Ken Lindsay, immediate Past President of the EANS and current Chairman of JRAAC, spoke to Susie Hide on 2nd September 2010

SH: Do you have a medical family background?
KWL: Not at all. My father was an accountant who later became a company director

SH: What made you decide to go into medicine?
KWL: As a boy, I always wanted to go into medicine – or more particularly surgery. I used to enjoy making all sorts of models, and when I saw TV programmes featuring surgery, I knew that this was what I wanted to do.

SH: And into Neurosurgery?
KWL: In 1970 I was doing a house job in general medicine in Glasgow, probably intending to specialise in general surgery. The use of an echo-encephalogram (A-scan ultrasound) machine had been shown to us during my neurosurgical teaching when we were students, and I knew that there was one at the back of a cupboard in the hospital, though it was never used. One afternoon, I remembered about the machine, brought it out and tried it on a patient who had had a stroke. The results appeared to show midline shift, and I spoke to my registrar, who first confirmed this and then telephoned the consultant neurosurgeon, who subsequently took the patient to theatre and removed a chronic subdural. I suppose it was this that stimulated my interest in neurosurgery.

I had always felt that a good background in physiology was vital, whichever surgical specialty I chose to follow, and I therefore decided to do a three year PhD in neurophysiology. Following this, I gained an interdisciplinary research fellowship, which enabled me both to continue with neurophysiology, and to start my training in neurosurgery.

SH: Which area did you specialise in, and why?
KWL: My special area of interest was vascular surgery, specifically aneurysms (another colleague in the unit dealt with all the AVMs) and even more specifically, posterior circulation aneurysms. Of course there have been significant changes in this area over the last ten years, with most patients now going to the radiologists for coiling. My other area of particular interest was surgery for epilepsy.
My first consultant job was in London (the Royal Free). When I returned to Glasgow in 1988 I took over from Sam Galbraith who had gone into politics. His interests were in these topics – one reason which encouraged me to apply for his post.

SH: What qualities do you feel that a good neurosurgeon should have?
KWL: Patience, determination, and an "obsessive" quality which demands perfection (some might call this fussiness!)

SH: Do you have -any neurosurgical "heroes"?
KWL: During my training I didn't spend anytime abroad doing a fellowship e.g. with Yasargil – I'm Glasgow born and bred, and always intended to train in Glasgow. I was incredibly lucky to find myself in an excellent unit at the start of my training (*Ken started his neurosurgical training in Glasgow in 1975/76, immediately after the publication of the first paper on the Glasgow Coma Scale in 1974*) – and whilst it is the academics, Bryan Jennett and Graham Teasdale, whose names are widely known, the other neurosurgeons within the unit – Alistair Paterson, John Turner and Rab Hide – also had a huge influence on me. These are my neurosurgical "heroes" – all my trainers in Glasgow.

SH: To what extent did you involve the patient and their family in the decision making process?
KWL: I believe that it is critically important to try to explain as much as possible to the patient – at a level that they can understand, which will obviously depend on the particular patient. I also made sure to involve the family in discussions before carrying out any intracranial procedure. When one of my trainees was conducting a procedure him/herself, I was happy for him/her to discuss this with the patient, but when I was operating, I always spoke directly to the patient. I feel that the best way to avoid litigation – an issue which is an increasing concern – is to ensure that one has discussed things as fully as possible, and at an appropriate level, with the patient and family.

SH: How and why did you become involved with the EANS?
KWL: One of my colleagues in the unit in Glasgow was a member of the S.A.C. *(the UK Specialists' Advisory Committee, which supervises specialist training in the UK)* and was instrumental in my being appointed to this committee, of which I later became chairman. When the position of UK delegate to the EANS Training Committee became vacant, I suppose that I was the obvious candidate – Glenn Neil Dwyer asked me if I would participate; I agreed, and things just developed from there…..

SH: What do you believe to be the role of the EANS? And what do you feel should be its objectives over the next few years?
KWL: I think that the EANS has already fulfilled, and continues to fulfil, its original objective of promoting the exchange of ideas and matters of academic interest between neurosurgeons in different European countries, through the European Congresses, Annual Meetings, and particularly the EANS Training Courses.

Looking to the future, however, I think that there will be a need for the EANS to become increasingly involved in the political arena, probably by strengthening its links with the UEMS Section *(the body with statutory responsibility, devolved from Brussels, for standards and training).* We also need to ensure that the EANS acts as an "umbrella" organisation for all the fast developing neurosurgical subspecialties…. I think that the recent decision by the EANS Executive Committee to form specialist Sections is a wise one.

SH: How do you think neurosurgery will develop over the next ten or twenty years?
KWL: There are a number of areas where things will inevitably change. Endovascular techniques will continue to develop, taking more of these cases from the neurosurgeons to the neuroradiologists. I also think that neuromodulation techniques will develop further – these stimulation techniques are much more attractive than the older methods, where tissue is destroyed.
Whilst radiosurgeons will continue to take over the treatment of some tumours, I feel that there will always be a need for surgery, especially in respect of benign, non infiltrative tumours. During the past few years, we have seen a number of spinal procedures shift from orthopaedic surgeons to neurosurgeons – both here in the UK and in the rest of Europe. There is undoubtedly, however, a possibility that "Spinal" surgery will develop as a speciality in its own right – and as a neurosurgeon, I would counsel against this.

SH: How do you choose to spend your spare time? Are you enjoying retirement – or do you miss the hospital? Even now that you are retired, are you still involved in neurosurgical activities?
KWL: When I was working fulltime as a neurosurgeon, I always felt it vital to retain, and to pursue, other interests. Neurosurgery was never my whole life. These other interests have

stood me in good stead in my retirement – in fact, during the past six months, I have been far too busy to miss the hospital. My "outside" interests include photography, golf and skiing. I have also spent quite some time recently working on the 5th edition of my book, "Neurology and Neurosurgery Illustrated". There are also a variety of other interests which I would like to develop in future…….. and it's great to have the time to read properly.

I am currently Chairman of JRAAC (*the Joint Residency and Accreditation Committee*) and very much enjoy having this contact with the neurosurgical world. I intend to attend most of the next few EANS Annual Meetings, through to the European Congress in Rome in 2011. But after that, who knows?

SH: And what about your own wife and family – are any of them involved in neurosurgery?
KWL: My wife, Margaret, worked as a neuro-radiographer, but has been retired for the last two or three years. *(Many of you may remember Margaret, who did sterling service helping Stephanie Garfield-Birkbeck at the EANS Training Courses).* We have two sons, neither of whom is involved in medicine – though one of them is a dentist in the army…