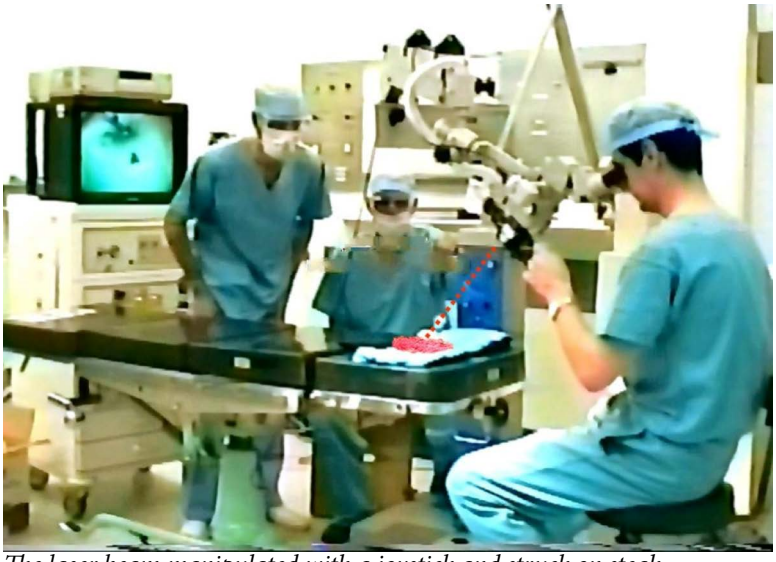
Six months before, the notion of getting the laser seemed so unreal. And suddenly, now it was there, in the theatre. But what to do with the machine, how to use it, what would the parameters be? And safety aspects? Nowhere to go to, no courses, no books, just a few articles, mostly describing clinical results. The basic knowledge did not exist.

I decided to undertake bench experiments. We had three technicians in the theatre: Dennis, Paul and Gordon. I asked them if they would stay back and help me with the machine. I would, of course, pay them for doing this extra work outside their hospital job. They agreed and were delighted to be the explorers with the surgeon. Everything was new to them as well, and there was an element of curiosity. But much more than that,

L-R, Dennis, Nirmal, Gordon, Paul and Vasant



Staff nurse Paul getting the Coherent Laser machine ready for bench experiments (1982)



The laser beam manipulated with a joystick and struck on steak

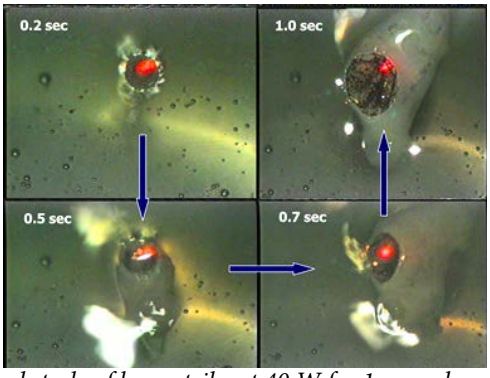
unwittingly, they started to have their input; it did not matter if I was a surgeon, and they were the technicians! We all were learning. Later, a nurse, Caroline, also joined in.

We got the machine out in the main theatre along with the microscope upon which the laser was mounted. We put on the protective goggles and started the machine. After familiarising myself with the controls, it was now time to fire it – yes, but on what? One of them said, how about a steak? Good idea. The butcher's shop was just across the road.

One of the boys (that is what they were labelled by Nirmal affectionately sometime during one of the courses) operated the video, the other one controlled the settings on the machine, and the third assisted me.

Steak and egg white as biological model

I struck the steak with the laser beam set at various power and exposure times. Then I cut through each laser strike to assess the depth and the width of the burn. The whole experiment was video recorded. There are thirty frames in one second on U-Matic tape. By studying the recording frame by frame. I learned the effects of the laser strikes at various settings.



Time lapsed study of laser strike at 40 W for 1 second on egg white

Later I thought of using an egg white. A single laser strike on the surface showed the char. But underneath the surface, the egg white formed a coagulum. The extent of the coagulum was directly related to the power setting and the exposure time.

The egg white model proved most useful to see the heat spread during each strike. It also showed that the spread was related to 'fluence' – the speed at which you pass the laser beam on the egg white. The slower pass showed deeper thermal damage.

The literature search fails to show a systematic approach to the new laser technology. Our YouTube video of 1982 shows a systematic approach to the full and safe use of the lasers in the oral and laryngeal surgery with bench experiments and surgical cases (https://www.youtube.com/watch?v=cCBTLWo2DJM: Laser Technology in ENT in 1982. Pioneering Work of Mr Vasant Oswal, UK. Warning: contains graphic images).

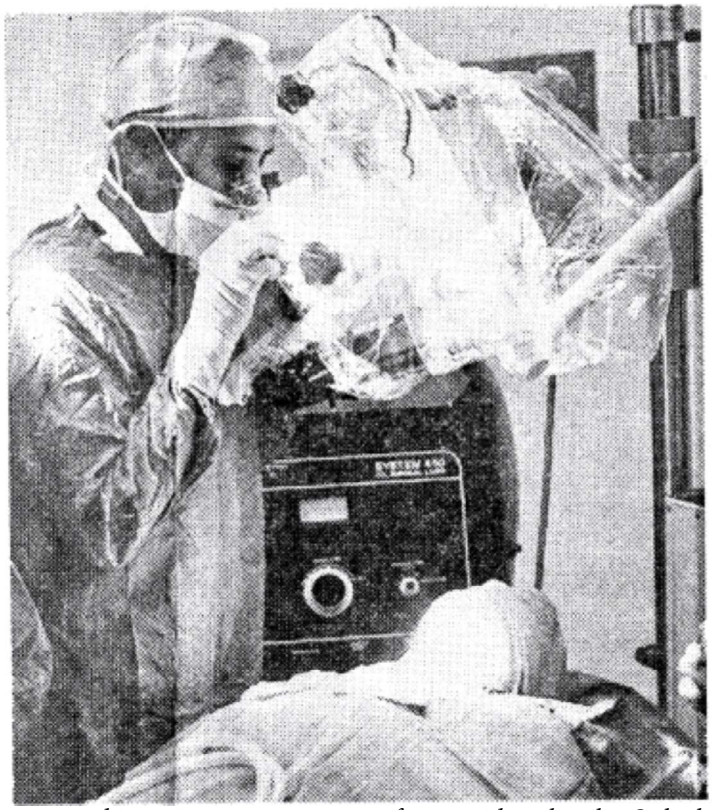
Laser Physics

Asia Pacific Laryngology Association website: https://www.aplassoc.com/.[11]
Those who are interested in more in-depth reading on this fascinating topic, I strongly recommend logging on to the Asia Pacific Laryngology Association website. When you click the home page, scroll down to 'E-Learning Programme, an open access resource. The only requirement is to enter your eID and self-generated password, a one-off process. Click Lasers in Laryngology to access it. The text covers the basics of laser technology and clinical applications, explained with graphic slides.

The first patient for laser surgery: cancer of the tongue

Everyone in the hospital was getting anxious. When was I going to use the laser on the patient? Who is going to be the first patient?

Although I had carried out several bench experiments, they do not necessarily equate to using the laser for actual surgical procedures. The most telling aspect was the lack of feedback associated with the knife. You needed to assess the progress frequently since the laser cutting cannot be speeded up just by pressing the foot that bit harder! And the power cannot be increased either since it will simply spread sideways.



Patient's face wrapped in moist gamgee to protect from accidental strike. Only the oral cavity is accessible.

One of my patients with tongue cancer needed a surgical procedure to cut out the cancerous part. I was now confident that the laser could remove the growth instead of the knife. If things did not work out as expected, I could always go to the conventional method and complete the surgery. I explained to the patient that I could use the laser and told him how the laser is just another knife, but with some beneficial properties. We obtained specific consent for the use of the laser.

The most agreeable aspect was the totally dry field, with no bleeding until you happen to strike a fair-sized blood vessel. The shrivelled tissue seals off the cut end of the capillary-size blood vessels, thus stopping them from bleeding. At the end of the surgery, I sutured the raw surfaces as usual.

Everything seemed to have gone well, and the patient was sent back to the ward. Nothing much happened that day. The patient was comfortable, awake.

The patient, after the laser surgery on the tongue

The following day, I went to see him in the ward. To my utter surprise, he was having breakfast – full English breakfast! 'No pain?' 'No,' was the reply. Now that was another striking feature of laser surgery that was completely unforeseen. The laser energy had sealed

WEEKEND GAZETTE, Saturday, April 17, 1982

Light fantastic

EVERY so often an appeal is launched which captures the imagination of the people of Cleveland.

Barely had the £¾ million scanner appeal closed before people began plotting to whip up £40,000 in the constant battle to beat the most feared and cruel of all diseases — cancer.

The North Riding Infirmary in Newport Road, Middlesbrough, asked for the money to buy a laser which could eradicate ear, nose and throat cancer with more ease than any scalpel.

The people of Cleveland heard the appeal and set about answering the latest call for help.

Cancer is being attacked on all sides — by X-ray, by surgery and by chemotherapy.

The laser would bring tomorrow's technology to our doorstep today making the Infirmary one of the most technologically advanced units in the country.

The laser and the whole body scanner will be used together — the scanner to pinpoint the cancer and the laser to treat it.

The laser is the latest in modern surgery. Its precise beam of light can but down to ¼ millimeter through delicate tissues and burn through the diseased, cancerous tumours.

It is finer than a scalpel and can be used with a microscope to perform the most delicate of tasks, causing minimal bleeding and leaving less scarring for the patient.

Consultant surgeon at the Infirmary Mr Vasant Oswal, calls the laser his "baby."

He first came across it at an

The laser with people appeal

Weekend Backgrounder

"It was still experimental and needed further research. As progress went along its use was getting more and more established," said Mr Oswal.

Report By LYNN DALY

In June last year Mr Oswal decided that it was time for the Infirmary to move ahead of the times and buy a laser for itself.

"There are five Ear, Nose and Throat units in the region and none of them has a laser. If we waited for the authorities to provide us with one we could be queing up for at least five years, so we decided to buy our own," said Indian born Mr Oswal.

vince the then Cleveland Area Health Authority that the appeal was a viable proposition.

"It took a two-and-a-half months to convince them and finally they made up their minds and said yes. They pay the maintenance so we needed their permission," said Mr Oswal.

Overwhelmed

Once the go-ahead was given a nine-strong committee was formed and the appeal was formally launched. A saturation publicity campaign was mounted and the public took over.

"We were overwhelmed by the response" said Mr Oswal. Maybe because it is an old hospital or maybe it is because people do want the best

● Consultant surgeon Vasant Oswal performs a laryngectomy at North Riding infirmary using a laser machine on loan for a day.

money came in," he said.

Just four months into the appeal, the fund has topped £80,000.

The Infirmary hopes to order its laser by the end of May and have it installed and in use at the hospital before the end of the year.

"It is going to be used all day every day for cancerous and non-cancerous growths. I couldn't ask the people of Cleveland to provide for something that wouldn't be used all the time," said Mr Oswal.

"I don't want people to think it is going to be a

a worthy cause and will be the most advanced treatment for ENT cancer available today," he said.

A laser for the Infirmary would mean a more comfortable, speed and convenience for patients and surgeons.

Best

"It would mean so much not to have to send patients out of their own area. We are one of the best hospitals of our kind in the country and a laser will make us even more advanced," said the 47-year-old surgeon.

"It is the most sophisti-

make the hospital somewhere that people want to come and work and be treated.

"Already we are recognised by the Royal College of Surgeons as a unit where standards are high enough to teach. There are only three registrars in the Northern region — two in Newcastle and one who rotates between here and and Dundee," said Mr Oswal.

The laser would not only benefit the people of Cleveland but others from North Yorkshire, Durham and Cumbria.

Mr Oswal has already treated two patients with the laser, while it was on loan from the American company who are supplying it.

He removed part of a cancerous tonsil from Northorpe mother Mrs. Christine Gibson who is now part of the appeal fundraising committee, and performed a laryngectomy on a male patient.

The hospital has already progressed in leaps and bounds since Mr Oswal arrived there in 1963. The hospital's capacity has more than doubled in size and there are now four consultants instead of two.

Skill and hard work has earned it and its surgeons a reputation as a valuable and talented unit.

Now the technological dream is nearing a reality, thanks to hundreds of groups and organisations who have concocted every conceivable money-raising event.

"If other countries have the laser, why not us? If I was a patient here I would like to think I would be getting the most advanced technology on my doorstep. With the laser

Media publicity

off the nerve endings, and thus the patient did not experience pain from the wound. Pain from the tongue? Just bite your tongue and see how painful it can be. When I examined his mouth, another surprise, all the stitches had given way. Because there was no pain, the patient was moving his tongue freely for speaking and eating, and thus the stitches were gone.

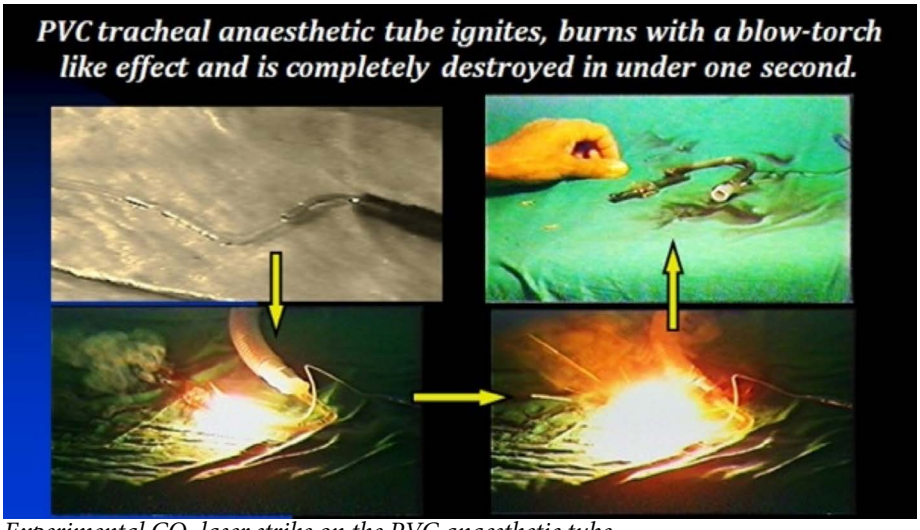
Another lesson for me: there is no need to stitch the wound!

Yet another surprise, with conventional surgery, there is a fair bit of swelling around the operated area – an inflammation. But with laser surgery, there was virtually no swelling around the wound. Because of this, when healing was complete some six weeks later, there was minimal scarring. As a result, a functional movement of the tongue was well preserved speaking and swallowing. In every respect, therefore, the laser proved to be a preferred method for surgery in the oral cavity. The pathologists were very interested to see the microscopic effects of laser strikes. There was a zone of extensive charring which made it difficult to define clearance. The spot size of my first machine was 700 microns. Advances in technology reduced the spot size and also Digital AcuBlade Micromanipulator[12] addressed this issue.

A ground-breaking event indeed for two reasons, the public appeal raised a huge amount of money in a record time of just four months, and it brought tomorrow's world to that North-East corner of England, the County of Cleveland! It received substantial press publicity.

Anaesthetic tube: a fire hazard[13]

In laryngeal surgery, there remained one shortcoming – the evermore presence of the flammable anaesthetic tube. The airway and the voice box are shared by two interdependent medics, a surgeon and an anaesthetist. The anaesthetist puts the patient 'under' by inserting an anaesthetic tube in the larynx. It has to stay there throughout the procedure. Aluminium tape wrapped around the tube was one solution, but not ideal. Sharp edges of the tape were traumatic, and occasionally, the tube was exposed between the spirals in the oropharyngeal curvature.



Experimental CO_2 laser strike on the PVC anaesthetic tube

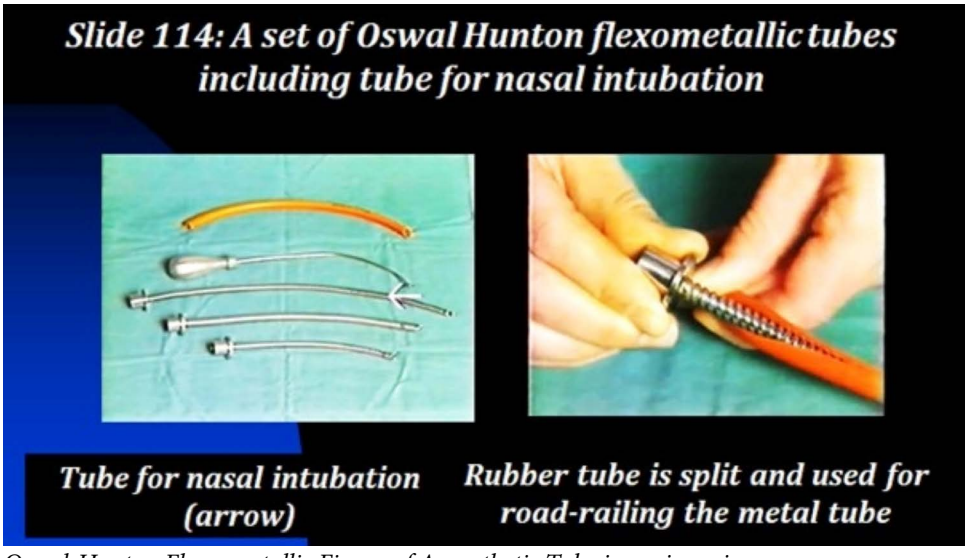
While discussing the anaesthetic management of a patient who was to undergo a laser laryngeal surgical procedure, I asked John Hunton, our consultant anaesthetist, what would happen if the laser beam struck the anaesthetic tube. He said, 'Don't know, let's find out at the end of the list.'

I got the equipment ready; John connected a plastic anaesthetic tube to his machine and laid it on the operating table in the theatre. We had a bowlful of water just in case there was a fire. I positioned the laser machine and struck the tube with the beam. The tube ignited instantly, and it was set on fire, no, not fire, more like a conflagration. I put the tube in the water, but it continued to burn underwater. I asked John to stop the oxygen. The fire had destroyed most of the tube, leaving charred debris on the towel. The whole sequence was recorded on video.

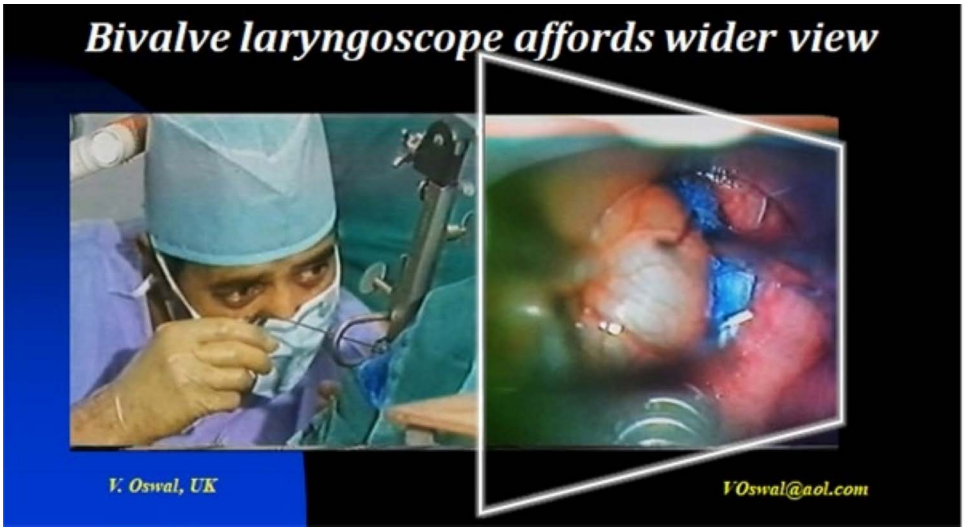
We were all a bit dazed by the experience. A strike on a rubber anaesthetic tube also resulted in fire, but slightly slower. There was a fair bit of smoke in the theatre.

Oswal-Hunton fireproof flexible metal anaesthetic tube[13,14,15,16, 16a]

One day, while having a shower, I suddenly thought, why should the tube not be a flexible metal tube like a shower hose? We designed a prototype with the help of the medical physicist Dr John Haywood and John Hunton, and it worked well. A hunt for a suitable material was successful; a role of coiled flexible stainless steel pipe came from Sweden. The flexible metal pipes were used for electricity cables to protect and bury them underground. I found a surgical instrument manufacturer in Lancashire; he came with his engineer to see the requirements. A length was processed, and out came a fireproof tube, later called 'Oswal-Hunton Flexo-metallic Fireproof Anaesthetic Tube' patented by J.B. Masters, the manufacturers. They also made dedicated non-reflective instruments with hollow tube handles for removing smoke continuously from the operating site.



Oswal-Hunton Flexo-metallic Fireproof Anaesthetic Tube in various sizes



Oswal-Hunton fireproof flexible metal anaesthetic tube in use

The first paediatric patient

The patient was a child of five, with multiple warts (papilloma) affecting her voice box. I had listed her for surgery first thing in the morning to have a full day of observation to take care of any complications should they arise.

My main worry was about the state of the airway (larynx) after the surgery. Conventional surgery with cold instruments does produce significant airway swelling. Therefore, it is a sound practise not to remove all the nodules in one go. When I used the laser for the first time on a patient with tongue cancer, it certainly did not produce any swelling. But still, this was my first laser surgery on the larynx and that too on a child. If the larynx would swell up, it would result in breathlessness in the postoperative period, in the ward. If the obstruction is severe, then her airway would have to be restored immediately by making an opening in the neck as an emergency. As a precaution, I had arranged for an experienced registrar to stay with the patient with an emergency tracheostomy set at hand. It would be risky to bring the patient back to the theatre in the lift; anything could happen en route.

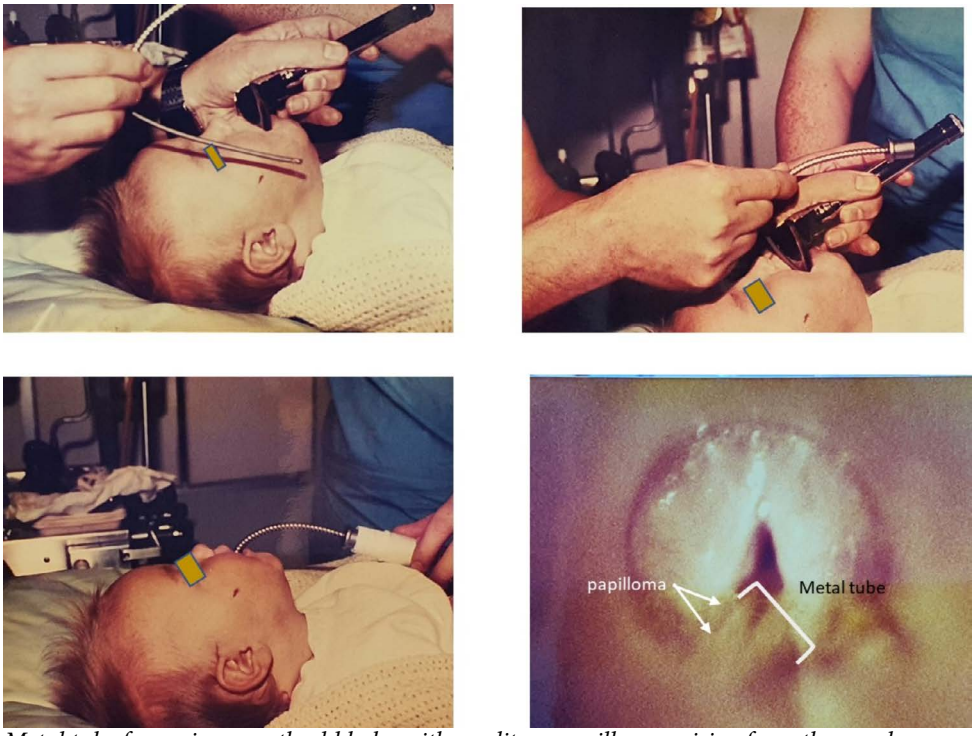
The operation went on without any hitches. I vaporised and excised most of the nodules with the laser. The procedure lasted over an hour. The metal anaesthetic tube was reassuring.

Just before the lunch break, a call came from the sister in the ward. I imagined the worse and told the sister that I would come up to the ward straight away. She said, 'Don't worry Mr. O, she is fine, I can't keep her in her bed, she is running around in the ward.' It was not short of a miracle. My hard work to raise the money by public appeal, get the laser, teach myself how to use it, do all the bench experiments in the evenings and the weekends – it all appeared to be worthwhile and rewarding. I will never forget that day.

Confidently, I undertook more surgical procedures in the mouth and the larynx. In one patient, I removed the whole tongue, which was extensively affected by solid swelling (Lymphoedema) following radiotherapy.

Metal tube for papilloma in a nine-month-old baby

A nine-month-old baby presented with a papilloma. We were now well experienced and approached the problem proactively. Our instrument maker designed a 'baby tube', four millimetres in diameter. The flexible proximal end allowed the tube to follow the curvature of the oropharynx and come out of the mouth. He and his technician came on the day of surgery. John passed the tube, and we took a lateral x-ray. The distal end was butting against the posterior was of the trachea. It needed a forward angulation of fifteen degrees, to follow the baby's subglottic anatomy. The technician bent the distal end of another tube. We cleaned it with alcohol and John replaced the tube. Another lateral view showed it to be in the centre of the trachea. We learnt that the distal one centimetre needed a forward angulation of fifteen degrees, to follow the baby's subglottic anatomy.

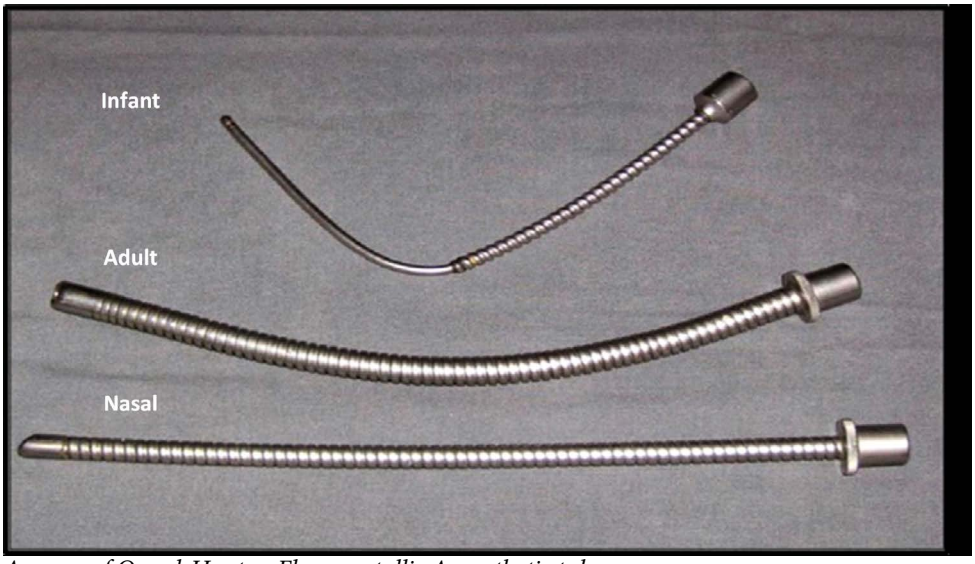


Metal tube for a nine-month-old baby with a solitary papilloma arising from the vocal process on the left side

A few strikes on the papilloma cured the condition, with no recurrence.

A range of Oswal-Hunton Flexo-metallic Anaesthetic tubes for all age-groups

We designed the fire-proof flexible metal tubes for all age-groups including the infants and female adults. We also designed nasal tube for patients with difficult oral intubation.



A range of Oswal-Hunton Flexo-metallic Anaesthetic tubes

The metal tubes were also used by Norton[16a] in the US. However, they were for adult patients. The smallest metal tubes available had external diameters of 6 mm or 7 mm which were too large to use in younger patients. We designed and marketed a range of the flexible metal tubes, for all age-groups, including the infant tube.

The word spread around about the increasing number of cases undergoing laser surgery. Richard phoned to say that some surgeons wanted to see me operate with the laser and came with a surgeon. Every week we had a visitor, sometimes with their theatre sister.

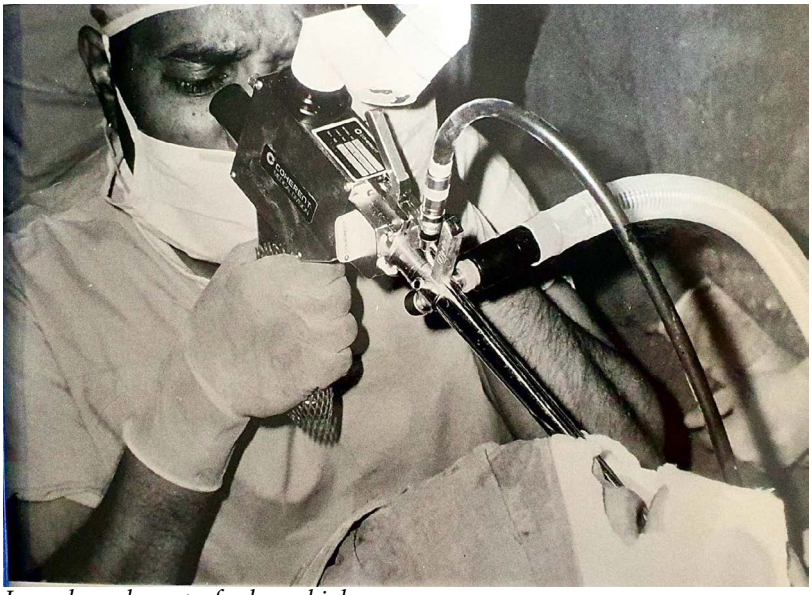
Our theatre sister was concerned. The theatre was already overloaded in the first place, with the operating microscope, the laser machine and a dedicated suction unit. The anaesthetist had moved towards the foot end of the table to make room for the equipment around me. We were also running out of greens since a set number came from the laundry. I assured our theatre staff that I would restrict only one visitor per list.

Lower-airway obstruction due to cancer of the lungs

Cancer of the lungs is common, especially in heavy smokers. In some cases, cancer invades the bronchi and the trachea. The patient finds it increasingly difficult to take in enough air. These can be desperate cases.

I had bought a bronchoscope attachment with the laser.[13] This device enabled me to take the laser beam further into the airways, where the lung tumour came into the bronchi and caused breathing difficulty to the patient.

Until now, there was no treatment for such cases apart from stenting the airway for temporary relief. With the advent of laser technology, it was possible to vaporise the tumour with the laser beam, thus re-establishing the airway. Of course, the tumour would grow again, and such patients needed repeated laser vaporisation. Eventually, the patients would succumb to cancer when their general condition deteriorated. Chest physicians and sometimes chest surgeons saw such cases since the pulmonary surgical speciality was not well-developed.



Laser bronchoscopy for bronchial cancer

The publicity for laser somehow concentrated on its use in cancer since the media require sensational news. Soon, a case of cancer obstructing the lower airway was sent to me to see if I could relieve the obstructed airway with the laser treatment.[17]

During my first bronchoscopy for an obstructing tumour, I started vaporising the tissue. There was much charring. At one stage, part of charred tissue sparked. It caused other charred tissue to ignite. The flare thus spread quickly, igniting more charred tissue. The flaming subsided when all the charred tissue had ignited and flared. The experience was frightening, although everything turned out to be satisfactory. A few more cases came. However, the flaring did not happen in every case. I still needed to know why I saw a flare in some cases and not in others.

By now, it was summer, and we had some pleasant evenings for barbecue. My eyes now instinctively looked at everything which had an ignitor and a flammable material. When I lit up the barbecue, initially, there was smoke all over. As the temperature rose, the charred smoke particles in the hottest part of the barbecue ignited. The ignited smoke now becomes an ignitor for the rest of the smoke, flaming instantly.

Therefore, this is how flares occurred; part of the hot tissue burns, producing charred particles and vapour. Continuing laser action heats any charred particles in its path. These then flare and act as ignitors to other charred tissue, which burns furiously in the presence of oxygen in the airway.

Patients from near and far

My caseload for laser bronchoscopy took off, and I started getting referrals from Newcastle, the Midlands, and Scotland. A chest surgeon from Newcastle, Graham Morritt, asked if he and his anaesthetist could come and see the procedure since they thought of getting the laser for their hospital. A medical article on laser bronchoscopy with the CO_2 laser was published in The Journal of Laryngology & Otology in February 1988.[18]

Laser surgery on private patients

No, I took a conscious decision that I would not use the laser on private patients, not even one patient. The people of Cleveland bought the laser with funds raised by public appeal. The machine belonged to them and the publicly funded NHS. If a private patient needed laser treatment, then he/she would be listed as an NHS patient. Every patient was treated with the laser under the NHS as per each patient's medical needs.

The First British Conference on the CO_2 laser in ENT-H&N surgery

Richard told me that the number of requests to see the live surgery was constantly increasing. Furthermore, there were also surgeons from abroad who wished to see the live surgery. He came up with the idea that we should organise a conference.

He also suggested that he would demonstrate the use of the laser to a large number of surgeons in one go. But I told him it is not the demonstration of the machine and the laser beam; it is the hands-on and the surgical use that the surgeons would be interested in watching. At the conference, a video recording may demonstrate the surgical applications, but the actual handling of the laser beam would not be possible during the conference due to safety reasons. It led to the idea of organising a 'Hands-on course'.

Richard advertised the conference with a pre-conference 'Hands-on course'. Posthouse Hotel on the outskirts of Middlesbrough had adequate function rooms for our needs. Three months on, there we were, and with only half a dozen applicants to the conference, it seemed we were going to run into losses. Of course, the company would underwrite the losses, but a handful of attendances in a large room would not do much for the laser sales! Anxious times. However, as the event date came nearer, the number started increasing.

Inevitably, as the numbers increased, we faced another problem – the capacity of the function room was insufficient. In the end, applicants were told that there would be a standing room only! Even then, they came.

'Sharplan' was another laser company that had imported their machine from Israel (owned by **'Shar**on and Ka**plan** = Sharplan). They were a bit late in getting the machine into the UK. Upon hearing about the conference, they approached me that they also wanted to take part in it and exhibit their machine. They were ready to pay a substantial sum of money for the conference. But Richard objected. He argued that 'Our company Coherent' had taken the financial risk at the beginning when things were not going so well, and now seeing the success of the event, others wanted to cash in, with zero risk. I accepted his commercial argument.

The First Hands-on Laser Course: three hours long!

Before the First British Laser Conference, we ran a course lasting three hours. We asked the Post House hotel management to make a room available for the demonstration.

They were very accommodating, removing the bed and rearranging the room with additional chairs. Laser strikes do produce significant amounts of smoke. To pre-empt any problems caused by the activation of the smoke alarm in the bedroom, we asked the management if they could switch off the smoke detector in that bedroom. It was not possible

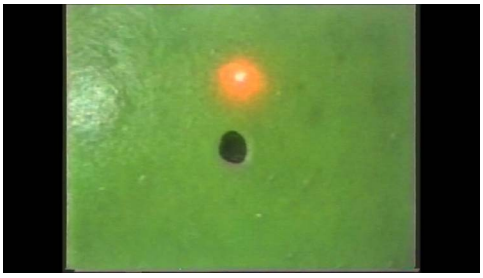
to turn off the alarm in just one bedroom, so the whole circuit for that section of the hotel was turned off. Looking back, this was quite a risk. Had there been a real fire in one of the bedrooms at the same time, it would have been undetected with potential disaster.

Four surgeons enrolled for the hands-on. First, Richard explained the controls of the machine. Then we all donned the laser-specific protective eyewear, and I demonstrated how to use the laser to ablate the area of the apple skin where the HeNe beam struck, how to control the joystick to draw a line etc.[19]

One course participant sat at the machine and held the joystick with a fist. We told him to hold it like a paintbrush, move it in different directions and watch the red spot moving with it. We then set the machine to a single shot exposure of one second, at a power setting of 10 W and asked him to activate the laser by pressing the foot pedal. It caused a circular burn on the apple skin.

Joystick

Foot pedal

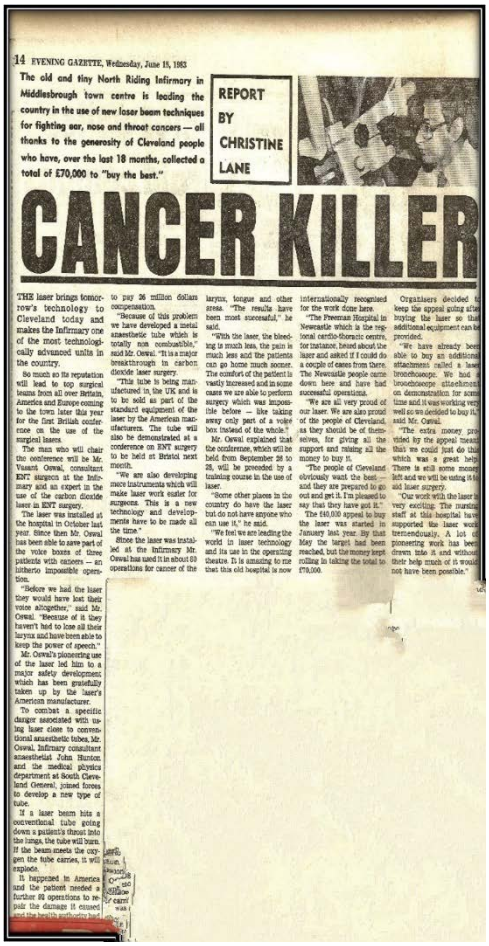


Strike on an apple (aiming beam in red)

After a few more strikes, the surgeon could control the joystick to write his initials on the apple. We then asked him to move the joystick slowly to cause a deeper burn. At the end of the exercises, we sliced the apple through the burn to assess the depth of destruction to the power setting, exposure time, and the joystick movement. The excitement was palpable.

Finally, I showed them some video clips of laser surgery I had carried out on patients. After the discussion, the session ended. Now, they had had the first-hand experience of using the laser and the video demonstrations of its surgical application. Thus, a very satisfying and successful session became 'the First Hands-on Laser Course' in ENT-H&N surgery' in 1983, followed by annual courses over the next twenty-eight years. With the international participants, the course was renamed: Cleveland Hands-on International Laser Course. Richard was delighted since these were his potential customers.

Transcript of an article, Evening Gazette, Wednesday, June 15, 1983, Report by Christine Lane



14 EVENING GAZETTE, Wednesday, June 15, 1983

The old and tiny North Riding Infirmary in Middlesbrough town centre is leading the country in the use of new laser beam techniques for fighting ear, nose and throat cancers — all thanks to the generosity of Cleveland people who have, over the last 18 months, collected a total of £70,000 to "buy the best."

REPORT BY CHRISTINE LANE

CANCER KILLER

THE laser brings tomorrow's technology to Cleveland today and makes the Infirmary one of the most technologically advanced units in the country.

So much so its reputation will lead to top surgical teams from all over Britain, America and Europe coming to the town later this year for the first British conference on the use of the surgical lasers.

The man who will chair the conference will be Mr. Vasant Oswal, consultant ENT surgeon at the Infirmary and an expert in the use of the carbon dioxide laser in ENT surgery.

The laser was installed at the hospital in October last year. Since then Mr. Oswal has been able to save part of the voice boxes of three patients with cancers — an hitherto impossible operation.

"Before we had the laser they would have lost their voice altogether," said Mr. Oswal. "Because of it they haven't had to lose all their larynx and have been able to keep the power of speech."

Mr. Oswal's pioneering use of the laser led him to a major safety development which has been gratefully taken up by the laser's American manufacturer.

To combat a specific danger associated with using laser close to conventional anaesthetic tubes, Mr. Oswal, Infirmary consultant anaesthetist John Hunton and the medical physics department at South Cleveland General, joined forces to develop a new type of tube.

If a laser beam hits a conventional tube going down a patient's throat into the lungs, the tube will burn. If the beam meets the oxygen the tube carries, it will explode.

It happened in America and the patient needed a further 92 operations to repair the damage it caused, and the health authority had to pay 26 million dollars compensation.

"Because of this problem we have developed a metal anaesthetic tube which is totally non-combustible," said Mr. Oswal. "It is a major breakthrough in carbon dioxide laser surgery.

"This tube is being manufactured in the UK and is to be sold as part of the standard equipment of the laser by the American manufacturers. The tube will also be demonstrated at a conference on ENT surgery to be held at Bristol next month. We

larynx, tongue and other areas. "The results have been most successful," he said.

"With the laser, the bleeding is much less, the pain is much less and the patients can go home much sooner. The comfort of the patient is vastly increased and in some cases we are able to perform surgery which was impossible before — like taking away only part of a voice box instead of the whole."

Mr. Oswal explained that the conference, which will be held from September 26 to 28, will be preceded by a training course in the use of laser.

"Some other places in the country do have the laser but do not have anyone who can use it," he said.

"We feel we are leading the world in laser technology and its use in the operating theatre. It is amazing to me that this old hospital is now internationally recognised for the work done here.

"The Freeman Hospital in Newcastle which is the regional cardio-thoracic centre, for instance, brags about the laser and asked if I could do a couple of cases from there. The Newcastle people came down here and have had successful operations.

"We are all very proud of our laser. We are also proud of the people of Cleveland, as they should be of themselves, for giving all the support and raising all the money to buy it.

"The people of Cleveland obviously want the best — and they are prepared to go out and get it. I'm pleased to say that they have got it."

The £60,000 appeal to buy the laser was started in January last year. By that May the target had been reached, but the money kept rolling in taking the total to £70,000.

Organisers decided to keep the appeal going after buying the laser so that additional equipment can be provided.

"We have already been able to buy an additional attachment called a laser bronchoscope. We had a bronchoscope attachment on demonstration for some time and it was working very well so we decided to buy it," said Mr. Oswal.

"The extra money provided by the appeal means that we could just do that which was a great help. There is still some money left and we will be using it to aid laser surgery.

"Our work with the laser is very exciting. The nursing staff at this hospital have supported the laser work tremendously. A lot of pioneering work has been driven into it and without their help much of it would not have been possible."

are also developing more instruments which will make laser work easier for surgeons. This is a new technology, and developments have to be made all the time.'

Since the laser was installed at the Infirmary, Mr Oswal has used it in about 80 operations for cancer of the larynx, tongue and other areas. 'The results have been most successful,' he said. 'With the laser, the bleeding is much less, the pain is much less and the patients go home much sooner. The comfort of the patient is vastly increased and in some cases we are able to perform surgery which was impossible before – like taking away only part of a voice box instead of the whole.'

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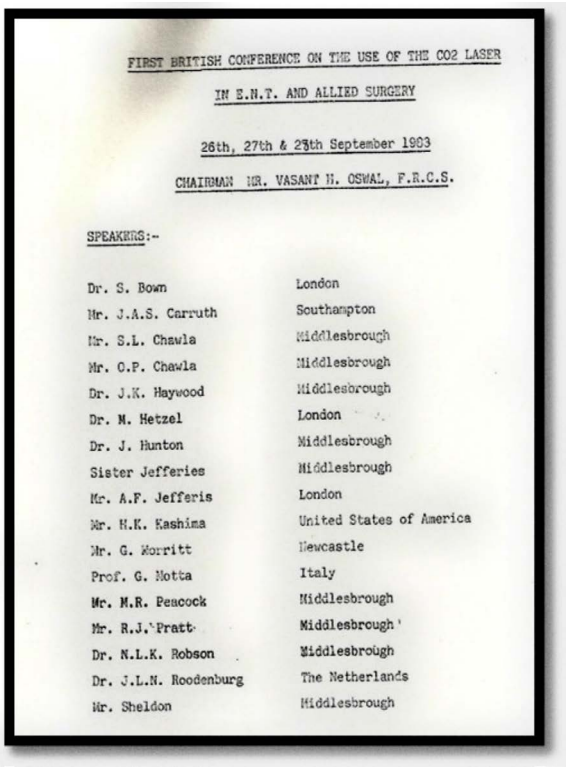
We feel we are leading the world in laser technology and its use in the operating theatre. It is amazing to me that this old hospital is now internationally recognised for the work done here.

The Freeman Hospital in Newcastle, which is the regional cardio-thoracic centre, for instance, heard about the laser and asked if I could do a couple of cases from there. The Newcastle people came down here and have had successful operations.'

'We are all very proud of our laser. We are also proud of the people of Cleveland, as they should be of themselves, for giving all the support and raising all the money to buy it. The £ 40,000 appeal to buy the laser was started in January last year. By that May, the target had been reached, but the money kept rolling in taking the total to £ 70,000. Organisers decided to keep the appeal going after buying the laser so that additional equipment can be provided.

'We have already been able to buy an additional attachment called a laser bronchoscope. We had a bronchoscope attachment on demonstration for some time and it was working very well so we decided to buy it,' said M Oswal. The extra money provided by the appeal meant that we could do this, which was a great help. There is still some money left, and we will be using it to aid laser surgery. 'Our work with the laser is very exciting. The nursing staff at this hospital have supported the laser work tremendously. A lot of pioneering work has been drawn into it and without their help much of it would not have been possible.'

The conference



FIRST BRITISH CONFERENCE ON THE USE OF THE CO2 LASER

IN E.N.T. AND ALLIED SURGERY

26th, 27th & 28th September 1983

CHAIRMAN MR. VASANT H. OSWAL, F.R.C.S.

SPEAKERS:-

Dr. S. Bown	London
Mr. J.A.S. Carruth	Southampton
Mr. S.L. Chawla	Middlesbrough
Mr. O.P. Chawla	Middlesbrough
Dr. J.K. Haywood	Middlesbrough
Dr. M. Hetzel	London
Dr. J. Hunton	Middlesbrough
Sister Jefferies	Middlesbrough
Mr. A.F. Jefferis	London
Mr. H.K. Kashima	United States of America
Mr. G. Morritt	Newcastle
Prof. G. Motta	Italy
Mr. M.R. Peacock	Middlesbrough
Mr. R.J. Pratt	Middlesbrough
Dr. N.L.K. Robson	Middlesbrough
Dr. J.L.N. Roodenburg	The Netherlands
Mr. Sheldon	Middlesbrough

The faculty

The conference started the next day at 9 AM. Nirmal and my hospital secretary, who had taken time off, handled the reception desk. They registered the delegates, handed out a name tag and the conference bag and directed them to the refreshment area. Within a few minutes, we announced for everyone to enter the function room and be seated. A one-hundred-seater function room was soon filled up, to the extent that some who came a bit late, had to stand in the back.

I chaired all two days of the conference since no one knew anything about the lasers – apart from one, John Carruth from Southampton, who also had a laser, but his work was mainly in the mouth. Some years on, I offered to host one of the annual BMLA conferences, but he said Middlesbrough is a small town and unsuitable for the national

Venue: Post House Hotel, Middlesbrough, UK, Vasant Oswal second from left

The first hands-on international Cleveland laser course in ENT-H&N surgery, 1983. Richard Koronowski (bottom, right) demonstrating the laser

conference! Never mind. That small Middlesbrough town trained more than 500 surgeons over a span of 28 years from all over the world, securing its place on the map.

Three invited faculty members were Giovani Motta from Italy, Haskins Kashima from Johns Hopkins in the USA, and Roodenberg from Belgium. Our faculty was John Hunton, the anaesthetist, John Haywood, the physicist, a fireman from the Cleveland Fire Brigade and me.

During the introductory remarks at the conference, my first slide was simple.

This conference has the following objectives:
THE LASER

1. What is it?
2. How does it work?
3. What surgical procedures can it be used for?
4. Is it safe?
5. Can I have a go?

Two days went by very quickly. In the room, there were all sorts of people. 'The curious, the technology-minded, the sceptics, the listeners, the participants, and 'what is wrong with the pair of scissors that I used all my life?'

I heard a couple of them saying: 'Why the hell does he want to spend all that money just to look at smoke?' A colleague from a nearby town asked me point-blank: 'What is your waiting list for tonsils? Why don't you spend your operating time to bring it down, rather than play with this toy?' Years later, he came as a participant to learn about the laser during one of our courses.

Haskin Kashima

R: Haskins Kashima (USA), Vasant Oswal (UK)

Haskin Kashima's presentation was polished, authoritative. He was confident, deliberate and fluent. He began his presentation with that well-known adage, 'If all you have is a hammer, everything looks like a nail'.

My foreword in all my laser books clearly states the following: 'Laser should be used only if it gives equitable or better results. It is not a panacea, it is a tool, and like any other tool, it is the hand behind it that produces the result.' And add to that, 'The surgeon operates, but the patient heals' completes a list of all the variables which determines the oucome.

'Professor Motta, you are going to miss your flight'

Giovanni Motta (Italy)

We all get very passionate about our work and our technique. Giovanni Motta from Naples was a committed laser surgeon. He was due to leave on the morning of the second day due to a tight airline schedule. So, I had arranged his last talk accordingly.

Someone in the audience asked a question and disagreed with him on that topic. So, the two went on and on and on. Julie, my secretary in the back, showed me her watch, wildly gesticulating that he must leave the taxi is waiting. I nodded my head and again got involved in the discussion.

In the end, Julie came charging straight to Motta and shouted: 'Prof Motta, if you do not leave now, you will miss your flight,' and took his arm. Giovanni calmed down. 'Thank you very much; you are very kind,' – and repeating that right up to the exit door, he left to catch that flight.

A very successful day ended with a social evening at home.

Social evening at home

The BBC News[21]

The word about this miracle tool soon went round. The BBC broadcast it as a news item,[12] along with a report about the First British International Laser Conference in Middlesbrough in September 1983, with over one hundred delegates from around the world attending it

BBC News

The second and subsequent hands-on courses

The hands-on course requires an operating microscope with a video camera and a monitor, a laser machine and dedicated suction equipment. Richard Koronowski was enthusiastic and agreed to provide all the necessary equipment, including the operating microscope. We designed the second course as a full-day event on a Saturday, with Richard, my registrar Dr Chawla and me as the course faculty. The participants came to the hotel the evening before at the Post House Hotel, the course venue. The morning lectures consisted of basic laser science, safety, anaesthesia and clinical applications. In the afternoon, it was hands-on with the laser.


(Left to right) Mike Peacock, Jean and Frank Martin, Chawla

Simulation laser surgery on a pig's tongue

Although in the first course an apple was used, it hardly mimicked the real-life use of the laser. I designed a biological model by getting a pig's tongue from a butcher shop, using a clipboard to hold it firmly in place. Only a portion of the tongue was exposed, with a moist towel covering the rest of it to ensure there was no ignition of the clipboard. To mimic leucoplakia, I used an electric soldering iron to create a few discrete white patches – for vaporising with the laser beam. In addition, there were plenty of elevated glandular papillary areas in the posterior part of the tongue; they served as tumours for the laser excision.

The groups rotated between the hands-on sessions and watching the recorded video clips, demonstrating the laser surgery I carried out in the past few months. The recording showed pre-, intra- and postoperative clips.

Simulation laser surgery on a pig's larynx

Access to the structures in the oral cavity is relatively easy for laser surgery. However, access to the laryngeal pathology is more demanding. The larynx is viewed through the operating microscope via a narrow aperture of the laryngoscope. The beam is manipulated with the joystick to pass through it. The red spot of the guide He-Ne beam is positioned on the target tissue. A precise alignment of the target and the beam is crucial to avoid damage to the normal tissue. It is also necessary to use micro forceps to grab the tissue and a suction cannula to remove the smoke continuously.

It was clear that only by providing hands-on training on the larynx, could the course achieve its objective. There was no question of using a human cadaver due to the Human Tissue Act.

The animal larynx was the obvious answer. The larynx of a ram resembles closely that of a human but wasn't easy to obtain. A sheep's larynx is much smaller. In the end, I decided to use a pig's larynx. It had a large epiglottis which is presumably responsible for the grunting sound of a pig. Cutting it off from the base provided an excellent exposure to the vocal structures. The vocal folds resembled the human larynx.

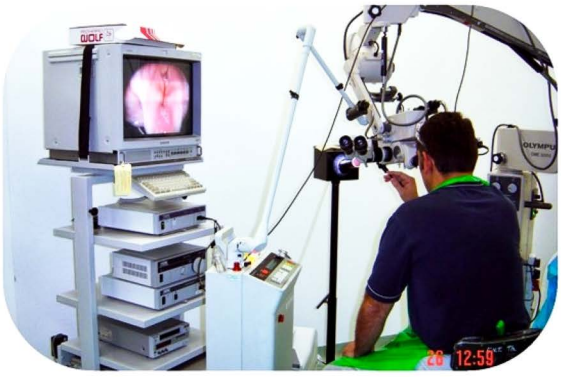
Harvesting the pig's larynges

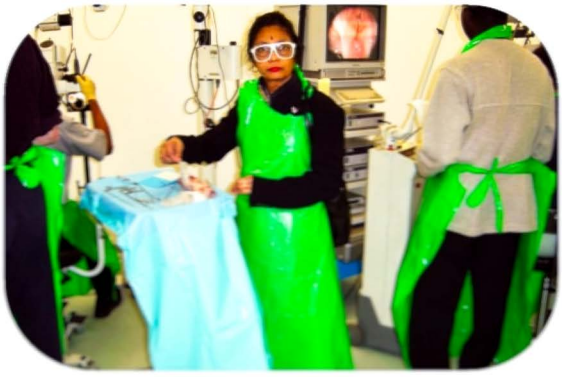
Our family butcher Mr Short was very happy to get me the pig larynges in large numbers directly from the abattoir since they were not suitable for human consumption and ended up as waste.

The fresh pig larynges were delivered by Mr Short a night before the hands-on day. The specimens came with much surrounding tissue, and the large epiglottis needed removal. The preparation went on well into the wee hours of the night. For the subsequent courses, Nirmal had the idea of getting them ahead of the course dates, preparing them and then deep-freezing them. Just a few hours before their use, they could be defrosted. This process kept them fresh and supple for the course – full marks to Nirmal. Nirmal's only condition was that I could not store them in our domestic freezer, so I bought another freezer and put it in the garden shed. The tongue specimens were prepared and stored the same way.

Simulation box for the laryngeal surgery

Having procured the animal larynx, it needed some means of securing it to maintain the endolaryngeal orientation. To mimic the real-life micro-laryngeal laser surgery, I designed a simulation box made of wrought iron[14]. It was in two parts. The first part was the spring-loaded metal laryngeal mount which held the larynx securely to resist movement during the endolaryngeal manoeuvre. The second part was a cubicle box with a sliding cover. There were two small outlets on the back wall for connection to the suction





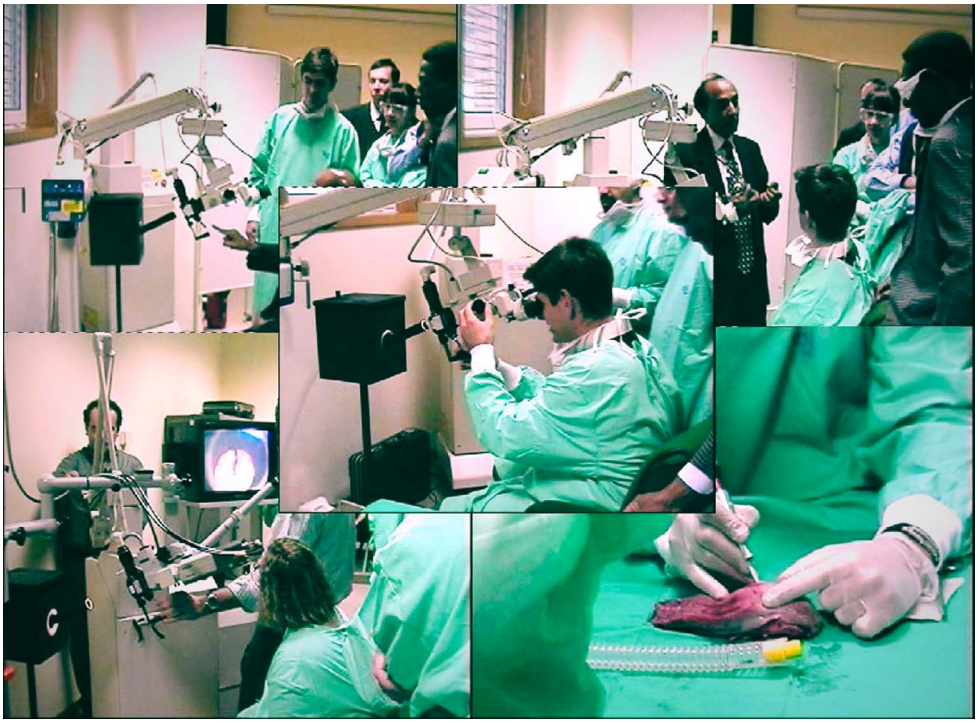
Cleveland International Hands-on Laser Course

machine to remove smoke. The front of the box had one large circular outlet in the centre. It had the exact dimensions of the laryngoscope. A length of a metal tube was soldered onto it and extended proximally to mimic the oral end of the laryngoscope. The microscope was aligned with the simulation laryngoscope arm of the box, and the larynx was viewed through it. The mount was manipulated from the top to fully see the vocal folds and the arytenoids through the microscope. The top was then closed with a sliding metal cover. Finally, the assembly was mounted on a telescopic stand to raise it to the same level as real-life laryngoscopy.

The local wrought-iron shop manufactured the simulation boxes. As in a real setting, the trainee had to manipulate the operating microscope and the laser beam to pass through the centre of the laryngeal arm of the simulator and position it precisely on the target. An article on the simulation box was published in the Journal of Laryngology and Otology (JLO).[22]

After a while, the sales of the laser machines took off. The demand for training also shot up. One course per year, training ten surgeons, was hardly sufficient to meet the demand from the UK and Europe. I had to accept to run courses every three or four months as per the demand.

Expansion of hands-on stations



Cleveland International hands-on Laser Course, UK 1983-2010 (Vasant Oswal, right, in suit)

Running courses as per the demand soon started taking its toll on me. I ran out of steam. Everyday hospital commitments during the week and Saturday/Sunday courses meant that I had no break. Richard and I sat together one day to discuss this issue. Lectures were no problem; you could have ten, twenty or forty people. It was the hands-on part that was taking a toll. I told him that we should provide additional hands-on stations to be able to train more surgeons during the same limited time. He agreed to provide more equipment to increase the hands-on stations and brought a couple of his colleagues to man them. Now we were able to accept thirty-six participants per course every six months.

Cleveland International hands-on Laser Course

The course by now had acquired an international reputation. Therefore, I decided to establish an international faculty expert in laser applications in an anatomical area of the ENT. Paul Bradley, an Oro-Facio-Maxillary surgeon from Edinburgh, was very enthusiastic about teaching. Marc Remacle from Belgium was running a similar course there. So I told him, 'I will come to your course, even send some participants who could not be accommodated here, in return you come over here and become part of our faculty. Little did I imagine that we would become close friends in years to come and co-edit two laser books, now regarded as standard reference books.

A few surgeons approached me and asked if they could join the faculty. But, of course, I

Cleveland International hands-on Laser Course

had to be careful not to dilute the quality of the course. I, therefore, invited them as guest faculty to start with to assess them as potential permanent faculty members.

During a laser conference in Los Angeles where I was presenting, a participant introduced himself and asked me if he could become the course faculty. It was Jean Abitbol from Paris. His excellent work on voice disorders earned him a permanent place on the faculty.

The course became very international, with participants from all corners of the world: Canada, the US, South America, most of Europe, Scandinavia, the Middle East, the Far East, Russia, and so on.

More wavelengths such as the KTP, Ho:YAG and the diode laser came on the market for ENT surgery in the following years. We increased the number of stations to four. The course extended to three full days, two days of lectures and one full day of hands-on. Shashi Kaluskar from Northern Ireland took over the KTP, and our own Udi Kumar did the Ho:YAG. Later, we added live surgery demonstrations due to the enthusiasm of Frank Stafford from Sunderland. Buses took all the participants to his hospital. Due to logistic difficulties, we decided to run the live surgery in-house in Middlesbrough. Richard Wight, Liam Flood and Udi Kumar provided excellent support by undertaking various surgical procedures with live transmission to the lecture theatre. Each course now offered thirty-six places. Even then, there were more last-minute requests.

&Post Wednesday, October 4, 1995 11

Pioneer doctor helped to train a further 400

THE doctor who brought laser surgery to ear, nose and throat ops on Teesside, Mr Vasant Oswal (left), is retiring, having been a consultant for 25 years at the North Riding Infirmary, Middlesbrough.

THE doctor who brought laser surgery to ear, nose and throat ops on Teesside is taking a bow.

Mr Vasant Oswal retires after 25 years as a consultant at the North Riding Infirmary, Middlesbrough.

Shortly after his arrival at the infirmary, Mr Oswal introduced delicate surgery to remove head and neck cancers — work which continues at the hospital today.

In 1981 he developed this work by introducing lasers, launching a public appeal to provide the necessary technology. As a result of this pioneering venture, patients were referred to the Infirmary from as far afield as Aberdeen and Staffordshire.

Mr Oswal has since been a key figure in training other doctors to use laser technology in his field. Some 400 surgeons worldwide have been trained through the faculty he established.

By his retirement in 1995, some 400 surgeons had been trained during the Cleveland International Hands-on course.

A surgeon from York down the road, whom I knew personally, put a last-minute application for the course. The course was packed. 'Come on Vasant, you can't say I can't come.' No, I could not!

By the time I passed on the helm to my colleague Richard Wight in 2002, I had trained more than 400 surgeons attending the Cleveland International Laser Course. Since my retirement in 1995, I have also travelled to many countries globally and trained hundreds more surgeons worldwide.

Nirmal and the three technicians from our operating theatre were a permanent fixture of the course

faculty. Caroline Gowland joined the team later on. I made sure to thank them publicly during each course.

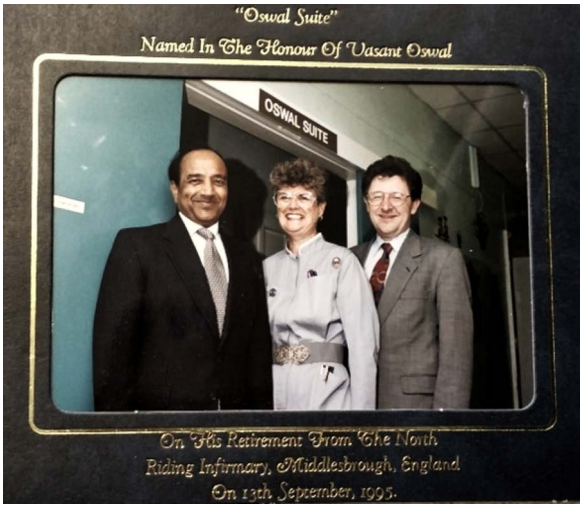
The course dinner was the highlight. I invited the Chairman of the hospital trust (Audrey Collins, centre, in pink dress)and the Mayor of Middlesbrough to every course dinner. It was very much a formal affair; I had to wait at the entrance door to receive the mayor wearing the chain of office. All the delegates were already seated. As we made our way to the top table, everyone stood up and clapped.

The last Hands-on Laser Course in 2012[20]

L-R: Paul Bradley, Vasant Oswal, Hema Kaluskar, Beatrice Abitbol, Nirmal Oswal, Audrey Collins, Mayor and Mayoress, a participant, and (Far R) - Shashi Kaluskar

The course which started in 1983 ran annually for the next 28 years, finally closing its doors in 2012. This was one of the longest surviving laser courses by a long shot.

Oswal Rhinology Suite



"Oswal Suite" at the Infirmary L-R: Vasant Oswal, Pauline Altringham, John Gibb

One day, as I went to see a patient in ward four at the infirmary, the ward sister Pauline Altringham accompanied me to an area separate from the main ward. It had an entrance and three single occupancy rooms. As we approached the entrance door, I was surprised to see a board 'Oswal Suite' above the door. I asked the sister what it was all about. She said admin, and we decided to honour your laser work somehow and thought we name this three bedded suite 'Oswal Suite'. I was speechless. In the NHS hospital, to designating a facility to honour someone was almost unheard of. NHS is teamwork, no single person gets credit or recognition. And only for this reason alone I was taken aback to know that the staff had honoured me in such a subtle way.

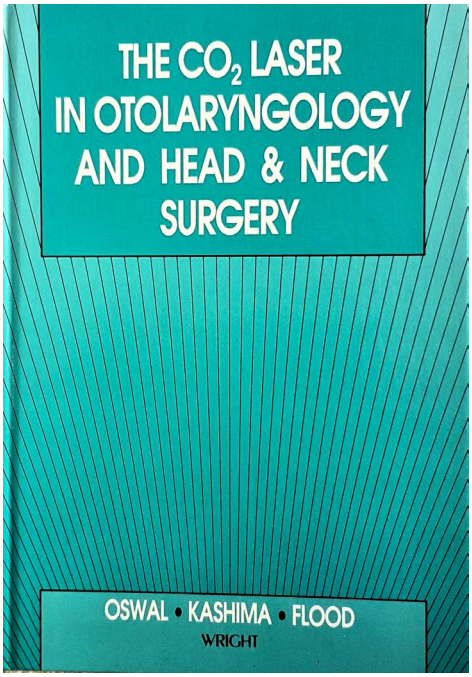
'Oswal Rhinology Lab'

When we moved to the James Cook University Hospital, they decided to call one of the consulting rooms in the outpatient as 'Oswal Rhinology Lab', since by 2002, when we moved there, I was doing only the nasal laser surgery with the Ho:YAG laser.

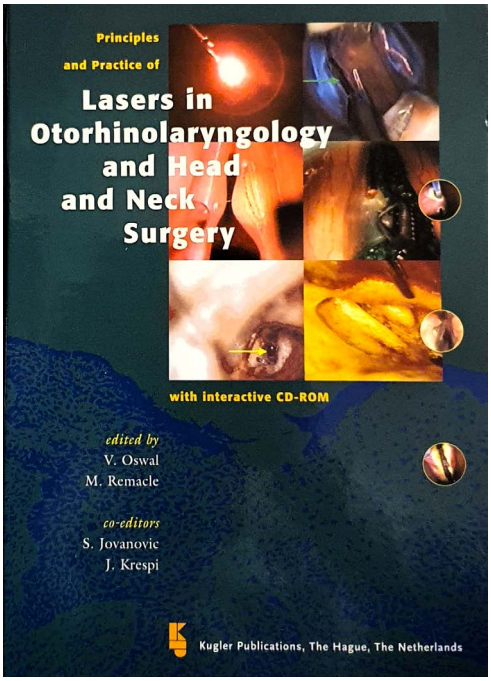
'Oswal Rhinology Lab' in the ENT dept at James Cook University Hospital

Publication of three books on Lasers in ENT

Around 1985, Wrights publishers asked me if I could write a book about laser in otolaryngology since they got to know that the ENT department in Middlesbrough was leading the country in the use of laser technology. I already had contact with Haskins Kashima of Hopkins. He agreed to join me as an Editor. Fortuitously, Liam Flood joined us as a consultant colleague. I had interviewed the candidates for the post, and Liam came over as a fluent personality with good experience in writing articles. Liam was happy to join in as well. It couldn't be better; I had a built-in Editor in my department.



The CO_2 Laser in Otolaryngology Head & Neck Surgery
Publishers: Wrights, The UK, 1988
Editors: V. Oswal (UK), H. Kashima (USA). L. Flood (UK)



Principles and Practice of Lasers in Otolaryngology and Head and Neck Surgery
Publishers: Kugler Publications, The Netherlands, 2002
Editors: V. Oswal (UK), M Remacle (Belgium), S. Jovanovic (Germany), J. Krespi (USA)

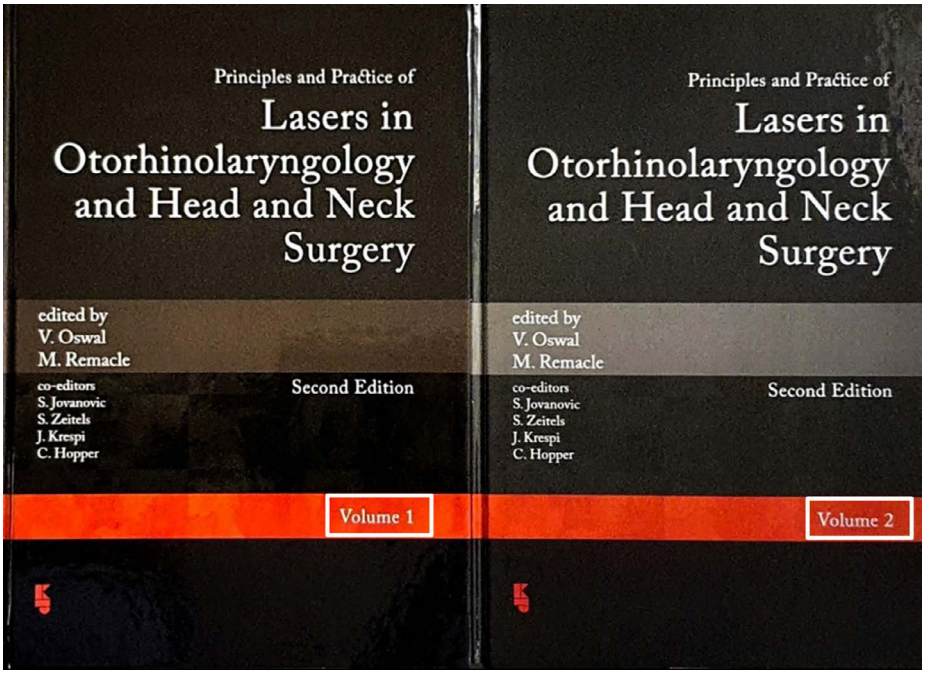
The problem of writing a book with Americans is the language. An often-heard aphorism, 'The US and the UK are the two nations divided by the Atlantic and the language', was very much evident when Kashima presented his work at our CO_2 laser conference in Middlesbrough. E.g., anaesthetist in the UK is a consultant grade, whereas, in the USA, it is a technician grade. The equivalent of a UK consultant anaesthetist is, in the USA, an anesthesiologist!

After much thought, the publishers and I decided that I would write the book in Anglicised English. Wherever there were significant technical (and not merely linguistic) differences, I decided to have subchapters entitled 'UK experience' and 'USA experience'. It took me three years to formulate the contents, get the authors, edit the contents, get their approval for any changes and so on before finally the book got printed in 1988.

In the nineties, laser technology grew substantially. There were many requests to include other wavelengths. Therefore, I embarked upon writing a second book and titled it Principle and Practice of Lasers in Otolaryngology and H & N Surgery. The proposal was sent to a few international publishers. Kugler Publications of The Netherlands were quick to respond and Peter Bakker, the owner, came to see me in London. A somewhat substantial book was published in 2002.

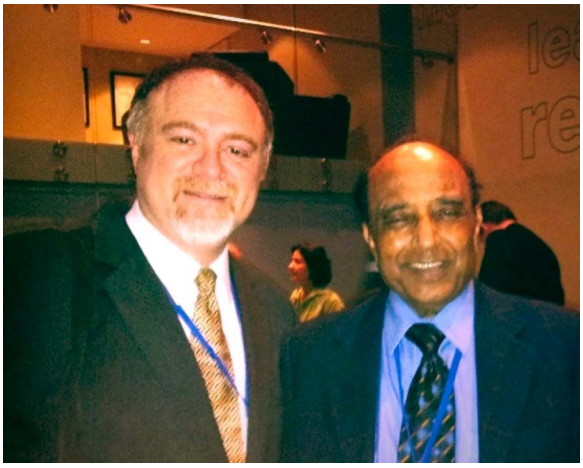
By 2011, the publication was out of print. A second edition was planned. Again, it took me another three years. The laser usage was established firmly in the ENT, with many more wavelengths in regular use. We ended up with 900+ pages! Simon Bakker, Peters

Marc Remacle (Belgium, left) and Vasant Oswal



Principles and Practice of Lasers in Otolaryngology and Head and Neck Surgery (Second Edition; two volumes)
Publishers: Kugler, The Netherlands, 2014
Editors: V. Oswal (UK), M. Remacle (Belgium)
Co-Editor: S. Jovanovic (Germany), Steve Zeitels (USA), J. Krespi (USA), C. Hopper (UK)

son, was now in the driving seat. He decided to publish the writing from 57 authoritative contributors worldwide in two volumes! Heavy! The work saw the daylight in 2014, with Remacle (Belgium), Jovanovic (Germany), Krespi and Zeitels (USA) joining me as editors and co-editors.



Steve Zeitels (USA; left) and Vasant Oswal (2012)

The Globe-trotting future

By now, I was one of the handful of 'experts' on the international scene in lasers in ENT. Also, having authored and edited the first book on the CO_2 laser in 1988, my name got around. Little did I imagine, when I decided to acquire the laser in 1982, that my life was destined to a globe-trotting future, keeping me fully occupied in the clinical and academic field for decades to come. So come with me and enjoy 'Oswal's Travels'.

Anaheim, Agra, Ahmadabad, Amsterdam, Antwerp, Alexandria, Athens, Atlanta, Bahrain, Bangalore, Bangkok, Barcelona, Berlin, Birmingham, Brussels, Budapest, Buena Saris, Cairo, Cardiff, Chennai, Dallas, Dharan, Delhi, Edinburgh, Florence, Fort Lauderdale, Geneva, Glasgow, Hong Kong, Hull, Hyderabad, Indore, Jaipur, Kathmandu, Kota Bharu, Kuala Lumpur, Leicester, Lithuania, Lucknow, London, Los Angeles, Madrid, Manchester, Marbella, Miami, Middlesbrough, Mumbai, Munich, Naples, Newcastle, New Orleans, Nice, Orlando, Palma de Majorca, Paris, Pattaya, Porto, Prague, Pune, Rome, Rotterdam, Rosario, St. Petersburg, San Diego, San Hose, San Francisco, Salisbury, Sicily, Singapore, Sydney, Tarragona, Tokyo, Toronto, Venice, Vilnius, Washington, Zaragoza

Globe trotting

In the nineties, I was very much in demand to run the courses abroad. Some surgeons attending our course asked me if I could run courses in their country since not everyone could come to our course in England. Other invitations came from surgeons I had never met or known about them. It led to me running courses in Kuala Lumpur and Kota Bharu in Malaysia, Oporto in Portugal, Geneva in Switzerland, Cairo in Egypt, Dhahran in Saudi Arabia, Rosario in Argentina, St. Petersburg in Russia and several cities in India and Europe. It is hard work to do demonstration surgery in a new, unfamiliar place. If you think it is prestigious to teach, run courses and undertake live surgery in foreign locations, think again!

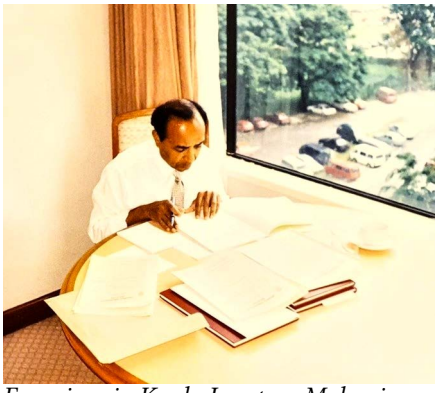
I was invited to chair many laser conferences all over the world. Sometimes, invitation dates gave me very little turn-around time. Once, we had to pack two sets of bags, leave one set at the Teesside Airport Hotel, go to a conference, return to the hotel, swap the bags and take another flight.

It is fun to share some experiences of visits to these faraway places.

Kuala Lumpur, Malaysia: Pig larynx

I was aware that the pig larynx would not be accepted as a biological model in Muslim countries due to their rule. The Cleveland International Laser Course brochure clearly stated that the hands-on would be on Pig Larynx. While accepting the invitation, I did mention the pig larynx. As expected, they said they would not have pig larynx but not to worry since they would have enough cadaver larynges from unclaimed bodies. When the time came, they could manage only one cadaver larynx. They had to get pig larynges. They marked a part of the lab where I had to do the hands-on training. I forgot the boundary line and crossed it at some point, but someone immediately stopped me and requested me to go within the boundary. Out of curiosity, I asked them what happened to that area after the course. They told me that they undertake some purifying ritual and then reclaim it. When in Rome, do as the Romans do! This old proverb supposedly comes from St. Ambrose's answer to St. Monica and her son, St. Augustine, who asked whether they should fast on Saturday as the Romans do.

Kuala Lumpur, Malaysia, External examiner, Universiti Kebangsaan Malaysia (UKM)



Examiner in Kuala Lumpur, Malaysia

I was invited as an external examiner for MS (ENT) by Dr Singaram, the head of the ENT department, UKM, Malaysia. It is hard to be an examiner in countries abroad since English is not their native language. You do not want to be harsh and still judge the candidates as per your standard. I do believe I did the job well, overall.

Oporto, Portugal: Have you lost your luggage?

A visit to Oporto was hilarious. I was doing a private clinic. Nirmal had brought my suitcase and put it in my car. I went directly to the local Teesside airport, flew to London, changed the plane, and got to Oporto. In the arrival hall, everyone had left, but I was still waiting for my case.

'Have you lost your luggage?'

'No, you lost it.'

'What is the make and colour of your suitcase?'

'No idea, my wife knows.'

'Leave the keys here for custom clearance, when it arrives tomorrow evening, we will send it to your hotel. What is the address?'

'No idea, Arthur Conde, the surgeon, has arranged it. Oh, can you go quickly outside and tell him to wait, otherwise he will think that I have not arrived and go home.'

Arthur asked me, 'Mr Oswal, the slides?'

I said, 'They have gone, lost with the suitcase'. His face turned pale.

'Don't worry, they are here in my cabin baggage!'

We went to the late-night shopping centre, got some toiletry, and got to the hotel.

I phoned Nirmal and asked her,

'If I wash my undies, will they dry by tomorrow morning?'

'No. Is there a hair dryer in the bathroom?'

'Yes, but it is fixed to the wall.'

'Then just turn the underwear inside out and wear the same. Don't wash it, it won't dry.'

After the course, Arthur and I went to get some clothes. Nirmal buys my undies from M&S. No change. However, all their stock in this shop had fancy flowers or other prints and colours. I asked Arthur, 'if I wear one of those, will you marry me and go on our honeymoon?'

We were about to leave the shop when he asked me: 'How are you going to take these with you tomorrow?' We bought a suitcase.

I narrated all this jokingly during my speech at the course dinner. There was roaring applause. Did I see Arthur blushing?

After dinner, I went to my room.

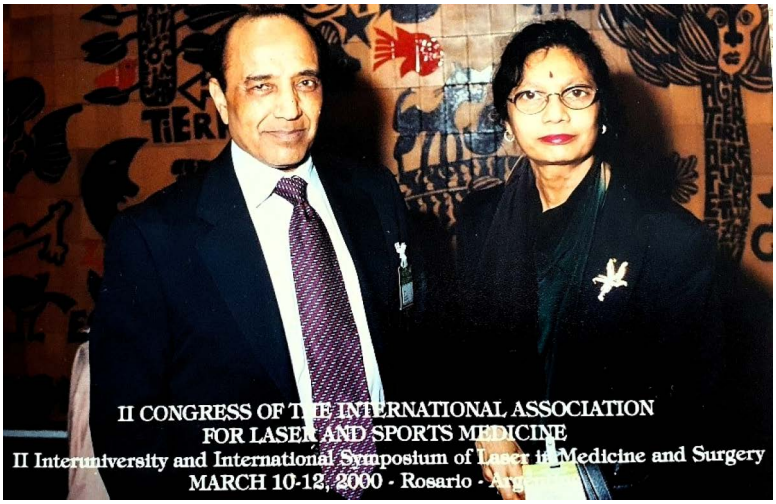
My 'lost' bag was looking at me with a grin, short of asking me, 'Where were you? I was looking all over for you…!'

I returned to England with two suitcases! The customs duly stopped me – when I explained, there was a good laugh all around.

Rosario, Argentina – Flamenco dance of Indian origin?

I received a mail one day inviting me to run a laser course in Rosario, in Argentina. ENT surgeon Hector Ruiz had heard my talk at one of the conferences in the USA – hence the invitation. This was the first time I took a trip to Latin America. We stayed in Buenos Aires for a few days and made a point of visiting a Flamenco evening before travelling onwards to Rosario.

Hector and his family came to the airport to welcome us. The course was well-organised and well-attended. The following day Hector took us on his speedboat for a thrilling experience!



Rosario, Argentina

Paris, France: You either see the slides or hear the speaker!

Jean Abitbol from Paris has taken part in our permanent course faculty for a while. He asked me if I could also run a course in England on voice disorders since that was his leading practice. Compared to Europe, voice disorders and their management had not developed in the UK in the nineties. I had my doubts about whether there would be many people attending.

Therefore, I said, 'But why don't you run a course in Paris where you will get a good attendance from Europe?'

He said, 'I do not know how to organise a course, why don't you give me a hand and we do it together?'

'OK, we can do that.'

The first course was organised sometime in 1992. I gave Jean all the information and asked him to organise a venue and a trade exhibition.

When I got to Paris, he took me to a private hospital where a marquee was erected on the grounds of the hospital. There was a desk, projectors and a few chairs. There were about twenty people including the organising staff, trade exhibitors and the participants. I introduced the course in the usual way. When they started projecting the slides, the bright sun came out of the clouds. A diffused bright light came in through the white marquee. It was so bright that no one could see the slides. But they could hear the talk!


Jean Abitbol. Paris

After lunch, suddenly, the sky was overcast and dark. The weather was ideal; we could see the slides and also hear the talk. However, as luck would have it, it was not long before the rain came with huge drops splattering on the canvas of the marquee. Now, we could see the slides but could not hear the talk.

The overall experience was very educational and

rich in content. Live surgery went well; Jean came to the marquee between each case to discuss the surgery.

A lesson was learnt for the next course! Slowly but surely, the course matured. The venue moved to Hotel Novotel Tour Eiffel, Paris.

Having worked in New York and Philadelphia at the Voice Foundation, Jean had gathered some excellent world-renowned speakers: Bob Sataloff, Michael Benninger, Peak Woo, Tom Murray and many others. The course was of a high calibre, and all participants learned a lot about voice disorders. Once, Jean demonstrated a live performance by a saxophonist while watching his vocal folds move to produce various tunes.

When Jean approached his last course, he particularly invited me, saying, 'You started that course, now, you have to finish it.'

Very touching. I had introduced Jean to many countries since he is an excellent speaker, his material is of high quality, his slides are unique, and so are the videos. There was much to learn from him and his faculty.

In particular, I took him to the Deenanath Mangeshkar hospital in Pune as course faculty and a speaker to the Pune branch of the Association of Otolaryngologists of India. To my great delight, his impressive performance led to a series of invitations from different parts of India and the vast Indian subcontinent, thus exposing the ENT surgeons in that part of the world to the budding sub-speciality of voice disorders and voice surgery.

He also contributed a chapter to my laser books with the joint authorship of Bob Sataloff from Philadelphia. Bob is a wonderful person. His knowledge of voice is extensive, and, what's more, he is a vocalist himself, performing many times during the course dinners.

Mumbai, India

When I worked as SHO at the Bombay Hospital in 1960, it was only a short distance away from the 'Nariman Point', a reclamation area of the Arabian Sea. In the nineties, hotel suites with this view of the Marine Drive and the Arabian sea, dubbed 'Queen's Necklace', from the eighteenth-floor suite in The Oberoi, were the most expensive suites anywhere in Mumbai.

'Queen's Necklace', Marine Drive, Mumbai, India

The Oberoi was one of the several targets for a terrorist attack in 2007, with fatalities in large numbers.

Tata Memorial Hospital, Mumbai

The Sir Dorabji Tata Trust commissioned the Tata Memorial Hospital on February 28, 1941. In 1952, the Indian Cancer Research Centre was established as a pioneer research institute for basic research – later called the Cancer Research Institute (CRI). In 1957, the Ministry of Health took over the Tata Memorial Hospital. The next milestone was the transfer of administrative control to the Department of Atomic Energy in 1962. The two arms merged in 1966 to be titled The Tata Memorial Centre (TMC), with a mandate for Service, Education & Research in Cancer.[23]

Every year nearly 43,000 new patients visit the clinics from all over India and neighbouring countries. Of these, almost sixty per cent of cancer patients receive primary care almost free of any charges. Over one thousand patients attend the OPD daily for medical advice, comprehensive care, or follow-up treatment.

Jean and I ran their laser course. The laser was built in-house. When I activated it with the foot pedal, nothing happened at the HeNe spot. Instead, a tissue burnt a few millimetres away from it. The HeNe and the CO_2 beam were malaligned, a not-uncommon occurrence while being wheeled into the theatre. I struggled to get going and asked the technicians to help me. But no success. So, I decided to burn a series of very shallow spots, and when the burn was on papilloma, I got the bearing and completed the surgery.

During the lunch break, both Nirmal and Beatrice – Jean's wife, an Obs Gynae consultant in Paris – scolded me for taking too long to do the surgery, which should have taken no more than ten minutes. Then I realised that my microphone was on, and the whole auditorium heard my frustrations.

Cairo, Egypt: 'Are you ungry, Mr Oswal?'

I was invited by Colonel Zakaria of the Egyptian Army, whom I had never met before. First-class tickets by Egypt Air took us to Cairo at about 2 AM. A handful of passengers got off; their cars had come up to the nose of the plane. Nirmal and I got off and just stood outside, not knowing which way to go. Our regular class was economy, and you followed the passenger in front of you to deplane.

But shortly, an army truck pulled up, and a soldier in full uniform asked me if I was Dr Oswal. The soldiers smartly saluted, and we were escorted in the army vehicle to the terminal building. Dr Zakaria, his wife, and a few others had come to welcome us at 2 AM! We sat for a while, drinking ice cold coke. Then, we were asked to give our passports and the luggage tags to someone. Half an hour had passed, but there did not seem any movement to go to the hotel. So, I asked if we were ready to go since I had a full day's programme the next day.

'We are waiting for you to finish your coke.'

'Oh, sorry, and our passports?'

'They are ready, stamped, as well.'

'Oh, thank you. And the luggage?'

'It is already in the car.'

'What time tomorrow I get to the hospital?'

'A car will come to pick you up around nine. The driver's name is Ahmed.'

I had to pinch myself to appreciate the VIP treatment we were getting. But then, we were the guests of the Egyptian Army! By the time we got to the hotel, it was 4 AM.

The next day, Ahmed arrived. He had no idea where he was supposed to take us. I told him to take me to the army hospital. Which hospital? I said,

'The Military Hospital'.

'Yes Mr Oswal.'

After about twenty minutes, I sensed that Ahmed did not have a clue where to go since he stopped at a few places and asked the way. In the end, we got to a substantial building. I got out and went to the reception. Nobody knew anything about me. They told Ahmed this was NOT the military hospital.

Some fifteen minutes later, another building. I asked Ahmed to inquire if there was Ear, Nose and Throat department, pointing out my anatomy. He went in. It was boiling hot, but I was not going to go in that heat and hear yet again, 'This is not the Military Hospital.'

Five minutes later, Ahmed came back. We were at the right place. A few soldiers came and escorted me to the office, where more people in uniform came in and out of the office. I sat there. An officer who was sitting in the settee opposite me said after a while,

'Shall we go?'

'No, I am waiting for Colonel Zakaria.'

'I am Colonel Zakaria,' he said.

'Were you at the airport last night to pick us up?'

'Yes.'

He had been sitting opposite me all this time, but I did not recognise him in his army uniform! Embarrassing!!

My first day was seeing out-patients and choosing a few suitable ones for laser surgery. The first patient came in. Until then, I did not realise that quite a few did not speak English. So, I would ask the question; the nurse would translate it into Arabic and then translate it back to me into English. It was soon apparent that it would take twice as long to see each patient.

I asked the nurse to teach me some words to ask the patient directly, such as swallow, put the tongue out, etc. The next patient was a man; I told him in Arabic to swallow. He was confused! The way I pronounced it, that word meant 'pregnancy'.

Then there were women in a hijab. It took extra time to take it off. I asked the nurse if they could do that in the waiting room. That was not possible because there were also men in the same room.

I had told Nirmal that I would be back by lunchtime. In the end, it was four in the afternoon when I finished that rather exhausting first day.

The first thing I did in the operating room was to rearrange the equipment. Zakaria said my visit was already valuable, even just for doing that. Not surprising since we also had to do the same when we got our laser at the infirmary. Ten days went by very quickly. We were able to do some sightseeing such as the pyramids and the famous Cairo Museum. Invitations mostly took up the evenings. A couple of nights were spent cruising on the Nile, with all the high-ranking brass from the Army having dinner with us.

As a gesture of thanks, they gave us an all-expenses-paid two-day visit to Luxor. I finished that morning's work and joined Nirmal at the hotel for packing. Ahmed was to come and pick us up to go to the airport. Time was going by, but no Ahmed. Eventually, he came, and we were on our way to the airport. I told him we might miss the flight. He uttered the

usual phrase, 'Yes, Mr Oswal.' Did he agree that we would miss the flight? I started getting a bit anxious.

Finally, we were at the airport building. I went to the counter and told them my name. The person looked up the list but could not find any reference to Mr Oswal.

'Where is the consignment going to?' I showed him our tickets.

'Oh, no, not here, this is a freight terminal. Go to the passenger terminal'.

I was furious; I told Ahmed to take us there. But he did not know which way. After asking the clerk for the direction, we were on the road again. At a roundabout, he missed the turn. So, he U-turned and started going against the oncoming traffic to get back to the roundabout. I shouted,

'No Ahmed, No, No, No. Turn around, you are going against the traffic. Stop the car.'

I got Nirmal out and dashed to the curbside! He turned the car around, and we started going away from the terminal. At the next roundabout, he got the right road.

'Mr Oswal, are you ungry?'

'We will have something to eat on the plane.'

'No, no, are you ungry with me?'

'No, I am not angry with you Ahmed.'

'Sorry Mr Oswal.'

For the first time in two weeks, it was not the usual 'Yes Mr Oswal'.

We just made it to the plane.

When colonel Zakaria came to our course, I told him the story of Ahmed. He said, 'You should have told us what happened' I said, 'No, I felt sorry for him that he might lose his job.'

'No, don't feel sorry for Ahmed. He is smarter than you. He told us the other way round, that you were very late leaving the hotel and were nearly going to miss the flight. He had to drive very fast and got you there just in time.'

All those who drive the car for a living are smart, with their eyes and ears open. They have to survive on the road twenty-four hours a day!

Conference in St Petersburg, Russia: A 'US – Russia' international incident?

There was a one-day conference in a prestigious palace in St Petersburg in Russia. Ornate decorations, posh chairs, huge drapes. After all, Saint Petersburg was the capital of the Czars before The Great Revolution culminating in the Bolshevik establishing the USSR (Union of Soviet Socialist Republics). The docudrama 'The last Czars' is worth watching, with some original footage.

I was the Chair. As I started the introduction, I felt a tap on my shoulder. An interpreter was behind me; he had to translate everything into Russian.

Translating each sentence would mean that the conference would take twice as long, planned for a day. By mid-morning, a speaker from the USA was presenting. Suddenly, we heard a loud crash. One of the twin projector stands had collapsed. The projector and all the slides were on the floor. Some of them were glass slides that had cracked, damaging the film inside. The American speaker was furious. In Russian, the projectionist said, 'You had misloaded the slides, so the projector got stuck and the stand collapsed.' 'No, your goddam stand just collapsed,' the American shouted. The Berlin Wall had just come down; I thought there was going to be an international incident! I quietened down everyone,

A high-octane moment with Marius Plouznikov

took a short break so that the American speaker got his act put together again, and then continued with one projector.

Atlanta, Georgia

Three hours of sun exposure, caused seven years of hyperpigmentation on my face

It was in April when we went to a laser conference in Atlanta. From very cold England to a hot sunny Georgia, it was nice. The Coca Cola factory was just down the road from the hotel, at Pemberton Place, named after John Pemberton, the inventor of Coca-Cola. We took a walk to soak in all that sun, went around the exhibition area for a couple of hours, and got back to the hotel for lunch. Nirmal looked at me and asked, 'What have you done to your face?' I looked in the mirror. My skin around the eyes on the cheekbone and the forehead had darkened on both sides. I washed my face, but it did not help. There were a good couple of hundred skin specialists from all over the world at the conference. I asked Harry Moseley, the head of the photobiology unit in Scotland, and Sean Lanigan, the dermatology consultant, about my face. Solar eczema. A short exposure of two or three hours? Yes, it can happen. The pigmentation got darker over the next few days and stayed with me for years, seen clearly in all the photos taken on various occasions. After about seven years, the skin returned to its normal pigmentation. Who would have thought I needed to apply sun cream in April?

A twenty-three-hour day in St. Petersburg!

The conference was in June. When I got back to the room in our hotel, the sun was low. It shone into the room through the window on the west side. I had developed solar eczema on my face due to the exposure to strong sunlight in Atlanta, USA, as mentioned earlier. So, I was happy when the sun went down at about 11.30 PM. By 00.15, the sun rays entered the room from the same window on the west side. Intriguing indeed! The sun goes down below the horizon; there is twilight in the sky for half an hour or so. Then, the sun rises again, just a bit to the right (East) of where it had gone down (West) in the same window. It does not get dark for three weeks in June. You can easily read a newspaper at night in the natural light. The birds start chirping again within half an hour after sunset!

Pune, India

I ran several courses in my hometown Pune at the Deenanath Mangeshkar Hospital, described in Section VI. When this photo was shown to me – unbelievable, the laser beam should never be pointed at people or a non-target.

When this photo was shown to me – unbelievable, the laser beam should never be pointed at people or a non-target.

Antwerp, Belgium: Terrorist attack in Mumbai

From India en route to England, I had accepted to attend a conference in Antwerp, Belgium. Bert Schmelzer was the head there. He came to see us in the hotel lounge. During our conversation, he frequently looked away to his right. I got curious about what was diverting his attention from our chat. Then I noticed that he was watching the television behind us.

Bert Schmelzer, Antwerp

Suddenly, he said, 'Look Vasant, what is happening in India.' The news was on, covering the bomb attack on the hotels in Mumbai[24] the night before. It was November 26/27, 2008. A series of terrorist attacks took place at various locations in the same part of Mumbai as where we were the night before. As it turned out, twelve coordinated shooting and bombing attacks were carried out during four days across Mumbai. At least 174 people died, including nine attackers, and more than 300 were wounded.

I get goose pimples whenever I recall that attack. A couple of nights more in India, and we would have been a target, one of the hotels attacked was The Trident at the Nariman Point in Mumbai – where we stay whenever we are in Mumbai. It is a ten-minute walk from Nirmal's parents' home. My sister's granddaughter was a manager in a jewellery shop at the Taj Hotel, the main target. She had left at seven in the evening, and the attack came soon after that.

Edinburgh, Scotland: Kilt pleats on the back or front

A joint International Laser Conference of the British Medical Laser Association (BMLA), the American Society for Laser Medicine and Surgery (ASLMS) and the European Laser Association (ELA) was to take place in Edinburgh, Scotland, in 2001. But the 9/11 terrorist attack on the World Towers shook the world. We had to postpone the conference to 2002. The Edinburgh Council and The Conference HQ Hotel agreed not to levy a penalty for postponement. The insurance cover had to be re-done. The insurance company agreed to underwrite, inserting a new clause not to cover cancellations related to terrorism – which from that time on became a 'known risk' in the world of insurers, and therefore, non-insurable! The conference ended up being one the most successful ever, held by the BMLA. There were some 650 delegates.

McOswald with my own tartan

All the BMLA execs decided to wear a kilt. Although I had worked in Dundee in Scotland for good three years, I never wore one ever! The arrangement was that we hire kilts for all. Someone delivered the kilt to our room. I asked the person how to wear it. He said, 'keep pleats in the back'. I heard him say: 'Keep the split in the back.' I checked the kilt, but there was no split, as some skirts have it. It was getting late, so I just pulled it up and fastened the buttons – instant McOswald with my tartan.

Harry Moseley, the conference president, was a bit besieged and asked me to carry on with all the formalities. So, there I was, with Nirmal, leading the procession to the dining tables. It was a grand event, money no objection since the attendance was large. I was moving around to ensure that everything was running smoothly.

At one point, the piper stopped me and, pointing at my kilt, said: 'Doctor, you are wearing your kilt the wrong way round.' I thought he was joking, but no. He said, 'Look at ours.' Rightly enough, their 'pleats' were on the back, whereas I had them in front. I said, 'But is there a split in yours? I do not have it in mine.' He said, 'There never is a split in the kilt.' The penny dropped; what I thought the delivery man said and I heard as split was, in fact, pleat. I felt pretty embarrassed, particularly having had been photographed several times throughout the evening, with the kilt wrong way round.

Vasant and Nirmal leading the VIPs to the top table (Harry and Anna Mosley behind them)

The piper said, 'No problem doctor', he put his hands under the shirt and inside the kilt at the waist. 'You go round one way, and I go round the other way'. As we were adjusting the kilt, I crouched in pain. He must have held my underpants as well with the kilt. The underwear could not go round, and my manhood was caught in them! Instinctively, I put my hand up my kilt and started adjusting the tangled parts. The piper said: 'Doctor, go to the gents and do it there; everyone is watching you here, with your hand up your kilt!' Felt

Embarrassing – Kilt worn wrong way round!

like I was in that hilarious film 'Carry on Up the Khyber'!

Concerning the revenues: we had made more than £ 80,000/- surplus, to be shared by the three-parent organisations.

A few weeks later, Harry Moseley, who lived in Dundee in Scotland, was a speaker at our course in Cleveland. He said, 'My wife and I had been invited for dinner by the organisers, Monarch, to celebrate our success.' The arrangements were that Anna (his wife) travelled from Dundee and met Harry in Edinburgh for dinner with the Monarch staff.. At about 6.30 that evening, some course staff told me that Harry wanted to speak to me urgently. 'Vasant, Anna and I went to the offices of Monarch, and found that the door to their office was locked and sealed. They've just gone bankrupt.' I said to him, 'Harry, if this is a joke, it is in bad taste.'

No, it was not a joke. The liquidators took over the company, took their fees first where there was cash – yes, from our ring-fenced account. Some months later, we managed to get our seed money back for the three organisations. But I made a princely sum of three thousand pounds on the side for the BMLA. The Americans had contributed to the seed money some three years earlier. Since then, the pound had strengthened against the American Dollar! A consolation prize. You may think so, I would rather take £ 27,000/-, our share of the surplus, and that exchange rate bonus of £ 3000/- as well.

Delhi, India: An enviable position for a surgeon

I suggested to the organisers of a Delhi laser conference to introduce a novel way of presenting a topic of 'Laser surgery vs Radiotherapy for early glottic cancer'. The topic should be enacted as a case of negligence against the laser surgeon in the court of law. All the actors were ENT surgeons. I was the judge, and there were International 'juries'.

A patient alleged that the phonatory outcome would have been better with Radiotherapy. His attorney brought in a witness to support the alleged claim. The defending attorney produced his witness, who supported the laser modality as a better tool to preserve the voice quality and overall survival rate.

It was a novel way of presenting the pros and cons of the two modalities, and the presentation turned out to be a winner. Of course, as the judge, I gave a verdict, the defendant not guilty of negligence! The attorney roles were excellent; one of the questions to Sachin Gandhi was about his annual earnings from laser surgery – he hesitated! You cannot get more real than that.

Vasant Oswal (Judge) and Major Ravi Kumar, ENT surgeon

Kathmandu, Nepal: Sad end to a pleasant experience

The ASEAN (the Association of Southeast Asian Nations) conference president invited me to their conference in Kathmandu, Nepal. With such an opportunity to see the Himalayas, I was delighted to accept their invitation. We were there for a week. First, there was an invitation by the British Ambassador to his residence. It was followed by Inauguration at the hands of the Queen of Nepal and the Crown Prince. My photo was taken, handshaking with the queen. The same year I read with a great deal of sadness of the Nepalese royal massacre that occurred only a month later, on June 1, 2001[25]. Nine royal family members were shot dead in a mass shooting by Crown Prince Dipendra, who slipped into a coma after shooting himself. The deceased included King Birendra and Queen Aishwarya.

Our wish to see the Himalayas did not materialise. Every morning at 6.30 AM, we went to the airport, only to be told that it was too cloudy, and the sightseeing planes were not flying. But one day, we (almost) made it. We boarded the plane. The engine started to rev, and we moved. After five odd minutes of a slow run, the aircraft stopped again. I looked out of the window. No, there was no Himalayas insight. I told Nirmal, 'That plane outside is the same plane as the one we saw when we left.' Indeed, we had circled the airport, and as we were about to take off, the message came of yet another day of cloud cover.

The Queen and the Crown Prince of Nepal

Vasant Oswal meeting the Queen of Nepal

Toronto by Concorde: in three and a half hours, cruising at 1200 mph, 11 miles up in the sky – the bad news and the good news!

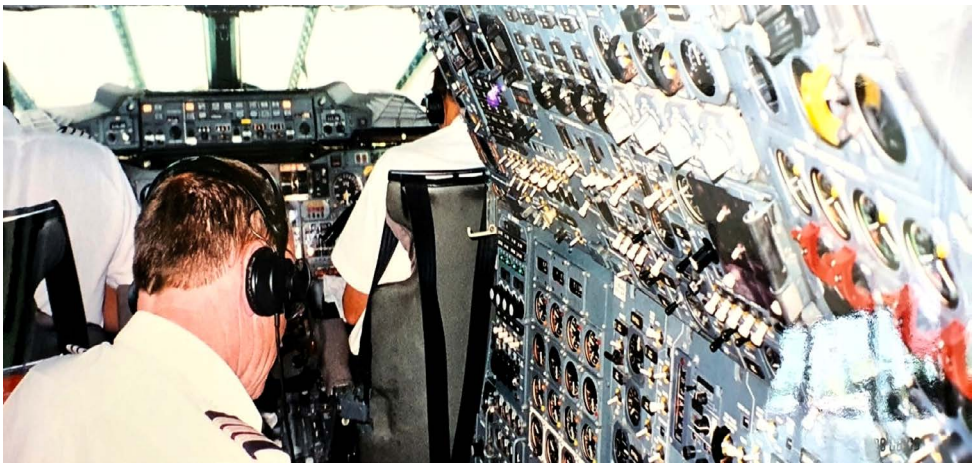
For one of the conferences in Canada, we took an opportunity to go by the Concorde[26], which was offering a week's holiday. An all-inclusive price was offering a one-way flight by the Concorde. The return trip was sub-sonic by BA. The price covered a five-star hotel and a sightseeing trip to Niagara by helicopter and by boat. In addition, there was an evening at a Broadway show.

The Concorde

As we were about to take off from the Manchester airport, the pilot welcomed us on board and said, 'We have the good news and the bad news. The bad news is, we are not going to Toronto but instead, we are going to Halifax. The good news is we are going to Halifax in Nova Scotia and not Halifax in Yorkshire! But look at it this way: you will have two Concorde rides for the price of one!'

There was an unusually high atmospheric pressure on England and the Atlantic Ocean that morning. As a result, the pilot said he would have to use a lot more fuel to get to the supersonic height of 55,000 feet, flying at 1250 miles an hour (standard commercial subsonic jet flies at 37000 ft with a cruising speed of 550 MPH), leaving him short of fuel to go all the way to Toronto. So, the nearest landmass was Halifax in Canada.

Manchester to Toronto in the Concorde in three hours



Concorde cockpit

Narrow low isle with two seats on each side

As we took off, we had a selection of vintage wines and, of course, a champagne breakfast. The meals were served according to the departure time, ten in the morning in England. After about 45 minutes of subsonic travel, the pilot announced, 'We will climb up to 55,000 feet (11 miles). During the ascent, we are going to go through the sound barrier, but you will not feel any difference apart from the rapidly changing altitude and speed display in the cabin.'

Sure enough, from 550 miles an hour, the display started to increase. At 700 miles an hour, we had gone through the sound barrier but never felt it! Eventually, we got levelled off at 55,000 feet and 1,200 odd miles an hour. The steward told us to look out of the window. The sky now was deep, deep blue – the likes of which you will never see unless you go that high. Then the pilot said, 'Your windows are going to feel warm, but it is normal, it is due to friction of high speed with the atmosphere.' And indeed, the glass was warm to touch. Then more drinks and a tour to the cockpit. What an experience! Now about two hours had passed since our departure. We got ready for lunch – so soon after breakfast! Then it was time to descent to subsonic level. Landing in Halifax was smooth. The journey time: three and a half hours.

We had to remain on board. Nearly three hours had passed on the land. Then, the announcement came that the two airport personnel, the Canadians and the British, were in touch to calculate the weight of the plane, the take-off speed, and many other details since the runway was not designed for the Concorde take-off. It made us feel so special.

Eventually, we took off for our intended destination: Toronto, but at subsonic speed. OK, the journey took as long as by the subsonic flight. But we did not go by Concorde to save the travel time. No, we went by Concorde because, well, it was the Concorde.

The magnificent feat of engineering, the supersonic passenger aircraft, was taken out of service following a crash in Paris in July 2000. Unfortunately, the crash cost the lives of all passengers and crewmembers.

Naples, Italy: Smoke, smoke and more smoke

Giovanni Motta from Naples was running a laser conference. Coherent had arranged for me to go to that conference since I was a prospective buyer. The timing was tight, so I had to take a helicopter ride from Heathrow to Gatwick – 15 minutes. After the lectures, we were bussed to a hospital a few miles away. There was no other transport, so we were stuck there for the whole day. Live surgery started; we saw the burn, then more burn and then smoke, and yet more smoke. And yet more smoke. Once you have seen smoke, any other smoke is much the same, not very exciting. Finally, after about twenty minutes, we, the British delegation of five, looked at each other and made our way to the door. It was a beautiful sunny day. I breathed in that lovely continental warm air and said, 'What a nice fresh air, and lit up my pipe'. Brian Duff from Preston said, 'Oh no, not more smoke.'

A trip to Capri and artwork from the Nepalese School of Art completed the smoky conference. Upon arrival at Gatwick, Richard said he would take me to the King's Cross station. But he was not very familiar with the roads. In the end, we arrived at the station. I dashed to the platform as the guard was blowing the whistle. I just made it to the nearest carriage. I did not have time enough even to make sure that I got the right train. 'To Newcastle?' I asked the couple sitting opposite. The man quickly said, 'No, to Penzance.' His female companion promptly said, 'Oh George, stop it. Yes, to Newcastle.'

Pompeii, Naples: See Naples and die – every bit true

There were a few more visits to Naples to lecture Giovani Motta's students at Naples University. Although each stay was memorable, a trip to Pompeii has to be the top. Pompeii, along with Herculaneum and many villas in the surrounding area, was buried under 4 to 6 m (13 to 20 ft) of volcanic ash and pumice in the eruption of Mount Vesuvius in AD 79[27]. The moment of the eruption was largely preserved under the ash, suffocating all its inhabitants. The excavated city offers a unique snapshot of Roman life, frozen in time when it was buried, and a detailed everyday life of its inhabitants. To walk on the pebbled streets still bearing the cartwheel marks and see the people frozen in time since 79 AD in their own houses in the town leaves an indelible mark forever. The hot volcanic ash suffocated them instantly in whatever positions they were in. The rock and the ash around them are carefully removed, and the surrounding remains filled with plaster of Paris. When dried, the excess is chipped away. The skeletons are thus converted into bodies, as they would have been when they suffocated – sitting, lying down, bending, kneeling or whatever.

Volcano Campi Flegrei, Naples: What if the roof collapses?

While visiting Naples, we went to see Campi Flegrei[28], near the port of Pozzuoli. It is a collapsed volcano which means it does not have one prominent vent or a central peak. Instead, there is a vast magma chamber deep underground. This kind of volcano creates the most explosive and destructive volcanic eruptions. The guide took us to the 'roof 'of the volcano, which felt hot under the shoes. He gave us a metal knitting needle and asked us to push it through the larva rock and hold it there for thirty seconds. It was pretty hot to touch!

Pizza Margherita, Naples: The most authentic that there is

The Pizza Margherita, the iconic Neapolitan pizza, is famous worldwide. Its story allegedly began in a narrow alley in Naples in Pizzeria Brandi's restaurant[29]. Chef Raffaele Esposito created it in honour of Italy's unification, with the three toppings – basil, mozzarella, and tomato – representing the Italian flag's green, white, and red. A plaque was unveiled in 1989 near the Pizzeria Brandi to mark the 100th anniversary of its birthplace. We went to the restaurant to experience the authentic taste of the pizza and savour the nostalgic feeling. There are many stories about the origin of this pizza, but they all indicate that this pizza goes way further back.

Sicily, Italy

Dr Galleta, far right

The young professor Galleta (far right) saw me at the conference in Russia. Then, one day, I had a mail from him inviting me as the Chief speaker at a conference on lasers he was organising in Sicily. His chief gave an inaugural speech in broken English. After several minutes, there was no sign of him stopping. No one in his department dared tell him to wind it up. The young professor asked me to intervene! I picked up a microphone, went up on the stage and said, 'What an excellent facility you have created in this small place, Sicily, it could not have been easy.' That prompted him to tell me a lot more about his department. I listened for a while and said, 'Fascinating, I would like to hear more about it, but first let us have a glass of wine.' We went up to the bar, the young professor's face lit up with a big thank you!

We also took the opportunity to see Mount Etna, an active volcano on the east coast of Sicily.

Florence, Italy

Laser Florence – 2003
Leonardo Longo (left), the Founder President of IALMS

Leo Longo separated from the European Medical Laser Association and established the International Academy for Laser Medicine and Surgery (IALMS)[30] in 1999. As the Founder President, he held annual courses and conferences in Florence, Italy, under the banner of Laser Florence.

Leo asked me to be a board member; thus, the conference was a fixture in my calendar in the first week of November. Wonderful city. But to get to it wasn't easy in November, out of season. So, you had to go to Pisa and take a train or a taxi. The administration of the conferences was a family affair with his charming wife Patricia and children taking an active part. Nirmal enjoyed the trip since his children wanted to learn to speak English from her!

To Florence by the Venice Simplon-Orient-Express

One year, we decided to do a long job of going to Florence. We picked up the Orient Express to Venice. Posh. We were crossing the French and the Austrian Alps in style!

The wine came. In no time, there were a few empty glasses on the table – some white, some red. The couple opposite was young. After a while, the young man was unsure which glass was his.

'Oh, which is my glass?'

'The one with the lipstick on it,' I said.

That broke the ice, and we had an incredible journey to Venice.

Murder on the Orient Express? No, there was none that night (Murder on the Orient Express, a book (1934) by English writer Agatha Christie, also a film release in 1974 and again in 2017).

We had a short holiday in Venice before travelling to Florence. Hard work going to so many conferences and courses? Yes indeed – keep reading!

London to Venice by Venice Simplon-Orient-Express

The only way to travel from London to Venice: by The Orient Express!

Palace on Wheels – India: 'If it is good enough for him, then it is good enough for me'

Welcome Reception, Palace on Wheels

I was invited to Lucknow in India to run their laser course. We took this opportunity to have an eight-day tour of Rajasthan aboard an old Maharaja Train, now known as 'Palace on Wheels', a Government of India enterprise.[31]

The tour lasts a week aboard the train. The journey starts in Delhi. The train goes around the princely states in the North of India: Jaipur, Jodhpur, Udaipur, Jaisalmer, Agra and returning to Delhi. The travel between the towns is by night, arriving at the next destination in time for breakfast. After breakfast, you are taken aboard a luxury bus for a guided sightseeing tour of palaces and the city.

Nirmal, Martin & Pen in the Palace on Wheels

A sumptuous leisurely lunch is served at a palace, commercialised into a hotel or a resort. Then there is another sightseeing tour in the afternoon before the bus arrives back at the train station for a short rest and dinner aboard the train.

The train has twenty carriages; each carriage has four luxuriously fitted bedrooms with en-suite bathrooms. There is a 24-hour butler service, with one butler at each end of each carriage.

The evening meal, prepared in the onboard kitchen, is served in two beautifully appointed aptly named the King and the Queen carriage. Another carriage has a lounge with a pay bar for drinks, completing the full luxury treatment!

The all-inclusive ticket covers absolutely everything; you only pay for any drinks ordered at the bar.

When we arrived at the station, the waiting room for boarding the train was packed. There was just one seat. A woman next to it was writing on a pad. I asked her if the seat was available, she said, 'Yes, you can sit here.' She was from England, with a very English accent. She said, 'I always keep a diary of all my travels.' I asked her where she lived in England. 'Sussex.' 'I live in Yorkshire.' Just at that point, I saw a bespectacled man come and start talking to her. Her husband. 'Oh, I am sorry, I took your seat' I apologised and started getting up. 'No, no, do sit down.' It was the beginning of a friendship that would last many years. If we went down south for conferences, they would visit us for a meal together. If they were travelling up north to see their friends, they would stop at our place to say hello. Pen and Martin. A memorable trip indeed.

At Jodhpur, Prince Charles was also in the town with the Maharajah at the time of our visit. Well, 'If it is good enough for Him, then it is good enough for me!'

Nirmal's uncle and his family live in Jodhpur. Although we married in Jodhpur in 1962, I had never been back since then, so they were all delighted to see us. And at a stop in Jaipur, another family came to the train to meet us – so nice of them.

Laryngology Conference, Ahmedabad: Fancy dress party mixed with business

I was a Mughal Emperor in a drama performed during the open day in my secondary school. They kept telling me to speak into the microphone. My logic told me: how could I? There were no microphones in the Mughal era.

But I am destined to be a Mughal Emperor! In the old tradition, the Emperor held a weekly audience where any subject was free to bring a grievance or a complaint of wrongdoing and ask the Emperor to intervene for justice to prevail. During a Laryngology conference in Ahmedabad, India, in 2016, I took a role of a Mughal Emperor with other seniors as the members of the 'Durbar' or council. A medico-legal topic was dramatised against a surgeon in the Emperor's Durbar for justice!

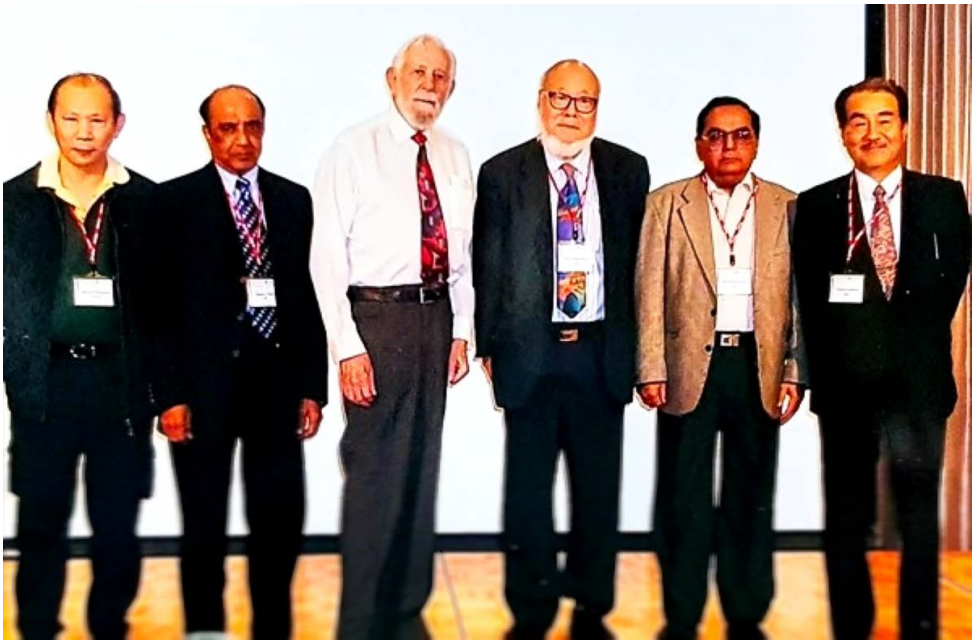
Tokyo, Japan: A once- in-a-lifetime experience

We had booked a seven-star hotel for a conference in Tokyo – a long way from England. The Japanese hospitality was out of this world.

While visiting Japan, we took a day trip to Mount Fuji – a unique experience to see it and smell the sulphur in the atmosphere.

Play acting as The Moghul Emperor,
Laryngology Conference in Ahmedabad, India, 2016

World Federation of Societies for Laser Medicine and Surgery, Tokyo, Japan
Sitting, Vasant Oswal, second from left, Nirmal Oswal, third from right



L-R Narang, Oswal, Kaplan, Atsumi, Krishna Rao, Oshiro

L–R: Vasant Oswal, Patricia Longo, Leonardo Longo, Abe, Isaac Kaplan Marsha Kaplan, Nirmal Oswal

Nirmal with Geishas in Kyoto, Japan

After the conference, we went to Kyoto by the Bullet Train. The station looked more like an airport. The decor in the carriage was also befitting, and so were the uniforms of the staff. And to top it all, our seat numbers were 13A and 13B – it was 13th September – my birthday!

Kyoto is a cultural city. We purposely checked into a hotel with Japanese style décor, sitting on the floor mats, having tea, a hot spring on the property, and only Japanese food. We mostly tried local delicacies.

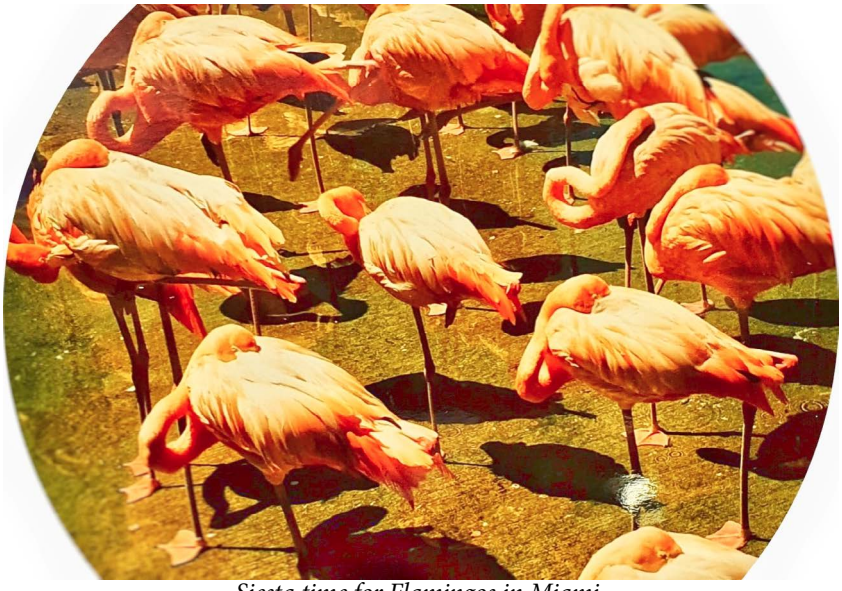
Kyoto is famous for the geishas[32]. The only way to attend a geisha performance is to get into one of these enclaves, and the only way to get into one of them is to be introduced by someone already accepted.

Miami, USA: 'Now you all pretend to sleep – for a camera shot'

We were going to Miami for the IFOS conference. It was May, boiling. Even the Flamingos were having an afternoon nap.

In the evening, we went to get a pizza around the corner. We just wanted one pizza between the two of us. The owner made a two-foot diameter pizza and gave it to us. We said, no, we only want a small pizza. He said, 'Take it and eat it, take it home, eat it for breakfast.'

Nirmal took a small portion and gave me one. She gave back the remaining and said to him, 'Someone else might eat this.' He took it back from her and put it straight into the bin without any expression on his face. We felt so guilty about wasting food.



Siesta time for Flamingos in Miami

Geneva, Switzerland: Half sheep's head

Nirmal accompanied me everywhere and helped me during the hands-on courses. In Geneva, where the surgeons were holding a course on Eustachian tube laser surgery, the anatomy department brought her a half sheep's head for the hands-on course and asked her if it was OK! A far cry from the usual housewife's work.

Paragliding over the Swiss Alps

After the conference in Geneva, we went to Interlaken in the Swiss Alps. We came across a booth by the roadside, advertising paragliding. Out of curiosity, I asked the staff as to what was involved.

'We take you to the top of the mountain, at the beginning of the slope. There you stand in the parachute with the pilot behind you. Then both of you run down the slope, and you are airborne. The pilot navigates all the time, and you enjoy flying for half an hour. Then the pilot brings the parachute down to the lawn of the Victoria hotel (that is where we were staying).'

'Do you think at the age of eighty, I am too old?'

'No, our oldest one was 87-year-old, he went up without any problem.'

Paragliding over the Swiss Alps at 2000 ft above Interlaken, Switzerland

'OK. But did he come down as well?' There was a laugh.

I decided to have a go, but Nirmal said no. The next day, Nirmal changed her mind and said she would also go. She was wearing a sari and did not have any trousers. I told her, 'no problem, you will have two parachutes as you came down – safer, going up in a sari.' The receptionist had a hearty laugh. She said we would give you a pair of trousers; you can change in the ladies room at a nearby hotel.

All that remains to say is get a unique experience of paragliding if you can, with nothing but the air surrounding you, flying two thousand feet up in the sky, like a bird.

Mad cow meat in Munich: Not the best description of a steak on the plate

I had accepted the invitation by Professor Lenz to present the work on laser nasal surgery at his conference in Munich. However, we had travelled from Mumbai to Heathrow just a day before his conference. Therefore, I had to tell Nirmal to stay in the Hilton at the airport, and I went to Munich. I recall an incident at dinner – the steak was on the menu. Hermann was uncomfortable and asked me if I would eat cow's meat. 'Mad Cow's disease is going around!' That put me off the dinner altogether, steak or no steak!

King Fahd Military Medical Complex, Dhahran, Saudi Arabia

I was invited to participate in the conference organised by Brigadier General Dr Saud Alsaif, the head of the ORL-H&N Surgery at King Fahd Military Medical Complex, in

Vasant Oswal with Brigadier General Dr Saud Alsaif

The ubiquitous camel!

Arabic national attire for the social function, Nirmal covering her head for fun!

Vasant Oswal in Dharan, Saudi Arabia. People should not be judged by the way they dress but by the way they conduct in the society they live in – wise words of my uncle

2003. The conference was soon after 9/11, there was a degree of apprehension to travel, and no one from the USA came. But there were some from the western countries. Nirmal was concerned that they might ask her to cover her face as per their social customs. I wrote to them, and they assured me that she would not have to do that.

We were accommodated in a five-star hotel surrounded by a very high wall with tight security. Each morning we were taken to the hospital in a military convoy and brought back in the evening. The social evening was excellent. We all were to wear the national dress. Nirmal and the wives of the other two guest speakers were taken to the shops to choose the material for their dress, but for men, a tailor came to measure up.

The highlight was a visit to a refinery, where we were given a guided tour.

USSR: Union of Soviet Socialist Republics (1922–1991)

After the start of World War II, the Soviets invaded and annexed territories of several Eastern European states, including eastern Poland and the Baltic states. Soviet forces captured Berlin and won World War II in Europe on 9 May 1945. The territory overtaken by the Red Army became satellite states of the Eastern Bloc. I was old enough to understand that, along with the USA, the USSR[34] emerged as the global power with a vast landmass. As I approached my retirement, the USSR and the Berlin wall collapsed.

Professor Marius Plouzhnikov, Head of the ENT Department in the First Pavlov State Medical University of St. Petersburg, Russia

During the EUFOS Conference in Naples, I was chairing a session. Professor Marius Plouzhnikov, Head of the ENT Department in the First Pavlov State Medical University of St Petersburg in Russia, presented a paper on permanent recovery of sensorineural deafness if you sent people on holidays. As chair, I asked him if it was only temporary recovery due to the threshold shift. He said, 'No, the improvement in sensory neural loss of hearing is permanent.' He had published the work in the Russian Medical Journal in the Russian language. Further discussion followed, and I asked him to send me the published paper, although it was in Russian.

Chair, International Conference of Young Otolaryngologists in Russia

My discussion must have made an impression on him since, within a short time, I received a mail from him inviting me to chair an International Conference of Young Otolaryngologists in Russia[35]. It involved forming a jury board under my chairmanship that would judge the presentations by the young trainee doctors and award the best presentations. The prizes consisted of an all-inclusive attachment to various centres around the world for a period of two to four weeks.

I enquired with my contacts in Europe if they would be prepared to get involved in this role, and, surprisingly, there was a tremendously positive response.

Welcome at St Petersburg airport

In due course, I received an invitation from Marius' university to visit his department and participate in the Academy of Young Otolaryngology and Head and Neck Surgeons conference in St Petersburg (formerly Leningrad, hence the airport code is LED). We were welcomed at the airport by Marius and his secretary Elena. They drove us to the hotel. I was happy to be in Russia and honoured to be invited and stay in paid accommodation.

International Conference of Young Otolaryngologists, St. Petersburg

I encouraged the young doctors – who were palpably nervous, to come to the stage and present their papers. Questions to the presenter followed each paper. First, I asked some questions, then a professor in the audience stood up and asked the doctor if he had read his article in the journal. I could see the nervousness on the face of the young doctor. I ruled that only one question was allowed, strictly, about the presentation.

International Jury Board, St. Petersburg

The doctors mostly came from the 'old' Soviet countries. Their English was poor, their slides were hardly legible, and some had learned the presentation by heart. The presenters had their eyes glued to the audience, focusing somewhere in the distance. They had memorised the presentation in a parrot fashion, so there was no need to look at the slide, and 'next slide' was part of the memorised text! They were presenting the work of their chiefs with no clue about the subject matter.

After the award ceremony, one hour was reserved for me to analyse their presentation and tell them how to improve. For example, I showed the doctors how to make legible slides, look into the audiences' eyes to establish eye contact with them, etc. I also told them how they could improve their English and so on. I could see their attentiveness and how they were delightfully surprised at my accessible communication with them without any ego of seniority - they were probably not used to these ways from their chiefs.

'Actual Member by invitation' – 'Distinguished Otolaryngologist'

Award: 'Actual Member by invitation' – 'Distinguished Otolaryngologist'

I was awarded the membership of the Academy with the title 'Actual Member by invitation' – 'Distinguished Otolaryngologist', The International Academy of Otolaryngologist and Head and Neck Surgeon, Russia.

Marius's secretary Elena Berezkina did all the work organising the conferences and courses. She was the soul of the department, as all the medical secretaries are. But more than that, Elena had to manage the correspondence in English and Russian, which she did impeccably. She was always cheerful and never showed the stress of the enormous task she had to do on every occasion of an international event.

Bert Schmelzer from Belgium was of tremendous help in sorting out the ranking of the presenters and giving them an appropriate award. In this respect, he had a particular sense to know which presenter would get the most benefit from their prize. Thus a high-value prize of spending a couple of weeks at the ENT department in Europe or the USA with all expenses paid for did not always go to the best presentation, but to a presenter who was deemed to benefit the most from that award. The decision was always unanimous under Bert's watchful eye, with no interference from Marius, neither during the deliberations nor after the awards were announced.


Ms. Elena Berezkina

I am proud that over the number of visits that followed, there was a remarkable advance in their presentation skills, general grasp of the subject and marked improvement in spoken English. Moreover, our visits were beneficial in improving the overall performance of doctors from Ukraine, Belarus, Chechnya, Uzbekistan, Kyrgyzstan, Azerbaijan, Latvia, Lithuania, Estonia, Georgia, and many other countries from the former east USSR.

NP Simanovskii Gold Medal

As 'Chair' of the Young Otolaryngologists Association, we went to Russia every two years and saw the new nations from the Soviet Union Era gradually changing under the Western influence. Some ten years on, the newly qualified doctors spoke fluent English, and their presentations were as good as any. Marius Plouzhnikov honoured me by awarding the 'NP Simanovskii Gold Medal' in 2006 for contribution to young doctors' training from Russia and the old USSR – it was the first time an award was given to a non-Russian person.

Nikolai Petrovich Simanovskii (1854–1922) was a Russian physician who established Otolaryngology as an independent scientific discipline. Simanovskii founded the clinic for

*NP Simanovskii Gold Medal awarded to Vasant Oswal by Marius Plouznikov**

ear, nose, and throat diseases in Russia and was appointed as the first chair.

Marius Plouzhnikov

The coverage of my position as chairman of the forum for training young otolaryngologists from the old USSR countries cannot be complete without paying tribute to Marius' passion and perseverance. He brought global expertise to St Petersburg and persuaded them to establish prizes and all-paid observer attachments to their units in Europe and the USA. To be completely impartial, Marius never took part in the judging process, which was entirely left to the international juries under my chairmanship.

Marius passed away in 2008, but his legacy has been immortalised by creating an annual Marius Plouzhnikov Memorial Lecture, successfully held since his death.

Marius and I became close friends

Sergei Karpischencho – the new Head of the department in St Petersburg

Sergei Karpischencho

During the visit following his death, we were welcomed by a young man. He introduced himself as Professor Sergei Karpischencho, the new Head of the department in St Petersburg. 'You will not remember, Mr Oswal, but I was a trainee, presenting at the conferences of which you were the Chairman. I also won a prize for best presentation during one of them. Now I am the Head of the Department.'

There cannot be more joyful moments than what I was hearing – so satisfying that I had been instrumental in bringing the doctors of so many former USSR countries to an international standard so that one of my trainees is now the Head in St Petersburg.

Conferences in the COVID-19 pandemic: Zooming is wonderful if you have a reliable internet!

The Covid pandemic has changed the 'normal way' of life, I think forever. In 1806 Dr Edward Jenner created the smallpox vaccine. It gave lifelong immunity, and even then, it took 171 years before smallpox was eradicated from the face of the earth in 1977. Such will not be the case with Covid since the immunity is not lifelong, with the current state of knowledge.

A new 'Covid' way to hold a conference, Delhi, February 2021

All the live conferences stopped and were taken over by online platforms such as Zoom. Such a conference was held in February 2021, in Delhi, India. I was given the honourable title 'Chief Patron'.

I hope you enjoyed our stories. Now back to the Infirmary.

Further expansion of the ENT department in the eighties

By 1985, my laser workload had increased substantially with regional and supra-regional referrals. When we advertised a Consultant Job vacancy, we had a highflyer from London, Liam Flood, coming up to Middlesbrough. He had just returned from the States after a year of job experience.

I asked him, 'Why Middlesbrough?' 'Oh, but you have an excellent department, everything under one roof, modern theatres, the laser, you underestimate how good your department is compared to many in London.'

Liam Flood

Music to my ear. Honestly, no exaggeration.

'Why did you not stay in the States? More money, more everything.'

'I prefer the UK system of Health Care and value our NHS'

On every point, he was scoring. His appointment was followed by another one, Maurice Hawthorne, in 1988 to replace Martin Horowitz. Another highflyer.

Are we there now? Middlesbrough no longer a backwater of England? But I still had my doubts. Were these young guys using my department as a steppingstone to greener pastures should the vacancy arise? No, not a single one ever did that! Then what?

I told Liam Flood, 'From Middlesbrough, you will never be on any of the committees in London.' He proved me wrong. Liam was appointed to a high academic career – associate editor of the Journal of Laryngology and Otology, Membership of the National Institute for Clinical Excellence (NICE), an Examiner for the FRCS, and so on.

When Maurice Hawthorne joined us, I said the same to him. Even more, I bet a fiver; they would never join any committees. I was glad to lose the bet. Go on the internet, click on their names, and you will see what I mean. Maurice established and headed the Regional Cochlear Implant Programme. He also chaired the Examination Board for the Royal Colleges and other prestigious positions.

We appointed two more consultants. Derek Bosman, our registrar, was later appointed with a particular interest in paediatric ENT.

All my operating time was taken up by laser surgery cases which came from near and far, and I had to stop doing any external H&N surgery. Therefore, we appointed Richard Wight to share it with Frank Martin.

Princess Diana: A most photographed lady

Princess Diana visited Middlesbrough to inaugurate the maternity wing in a local hospital around 1985. She was introduced to all the senior consultants from the hospitals in Middlesbrough, and I was one of them. A tall, pretty lady with piercing eyes is how I remember her. Her faint smile suited her persona as she looked at me.

When a tragic world event occurs, it leaves an indelible mark of what we were doing at that specific moment. Such was the case on that fateful evening when Princess Diana was involved in that terrible car accident. Steven's brother Ian was getting married, and we all were in a London hotel for the event. Nirmal had gone to bed around midnight. I hung around and eventually went to the room. I still was not feeling sleepy, so I put the television on. Princess Diana's car crash was live on the news. My eyes were glued to it all night long, watching and listening to the horrible news. The event unfolded throughout the night and the early hours, and finally, the confirmation came that she was no more. There was a spontaneous outpouring of national grief. We sat all day long, watching her funeral with wet eyes.

Princess Diana being introduced to Senior Medical Staff. Vasant Oswal far right, facing the Princess

'Can't come, been busy photographing kids' bums all night'

I used to ask the photographer at the Middlesbrough General Hospital to take photos during a suitable surgical procedure for teaching purposes. One day, he said, 'Can't come, Mr Oswal, I have been busy photographing kids' bums all night'.

It was in 1987. Sensational news had appeared in the local newspaper. Social service agencies were taking several children under their care because of alleged sexual abuse, based on a diagnosis made by two consultant paediatricians, Marietta Higgs and Geoffrey Wyatt. Before the arrival of consultant paediatrician Marietta Higgs, the incidence of child abuse in Cleveland was similar to the national average.

The number of foster homes quickly ran out. Over the May Bank Holiday weekend, 23 children were admitted to Middlesbrough General Hospital.

The alarmingly high number of child abuse cases reached national publicity. The test used to establish child abuse was contested by the area police surgeon, and cooperation between the social workers, the police and the hospital doctors involved in the diagnosis began to fall apart.

The Minister of State announced a statutory inquiry on July 9, 1987, headed by Justice Baroness Butler-Sloss[37]. There were 121 diagnoses of child sexual abuse, 43 of which Dr Higgs had made and 78 by Dr Wyatt. By the end of the inquiry, 98 children had gone home, but 21 were still in local authority care.

The report highlighted many shortcomings of all agencies involved in handling suspected child sex abuse cases. 'Generally, the professionals had been inconsiderate to parents, failed to communicate and failed to undertake any wider assessment of the situation [37].'

In ENT, nearly forty per cent of our patients are children. There was a close professional liaison between the paediatricians and us. I had known both Marietta and Geoffrey professionally for a while.

The children's ward at the Infirmary was on the first floor, with twenty inpatient beds. Having twenty inpatient children meant a potential for child abuse, and everyone with access to the children's ward was a suspect. Following the publicity of child abuse cases

in Cleveland, the hospital administration installed a combination lock and circulated the code only amongst the senior medical and nursing staff. The trainee grades were not allowed to visit the ward; such was the impact of this most disturbing and demoralising episode on our doorstep.

Police clearance for a trainee doctor

In the middle of all this, a senior trainee grade (senior registrar) came from the NHS hospital in Dundee Royal Infirmary in Scotland to complete a further two years of his training at the Infirmary.

As per the protocol, he had a certificate of police clearance from the Scottish Constabulary. However, the Cleveland Constabulary refused to accept a clearance certificate from an authority outside their jurisdiction. He was not allowed to go to the children's ward until he obtained a police clearance certificate from the Cleveland constabulary. The clearance did not come through for a while; the police authorities told us that they were busy and preoccupied with dealing with the child abuse cases.

The complexity of life is mind-boggling. Child abuse as an entity did not even exist in everyday life until then. Suddenly, it started ruling everyone's life. When examining a child, we ensured that a female nurse was present, along with (one of) the child's parents.

During an outpatient, I saw a child with ringing in his ears. This symptom required examining the child's ears and the whole body for any possible generalised condition responsible for the ringing (neurofibromatosis). Usually, I would ask the parent to remove the child's upper clothing and examine the limbs, the abdomen and the back. But I had to be cautious. First, I explained to the mother the reason to examine the ears and the child's whole body and asked for her permission. Then I told the nurse to examine the child, ensuring that I did not touch the child. It felt so very wrong. As a trainee, I was taught to gain children's confidence by holding them and bringing them close. Likewise, a tiny child was sat on my knees while examining the ears.

When I started thinking about it, I recall a child I had seen in Dundee as a registrar in 1964-67. A three- or four-year-old child had circular scars all over the body. I asked the mother what caused them; the reply was somewhat vague. I did not think anything further at that time, but later, I realised that they must have been burn marks from cigarettes butts. Child abuse can be sexual, physical or mental abuse or any combination of those ills.

Editor-in-Chief of ENT & Audiology News (1992)**

In 1992, a magazine with the title ENT News (now known as ENT & Audiology News) came in the post. It contained some articles and advertising but no 'news'. If you pick a magazine titled ENTNews, you expect to read the news of recent events about ENT. I did not take much interest in it; however, I did write to the Editor that I expected to read the news as per the title of the magazine but did not see any.

To my surprise, I received a phone call from the publishers that they would like to discuss with me if I would take on the editorship. Although I wrote and edited the first book on the CO_2 laser in Otorhinolaryngology in 1988 with my colleague Liam Flood and Haskins Kashima of Johns Hopkins, it could hardly be classed as an experience in

journalism. Moreover, I had not come across any medical journal which had advertising as its sole revenue.

Cedric Chater and Rosaleen Shine came over; we discussed an editorial role. I accepted on the condition that I would not want any remuneration.

The publication was bi-monthly. It was sent, free of charge, to most ENT surgeons and audiology professionals in all departments across the UK.

I modified the review process by introducing critical appraisal of the recent literature published in the established ENT journals. The appraisals rather than just reviews turned out to be of particular interest to the ENTNews readership, increasing their appeal substantially. In a busy work schedule, they may not get time to browse the journals.

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Performing Arts Medicine News

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Clinical Risk.

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FACE

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34 Beacon St, Boston, Massachusetts, 02108, USA
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Journal of Telemedicine and Telecare

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Acta Otolaryngologica; The Scandanavian Journal of Logopedics and Phoniatrics; Scandanavian Audiology

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May/June 1996 issue of ENT News

ENTNews gave them an appraisal to read the article in full if interested. The appraisals also provided the authors and the editors of the reviewed journals useful feedback on the appeal of the articles. I also introduced several current topics. And the advertising kept them abreast of innovations and new products.The advertisers would want a wide readership who would like a variety of newsworthy content. Slowly but surely, some ideas came to my mind to expand the content. I discussed them with Rosaleen Shine, and we developed them further. Rosaleen was highly competent and pleasant. I learned the ins and outs of market forces from her, and I provided her insight into what a surgeon would like to read.

ENT News expanded into a one-stop resource for comprehensive ENT coverage: scientific literature on the current clinical thinking, the industry news of newer technology, reports from conferences, a lead article on a particular topic in detail, book reviews to encourage readers to get the books for themselves or their institutional libraries, events diary for future attendances, etcetera.

I appointed 'section editors' to gather the relevant material for publication. Inevitably, I had to nominate myself as 'Editor-in-Chief'.

UK distribution was well-established. But I wanted its overseas circulation to benefit most private practitioners who did not have access, time, or inclination to go to the library. Due to my pioneering work on lasers, I had travelled widely, as described earlier, and taught laser surgery to many surgeons in several countries. Through these contacts, I created an international network. I appointed them as editors, stipulating that they would actively seek suitable material and get the experts in their field of interest to contribute.

Global presence of ENT and Audiology News: the next best thing to any ENT inventions – the past, the present and the future

Within a year or so, the international circulation took off. But soon, mailing costs started to mount up. A thought came to my mind. The international instrument and the equipment manufacturers usually have local or regional distributors. I knew this when I bought the American Coherent laser machine from the 'UK distributors'. They also have region- or country-based databases to advertise their products. It seems a tailor-made vehicle for a local distribution of the ENTNews. The copies are bulk mailed to them. The companies could sponsor the expense and distribution and promote their products simultaneously.

Surprisingly, several companies took up the idea and soon the ENTNews became a global platform for all sorts of dispersal of information about ENT.

The communication was via fax machines. At one stage, I had to have a couple more devices to keep pace with the flow of documents. Each issue had a deadline for receiving contributions, editing them and sending them back to the author to accept any changes. The final journey involved editing by publisher's editors, printers, binders, and posting! Before you finished the current work, the deadline for the next one came up, since the issue was published every two months – a frequency necessary to ensure that the news remained 'current and relevant', as per the title, 'ENTNews'!

The global contributions meant that the fax machines would start receiving material from East Asia during their working hours, but still the night in the UK. And by the time the working hours began on the West Coast of the USA, it was bedtime for us here. Each working day was thus an eighteen-hour day.

Also, the fax transmission printed pages and pages. I then had to type them on my computer, editing and correcting the text as I went on. It was followed by printing and faxing them back for the author's approval. And if the author introduced more material or corrections, I had to repeat the whole process. I had to 'Anglicise' the English text to maintain a flow of the material even from English-speaking countries since written English also has many regional 'dialects'.

Some four years later, in 1996, I decided to move on and let others carry on from where I had left off. I don't know what is in the ENTNews that all the Editors are active and not just happy to see their names in the list. Long after my retirement as Editor-in-Chief in 1996, even I recently wrote about Jean Abitbol, an eminent voice surgeon in the column 'in conversation with' on the eve of his retirement.

I am proud that, at the helm of ENT News as the Editor and then Editor-in-Chief in its formative years during 1993–1997, the magazine took shape which, more or less, still has some twenty-eight years later. Eighteen thousand copies go to over one hundred and fifty countries every two months. It acquired a reputation as 'the most widely read ENT journal anywhere, globally.

Encouraged by its commercial success, the publishers added a large section of Audiology, and the title now is ENT & Audiology news. In addition, the publishers put out further titles: Cardiology News, Eye News, the PMFA journal, Urology News & World Dentistry News.

Neena's dental college admission (1984)

Neena got the required grades to get admission into the dental course at University College London in 1984 and graduated from the University of London in 1989. She met Steven Howarth, a dental student in the same college and got married in 1992 in a Church in Skelton, a small village a couple of miles from our home.

Neena's Church Wedding in England

My mother Bai, my sister Pushpa and Nirmal's sister Sushila had come from India for Neena's wedding. It was a friendly family gathering, a delightful occasion with Steven's family and friends coming to North Yorkshire.

During my speech, I heard a child coughing rather loud. I looked in the direction and remarked to the mother: 'Tonsils and adenoids madam? We have an anaesthetist here and a kitchen table.' I later came to know it was Steven's 18-month-old niece!

The Grand National was on. Unbeknown to me, my colleagues from the hospital had a little bet going around of how many minutes I would speak. I must have a bad reputation to go on and on and on. As the time went on, those who were about to lose said, 'Shut up, Vasant, shut up, I will lose otherwise!' Liam remarked, 'You surprised us all that it was about thirteen minutes.'

Neena's Church wedding in England

A family photograph, Neena and Steven's wedding, All Saints' Church, Skelton-in-Cleveland

Neena's wedding reception in India (1992)

Neena wanted a wedding in India as well. So we decided to have a reception type of function in Pune, my hometown, rather than a full-fledged Hindu marriage.

The family back home was delighted. There was no girl in my brother's family, all boys. In a girl's wedding, women see something of their own, perhaps like their own wedding some years back. My brother's wife, Bhabhi, was particularly delighted since she had four boys and no daughter. Moreover, the function would be a complete novelty, the English groom with his family and friends, and a British born bride.

Having left Pune some thirty-odd years back, we had no idea of anything – the cost, the invitations, the food, all that was left to them to organise. Neena and her entourage, about eight of them, flew to Mumbai. They stayed in a hotel nearby where Nirmal's parents lived. A visit to Nirmal's parents' home was a starting point. Then we all made a four-hour journey to Pune by train.

All the family members had come to welcome us at the Pune station. They put a garland around each person, and we made our way to the hotel. That evening, there was a get-together at my mother's place. Everyone was beautifully dressed up.

The reception ceremony was in a marquee. I had told Bhabhi to arrange two bands, one playing Indian music and the other Western music. They took position alongside the central aisle and entertained the guests by playing alternately.

After meeting the couple and a photo, the guests went to many stalls in the marquee serving various foods. The whole atmosphere was unique, with the two cultures coming together on a joyous occasion. By late evening, a substantial crowd had gathered. The Western tune played, and some took to the dancing floor. When they finished, the Indian band got inspiration and played tunes similar to Western music. The two ended up competing with louder and louder music. The locals also joined in, and the whole marquee came alive; even senior orthodox women from the community took to the floor – never witnessed before in Pune.

When everyone had gone, we sat down to enjoy our dinner. My family told us that the evening was unique.

The visitors made a return journey to Mumbai onward to Goa for a short break, and we two made our way back to England.

The family in Pune was delighted and overwhelmed by the effort Neena, Steven, Steven's parents, family, and friends made to come to Pune, some five thousand miles away, and be a part of the culture so entirely different, a once-in-a-lifetime experience. They did their best to make the occasion a success and created fond memories that lingered on for many years in the community in Pune.

Neena and Steven settled in England as dental practitioners.

Neena and Steven with family and friends from England

Neena and Steven with Vasant's family

Neena and Steven with Nirmal's family

Neena and Steven Howarth at our home in North Yorkshire

1995: Time to throw the towel in? Yes, gracefully, rather than be counted out

Time was going by. I was approaching that magic number, sixty, in 1994, the earliest one could retire and enjoy the NHS pension. Would I want to go at sixty or would I go on to sixty-five, the standard retirement age for men, when the state pension also kicked in? That would be in 1999.

All my professional life, I had tremendous job satisfaction. Having had such an active career, the thought of retiring one day just because I would be sixty or sixty-five was abhorrent. Also, in the late eighties, we had acquired a new type of Laser, a Ho:YAG laser, which was more suitable for nasal surgery, and I was pretty busy developing its clinical uses. I designed some specific instruments for this Laser.

The Ho:YAG laser was also suitable for treating patients with watering eyes by making an opening in the inside of the nose. These patients came from the ophthalmic department, resulting in an increased workload.

Retirement: no, change of a hobby

When we start work, retirement is not on the menu. On the contrary, if you enjoy your work, there is an upswing for the next twenty-odd years. As a consultant surgeon, you are in the driving seat. Most hospital-based activities revolve around you. The patients are glued to you with their ears in anticipation to hear what you have to say about their illness. The operating list cannot start until you have arrived. You are in command, and you are in demand. Totally. And you savour every moment of it. You almost believe that the world cannot go round without you.

Retirement means leaving all that. The moment you retire, you are, suddenly, nobody. When Martin Horowitz came back a day later to collect his personal belongings, he was perturbed that his nameplate on his parking space was already removed and replaced with

someone else's name. 'They could not wait even for a day,' he said with some dejection.

It is usual to make your last day of work a Friday. The following weekend is like any other weekend. When Monday morning comes, you do not need to look at the clock, wear a suit and a tie, have a quick breakfast, grab your briefcase and off you go – almost a robotic life you have been living for the past thirty years. But this Monday, it is different. You have a leisurely breakfast, take a walk in the garden, coffee, lunch, back in the garden.

If you happen to go to the hospital as a patient, you queue up at the reception, take your seat amongst other patients, and watch the consultant's room in anticipation if you are the next one. Now you are on the wrong side of the door. Your colleagues have no time to talk to you, except a courtesy 'hello'.

And what about your home life? Martin Horowitz said, 'Vasant, the first thing you do not do is volunteer to do housework. Your wife had organised her routine without you during all those years. And she needs to continue with that – she has not retired from her housework; she has no time or a slot for you. You are not welcome to give her a hand. You are neither a consultant nor a husband or a father; you are a stranger at 9 AM on that first Monday – yes, a stranger in your own home.'

To divulge a bit, when I retired, I told Nirmal I would clean the windows. So she showed me how to clean the windows – show me? A consultant surgeon? Once, in a restaurant, a window cleaner happened to clean the window where we were eating. I took in how he was cleaning, almost mechanical movements of his hands. I told Nirmal, 'I would show you how to clean the windows as the window cleaner does.' She said, 'I have been cleaning the windows for the past thirty years, and you will show me the correct way?' 'Just because you have been doing something wrong for the past thirty years does not make it right.' Then I cleaned the window my way and told her, 'This is how you do it.' She said, 'Good, now do all the other windows your way. You will soon get bored and give up.' She was spot on.

You miss being amongst people, committing, being answerable, and everything else that goes with a job, work or whatever else you have been doing before retirement. But the time does come to retire. There may be many reasons.

On-call commitments

The only insecure part of the work was on-call commitments, particularly when you get a bit older. Unlike today, there were only two types of contracts, maximum part-time or full-time. Both contracts included the money for on-call commitments. Therefore, one could not give up just the on-call part of the contract and forgo part of the salary in place of having to share the rota.

The surgical speciality is demanding. After a full day's work, you have to be on calls:

- Go out in the middle of the night to save somebody's life.
- Put out a one hundred per cent performance, no less, just because you had a hard day.
- Still get to the regular commitment the next day sharp at nine AM.

You can do all this lifelong, get a feeling that you are indispensable. But as you approach the late fifties, ageing starts crawling in, and with that, the insecurity begins creeping in. Will I be able to perform a tracheostomy on a three-year-old in the middle of the night after a full day's work? Will I be able to stop a copious nosebleed? Will I be able to remove an open safety pin from someone's oesophagus?

The worse time to get a call is around midnight. You are ready to get some sleep, and the phone rings; you need to go out. Another wrong time is that first hour or so when you are

asleep. At times, I got the call, said I was coming, and just fell asleep again. The phone rang again after a while, and I realised what had happened. From that time on, I told Nirmal to make sure I got up and went.

Once, I was called out at two AM. On Borough Road, at traffic lights, I stopped, and when the lights changed, I crossed the junction. Suddenly I realised that a dreadful thing had happened. I stopped when the lights were green, and when they switched to red, I crossed the junction. Following that incident, I started taking a cab.

It is unfair to ask the surgeons of advancing age to be on call and continue the full daytime commitment the following day.

If I were to retire at sixty, then I would not be on call, but equally, I would have to leave all the clinical and operating work, which I liked.

Tracheostomy on a delivery table – wrong-end (not wrong-side) surgery

In ENT, the most telling emergency is an obstructed airway due to a laryngeal disease, mainly cancer, which needed emergency surgery to open the airway in the neck (tracheostomy), bypassing the obstruction.

Once, I had to travel thirty-five miles from home to Hartlepool in the middle of the night to undertake a tracheostomy in an unusual case.

The patient was in labour in a dedicated 'Labour, Delivery and Recovery' room. She had received a punch in the face during domestic violence; her broken jaw was wired to the maxilla to stabilise it. She could not get enough 'wind' to push the baby down during the labour since she could not open her mouth to take that extra air in. The baby was getting distressed due to the prolonged labour. The obstetrician decided to do a caesarean, for which he asked for a general anaesthetic. The anaesthetist was unable to intubate her through the nose and summoned me to do the tracheostomy. I took the 'trache tray' from the Infirmary to ensure I had all the instruments I needed.

She was on the delivery table, which was fixed to the floor. It had a fixed backrest and leg holders to maintain a lithotomy position. The overhead light was also fixed to shine on the lower end, with no adjustments.

I needed her to lay flat with an extended neck for the tracheostomy. However, it was not possible due to the fixed backrest. I wore my headlight, laid the instruments on a sterile trolley and positioned a cushion behind her shoulders to extend the neck. This manoeuvre resulted in foetal distress. I had to work quickly to secure the airway with a tracheostomy. There was no ENT assistant, and the obstetric nurses did not know the instruments, so I had to pick up each instrument myself from the trolley. The obstetrician helped me to hold the tissues apart. Being an H&N surgeon, I quickly got on to the trachea and opened it to everyone's relief. But it was a challenging procedure in every respect.

Since my medical college days, I had not seen a caesarean, so I stayed on to see the baby delivered and give that first cry – a gratifying and emotional experience for everyone in the room.

In his later years, Martin used to ask me to check the blood report to see if all was OK. A two-line report had expanded into a two-page report, and he could not keep pace with the progress in medicine. And I dare say we all find ourselves in a similar situation – although it is hard to admit.

Are you still above the ground? Yes, I expect so

I have a formula for a consultant surgeon's working years. It is divided into a seven-year stint. Why seven years? That is how long it takes to train a surgeon, after which you are ready to be a consultant.

Zero to seven years:
You have just got to the top of that ladder, on top of the world. But your colleagues compete with you for positions on professional bodies, for keeping their share of private work and many other things. You do not get much respect from your senior registrar, who will be a consultant soon. For example, while doing a laryngectomy, my senior registrar said: 'Are you not going to remove his thyroid gland?' I replied, 'No, I never do'. 'Are all those who do as per published work are silly then?' 'The corollary of what you say is that if they are not silly, then I must be.'

Seven years up to fourteen years:
You are mature; your newly appointed colleagues don't compete with you; they accept you. The same goes for the trainees and other hospital staff.

Next fourteen to twenty-one years:
Greys start appearing. You pull them out for a while but cannot keep pace, so you accept or start using a dye. You are getting bald in the back, but you don't know until the patch is big enough to notice it from the front. You have to get a pair of reading glasses and place them on the nose just below the lower eyelid. The whole body is now somewhat rounder, the cheeks, the belly – a mature man. If you are popular amongst the staff, you become their father figure, even for their personal life. In your professional role, you are just about keeping pace with the 'current knowledge'. Sometimes your trainees tell you what they read for their examination and update you.

Twenty-one to twenty-eight years:
You have been around for a while. Children born when you started your job are now around, young, intelligent, fast-paced, a stethoscope around their neck and vocal, very vocal, not subdued as we were in our era. They are much more 'with it', with the technology. You have to ask them the meaning of abbreviated words: 'DNACPR' means if the heart or breathing stops, **D**o **N**ot **A**ttempt **C**ardio **P**ulmonary **R**esuscitation. When I was going to have surgery on my nose, I told John Hunton, my anaesthetist: 'If I am gone, do not resuscitate me to live a half-dead life – I will sue you.' He said, 'Vasant, 'you are not going anywhere; I got too much to lose' – he was my anaesthetist for all my private work!

Twenty-eight to thirty-five years:
'Oh, are you still above the ground?'

Thirty-five years to sixty-two years?
I am not done yet, continue to read on!

Honorary and later Emeritus Consultant ENT and H&N Surgeon (1995)

A thought came to my mind – why not retire and continue to work as honorary for a few sessions? This way, I would have the best of both worlds! The more I thought about it, the more appealing the idea was.

During one of the departmental administrative meetings I chaired, I announced my intention to retire on my sixty-first birthday, on September 13, 1995.

'However, I would like to continue to help the department by undertaking honorary sessions, two outpatients and one operating on Dr Kumar's list to which he has consented.'

There was a stunned silence. No one had even as much as a hint that I was contemplating retirement. I was pretty senior amongst them. As a Newcastle Regional Health Authority appointments committee member, I had interviewed them as candidates for the consultant vacancy and appointed them.

My proposal was approved unanimously. Hardly did I imagine at that time that I would remain part of the department for thirteen long years ahead, until 2008, well into my mid-seventies, stretching my career for over forty-five years!

Continuation of international academic activity after retirement: A true deterrent to the life (?) in a box

Although I had formally retired from my job in the James Cook University Hospital, I was much in demand on an international scene due to my pioneering laser work.

While visiting St. Petersburg for chairing the Academy of the Young Otolaryngologists Conference, a trainee surgeon approached me and asked me if I was from India. 'How did you guess?' I asked. He said, 'I am Dr Anuj Kaushik. I have done my post-graduation in ENT here. Now I want to go back. Could you help me get a job there since I have lived in Russia for twelve years? I do not have any contacts?' I asked him a bit more about his career.

It transpired that he had failed to score high enough marks to secure a seat in the medical college in India. A private Russian Medical College gave him admission. He learnt the Russian language, qualified, got a postgraduate degree in ENT and now wanted to return to India.

I directed him to my classmate from the 1955 batch of medical students, Dr Bhutada, a consultant ENT surgeon in Pune. Little did I imagine that this seemingly insignificant incident was a starting point to keep me busy for the next twenty-odd years, right up to writing this memoir!

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* Personal communication from Richard Koronowski, the sales manager of Coherent UK in 1982.
** Verified by the current ENT News office bearers.

SECTION VI

DEDICATED TO MS LATA MANGESHKAR

Nirmal and I with Lata Didi (~ 2019)

Lata Mangeshkar, a famous playback singer of Bollywood, is a household name, not just in India but in many countries worldwide Gifted with a melodious voice, she gave pleasure to innumerable people with her long singing career. I am fortunate to belong to her era, and even now, I hear her tunes frequently on YouTube.

But while we owe her our gratitude for the good times, to me, her benevolent act of promoting a hospital has ensured that she continues to be with us when we are down with an ailment. A thousand bedded not-for-profit hospital in my hometown Pune, India, provides a state of the art care for a lower and middle-income group of patients.

It is my fortune that I was instrumental in some small way to help establish the facility and also established a postgraduate training centre worthy of an accreditation by the Royal College of Surgeons of England. I dedicate section VI to our Lata Didi (sister).

Section VI

You will retire someday, won't you? (1995 - ~)

Honorary ENT consultant (1995-2008)

I had given up private practice long ago. When I proposed my appointment as honorary consultant to my colleagues, there could not be any objection on that pretext! I also did not want a personal list, so the existing nursing staff did not have to stretch. Instead, I would operate with Udi Kumar on his list. Udi was pleased to have a consultant assisting him. Finally, I would see any problematic cases of our consultant staff, assess them, investigate them and refer them back for further management if applicable. Likewise, I would also see any postoperative patients who needed further assessment to resolve their symptoms completely. My clinical role would be complementary to their work and, therefore, most agreeable to them.

I did two outpatient clinics and operated on Dr Udi Kumar's session. The situation was unique, even funny. Instead of the routine regular recurring clinics I ran when I was a consultant, the booking staff would ask me when I was available to do the clinics! The hospital also agreed to pay for my car parking charges.

We needed a rhinomanometry machine to investigate patients who did not get relief of nasal obstruction following nasal surgery. I volunteered to buy it for the department. Most patients came from Frank Martin since he did rhinology. I told the staff to book no more than four patients per clinic since they would need extra time to assess.

'Thank you, doctor, I have taken enough of your time'

The first patient had had nasal surgery for obstructed breathing, but still complained of persistent partial obstruction. I took a detailed history. Usually, in a regular clinic, the examination rather than the history gives you a clue. But here, the patient already had had one surgical procedure with only partial success. The history did not reveal anything significant to account for the partial obstruction. Internal examination of his nose also did not show any breathing obstruction. Having worked in ENT since 1960, I had come across cases of nasal obstruction due to narrowing at the entrance of the nose, a condition known as alar collapse. A routine nasal examination with a speculum or an endoscope does not show this condition; it can only be seen by tilting the tip of the nose upwards with a thumb. Following this age-old method, I could see that this patient did have an alar collapse that contributed to his breathing obstruction.

Without a patient, I am no longer a doctor!

I explained all this to the patient and also performed rhinometry. The patient was surprised that I could spend so much time on him. He said, 'Thank you very much, doctor, I have taken enough of your time.' Suddenly, a stark reality hit me. I could only be a doctor if I had a patient!

'Oh no, no, I have plenty of time to see each patient,' and I almost pressed him back into the chair!

Life was good. Enough time to assess the patient, carry out the investigation at the same appointment and find an obscure pathology not so apparent in a busy clinical set-up.

Operating was great, assisting my one-time registrar and taking over the case if he struggled. Some patients with hereditary bleeding condition (HHT – Hereditary Haemorrhagic Telangiectasia) were challenging. We used the Ho:YAG Laser for this condition with much success. Then there were cases of watering eyes sent by the ophthalmic department, which needed a drainage opening in the nose.

And oh, no calls, of course! This 'good life' of continuing to be a surgeon, without the usual hassle of commitments and calls, incredible as it may seem, continued over the next thirteen years, until 2008.

Closure of the Infirmary with the ENT department relocated at the James Cook University Hospital

The North Riding Infirmary on the last day before it moved to the James Cook University Hospital on Marton Road, a couple of miles away.

The Infirmary was getting old, and re-location was imminent. The day we closed the Infirmary for good is captured in the photograph, the nursing and admin staff and Nirmal and I, after we saw the very last ENT patient. I started my house job at this very Infirmary in 1963, and here I am in 2002, seeing this ENT and EYE hospital closing its door for good. I said goodbye to it with a heavy heart – my home in England all this time, apart from training posts in other towns between 1964 and 1969. In this Infirmary, I developed and pioneered the laser technology in 1982, taking the country and the world to tomorrow's world. The council decided against keeping the Victorian frontage and developing a shopping centre behind it. Now it is an Aldi supermarket.

Revalidation? Not for me, thank you!

I could have continued, but the General Medical Council of the UK introduced 'Revalidation' in 2009: 'every licensed doctor who practises medicine must revalidate'. What is revalidation? Medical revalidation is the process by which the General Medical Council (GMC) confirms the continuation of a doctor's licence to practise in the UK. All doctors who wish to retain their licence to practise need to participate in the revalidation process.

According to the GMC website, the revalidation process:

- supports doctors in regularly reflecting on how they can develop or improve their practice; this means attending courses and conferences or any other teaching process for a set number of hours each year.
- gives patients confidence that the doctors are up to date with their practice.
- promotes improved quality of care by driving improvements in clinical governance.

In short, has the doctor kept up to date with the progress in medical science and also delivered the care competently to the patient under his/her care? The revalidation process is designed to address this issue.

I thought that the concept of the revalidation process was sound and worthy of introduction. You will recall that we faced difficulties in our department in the seventies due to doctor X's drinking problem. There was no recourse, no built-in mechanism to resolve it. In the present era, GMC's Fitness to Practice would have provided a recourse to address such problems.

There is also a change in the approach of dealing with the doctor's problems. Wrongdoing is not punishable anymore; instead, there is a route towards helping the doctor get back on track. While medical practice is sacrosanct, medical doctors are human beings. The pressure to meet the increasing demands as one gets older can be unbearable. Errors can happen.

As I got older and became responsible for running the department, I invariably tried to help the medic or the nurses by having a 'quiet word' in private where patient care might/could have been compromised. This approach always put matters right and produced a desirable result. That said, there are cases where a stern action is necessary since a softly-softly approach may not have a lasting effect. Unfortunately, alcoholism falls into that category.

Be it as it may, revalidation made me decide that the time had come to give up all my clinical commitments. Belonging to the old school, my colleague's assessment of my work and vice versa was alien to me.

Emeritus Consultant Otolaryngologist and H&N Surgeon

The James Cook University Hospital honoured me by awarding a prestigious 'Emeritus' status on my retirement in 2008. Having started as a Senior House Officer in 1963 and ending in the same department as an Emeritus surgeon is a lifetime achievement – I can't ask for anything more! And in the process, having a clinical room named 'Oswal Rhinology Lab in that NHS hospital is an honour beyond my comprehension. But as I withdrew from the clinical commitment at James Cook, how was I to know that there was a further commitment waiting for me, that would keep me busy for the next twenty years?

Dr Kaushik in Pune(1999)

You will recall that Dr Kaushik, whom I met in St. Petersburg in Russia, wanted my help to settle back in Pune. I had directed him to my classmate Dr Bhutada, who was also an ENT specialist in Pune. During my subsequent visit to Pune, Dr Kaushik met me and thanked me for helping him find someone in ENT in Pune.

During the conversation, he mentioned that Dr Gandhi, an ENT consultant, would like to see me for any help I could give him, to establish an ENT department of an international standard in a hospital in Pune.

Deenanath Mangeshkar Hospital

The proposed thousand-bedded hospital facility was the brainchild of the world-famous Bollywood playback singer Lata Mangeshkar. Her father, Deenanath Mangeshkar, died in Pune in 1942 since he could not afford medical care for his illness. Thus, in his memory, the hospital was to be named 'Deenanath Mangeshkar Hospital.'

The notion had many positive aspects which appealed to me:

- The hospital was going to be in Pune, my hometown.
- I could help establish an ENT department that could offer the patients the most up to date care for their ailments.
- I saw this as an opportunity to give something back to the people of Pune, where I was born and raised.

The name of Lata Mangeshkar as the proposer for the charity hospital appealed to me immensely. Since my childhood and youthful years, I have been a keen follower of her melodious singing voice. It was my opportunity to say 'thank you' to her for the great pleasure I experienced, and still do, listening to her songs. And even more importantly, the hospital was for a lower and middle-income group (LMIG) of patients, a charitable, not-for-profit hospital. This group of patients would get healthcare to an international standard. It was envisaged to be a thousand bedded multi-speciality hospital, built in two phases.

Six acres of land was made available in a prime position, at no cost, by the Government of India for the project.

The Mangeshkar name

In Indian films, in that era, most of the movies had at least eight songs, sometimes about the story, but also, at times, they were just there for marketing. The movie's success was often due to the tunes rather than the story, which took a secondary role. The singers, famous for their singing voice, pre-recorded the songs. The actors and actresses mimed the songs during the filming. Many singers were able to modulate the voice for various actors so skilfully that the whole performance appeared very realistic.

Ms Lata Mangeshkar was one such very successful playback singer. She was a household name for her melodious singing voice in the world-famous Bollywood film industry. 'If you don't know Lata Mangeshkar, then you are not an Indian' – such was the impact of her tremendous singing range, all over India and many other countries in the Middle East, The Far East, and even Russia.

The Mangeshkar family

Deenanath Mangeshkar, the father of Lata, was a well-known Marathi theatre actor, a musician and a Hindustani classical vocalist. He fathered five children, who became famous in India and abroad for their musical talent.

Far right: Lata Mangeshkar Lata's siblings L to R: Meena, Asha, Usha and Hridaynath

Lata Mangeshkar (1929 – 2022)

Lata was the oldest daughter of Deenanath Mangeshkar.[2] She has recorded songs in over a thousand Hindi films and has sung in thirty-six regional Indian and foreign languages.

Ms Lata Mangeshkar's decades as Bollywood playback singer

In 1974, Lata became the first Indian person to perform in the Royal Albert Hall in London. She is a recipient of numerous National and International Awards for her contribution to music. In 2001, Lata received the Bharat Ratna, India's highest civilian honour. France conferred its highest civilian award (Officer of the Legion of Honour) in 2007.

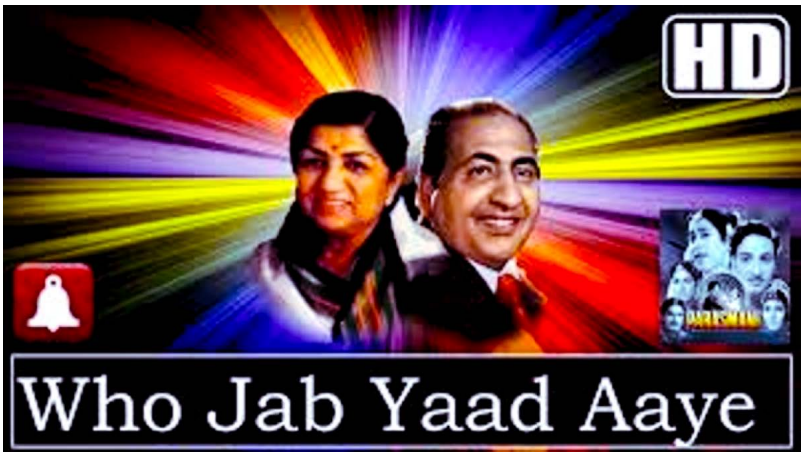
Asha Bhosle

Another daughter of Late Deenanath and the younger sister of Lata, Mrs Asha Bhosle[3] (nee Mangeshkar), is equally famous for her contribution to music. She has also done playback (lip-syncing) singing for over a thousand Bollywood movies. She had sung over 12,000 songs, officially acknowledged by the Guinness Book of World Records, as the most recorded artist in music history. The Government of India honoured her with the Padma Vibhushan award in 2008.

Lip-synching in Indian movies

Singers record the song before the filming of a scene. The actors lip-synch to the tune while shooting the film.

Actors Mahipal (left, Nirmal's father) and Gitanjali



Famous duet singers Lata Mangeshkar (left) and Mohammed Raffi pre-record the song for a movie 'Parasmani'

The site visit

I was expecting a board room of half a dozen old gaffers with silver frame spectacles nearly falling off the tip of their noses. But, contrary to my expectation, two young doctors met me and took me to the builder's cabin. The Mangeshkar hospital was nowhere in sight: there was no board room, no hospital. Instead, a few bulldozers were in action with heaps of dug-out soil all over.

Dr Kelkar, the Oncosurgeon, introduced himself as 'Medical Director. Dr Gandhi was the 'Head' of the ENT Department. Both of them were in their late thirties, at the most! They were working in another hospital called 'Sanjeevan Hospital'.

After the pageantries, they showed me a blueprint of the future Deenanath Mangeshkar Hospital. The drawing was substantial; it represented a fully operational 500-bedded phase one hospital planned for completion in a short span of eighteen months. It was to be followed by phase-two 500-bedded Super-speciality Hospital, some years down the road. Somewhat sceptical, I questioned the validity of the timetable, but the affirmative tone was oozing out of the senior doctor, Dr Kelkar. However, enthusiasm is not synonymous with reality or ability.

The Deenanath Mangeshkar Hospital blueprint (1999)

I had sat on several committees in England during the planning stages of the North Tees, and later, James Cook University Hospital. There were numerous 'feasibility' studies. Once I said to the chairman of one of the studies: 'I sat on many such committees, but nothing concrete comes out.' His brief reply was: 'Mr Oswal, 99.99% of feasibility studies don't get anywhere, but we would not know that until such studies were carried out…' I was born in British India and was quite conversant with a mature, near-perfect British bureaucracy. Nevertheless, the chairman's remarks topped it all.

But here on site, they were a bit more advanced, beyond the feasibility study. The foundation of the building was in progress. Reassuring? Perhaps. But to imagine a fully

operational 500-bedded hospital in eighteen short months? It needed a long stretch of the imagination.

The two surgeons elucidated their aims and objective for the whole hospital and, particularly for the ENT Department, ambitious to develop to an international standard. I said to myself, 'it took me my lifetime to make our Department in the Infirmary in England to a National Standard, and perhaps, with the Laser Technology, to an International Standard. The Department required highflyers as surgeons and hi-tech equipment to achieve such a status, which needed high finances. I somehow could not envisage Dr Sachin Gandhi from Pune to fit the bill and be one of the leading surgeons nationally, let alone internationally, with not even as much as an institute to show for it (yet!). But I was to be proved wrong, gladly, as we read later.

Finances

The capital for the construction and equipment of the hospital was to be raised from donations and bank loans. Sixty percent of the patients were expected to pay the total cost for their treatment, thus generating revenue. In line with the ethos of a not-for-profit facility, the generated surplus was used for treatment for lower and middle income (LMIG) group patients. A further twenty percent of poor patients received the treatment at zero cost.

The principle of 'never to turn away the patient on the basis of care not being affordable' would thus be fulfilled. Furthermore, these LMIG patients would also get high-quality treatment, equal to their full paying counterparts – all receiving ethical and rational treatment at an international standard. To me, this was a long shot by any count, with bulldozers joining in with their concerted cacophony around us.

But the opportunity to help people in Pune and the name of Lata Mangeshkar was overwhelming, and I accepted to do my bit towards this noble cause. Nearly a third of the budget flowed in from many donors – rich and poor, commoners and distinguished, Indians and foreigners – inspired by the concept and promoted by their beloved 'Queen of Melodies', Lata Mangeshkar.

At home with Ms Lata Mangeshkar

Charity begins at home

I had just sold the property where I had my consulting rooms in England. The sale proceeds were about £ 30,000/-. The money was not earmarked for anything in particular. We decided to donate it to buy the video stroboscope to make a start for the ENT department. What if the whole idea had collapsed, and the money had gone to waste? Having spoken to Jay Kelkar, Sachin Gandhi, and my brother Madan, I assessed that the project had an even chance of succeeding in reaching the winning post. It was a better bet than backing a horse – which, incidentally, I have never done!

Charity concerts by Lata Mangeshkar and her family

Most of the money was to be raised by a public appeal for donations. Lata Mangeshkar's name would undoubtedly draw sizeable funds. She undertook some concerts to raise money. I was told of a touching instance where a man with a small amount appeared at the event. 'I haven't got money to buy the ticket for her concert, but here is something for the noble cause to build a charity hospital.'

Mr and Mrs Mutha

Although my donation was substantial, at least it seemed so to me, it was not enough to buy the modern equipment to the international standard.

My next trip to Pune was fleeting, not lasting for more than thirty-six hours! I was due to run a laser course in Chennai on the east coast of India, then fly to Pune on the west coast to see my family and back to England. At the time, I had lived in England for the past forty years and had no contacts in India to approach anyone for donations. Therefore, during the visit, I asked my brother Madan if he knew anyone in the community who could donate some money to the project. To my surprise, he told me that one of his friends, Mr Mutha, a businessman in his late seventies, was looking for a home for the surplus money from the sale of his business. The amount in question was big – three times as big as mine.

'Could we see him?'

'No, tomorrow, is Ganesh Immersion Day (a religious procession) and the roads will be blocked'.

'Not at eight o'clock in the morning. As far as my memory goes, the procession does not start until eleven-ish.'

'He is also a bit curt in his dealings with people.'

'That would not bother me, if he says no, I would be neither better off, nor worse off. I would have gone there with an empty pocket and come back with an empty pocket. What is the difference?'

'OK, I will phone him and tell him that we will see him tomorrow.'

Mr and Mrs Mutha were awaiting our visit. After initial formalities, I raised the topic of donation. They said they wanted to but were unsure whether their hard-earned money would go to the worthy cause or be frittered away by the admin people. I assured them that in my opinion, the proposed project was a worthy cause, and as far as I could ascertain:

'These people are genuine and will use the money wisely and prudently. However, I have

to say that, since I live abroad, I don't know them personally, and I will not be here to ensure that the money is spent wisely. All that I can tell you is that I have put my money where my mouth is and donated a large sum of £ 30,000/-. That is about the only recommendation I have. If I lose my money, you will also lose yours.'

'What would the money be used for? We had a blood bank in mind.'

'No, every hospital has a blood bank or an access to the blood bank as an integral part of the set-up. I am known Internationally for expertise in the laser surgery, and I would suggest that your donation be used to purchase a laser, to take the hospital straight in to the twenty-first century. Moreover, as I am an expert, they would be trained by me to a very high level of competency.'

Then I explained to them a bit about laser technology. I was adept in that as well, having given many such talks while raising the money by public appeal to buy our laser in England!

As we were about to leave, Mr Mutha, after consultation with his wife, said: 'OK, we are happy to donate the money.'

Far from being discourteous, the couple were most polite. On top of that, Mr and Mrs Mutha took a spontaneous decision to donate a large sum, one hundred Lac Rupees (100,000,00) – locally known as one crore rupees, which, in terms of British Sterling Pound, came to approximately one hundred thousand pounds. And, if the difference in cost of living between the two countries is factored in, an adjustment of times-five value took the donation to a princely sum of half a million pounds! The most fruitful half an hour I ever spent in my lifetime. My brother was equally taken aback. He had never known his friend so courteous and so generous. Both surgeons were delighted with the news, and an order for all high calibre up-to-date equipment, including the CO_2 laser, went out. Naturally, the Mangeshkar family were delighted with such a large donation.

Inauguration of phase one

Some eighteen months on, the announcement came of the inauguration of phase one, consisting of a five hundred-bedded facility, by of the then Prime Minister of India, Mr A. B. Vajpayee, on November 1, 2001. Reports of the inauguration of the DMH appeared in the local newspapers,[5] the gist of which was:

'The Medical Director of the hospital Dr Kelkar is confident that the first patient will be admitted towards the end of the month of October 2001. The training of the nurses, ward boys, staff doctors and medical specialist is in full swing, and the first patient is expected to be attending by the end of the month. Although 95% of the equipment is scheduled to arrive in the next fortnight, our schedule is out of gear due to the terrorist attack on the twin towers of the World Trade Centre in New York.'

'The clinical departments are organised floor-wise to assist smooth flow of the patients. Particular attention has been paid to the needs of the relatives by providing adequate waiting spaces and telephone points.'

'Even accommodation for the relatives has been catered for. Pune is a metropolis, the largest city after Mumbai in the state of Maharashtra and the catchment area was expected to be substantial.'

Security in Pune on the eve of the inauguration

In normal times, the high-profile inauguration at the hands of the Prime Minister of India would draw in top-level security arrangements. And if 9/11 had put the whole world at the highest alert level, then it is no wonder that the whole of Pune got the security rating at the highest category possible.

The district police, armed paras, helicopters and police dogs everywhere

The local police took over the hospital site three days ahead, and no unauthorised person was allowed to go in. The invited dignitaries received the police pass for car parking. All the seats were individually allocated with the name tags of the guests. On the day of the inauguration, the hospital site and a large area were buzzing with reconnaissance helicopters, armed paras, bodyguards of politicians, the district police and police dogs.

Being British nationals, Nirmal and I were 'foreigners'. Our passes had to come from the central government in Delhi. Nirmal's pass came a day ahead, but mine did not. Oddly, Mr Mutha's pass was also to come from Delhi. The hospital admin enquired with the local police, but they said it was not in their hands; passes had to come from Delhi.

The function was to take place at 3 PM. As hours went by, it seemed likely that myself, Mr Mutha and a few others – all of them were men – were going to miss the function. Then, at about 1 PM, the cars of the invited guests started to come in. Our driver stopped at the police cordon, I got off, and the car with pass-holders, Nirmal and a couple of our family members and, Nirmal's father, Mr Mahipal, went in. Sachin Gandhi came out and stayed with me, in dismay. There was nothing anyone could do; such was the level of security.

Now just an hour was left, and suddenly, the admin personnel from the hospital came out, waving the passes in their hands. And you could almost palpate everyone's relief.

Everyone had to queue up and go through the metal detector. No one was allowed to carry anything – even the ladies were not allowed to take their ubiquitous handbag!

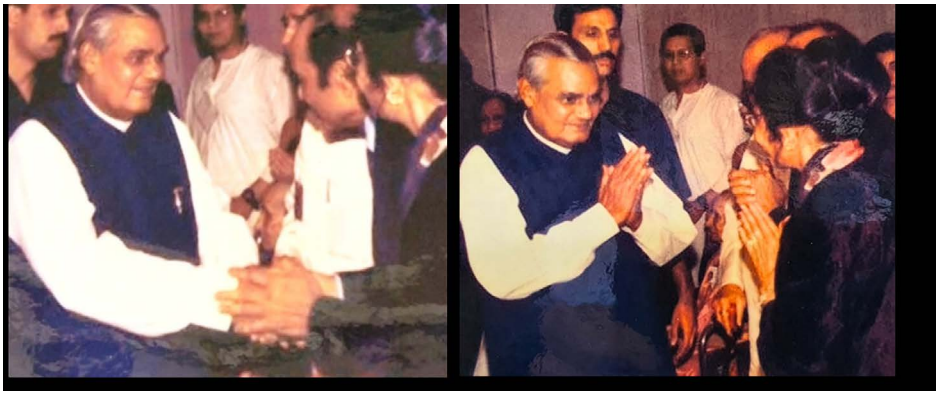
Meeting Mr Vajpayee, the Prime Minister of India

As VIPs, we were taken through a special entrance and presented to the Prime Minister. A charming person with an omnipresent smile. 'Namaste.' Namaste is usually spoken with a slight bow and hands pressed together, palms touching, and fingers pointing upwards. No person-to-person contact, as in the western culture of handshaking.

Did the ancient Hindu culture know the fomite transmission of the likes of the coronavirus? I wonder. A photo-op, and you moved on.

But having lived in England for so long, I instinctively put my hands forward to shake hands with him, and he reciprocated. However, for Nirmal, he did the Namaste; it is customary that in India, men do not shake hands with the ladies. We took our allocated seats. Mr Vajpayee, apart from being the Prime Minister, was also a notable poet and a writer.

Inaugural speeches, or for that matter, any speeches, are slowly erased from our memory and replaced by more recent events. However, some stay with you forever. I will always recall Mr Vajpayee's explicit remarks during his inaugural speech:



The Prime Minister Mr Bajpai shaking hands with Vasant Oswal and Namaste to Nirmal Oswal

'You have put in a tremendous effort and faith in building this excellent hospital. But I am facing a dilemma. If I wish you success in your venture, it would be because there are a lot of ill people in Pune. If, on the other hand, you fail to succeed, it would be bad news for you, but good news for Pune that the residents are a very healthy lot!'

Something different, advanced, unusual in medicine? Yes, the Laser

The date we held the Laser Conference in the Mangeshkar Hospital has to be carved in stone. You will recall my older uncle writing me a note in 1963 when I was to go to England for that house job. The note read:

'You are going to a foreign country for higher studies. Do something different, advanced, unusual in medicine and bring it back to India'.

A visionary? Perhaps.

Indeed, the laser was different, advanced and unusual. And I brought it to India.

Conference on Lasers in Laryngology at the DMH, India

After the usual inauguration speeches and the candle-lighting ceremony (an age-old custom of lighting wicks on a brass stand known as Samayi – symbolising illumination to lead those present – from darkness to light), the course started in earnest.

Appointment of Consultant staff to the ENT department

Sachin Gandhi surprised me when he told me that I must interview some doctors for an appointment at the department. 'Why me? Why not you?' He replied, 'Sir, they are all my seniors, I was postgraduate student under some of them. It will be awkward for me and for them, if I interviewed them to work under me as head of the department.' Very true! What an embarrassing position to be in!

Candle lighting

From left to right: Virgilijus Ulozas (Lithuania), Sachin Gandhi (India), Vasant Oswal (UK), Hesham Negm (Egypt), Late György Lichtenberger (Hungary)

So, I chaired the process, with Sachin sitting along the side of the table against the wall. One by one, the candidates came in. During the interview, I would cast a glance towards Sachin, and he would indicate his opinion with a slight movement of his head. In India, it is customary to move the head in three ways, each having a separate meaning. When it moves horizontally – left/right/left in quick succession, it means no. When it moves up and down

to the sternum, it means yes – both more or less universal gesticulations. But in India, there is the third movement – the head is bent on one side and then the other side with the pinna nearly touching the shoulder. It means 'may be'.

I quickly got the hang of it and made the appointment as per his choice. I particularly remember one candidate – he was head of the ENT department at the J.J. Hospital, a government-run immense establishment with attached Grant Medical College in Mumbai, the oldest establishment in that part of the world. I did my Masters in ENT there in 1963! The surgeon was nearing the age of fifty-five and wanted to plan for an easy and lucrative life post-retirement. I discouraged him. 'In the private practice, you will have to "work", remove stitches yourself, discharge patients, no trainee doctors. My advice to you is, even if I appoint you, do not accept the job.' He sumptuously thanked me for the sound advice and left. In later years, whenever we met, he always smiled in a way that did not need vocalising.

Gandhi Family

Although our contact with Sachin Gandhi started as professionals, soon we became part of his family. His wife Sharmila always wanted to spend time with Nirmal to observe and learn many things to join Sachin during his social functions following conferences and courses.

Their two sons, Aditya and Akshay, also joined in during many memorable evenings. As time passed, we became their family members. The older boy Aditya is now a qualified engineer and the younger, Akshay, will soon qualify in medicine.

Sharmila and Sachin Gandhi

Aditya (left) and Akshay Gandhi

Sachin Gandhi

They say most things happen not by design but by people being in the right place at the right time. Sachin happened to be in Pune, my hometown, in a prestigious hospital named after the Mangeshkar family, and I, towards the end of my career, wanted to do something worthwhile for folks back home.

I visited India three times a year, went to the outpatients and the theatre, and taught Sachin advanced surgery. In England, I had been a Royal College of Surgeons tutor for postgraduate trainees for over twenty odd years at a higher surgical training level (old registrar and senior registrar grades). I was also known for pioneer work in laser surgery in ENT. I ran annual Cleveland International laser courses for over twenty years, edited-authored three reference-standard books on lasers in ENT, and travelled widely for teaching surgery with laser technology. This expertise was all on the plate for Sachin, without going anywhere abroad, let alone even outside Pune! I taught him instrumentation, laser setting, safety, choice of cases, managing them post-operatively, etc.

Sachin got himself into prominence as one of the leading laryngologists in India. His patient base spread internationally. The following few years saw the expansion of the department, with further addition of hi-tech equipment and instrumentation. In the latter part of the twentieth century and the current twenty-first century, the finesse in diagnosing and managing diseases and disabilities is hi-tech driven. Sachin Gandhi found resources to upgrade his department to the international standard, which was his dream at the start of the hospital. The department now boasts of being one of the leading facilities, comparable to any well-known centres.

(From left to right) Sitting: Sachin Gandhi, Marc Remacle, Dr Apte, Nirmal and Vasant Oswal; Standing: Vrishali (voice therapist) and Pallavi (clinical assistant)

His clinical assistant Pallavi supported the departmental activity, and the speech consultant Vrishali looked after a crucial aspect of laryngology: speech and voice therapy.

Out-patient clinics

Vasant Oswal Voice Disorder Clinic

Sachin kindly named the clinic: Vasant Oswal Voice Disorder Clinic. If you log on to the Google map of Pune and search for the clinic name, you get directions to it!

In the early years, Sachin was keen to make the most of my visits to learn not just the surgery but also managing the department, expanding it, and, more importantly, getting me to do some surgical procedures which were new to him. The hospital was popular, and it attracted patients from a wide area with various clinical conditions.

Another huge donation from Mr and Mrs Mutha

By now, about three years had passed since the inauguration in 2001. I was making at least three journeys each year to do the teaching. During one of my visits, my brother said, 'Mr Mutha, the donor, wants to see you.' I was a bit concerned in case anything had gone wrong.

'I sold more of my business, and I want to donate more money to the hospital.'

'How much?'

'Five crores.'

I felt a lump in my throat. In British currency, considering the exchange rate, it would be a couple of million pounds.

'I will ask Dr Kelkar what he wants to do with it.'

Dr Kelkar was speechless and also could not think how we could use this large sum of money. After all, you don't get that much money every day!

'You say how we should use this big donation.'

'Yes, build an annex for cancer treatment and care, a four-storey building adjoining the main building with access both from inside the main building and from the outside. Call it a Cancer Centre and name the facility after them.'

'OK'.

It was incredible that a couple of million pounds was spent in under five minutes and a very worthwhile project conceived.

'Shrimati Vimalbai Mutha Cancer Centre' inaugurated by Bollywood superstar Mr Amitabh Bachan

Within a few months, the centre was operational. It was named after Mr Mutha's wife, 'Shrimati Vimalbai Mutha Cancer Centre'. It was inaugurated by a very well-known film superstar, Mr Amitabh Bachan. Mr Mutha said that he would like to come to the hospital every day and help needy patients. So we gave him a substantial room in the new building for this worthwhile cause.

Money: an asset or a burden?

Mr Mutha owned a transport business with several hundred trucks that delivered scooters from the automobile factory to the auto dealers all over the country. But his lifestyle from his humble beginning never changed. He always wore plain clothes, mostly walked rather than go by car, and never smoked or drank alcohol. On more than one occasion, he said to me:

'You have given me peace of mind. Until we met, the money had become a burden to me and I did not know how to dispose of it. My children are well-settled and successful, so I did not want to leave it to them. You showed me the channel for a worthy cause. Now, I am peaceful in my mind. Money is no longer a problem for me.'

In the annexe built with his donation, he had a room as his office. He came in the morning and spent a couple of hours seeing relatives of patients who did not have enough money to pay the hospital charges. Then, he would try and raise funds for them through his business contacts. He did this for many years and found much solace in such a benevolent cause.

With my advice for donating to the hospital, Mr Mutha's money helped numerous needy patients and brought him much-needed peace of mind. It was a golden day for both of us – the day that brought inner satisfaction to us and help to the needy.

Money is an asset. Equally, it can be a burden.

The final act

Mr Mutha's wife, Mrs Vimalbai, who had chronic bronchitis, passed away. Mr Mutha continued to wind down his business. He made one final seven crore rupees (about £ 3.5 m). The money was held in a trust. The interest was used to top up the hospital bill for those patients who did not have sufficient resources to meet the costs in full.

On one fateful morning, as he was about to go out for his morning walk, he did not feel up to it and laid back in his bed, never to wake up again. He was ninety-two years old.

Late Mr & Mrs Mutha
Mr Modi, the PM of India and Mr Jay Kelkar (right to Mr Modi) at the time of inauguration of Phase II

Gradual maturity of the DMH

Back to the DMH. The next few years saw a gradual maturity of the DMH with the addition of several facilities. Jay Kelkar played an important role of medical director without salary. He continued to do his clinical work, which provided him with an income. The admin staff supported the vital work, which usually continues in the background. Sachin Vyavahare, the personal PA to Jay Kelkar, was omnipresent. Whenever I went to the hospital, invariably, he would come and say hello!

I went to Pune regularly and helped Sachin run annual laser and voice courses. I always made a point of getting someone from my international contacts to teach as an invited speaker. These included Mark Remacle and Bert Schmelzer from Belgium, Jean Abitbol from Paris, George Lichtenberger from Hungary, Hesham Negm from Egypt, Sergei Karpischencho from Russia and many more.

International visitors over the years (photo, courtesy Dr Gandhi)

Paul O'Flynn

Paul O'Flynn with Vasant Oswal

Some events in life are never forgotten. In 2010, I had exhausted my international contacts to take them to DMH. We were in Tarragona in Spain, attending the first meeting of the European Laser Association (ELA), of which I am Secretary-General. Colin Hopper, the Oro-facio-maxillary surgeon from the University College Hospital (UCH), London, was also at the conference. I knew him well since he was on the BMLA board. I asked him if he knew anyone in the UK who could go to the course in India as an invited speaker. 'Paul O'Flynn from UCH. Phone him.'

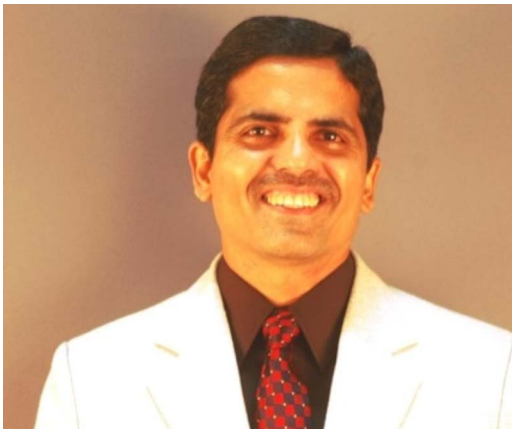
Paul, a cheerful, happy and jolly person, was delighted to accept the invitation. During the course, there was a live surgical demonstration. Sachin was operating on a laser case in one theatre; in the other, Jay Kelkar was doing Radical Neck Dissection. Paul, also H&N surgeon, was glued up watching the surgery on the neck. At one stage, he asked me, 'Is it a cadaver dissection of the neck?' I replied, 'No, it is a live demonstration on a patient.' He commented, 'I have never seen such a bloodless surgery before, with every structure so clearly demonstrated.'

The DMH Laryngology department awarded him the title of Honorary Professor – a well-deserved appointment

Paul O'Flynn (arrow) in the Laryngology department of DMH

Jay Kelkar awarded JLO Travelling Professor for the year 2014

Two years later, Paul wrote to me: 'I will be the President of Laryngology section of the Royal Society of Medicine (RSM) from October and am planning to ask Dr Kelkar to be Journal of Laryngology and Otology (JLO) Visiting Professor in 2014. Do you feel this is a good idea?' This visit was fully funded and involved lectures at the (RSM) in London, the Midland Institute of Otolaryngology and the Scottish Otolaryngology Society. 'Good



Dr Dhanandjay Kelkar,
Medical Director, DMH, Pune

idea? No, excellent idea. You and I both saw his neck op – as if he was operating on a cadaver! Yes, do that, he will do a complete justice to your invitation.'

There was also going to be a meeting with the International Department at the Royal College of Surgeons of England (RCS) to forge a link between the RCS and the DMH to accredit the DMH as 'Centre of Surgical Education and Training' by the Royal College of Surgeons of England.

Super-speciality phase II inaugurated by Mr Narendra Modi (2013)

The thousand-bedded not-for-profit DMH

Hand in hand, further expansion of the DMH was taking place as per the original concept. In addition, a super-speciality wing consisting of five hundred beds was undergoing construction on the grounds of the DMH. It was formally inaugurated on November 1, 2013 by the Prime Ministerial Candidate Mr Narendra Modi.

Here, let us pause a bit and take stock of the events so far. The hospital did not have corporate backing by a health care consortium to provide direction and money; it was a concept of the famous Mangeshkar family. The money was raised by charity donations involving masses of people at all levels, not just the typical wealthy donors. The original concept of two-phased development was now a reality. And the most unusual aspect of all this is the management board made of medics who are experts in their job as health care professionals and not institutional developers. The hospital is thus not under the influence of market forces, profit motivation, Government interference and so on. To create a health care facility of a high standard, as a charity hospital, on a scale where one thousand beds,

Inauguration of phase II by Narendra Modi, Prime Minister of India


Vasant & Nirmal Oswal with PM Mr Narendra Modi

representing all the specialities and some holistic angles such as the Yoga floor, is, by any standard, a fabulous achievement. Dr Jay Kelkar and his team deserve the highest accolade on this occasion of the inauguration of phase II of DMH.

A live link during the inauguration between DMH in Pune and the Royal Society of Medicine Laryngology Section meeting in London

Paul O'Flynn was to come for the inauguration of phase two. However, he was to chair a Laryngology section meeting at the Royal Society of Medicine in London on the same day. Fortuitously, the difference in the time zones between India and England coincided with him starting the meeting in London and the inauguration of phase II in India! Live communication was established between the DMH and the RSM. There was no prior announcement of the link in the programme. The audience in the London meeting was amazed to see me, Jay Kelkar and Sachin Gandhi five thousand miles away, on the

screen, with Paul introducing us. Paul and I spoke briefly to tell the audience about the hospital and the inauguration at the hands of Mr Modi, the Prime Minister-elect of India. Paul wished us a successful event. A memorable event for the two medical establishments, five thousand miles apart.

Super-speciality wing – phase two

Phase two was fully operational in 2017, following the commissioning of a super-speciality building encompassing further five hundred beds with the most modern medical facility comparable to any prestigious establishment anywhere. What's more, it is a not-for-profit facility aimed at lower- and middle-income groups (LMIG) of patients. The following is a brief extract of the article about the hospital, recently published in ENTNews.[8]

> Deenanath Mangeshkar Hospital (DMH) is now a 1000-bed medical facility in Pune, India. It is the largest non-profit multi-speciality hospital that provides state of the art diagnostic, therapeutic and intensive care facilities at an affordable cost to the lower- and middle-income group (LMIG) patients in a one-stop medical centre. The advanced medical facility includes joint replacement surgery, paediatric cardiac surgery, liver transplant, voice clinic, shoulder and sports clinic, and bone marrow and stem cell transplant unit for leukaemia patients. A capacity for 1000 beds, 500 with super-speciality designation, and a 105-bedded ICU with 20 theatre suits provide an inpatient facility for 50,000 admissions annually.

DMH as an academic institution?

As mentioned earlier, during the meeting with the RCS England, a concept was floated to link the DMH as the RCS England Accredited Surgical Education Centre. We need to go back to the incident when Paul O'Flynn watched a neck dissection on the screen and wondered if the demonstration was performed on a cadaver. Paul O'Flynn was now a member of the RCS Council, and no doubt that he initiated this idea of DMH to be the RCS England Accredited Surgical Education Centre. The process would involve a visit by the nominated council members to the hospital to assess the quality of teaching and all other aspects which go hand in hand with the title of an 'RCS England Accredited Surgical Education Centre'.

After the meeting, Jay Kelkar asked me what would make the DMH a training centre. The hospital was established solely for the treatment of patients, which it successfully did during the past ten years. But to brand it as a training centre it must have certain specific features.

In the eighties, I took over as a 'tutor' of the RCS at the North Riding Infirmary, the Centre for Higher Surgical Training accredited by all the Royal colleges in the UK. Such centres had a post of Senior Registrar who would undergo training to the level of eligibility to apply for a consultant post – the top post in the hierarchy of the hospital clinical staff. The consultant is wholly and solely responsible for his patient's clinical needs. There is no clinical person higher than the consultant, even in a 'supervisory role' for overseeing the consultant's clinical work. One of the consultants is appointed as

Administrative-in-charge, but not 'clinician'-in-charge.

I was well-placed with this background to advise Jay Kelkar to establish DMH as a postgraduate training centre. The modern teaching facility would be best served by a stand-alone dedicated 'Postgraduate Centre' with an administration staff, an academic head, and several lecture rooms to provide all sorts of training at all levels, including trainee doctors, nurses, ambulance staff, ancillary staff, etc. It also needed a conference facility, a skill laboratory, free and fast internet access, IT support.

All the above is relatively easy to achieve. However, the core of the postgraduate centre is the trainees and the trainers. Our conversation went on as follows.

I aired my concern:

'The primary aim of the DMH was to provide treatment for the patients, and the medical staff has done that admirably for the past ten years. These doctors are now ten years older, with set clinical practice and a guaranteed patient load, regular income, excellent working environment in a prestigious hospital with a super-speciality wing. Ten years on, they must be well settled on the domestic and social front as well, with children studying in the colleges, a substantial living standard with a car or two. And generally, apart from being on calls, they do not have any hospital commitment in their free time.

If you change your tack into an academic centre, it will require them to take on teaching that will not produce extra income. They will have to publish papers, keep up to date with science, and run regular courses. Moreover, academic work will erode into their free time with their families and friends, and they may not wish to do that, having reached a somewhat cosy routine in their life.'

To which Jay replied:

'You are coming to India soon, why don't you ask them yourself, explaining to them what is involved? It will be more direct, and you will be able to get honest answers, since you are an outsider.'

Meeting with consultants: becoming an Academic Institution?

To my surprise, quite a few consultants wanted to attend in order to learn what was involved in going academic. Within a week, Jay Kelkar reported to me an overwhelming 'yes' from all the consultants! The first requirement was to have a dedicated Postgraduate Centre, which required space and money. He said, 'Money is not an issue! But there is no space in the grounds of the hospital or anywhere nearby.'

An idea came to my mind. We had an Annex with a four-storey structure, built with Mr Mutha's donation. I told Jay to expand it by making two more floors as a PG centre. He at once accepted the notion. The next few months went by, but nothing seemed to happen. It was a long-drawn process where planning permission was necessary, and also the architect needed to survey. Then, finally, it transpired that the foundations could support only one additional floor. But a postgraduate centre needed a library as well, so one floor would be inadequate.

We have the 14th floor in the new block, not allocated to anything yet

During my next visit to India, Jay Kelkar told me that in the new super-speciality, an eighteen-storey structure, the fourteenth floor was for research but still not firmed up. It was possible to allocate it to the PG centre. I asked, 'How big it is it?' 'Come with me and I will show you.'

The floor had a foyer and four wings with several rooms that could be adopted for a PG centre with simulation lab, wet lab, library, an auditorium seating one hundred and fifty and another for one hundred and twenty, and, in addition, administrative offices, IT points and the lot. I immediately said: 'Get on with it.'

Deenanath Mangeshkar Postgraduate Teaching Hospital.

DMH was primarily established to provide as a medical care facility for patients. During my career, I firmly believed that an academic activity improves the standard of care since teaching requires up-to-date knowledge, indirectly influencing the quality of the care delivered. To the credit of the senior medical staff of DMH, they all welcomed the proposal of postgraduate teaching. Postgraduate training for Diplomate of National Board (DNB) started some years ago. But I wanted the training base to be accredited by an international body. After all, they wanted me to, as mentioned earlier, develop the ENT department to an 'International Standard'! Here we were, a recognition of the whole hospital commensurate with international norms, accredited by no less than the elite body: the Royal College of Surgeons of England.

Vasant Oswal, Hon Mr Prakash Javadekar and Paul O'Flynn

A dream-come-true

Most dreams don't see the daylight, but this one did! It was a reward of dedication, perseverance, resolve, commitment, passion, focus and hard work, step by step, but accomplished over the years, not weeks. Starting in 2000, when the hospital was no more than a few bulldozers digging the site, come 2021, there is a vibrant thousand-bedded medical and teaching facility of the calibre good enough to get an accreditation status from the Royal College of Surgeons of England.

The Vasant and Nirmal Oswal Centre for Postgraduate Education and Training (2017)

(Left to right) Nirmal, Paul, Vasant, Steven, Neena, Hon. Mr Javadekar, Jay Kelkar

Hon. Mr Prakash Javadekar, a union minister for Human Resource Development

In recognition, the DMH named the centre 'The Vasant and Nirmal Oswal Centre for Postgraduate Education and Training'. It was officially inaugurated on February 19, 2017 by Mr Prakash Jawadekar, Union Minister for Human Resource and Development. It is dubbed VNO centre!

RCS England Accredited Surgical Education Centre

A visit by the Royal College of Surgeons, England

The RCS accreditation

The VNO PG centre was now fully functional. The various training courses were re-oriented to follow the Royal College of Surgeons (RCS) of England protocol. Following a couple of visits by the council members, the Royal College of Surgeons of England awarded DMH accreditation as the 'Centre of Surgical Education and Training'. This accreditation is the highest award to the institution for providing a portfolio of courses in a dedicated training centre. DMH is the first centre in India to achieve accreditation. A council member visited the DMH in 2019, and The College granted accreditation for a further three years.

Furthermore, the RCS also accredited three training scholarships in laryngology. Incredibly, for the very first time anywhere globally, RCS had accredited training posts outside the UK and Ireland.

A dedicated centre for postgraduate training with more than 22,000 square feet of space was the epitome of a long journey since 1999. It caters for a sophisticated training environment for critical skills using advanced virtual simulation and hands-on workshops for postgraduate and practising healthcare professionals across a wide array of specialities, including surgery, critical care, anaesthesia, voice, lasers & orthopaedics – specifically, joint surgery.

RCS England approval for trainee posts in ENT department at DMH

The following few years saw the expansion of the department, with further addition of hi-tech equipment and instrumentation. In the latter part of the twentieth century and the current twenty-first century, the finesse in diagnosing and managing diseases and disabilities is hi-tech driven. Sachin Gandhi found resources to upgrade his department to the international standard, which was a dream at the start of the hospital. The department now boasts of being one of the best anywhere, so confirmed by the Royal College of Surgeons of England by approving three trainee posts in the department – the first such RCS accredited hospital in India.

My international contacts, invited speakers for every annual conference, were delighted with the experience. They are the world leaders in their own chosen subspecialty within laryngology, beginning to achieve a status of a stand-alone branch of ENT.

FRCS *ad eundem* for Dr. Kelkar and Dr. Gandhi

The Royal Colleges in the UK have provision to admit those experienced surgeons who have not passed the relevant Membership or Fellowship examination. They apply to be admitted via the fellowship *ad eundem* process. To be eligible to apply, the applicant is required to satisfy the Council that the standard of their training is equivalent to the length and type of professional training needed for the Fellowship examination of The Royal College of Surgeons.

Both Dr Jay Kelkar and Dr Sachin Gandhi applied to the Royal College of Surgeons of England via the *ad eundem* process. Remarkably, the Council voted in favour of admitting them as fellows of the College. They can thus add FRCS as a postscript to their names without passing any examination!

Fellowship *ad eundem* requires that they pay annual fees to the College to retain their fellowship and continue to use FRCS as a postscript.

Paul was instrumental also to award RCS accreditation to the DMH.

President Miss Clare Marx, RCS England

Royal College of Surgeons of England award Vasant Oswal FRCS by Election (2015)

The RCS England also awards Fellowship by election. A surgeon who has given outstanding service to surgery, medical science or the College is considered for an award. The process involves nomination by a member of the RCS. The Council considers the nomination, and if approved, FRCS by election is granted. Paul O'Flynn from UCH nominated me for such an honour. I did not know him until he came to DMH as an invited guest lecturer for their course. We got much closer since then, to the extent that he

Mr Vasant Oswal, MB, MS, DORL, DLO, FRCS (Ed.), FRCS (Eng)

President, Council, Colleagues and Guests,

At 80 years of age, Vasant Oswal is a little older than most receiving a Fellowship of the Royal College of Surgeons today.

I have been asked to provide a citation for him in 30 seconds per decade!

Vasant Oswal was born and bred in Pune, India, in 1934, before the Second World War when there were no cars or buses on the road, and public transport was by horse-drawn carriages called Tonga.

In 1960, he qualified in Medicine from BJ Medical College in Pune. His post-graduate medical career started in Bombay, now known as Mumbai, where he gained the DORL in 1961 and MS in ENT in 1963. He moved to England for further training and was awarded the DLO (RCS) in England in 1964. An FRCS Edinburgh followed in 1967 – an achievement he will finally top today.

After his appointment as Consultant in ENT in 1969 to The North Riding Hospital, he initially specialised in Otology. He undertook temporal bone dissections that were exhibited in the Wellcome Museum at the RCS and later photographed published in the Colour Atlas of Anatomy produced by Prof McMinn and Hutchings. Many of us have copies of this book on our shelves.

Yesterday, we found the temporal bone dissections on display in the Wellcome museum on the second floor here at the College.

Always interested in innovation, he realised the benefits of laser surgery in the larynx in the late 70's and raised the funds to buy one for his department in Cleveland 1982. He received acclaim for work on "Team concept in the management of laryngeal cancer" – now routine practice in MDTs. He developed bespoke instruments for laser surgery in the larynx, including a flexo-metallic fireproofed anaesthetic tube. He had worked out that oxygen, rubber anaesthetic tubes and CO2 lasers were a highly inflammable mix. He established an annual Cleveland International Laser course, which ran for 28 years, training hundreds of surgeons from all over the world.

He allegedly retired in 1995 but continued practice, writing, teaching and editing and as an Honorary Consultant until 2008, a mere 13 years later.

He became Editor in Chief of ENT News; the most read bimonthly ENT journal in fifty countries. He edited and wrote three major books on Lasers, first in 1988, the second in 2002 and the last one as recently as 2014 – long after his "official "retirement.

Not content to relax clinically or academically, Vasant has been a major driver and supporter of the development of the Deenanath Mangeshkar Hospital and Research Centre in Pune (his hometown) over the last decade. The hospital has a state-of-the-art Laryngology and voice clinic and supports international fellows for training. Now boasting more than 1,000 beds, this not-for-profit institute will soon have an Education centre named after Vasant and Nirmal (his very long-standing - or is that suffering, wife) Oswal in recognition of their personal and financial contributions. The hospital expects to open the Education centre by Diwali next year.

By capricious good luck, today is Diwali – the "Festival of Lights" – the largest and brightest of festivals in India. It signifies the victory of good over evil. Traditionally on Diwali night, Hindus dress in new clothes or their best outfit, light candles inside and outside of their homes, say prayers to Lakshmi (the goddess of wealth and prosperity) and having been on the equality and diversity course, I apologise for the gender-specific language. Then there are fireworks and a feast. This is almost identical to the plans for the rest of today's diplomates ceremony.

It is fitting that Vasant Oswal, a man who has built a reputation and career on lasers, is to be honoured on the festival of light. He has put back much to his hometown of Pune and to his profession. He has been rightly awarded many prestigious honours.

Today, President, he is a worthy recipient of FRCS England by Election.

Citation by Mr Paul O'Flynn on the occasion of an award, by Election, of FRCS of the Royal College of Surgeons of England (2015)

A meeting with President Clare Marx of RCS England after the formal event

started calling Nirmal 'Auntie'! He is the most cheerful personality one would like to be associated with. In 2015, the RCS England accepted my nomination and awarded me a Fellowship by election (equivalent to 'Honorary Fellowship').

An award of the fellowship *by the Council nomination* is held in high esteem. I am gratified that the College recognised my pioneering work in lasers, international teaching, and dissection of temporal bones exhibited in the Wellcome Museum since the seventies for trainee surgeons to learn the anatomy of the ear.

The British Medical Laser Association (BMLA)

Emeritus BMLA President Harry Moseley

BMLA President Vishal Madan (current in 2022)

The British Medical Laser Association was established in 1982. Now, in 2022, I am one of the few (if any!) surviving founder members. In its formative years, the BMLA activity, like everything else, was in and around London, and I did not participate in it apart from attending the annual conferences organised by willing members in their hometown. The surplus was usually divided between the host and the BMLA. Equally, the loss was covered by the BMLA from its funds.

Treasurer of the BMLA

A conference in Jersey during the nineties resulted in a considerable loss. The organisers had reserved all the rooms in the Grand Hotel for the BMLA members. The event was successful. However, the participants did not take up all the reserved accommodation. Therefore, the management sent invoices worth many thousands of pounds to the BMLA to make up for the loss of revenue resulting from non-occupancy of the reserved rooms. But the BMLA resources were nowhere near enough to settle the invoices.

During the hurriedly convened meeting of the members, I suggested negotiating with the hotel management. The suggestion was welcome, but there was no volunteer to take it on. Most medics are not business oriented. Everyone looked at me, expecting that I would volunteer to do this job, and I agreed. I told the management that the BMLA funds could not settle the invoice in total but make part payment towards the settlement with whatever money was available. If they went to court, they might win the case, but that still would not produce any money. BMLA, as a charity organisation, had no assets as collateral to raise a bank loan. The management agreed, and we saved the BMLA from bankruptcy proceedings. Everyone suggested that I should take on the position of treasurer, to which I agreed. I remained in that position for over ten years. During my tenure, the BMLA funds accumulated to healthy reserves, helping to support the lean years.

The Joint ASLMS/BMLA/ELA International Conference in Edinburgh, Scotland in 2003

The landmark BMLA hosted conference has to be the one held in 2003. The BMLA had achieved a substantial status by then with well-attended annual conferences of high calibre. I thought it was now time to spread the wings to foreign pastures.

I have attended a couple of conferences of the American Society for Laser Medicine and Surgery (ASLMS), and the European Laser Association (ELA)had also found its feet. I asked Harry if we could hold a joint conference between the BMLA, the ELA and the ASLMS.

ASLMS's reply was positive, and so was that from the ELA. We booked a venue in Edinburgh for September 2001, established the various committees and put out promotional material. The Americans were enthusiastic and promptly sent the seed money. 'All systems go', but a disaster came along – 9/11. Everything was cancelled immediately. The venue agreed to postpone to another date without penalty. September 22-23, 2003 was agreed. The Americans did warn us that even as much as a rumour came about any terrorist activity, they would cancel everything. To top it all, SARS (severe acute respiratory syndrome) came from the East.

Slowly but surely, the registrations started coming in. However, the numbers did not even meet a break-even point. I had told the PCO Monarch of Edinburgh to skin the costs as much as possible. No lone piper, no 'Haggis' performance, minimal décor for the dinner venue, etc. And suddenly, a couple of months before the conference date, the registrations took off. Everyone had been holding back until the last minute, just in case. In all those years of arranging conferences of all sorts, I had never seen so many 'Spot Registrations' at full price.

As the money came in, I continued to phone Monarch to spend a bit on more décor, flowers for each table, a piper to welcome us – we went to town when the number reached six hundred! The final total was 650. ASLMS awarded a life honorary membership to Harry and me. They also appointed me as a member of their overseas committee.

'To A Haggis'

Nirmal presenting a bouquet to the mayor of Edinburgh, with Harry looking over

It turned out to be a grand affair. Very successful in every respect, very memorable. Someone was looking after the BMLA from somewhere!

Of course, as mentioned in section V, the PCO could not sustain the losses incurred due to 9/11, and as many others did, they folded as well. We lost our huge, once-in-a-lifetime surplus of £ 80,000/-. Fortunately, there was enough left for getting seed money back for all three participants.

You do not know what a Haggis performance is? When the haggis is served, a skilled speaker dressed in full Scottish garbs, boldly and proudly recites the address 'To A Haggis' before it is devoured by all. Quite a spectacle, this tradition is still very much alive and thus deeply ingrained in Scottish culture. If you don't know what 'Haggis' is – look it up on the internet.

Chair, Education Committee, Vice President, BMLA

Over the years, I became a vanguard of the BMLA, creating and accepting the Chair of the Education Committee and Vice President of the BMLA. Now very senior, no one wants me to withdraw, since my experience comes in handy for any issues.

Harry Moseley from Scotland was elected President of the BMLA in the late nineties. His leadership, humorous disposition, dedication, and devotion kept him at the helm for over fifteen years. Harry and I became close colleagues, chatting away on many matters into the wee hours during the conferences, with occasional wee drams giving us company.

Nearing its fortieth birthday, the BMLA remains a prestigious and well-respected professional organisation, led by equally competent young ones, Vishal Madan, Jon Exley, Tom Lister and Raman Bhutani.

(Left to right) Anna Trelles, Nirmal, Mario Trelles, Vasant, Thanasis Ladas and Virginia Benitez

Secretary-General of the European Laser Association (ELA)

Although established in the early eighties, the ELA became defunct just after a few years. The remaining handful of members asked me to rejuvenate it. The Association was registered in The Netherlands. It was an uphill struggle due to language and the distance to go personally to sort out things. It took me a good part of four years to get it going again, and the first annual conference was held in Tarragona, Spain, in 2010, with Mario Trelles as President of the ELA. Mario played an active role in developing and expanding the ELA with the member organisations from Spain, Portugal, The Netherlands, the

Executive Council meeting followed by dinner, The Lake District, UK
(From left) Vasant Oswal, Harry Moseley (UK), Mario Trelles (Spain) Mrs and Dr Parakevas Kontoes (Greece), Mrs and Dr Carsten Philipp (Germany), Claudia Lugt (The Netherlands) Anna Trelles (Spain), Nirmal Oswal (UK)

UK, Germany, France, Bolivia, Peru, Paraguay, and Uruguay. His international status is well-respected worldwide. He continues academically at the University of Barcelona, Spain.

With Mario as the President and me as Secretary-General, we have worked as a team, with Claudia Lugt, Raman Bhutani and Tom Lister keeping the various aspects of its running in order. The annual conferences were held in the European member countries until Covid-19 disrupted the world. Rafael Serena from Spain has started Webinars as an educational programme during the current Covid Era.

Many of Mario's funny stories and his passion for quality wine makes him a very desirable company any time. In addition, Nirmal and his wife Anna have forged a friendship on matters of mutual interests.

Founder Chair, Asia Pacific Laryngology Association (APLA, 2018)

The introduction of hi-tech instrumentation and equipment had done much to advance the science of laryngology, to the extent that dedicated professional organisations started to crop up in various world regions. Incredibly, the American Laryngology Association was founded as far back as 1878! In the past quarter of a century, the British Laryngological Association, the European Laryngology Society, the Laryngology Society of Australasia and the Laryngology and Voice Association with HQ in India were also established with active academic programmes.

The Asia-Pacific region is vast. It also has the most diverse socio-economic strata in the world. Having established himself in the Indian subcontinent, Sachin Gandhi's natural progression would be his presence in the Asia Pacific Region.

I have had considerable experience in the professional organisation as a founder member of the British Medical Laser Association and European Laser Association. I floated the idea to establish the Asia Pacific Laryngology Association and produced a blueprint for him to follow. APLA was formally inaugurated in 2018, during the Bangalore annual conference of LVA.

The first APLA conference, Singapore, November 1-3, 2019

Our web designer for BMLA designed the logo of a hummingbird and the website for the Asia Pacific Laryngology Association (APLA). The concept was to take full advantage of the digital age and provide a digital e-learning platform via the APLA website.

My consultant colleague in England, Liam Flood, who had just retired, gave me a hand. Sachin Gandhi sent some clinical photos, and we developed quizzes for education. In addition, laser physics had several slides and comments on basic laser science.

The first conference of APLA was held jointly with the annual LVA conference in Singapore in December 2019. It was a very successful event with 355 delegates attending. The 2020 APLA conference was planned to take place in Manila, Philippines, but then the COVID-19 pandemic disrupted everything.

COVID-19 pandemic guidelines for APLA website (https://www.aplassoc.com/)

David Lau and his colleague Vyas Prasad from Singapore took the initiative to produce a guideline document to undertake laryngological clinical and surgical procedures in the face of Covid. I wrote part one, providing the basic knowledge on the coronavirus and the pathogenesis. The contributions for part two came from some twenty-eight surgeons around the world. The document was published on the website as open access, thus contributing to the objective of APLA as an e-learning platform.

Change of direction in 2020 – courtesy of COVID-19!

Following my formal retirement from James Cook University Hospital in 1995, both Nirmal and I have been very lucky to enjoy twenty-five long years travelling worldwide to

Vasant received Life Achievement award at 2022 New York Laser Meeting hosted by The European Medical Laser Association as recently as 10-15 March 2022

Panoramic view of Far Shirby, Home in Yorkshire, England

teach laser technology. We also experienced extraordinary thrills such as Trans-Atlantic travelling by Concorde twice and paragliding 2000 feet over the Swiss Alps.

As we planned our next trip in early 2020, the world came to a standstill because of the COVID-19 pandemic. We were grounded. It gave us a bit of a breather to take stock of the future. I am in my late eighties, and Nirmal is not far behind – a short shelf life, with 'sell-by date' fast approaching! We had an opportunity to look around for the first time and, more importantly, look at ourselves! Pandemic lockdown introduced a timetable for us. We imperceptibly slotted our daily routine into the pandemic restrictions.

For us, the pandemic has been a blessing! I now spend much of my time in the garden looking at the seasons, growing vegetables in earnest, writing this memoir, and still participating in the Zoom platform conferences. I got myself a thirty-five-inch monitor, a speakerphone, a webcam and a pair of clip-on lights. The 2019 postponed LVA conference took place on the Zoom platform from Delhi in February 2021, followed by the LVA-APLA Hybrid conference in Lucknow in India in October 2021, to catch up with the annual conference programme. They kindly gave me the honour to be Chief Patron of the event. The next BMLA conference would have been held in-face in May 2021, but also ended up as a Zoom conference. Then there are Zoom business meetings of the BMLA and ELA.

To say that the pandemic was a blessing for us is no understatement. There is no doubt that travelling gets harder as you get older. Transcontinental travel through many time zones and jetlag is fun but also punitive.

We had seen the world, travelling many hundreds of thousands of miles. British Airways records alone shows that since 2007, we had flown 325,384 miles, spent the equivalent of twenty-seven days in the air, visited fifteen cities in twelve countries! This does not include many thousands of miles flown before 2007, also by other airlines and to forty-two countries in the four corners of the world. So you can easily double or triple that mileage figure.

But if we have shunned the world and the virus, neither the world nor the virus leaves us alone. The world creeps in through the television, the new cases, the hospital admissions, the deaths, the vaccinations – every hour the same. You can almost write tomorrow's news today, give or take a few hundred deaths here or there. We now record the Six O'clock News, replay once and fast forward where you already know what is coming. This way we live our remaining life on our terms, with the garden, the fish in the pond, the doves in the aviary, the bugs in the soil.

Intensive gardening means no need for forced exercising during the pandemic lockdown.

Nirmal also has enough to do in the house to keep her on her toes. I make sure of that by not lifting as much as a finger to help her!

Only essential shopping once a week. Take precautions by the book, no short-cuts. For all that we care, life can go on like this for as long as it wants to. The life we lived was very full, the life we are living in this pandemic is also very full, and what is more, it was in the cards anyway, covid or no covid!

Our holiday home in the Lake District

A view of Lake Windermere at Waterhead from our holiday home

A beautiful view from our bay window. We enjoy walking in the Lake District, but on hold due to COVID-19!

Hungry body

When I was twelve or thirteen years old, I started going to the gym; I do not know what inspired me. It was not because I had friends who went to the gym, and I just joined them. I did not particularly want to build up my body either.

I did exercises like weightlifting, double bar, single bar and dumbbells. Then there were Indian-style exercises known as Hindu push-ups and squats that did not need any equipment. I did try sports, but I was no good at sports.

Admission to medical college involved undergoing a medical check-up. The tutor remarked that I had a good muscular build.

During my formative years to study medicine, there was no time to undertake any physical activity since I was fully occupied by building my career. When I got a permanent job as a consultant, we bought a starter home with a small back garden. Of necessity, I started tidying it up and maintaining it – this gave me a good bit of work-out. However, there is not much to do in the garden in the winter months. I, therefore, bought an exercise bike, a chest expander and a gym bench for a full-body workout.

In 1982, we moved to a bungalow that happened to be on a hill; it is our permanent home. It has a large front garden and a back garden. The land rises by about twenty-five feet in height from the bottom of the garden to the building line of our home.

Gardening on the hill is challenging. You need to build paths with a gentle slope, steps with the correct height and width, a lawn with a slope that retains sufficient water and so on.

Mixing cement manually is hard work. I bought an electric cement mixer

Spirit level is essential, eyeballing can be deceptive on a hill.

French polishing the dining table in the conservatory

Plumbing

Summer or winter, the work never stops!

I taught myself flag laying, crazy paving, building paths, retaining walls, lay patios, building steps with a correct height and width, *e.g.*, the elevation of each step should be ten inches and the width at least twelve inches. Going down correctly built steps conforms to a normal rhythmic movement of the body. This work was satisfying and productive, much better than exercising on the static bike or an exercise bench.

Pond in the garden

I took full advantage of the sloping land by constructing a pond with a retaining wall down the slope. It is a good thirty feet in diameter and three feet in depth. I got some Japanese koi carp and built filters to maintain the quality of the water. Keeping fish in an artificial pond has a definitive science about it. The pond is a home for various fish; some of them, such as the Japanese Koi carps, are highly bred for their beautiful markings. There are named varieties which are expansive, costing hundreds of pounds. And then there are other varieties: tench, rudds, common carps, mirror carps, blue and orange orfes, etc.

The pond in our garden

Watching the fish swim and feed them is very relaxing

In the summer months, they are active and need feeding frequently since they have no stomach. The oxygenation of the pond water has to be maintained at a sufficient concentration by using air pumps. The water need frequent filtration to remove waste. They are also liable to diseases which need water treatment.

The fish spawn in the spring. The females wiggle their bodies to squeeze out the eggs in the hundreds. It is a laborious process and can lead to fish dying, although we did not lose any of ours yet. The male fish of all varieties swim in large numbers over the eggs to deposit their sperm. Hundreds of offspring are born, but hardly a couple survive to make it to adult life. Nature has always assured species survival by providing far in excess – be it seeds of plants or eggs and sperm of the animal kingdom. How else would we get continuity

Pond in the winter. Air pump to keep the water above freezing point and oxygenated

The pond needs a regular maintenance

of COVID-19 if it was not for the latest Omicron with thirty mutations, increasing its infectivity and chances of survival significantly?

Koi carps live to a good old ripe age of sixty to seventy years. Some of our koi are thirty-five years old, they grew from nine inches to nearly two and half foot, with a massive girth! A variety named shagoi actually comes to you as you approach the pond.

A family of herons has also nested on the nearby wood. A heron with its long neck and narrow beak flies in and lands near the pond, stays very still for a long time and snatches an unsuspecting fish, swallowing some four or five nine-inch-long fish in one sitting, before flying away. Herons are particularly active in the spring when they have chicks to feed.

Our large pond is covered with wall to wall netting to keep our expensive fish safe from the hungry heron.

The heron, a regular visitor

Come winter, they become inactive, hardly moving around to conserve their energy. They do not take food even if you give it to them. They are poikilothermic or cold-blooded animals. The air pump ensures that there is some area free from snow and ice so that whatever carbon dioxide has been released by the fish in the water can escape into the atmosphere.

Do fish have a nose? No, there are not air-breathing animals. Nevertheless, they do have a nasal pit which has tissue responding to vibrations. On the other hand, amphibians, such as the frog do breathe air on the land and take in exchange gases through their skin when in the water. I read somewhere that croaking of the frogs was the first biological sound produced on the earth – sounds logical and scientific.

Keeping fish in the garden pond is a considerable amount of work. You need to use filters to keep the water at a correct pH and oxygenation. The oxygen concentration levels can be critical since hot weather reduces the oxygen concentration in the water. We have air pumps which aerate the water. A stream similarly oxygenates the water by increasing the surface area for diffusion of the oxygen and release of the carbon dioxide. They feed frequently in the summer months, so we have an computer-controlled automatic feeder.

But despite all these demanding requirements, it is very relaxing to watch them swim and come to you for food.

Bonsai trees

We have been regular visitors to Great Yorkshire Show held annually near Harrogate. I came across Bonsai trees there and liked the art as a hobby. I built a sheltered area at the height of four feet to place them to be seen at eye level. Over the years, I collected some twenty-odd specimens. Bonsai trees do not have a large reservoir of soil to hold the moisture and thus need frequent watering. I designed a method watering them continuously with a wick that sucks the water up the tray and moistens the soil as the water evaporates from the leaves. I wrote an article on it for Bonsai magazine. Now I use water computers to water them frequently. Some of my trees are thirty years old and acquired that aged look by putting on layers of bark.

Being 'trees', they stay out all year round, even when covered with snow.

Bonsai tree in spring and covered with snow

Doves

While my hobby is the garden pond, Nirmal's is keeping doves. We built an aviary to keep them safe from predators such as sparrow hawk or village cats. They are not locked away and do fly around.

Good company in the garden

The newly born have their feathers enveloped into a wrapper. Over a week or two, the outer layer gradually comes away, spreading the feathers. When the chicks fly around for the first time, the lay of the land is imprinted on their brain. Several such imprints make a home, and they never leave 'their' home. When it rains, the doves come out and lift their wings to wet the under surface. They then spend hours cleaning each feather. Beekeepers

They can be trained to take food from the hand

Dove chicks

tell me that bees do the same. If you move the hive by more than six feet, they cannot find it. When they move the hive to a newer field, the bees repeat the whole process. Nature is marvellous.

Growing vegetables

Our garden on the hill gave us natural uneven areas. On a higher area of the garden, I constructed a vegetable patch by holding the soil with used railway sleepers. This gave us a raised bed, avoiding water logging.

I laid paths four feet apart so that we could reach the soil from the path. This method of planting is called *potage* in French.

We grow a variety of vegetables nearly nine months of the year. We harvest them when we need them – what's for dinner - what is ready for harvesting - fresh from the garden. New potatoes have that smell of the soil even after cooking. I built an area for compost bins. We make our own compost, all kitchen waste goes to the compost bin, ready to use as compost

Raised bed

Preparing a patch and plating onions

Potage gardening: A kitchen garden

When I was a trainee, Nirmal asked me to go shopping with her. I told her I am not a potato and onion man. But now I am, very much so!

Anyone for a crunchy salad?

Can you smell that corn on the cob? It was just roasted!

Water computers save chores

A well-earned rest after a day's work!

The bountiful harvest

in about twelve months. We store potatoes and onions for the winter. Even in winter, we have a supply of winter cabbages and likes which happily stay in the ground even in thick snow covering.

Corn takes six months from planting to harvesting, but the wait is worth it. The saying: 'walk to harvest your corn and run back to the kitchen to cook and eat it', is every bit true. As soon as you harvest it, the sugar starts converting into starch. If you have always tasted corn bought from the supermarket, you will never know the difference.

Competition for food

Growing vegetables to get a regular supply from your garden is not a hobby, it is real work, it is time sensitive, and it needs knowledge. *E.g.*, brassicas need alkaline soil. They are susceptible to plant diseases. The cabbage butterflies lay eggs on the under surface of the leaves, the eggs develop into caterpillars with a voracious appetite, and before you know, all the crop is devoured.

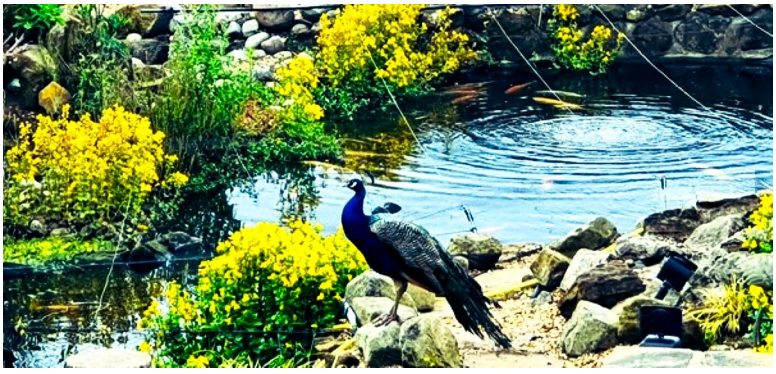
The eggs on the under surface of the leaves develop into caterpillars with a voracious appetite and before you know, all the crop is devoured. Even a net is only a partial protection.

A double caged bird feeder

We have a double cage bird feeder. The outer cage is just the right size for the small birds to get in to get the food from the inner cage. A squirrel tries to get the food but is unsuccessful. The woodpecker has learnt to hang on to the feeder upside down and get the food. But it lacks the memory to repeat the process and flies away, frustrated.

Partridges and pheasants are regular visitors to pick up the bird food which spreads around when the smaller birds eat from the feeder.

Rats enjoy tasty fish food, getting it by chewing the thick plastic container. And when you think you have won, the invisible enemy strikes – the vegetables can get a variety of diseases such as potato blight, attack by green flies, whiteflies, and a variety of bugs. Slugs are everywhere. The earthworms do an excellent job of aerating the soil, but if I am digging a patch, a robin or a blackbird or a thrush hang around waiting for a tasty earthworm. Cows in the field adjacent to the garden try to get my corn through the barbed wire fence.



Even a stray peacock found the pond attractive!

Having a substantial garden turned out to be a blessing during COVID-19. Now in my late eighties, I can easily put in three hours of hard gardening and still not be out of breath. Then there is window cleaning, painting, jet washing the patios, mowing the lawn. The joints are not gnawing, the muscles are not aching, and there is no sign of wear and tear in the build. If what precious little future goes as my present, that would be fine by me!

The hungry brain

I have always been an academician – now for over sixty years. Gardening and writing memoirs is fun but not a substitute for the hungry brain. Having exhausted the select few old movies on Netflix and Amazon, I found videos on YouTube in the hundreds, and at no cost apart from a Premium subscription to stop the ads. Physics, Space-time, the wave-particle theory, the history of tens of subjects – the brain is not complaining now. I watch some videos twice or three times to understand and remember the contents. The following day, a lecturing session for Nirmal – a revision for me!

It is such a wonderful elixir; I can't wait for the evening to come, taking me on a voyage lasting well into the wee hours!

Finally

Liam Flood

This is my colleague Liam Flood. From day one, when Liam joined us as a consultant in 1985, his easy-going, charming personality brought a breath of fresh air to the department. I recall his first clinic at the Infirmary, next door to my clinic. My nurse came into the room, giggling. She told me:

'Mr Flood saw this old lady. As she entered the room, Mr Flood stood up, shook hands, and asked her to sit down. Then he said to her:

'How nice to see you looking so well.'

Then he examined her, and as she was going out, he opened the door and said to her,

'You are doing very well'

The old lady, not used to these southern ways, was confused. She asked the nurse,

'What did the doctor say?'

'The doctor said you are all right'.

'Oh, that's good, init?'

This was different. We northerners have a 'down-to-earth' northern way. His was another way, a southern way, to deliver the same goods, treat patients as people, not as bodies on a conveyer belt.

His particular ability to write medical articles came in handy to raise the department's profile. The Infirmary was getting noticed nationally due to my laser work. His appointments on many national bodies firmed up the Infirmary as a high-ranking ENT centre. But for me, he proved most helpful when I founded the Asia Pacific Laryngology Association (APLA). Together we developed the quiz section – as an e-learning platform.

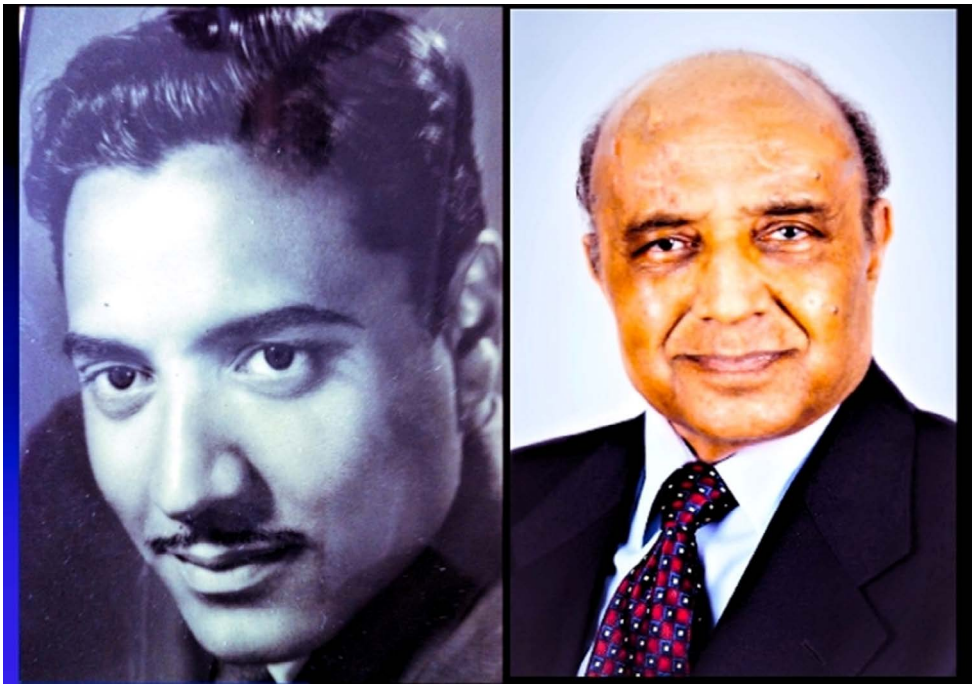
And when I floated the idea of writing this autobiography, he supported me with such enthusiasm that I felt compelled to take the project on, if not for my sake, at least for his.

I have been Editor in Chief of the ENTNews, authored and edited three substantial books on laser, and, in general, have been active in professional bodies and teaching.

I started with a few pages for the autobiography and sent them to him – he sent them back to me with quite a few corrections. So, I was a bit more careful; even then, there were corrections. Now, I went through the text with tooth and comb – no, there were still some, albeit minor, corrections. So, I accepted him as a superior human being as far as editing went.

But truthfully and sincerely, the credit for completing this autobiography goes entirely to his untiring enthusiasm to see it completed. In every walk of life, you do need a driver – it will not be an exaggeration to say that Liam is wholly creditworthy to see this work published as an autobiography. So, thank you, Liam, for being a real pal in our lives.

Epilogue



Swop maturity for looks. Why can't we have both as one?

Everyone has many events in life that changed their direction. Looking back, mine were all very positive for me – or put it another way, I made them positive for me. In a low-income family, the pressure of making ends meet takes a priority. When I was five, my father did not enrol me due to the stress of work to earn enough money for a family of five children, enough just to survive. So, I got the mill-hand to do it for me. When I got stuck on some homework in mathematics, and my father also could not help me, I persevered and got the correct answer – a little episode that was a Eureka moment for me and taught me to be self-reliant, a huge asset in life. When my batchmate Vijay Ghate took the only job in

ENT in Pune, I took myself to Mumbai; it opened up the world for me. As I was finishing the post-graduation in ENT, a mail came from England, five thousand miles away, to go for an 'interview' for a House Surgeon's Job in ENT. I did not hesitate! After FRCS, as I was homeward bound via a spell of two years in Libya, Colonel Gadhafi deposed King Idris, whose regime had appointed me as ENT consultant. But I did not change my plans, just modified them.

I got a job in England as a locum consultant in Wales. During this temporary fill-in job of a locum consultant, my consultant colleague in Wales suggested staying in the UK in a consultant job. The job was offered during the very first interview, so I became a Consultant ENT surgeon at 36, one of 350 such positions in the UK in 1970. I embarked upon changing the 'backwater image' of the North Riding Infirmary ENT department of 1970. With the help of my senior colleague Martin Horowitz, we became a centre for higher surgical training. The NHS did not have the money to buy the laser – I did not stop there; I raised it by public appeal. I can go on and on – but I won't. Failures or disappointments should be considered to be building blocks towards a brighter future and steering it to happen within reason. I did, without exemption, without regrets.

I hope you enjoyed reading my memoirs as much as I enjoyed living them. To put it all in a nutshell, I ... did it my way!

Au revoir my friends!

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Russia-Ukraine Conflict - Médecins Sans Frontières

As I was nearing the completion of this biography, the Russia-Ukraine conflict started and soon took an ugly turn. Unlike most readers of this book, the conflict is close to home for me.

Soon after the collapse of the Soviet Union in 1991, I received an invitation from The Head of the St Petersburg ENT department, Marius Plouznikov, whom I had met briefly during the EUFOS conference in Naples. He wanted me to Chair the International Conference of Young Otolaryngologists in St. Petersburg, lead a 'Jury' committee and award the trainee presentations with various prizes consisting of all-paid two weeks attachments to several ENT departments in Europe and the USA.

After the award ceremony, an afternoon was set for me to analyse their presentation and show them how to improve. The trainees mostly came from the 'old' Soviet countries: Ukraine, Belarus, Chechnya, Uzbekistan, Kyrgyzstan, Azerbaijan, Latvia, Lithuania, Estonia, Georgia, and many other countries from the east USSR. Their English was poor, their slides were hardly legible, and some had learned the presentation by heart. I could see their attentiveness to my talk and how they were delightfully surprised at my accessible communication with them without any ego of seniority - they were probably not used to these ways from their chiefs.

A two-yearly visit continued for many years. Their presentations improved to an international standard.

Marius honoured me with a gold medal. When he passed away, a young man met me at the airport – my trainee, Sergei Karpischenko, now head of the ENT in St Petersburg. At my invitation, Sergei visited the Deenanath Mangeshkar Hospital in Pune. Bridges were being built.

(Left) Marius (centre) with Members of the Jury. (Right) The trainees with their awards

The future is bleak. Will we go back to the life of the cold war or worse? The present conflict may create another Berlin wall and end our liaison. Medicine has no borders - Médecins Sans Frontières.

Section V covers this topic in detail.

The launch of the Autobiography during the Annual British Medical Laser Association Conference, Edinburgh, Scotland 25th May 2022

The launch of the 'Globe Trotting and 62 Years in ENT' took place during the welcome reception of the delegates gathered in Edinburgh for the 39th Annual Conference of the British Medical Laser Association. Befittingly, the function was held in an academic surrounding of Surgeons' Quarters at the Royal College of Surgeons of Edinburgh, founded in 1505! The room capacity soon overflew, and many were disappointed to miss this grand occasion, once in a lifetime for anybody. The current President Vishal Madan from Manchester did the honours and launched the book with Nirmal and Vasant looking over. The lucky ones soon grabbed a few print copies, with Vasant having to script his autograph. Vishal had ten questions about Vasant's 'Life and Times'. Although the time allocated was a quarter of an hour, the event stretched to well over an hour, understandably, to cover the long span of Vasant's career. The questions ranged from his medical training in 1955 to as recent as March 2022, when he received a Life Achievement Award during the 2022 New York Laser Conference hosted by the European Medical Laser Association. The flyers with a QR code to order a copy were soon gone; such was the enthusiasm of the delegates to know more about Vasant's illustrious long career.

Vishal Madan, the President of the British Medical Laser Association, Vasant and Nirmal Oswal (left to right)

Can I borrow your wig just for the photo-op?

BMLA Executive Council (2022)
Front row: Samira Syed, Reem Hanna, Harry Moseley, Vasant Oswal, Vishal Madan, Kerry Belba, Kathy Fan (left to right)
Back row: Jon Exley, Kerry Muggeson, Tom Lister, Stan batchelor Sanjay Rajpara, Raman Bhutani (left to right)

Online resource

1. The British Medical Laser Association Blog

The BMLA website blog (https://bmla.co.uk/category/blog/) focuses on Vasant's pioneering contribution to laser technology in 1982.

Meet the world authority in lasers in ENT and a pioneer in laser surgery: Vasant Oswal, MB, MS, FRCS (Eng.), FRCS (Ed), DLO, DORL

At 87 years young and allegedly retired in 1995 as a consultant, he is Vice President and Chairman of the Education Committee of the British Medical Laser Association, Secretary-General of the European Laser Association and has recently authored an autobiography. As recently as March 2022, The European Medical Laser Association awarded him the prestigious **'LIFE ACHIEVEMENT AWARD'** during the New York 2022 Laser Meeting for his contribution to Lasers in Medicine. We caught up with Vasant ahead of the 39th BMLA Annual Conference, which took place on 25 – 27 May 2022, at the Royal College of Surgeons in Edinburgh, to ask him questions about his life and career.

The interview is in two parts:
In part one, we find out more about Vasant and an insight into his career highlights spanning over long 62 years, what he is most proud of and the biggest changes he has seen in lasers in his lifetime.
In part two we videoed an in-person interview with Vasant during the conference.

2. YouTube Video on CO_2 Laser in ENT in 1982

Laser technology in Ent in 1982, Pioneering work of Mr Vasant Oswal, UK: Viewer discretion is advised.

The YouTube video (https://www.youtube.com/watch?v=cCBTLWo2DJM) consists of the original 1982 recording of the Bench experiments to understand the laser action on biological tissue models such as the steak and the egg white. It also shows the devastating effects of laser action should it strike the plastic and the rubber anaesthetic tube and the bespoke design of the fireproof Oswal-Hunton Flexometallic anaesthetic tube. The surgical part shows the earliest use of laser for tongue cancer and various lesions affecting the larynx - viewer discretion is advised.

3. YouTube Video on Team Management of Cancer of Larynx

Team approach for cancer of larynx : A 1972 award winning concept by Mr Oswal.

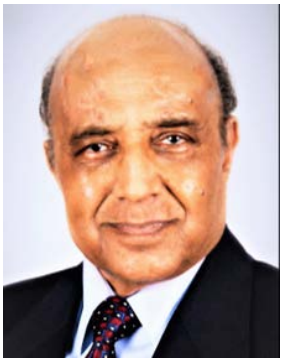
The original 1972 tape-slide programme is converted to the YouTube video format (https://www.youtube.com/watch?v=ACXqpMpBZsA). It describes the setup of the Head and Neck Service and Rehabilitation of the laryngectomy patients by a team of the medics, the nurses, the therapists and the Government-run rehabilitation centre. The 'team' concept evolved into the Multi-Disciplinary Team (MDT) approach, established in most disciplines. The tape-slide presentation received an award for the best entry in the world at The Centennial Conference on Laryngeal Cancer held in Toronto, Canada, to mark 100 years since Billroth performed the first laryngectomy in 1874 for tuberculosis of the larynx.

4. CO_2 Laser Physics

CO_2 Laser Physics on the Asia Pacific Laryngology Association website

The website of the Asia Pacific Laryngology Association is an open-access resource. Click on the URL https://www.aplassoc.com/ to access it. On the e-learning tab, register by entering your eID and self-generated password. Your eID will not be used for commercial purposes. Then click on login; it will open the e-learning portal. Click on Laser Physics to access 'The laser physics'. The graphic slides and the text explain all aspects of laser physics, including safety and the rationale for its clinical use. The site also contains quizzes for advanced self-learning.

Curriculum Vitae



Mr Vasant Oswal

MB, MS, FRCS (Eng.), FRCS (Ed), DLO, DORL

Mr Vasant Oswal is an Emeritus Consultant Otolaryngologist, H & N Surgeon at the James Cook University Hospital, Middlesbrough in Cleveland, England.

Mr Oswal's Current and Past Salient Positions

- Emeritus Consultant Otolaryngologist – Head and Neck Surgeon, James Cook University Hospital, Cleveland, UK.
- Fellow by Election, (FRCS, Eng.), Royal College of Surgeons of England, London, UK.
- Founder and Chair, Asia Pacific Laryngology Association Asia.
- Founder member and Honorary Vice President, British Medical Laser Association, UK.
- Founder member and Honorary Secretary General, European Laser Association, Europe.
- Founder and Chair, Education committee, British Medical Laser Association, UK.
- Founder and Faculty member, International Cleveland Laser Course, UK.
- Founder and Chair, Laryngology and Voice Association, India.
- Founder and Chair, Journal of Laryngology and Voice, India.
- Founder and Chair, Cleveland International Laser Courses, 1983-2010, UK.
- Chair, Postgraduate Jury selection board. The International Academy of Otolaryngologist and Head and Neck Surgeon, Russia.
- 'Distinguished Otolaryngologist' 'Actual Member by invitation', The International Academy of Otolaryngologist and Head and Neck Surgeon, Russia.
- Honorary Visiting Head, Deenanath Mangeshkar Hospital, Pune, India.
- Honorary Treasurer, World Federation of Laser Societies, Japan.
- Honorary Executive Council Member, International Phototherapy Association, Japan.
- Honorary Executive Council Member, International Society of Laser Surgery and Medicine. Tel Aviv, Israel.
- Honorary member, International Academy of Laser Medical Science, Florence, Italy.
- Fellow, The American Society of Laser Medicine and Surgery, USA.
- Fellow, The Royal Society of Medicine, England, UK.
- Past Faculty member, Eustachian tube laser surgery course, Geneva, Switzerland.
- Past Honorary treasurer, The British Medical Laser Association, UK.
- Past Faculty member, International Voice Care and Laser Voice Surgery Course in Paris, France.
- Past Visiting Faculty member, The International Laser Course, Mont Godinne

University, Belgium.
- Past Faculty member, Laser Surgery Course, Egypt.
- Past external examiner, University of Malay, Malaysia.
- Past President Elect, Int Soc for Endonasal Laser Surgery, Munich, Germany.
- Past Visiting Professor, Universiti Kebangsaan, Malaysia.

Medical Facilities and Orations named in the honour of Mr Vasant Oswal

- Oswal Rhinology Lab, James Cook University Hospital, Middlesbrough, Cleveland, UK.
- Vasant and Nirmal Oswal Centre, for PG Education & Training, accredited by the Royal College of Surgeons of England, at Deenanath Mangeshkar Hospital in Pune, India.
- Vasant Oswal Voice Disorder Clinic, Deenanath Mangeshkar Hospital, Pune, India.
- Vasant Oswal Oration, British Medical Laser Association, UK.
- Vasant and Nirmal Oswal Oration, International Cleveland Laser Course, UK.
- Vasant Oswal Oration, Laryngology and Voice Association, India.

Honours and awards

- 'Life Achievement award', The European Medical Laser Association at the 2022 New York, USA, Laser conference.
- 'NP Simanovskii Gold Medal', The International Academy of Otolaryngologist and Head and Neck Surgeon, Russia awarded him the prestigious 'NP Simanovskii Gold Medal in 2006, Russia.
- A Scroll, awarded at the 'Centennial Conference on Laryngeal Cancer', held in Toronto, Canada, in 1974, for the tape slide programme on Cancer of Larynx: A Team concept in the management of Cancer of Larynx - Best world presentation This concept is now ubiquitously known as Multi-Disciplinary Team established in several specialities The programme is converted into a video presentation and is on YouTube: (https://www.youtube.com/watch? v=ACXqpMpBZsA&t=23s). Toronto, Canada.
- 'Presidential Oration, India', awarded by the Indian Association of Otolaryngologists, delivered during their National Conference in 2013 in Pune, India.
- Chair, Postgraduate Jury selection board of The International Academy of Otolaryngologist and Head and Neck Surgeon, Russia.
- Honorary Member, Portuguese ORL Society, Portugal.
- Honorary Member, Rosario ORL Society, Argentina.
- Orator, Bombay Branch of ORL, India.
- Orator, Pune Branch of ORL, India.
- Entry in World Who's Who, 8th Ed, Marq Mac Dir Div, USA.
- Merit Award, Northern Regional Health Authority, UK.

Scientific Exhibits in The Anatomy & Pathology Study Centre The Royal College of Surgeons of England

Vasant Oswal conceived a novel teaching method by colouring various parts of human temporal bones showing a detailed anatomical structure of the external, middle and the inner ear. The specimens are permanently displayed in the Anatomy & Pathology Study Centre at the Royal College of Surgeons, London for teaching all future surgeons wishing to pursue a career in ENT, H&N Surgery. They are also published by Wolfe publications in 'Colour Atlas of Human Anatomy', edited by Professor McMinn and Hutchings in 1977

Scientific Inventions

- Oswal-Hunton Flexometallic fireproof Laser Anaesthetic Tubes
- Oswal Fibre Suction Cannula for Endonasal Ho: YAG Laser Surgery
- The laryngeal box: an aid to laser microlaryngeal surgery

Global Laser Training

Mr Oswal is a recognized world authority in Lasers in ENT, H & N surgery. He has taken part in courses and conferences as invited faculty in several locations across the five continents of the world.

Seventy-Seven Locations Worldwide, in Alphabetic Order

Anaheim, Agra, Ahmadabad, Amsterdam, Antwerp, Alexandria, Athens, Atlanta, Bahrain, Bangalore, Bangkok, Barcelona, Berlin, Birmingham, Brussels, Budapest, Buena Saris, Cairo, Cardiff, Chennai, Dallas, Dharan, Delhi, Edinburgh, Florence, Fort Lauderdale, Geneva, Glasgow, Hong Kong, Hull, Hyderabad, Indore, Jaipur, Kathmandu, Kota Bharu, Kuala Lumpur, Leicester, Lithuania, Lucknow, London, Los Angeles, Madrid, Manchester, Marbella, Miami, Middlesbrough, Mumbai, Munich, Naples, Newcastle, New Orleans, Nice, Orlando, Palma de Majorca, Paris, Pattaya, Porto, Prague, Pune, Rome, Rotterdam, Rosario, St. Petersburg, San Diego, San Hose, San Francisco, Salisbury, Sicily, Singapore, Sydney, Tarragona, Tokyo, Toronto, Venice, Vilnius, Washington, Zaragoza.

Major Scientific publications

Books:
Vasant Oswal authored and edited three medical books on Lasers in Otolaryngology and Head and Neck Surgery.

1. 'CO_2 Laser in Otolaryngology Head & Neck Surgery' (1988) under Wright imprint, UK.
2. 'Principles and Practice of Lasers in Otolaryngology and Head and Neck Surgery' (2002), published by Kugler of The Hague, The Netherlands.
3. 'Principles and Practice of Lasers in Otolaryngology and Head and Neck Surgery' – Second Edition (2014), published by Kugler of The Hague, The Netherlands.

Journal publications:

- Metal tube anaesthesia for ear, nose and throat carbon dioxide laser surgery. Hunton J, **Oswal** VH. Anaesthesia. 1985 Dec;40(12):1210-2.
- Anaesthetic management for carbon dioxide laser surgery in tracheobronchial lesions. Hunton J, **Oswal** VH. Anaesthesia. 1987 Nov;42(11):1222-5.
- Haemangiopericytoma of the nose and paranasal sinuses. Chawla OP, **Oswal** VH. J Laryngol Otol. 1987 Jul;101(7):729-37.
- The management of a neck mass: presenting feature of an asymptomatic head and neck primary malignancy? Barakat M, Flood LM, **Oswal** VH, Ruckley RW. Ann R Coll Surg Engl. 1987 Jul;69(4):181-4.
- Use of bronchoscopic CO2 laser in palliation of obstruction tracheobronchial malignancy. **Oswal** V, Flood LM, Ruckley RW. J Laryngol Otol. 1988 Feb;102(2):159-62
- Anaesthesia for carbon dioxide laser laryngeal surgery in infants. Anew tracheal tube. Hunton J, **Oswal** VH, Anaesthesia. 1988 May;43(5):394-6.
- Radiation therapy of laryngeal cancer: a twenty-year experience. Robson NL, **Oswal** VH, Flood LM.J Laryngol Otol. 1990 Sep;104(9):699-703.
- The laryngeal box: an aid to laser microlaryngeal surgery. Hampal S, **Oswal** VH. J Laryngol Otol. 1991 Nov;105(11):946.
- A pilot study of the holmium YAG laser in nasal turbinate and tonsil surgery. **Oswal** VH, Bingham BJ. J Clin Laser Med Surg. 1992 Jun;10(3):211-6.
- Life-size photograph transparencies: a method for the photographic detection and documentation of recovery from facial paralysis. el-Naggar M, Rice B, **Oswal** V. J Laryngol Otol. 1995 Aug;109(8):748-50.
- Endoscopic laser management of bilateral abductor palsy. **Oswal** VH, Gandhi SS Indian J Otolaryngol Head Neck Surg. 2009 Jan;61(Suppl 1):47-51.
- Role of transoral CO2 laser surgery for severe paediatric laryngomalacia. Gandhi S, **Oswal** V, Thekedar P, Mishra P., Eur Arch Otorhinolaryngol. 2011 Oct;268(10):1479-83.

Editorships

- Editor, E-Learning Programme, Asia Pacific Laryngology Association, Asia.
- Chair, Editorial Board, Journal of Laryngology & Voice, India.
- Past Editor in Chief, ENT & Audiology News, Scotland, UK, 1993-97
- Past Associate Editor, Lasers in Medical Science, 2008-2016, Europe.
- Past Member, Editorial Board, Photonics & Lasers in Medicine, Laser Therapy, Japan.
- Past Member, Editorial Board, Journal of Phototherapy, Japan.

Guest Faculty

- Laser Florence, Florence, Italy
- International Workshop on Laser Voice Surgery and Care, Paris, France
- International Workshop on CO_2 Laser Surgery in ENT, Laser ENT Microsurgery, Belgium
- Workshop of National Indian Association of Lasers in Surgery and Medicine, Indore, India
- Workshop of Lasers in ENT, Deenanath Mangeshkar Hospital, Pune, India.
- Workshop on Endonasal Laser Surgery, Sicily.
- Workshop, Lasers in ENT, Kuala Lumpur, Malaysia.
- Workshop, Lasers in ENT, Oporto, Portugal.

Guidelines for Laser Courses

Mr Oswal established guidelines for educational approval of Laser courses by the British Medical Laser Association. These guidelines were subsequently adopted by the European Laser Association.

Training courses and International Faculty of laser Experts

Mr Oswal established training courses and international faculty of laser experts in Otolaryngology and conducted Laser Courses in Argentina, Belgium, India, Italy, France, Germany, Malaysia, Portugal, Russia, Spain, Switzerland, etc. and helped to establish their own courses.

Membership of Learned Bodies

- Royal Society of Medicine, UK.
- British Assn of Otolaryngologists, UK.
- British Med Laser Assn, UK.
- European Laser Assn, Europe.
- North of England Assn of Otolaryngologists, UK.
- Assn of Otolaryngologists of India, India.

Past Appointments

- Chairman and Head, Department of Otolaryngology H&N Surgery, North Riding Infirmary, Middlesbrough, UK.
- Liaison Consultant, Northern Regional Health Authority, UK.
- Trainer, Overseas Doctors Training Scheme, UK.
- Trainer, Doctors on Scholarship for Higher Surgical Training, Malaysia.
- Council Member, British Medical Laser Association, UK.
- Chairman, Ed Sub-Com, University of Newcastle, UK.
- Member, Council of the North of England Society of Otolaryngologist, UK.
- Member, Senior Reg/Reg Appt Com Northern Regional Health Authority, Newcastle, UK.
- Representative, PG Dean, Joint Appt Com, Tayside H Board, Scotland, UK.
- Chairman, Med Staff Com, North Riding Infirmary, Middlesbrough, UK.
- Ext Examiner, MS (ENT) UKM, Kuala Lumpur, Malaysia.
- Trainer, Higher Surgical Training, RCS, UK.
- Member, UK Co-Ord Com Cancer Research, UK.
- Regional Consultant. Dept of Social Security, UK.

Special thanks

Liam Flood

This biography will not be complete without a word or two about special people whose help has been a pillar of strength for the two long years it took to complete this work.

Liam Flood has been my close consultant colleague since the day he was appointed to our department in 1985. His evermore cheerful personality was a source of comfort to many of his patients and colleagues. But he has one gift that stands well above anything else: his ability to edit, spot errors, suggest alternative wording, correct chronological errors – the list goes on. Even in my determination not to be beaten by him and check the work a few more times, he would still insert a correction or two, much to my annoyance with myself to have missed them! Perfection remained elusive; my good luck to have eagle-eyed Liam. So, as we wrap up this work, I am looking forward to taking a bit of a break and enjoying the summer of 2022, free from him scoring on me.

My sincere thanks, Liam, for all the patience you have to endure with the constant barrage of emails with attachments!

ENT & Audiology News

The magazine's concept that encompasses medical and trade updates has deep connotations. In the past sixty-odd years of my ENT life, the main driver of the progress in these dark cavities has been the technological advances of that era. *ENT and Audiology News* provided the readers with a one-stop resource of the clinical side and the innovations, updated every two months. It is small wonder then that the magazine acquired a large readership in some fifty (now it's 150) countries worldwide. I have been fortunate to be part of that process at its launch. As I write this memoir, the history takes me back to those heady days when Rosaleen and I worked in tandem, she gave me an insight into the commercial world, and I briefed her on the professional issues of the day. Together, we spent four long years developing the magazine by exchanging new ideas and topics, fine-tuning them and including them in the subsequent issues. What came out is the subtle blend, a valuable resource. The profession owes enormous gratitude to the publishers and the team for conceptualising the magazine. But my day-to-day interaction was with enthusiastic Rosaleen Shine. So, Rosaleen, thank you for the beautiful memories of those voyages to make the magazine such a success. And thank you also for providing an overview of the memoir with some valuable suggestions.

Kugler Publications

My association with Peter Bakker and later his son Simon at Kugler Publications started with the first publication of '*Principles and Practice of Lasers in Otolaryngology and H&N Surgery*' way back in 2002, three years in the making. Its success led to the second edition being published in 2014. When it came to deciding the publisher for my memoir, who could qualify more than the team I have known for the past twenty years? So, thank you Peter and Simon, for undertaking the publication of the two editions on the Lasers and now, my memoirs.

And finally, Nirmal Oswal

Thank you, Nirmal, for being there, always.

This is a remarkable tale, the life and times of a truly larger-than-life character. From his humble origins in 1930s India and his entry into medical training, we see a move to the UK for higher surgical training leading to an appointment as a consultant ENT surgeon in Middlesbrough. Amongst many career highlights, his temporal bone dissections in the Anatomy and Pathology Resource Centre of the RCS Eng. continue to help many generations of ENT trainees.

He established, de novo, a local head and neck cancer service, now known as Multi-disciplinary Team (MDT). He introduced one of the first surgical lasers into UK ENT practice. His literary output is enormous, with three books on Lasers. Since "retirement," he and his wife Nirmal travelled worldwide to teach. He founded the Asia Pacific Laryngology Association. He helped create a not-for-profit 1000 bedded hospital for a lower and middle-income group of patients in his hometown of Pune, work accredited by our RCS.

Liam M. Flood
FRCS, FRCSI

British Medical Laser Association

ENT& audiology news

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