Washington University and the Why of Anesthesiology

This issue of Anesthesiology celebrates another pioneer department in our specialty, that at Washington University. The goal of this series is to highlight and understand how a culture of excellence in research has been instilled in a department using different approaches in markedly different settings. A year ago, Lars Eriksson described how such a culture was created among mostly physician scientists at the Karolinska Institutet in Stockholm, in an environment of socialized medicine. Now, Alex Evers and William Owens describe how this happened at Washington University, a private medical center in a competitive, fee-based system with a healthy mix of PhD and physician scientists. Many articles from the Karolinska Institutet were clearly translational, with obvious clinical application. Many articles from Washington University are more fundamental, leaving many of us to scratch our heads after reading their titles. In both cases, they reflect a vibrant research community.

I'm currently traveling to Salt Lake City for the American Board of Anesthesiology, where for a week I will question nervous young professionals (candidates, as they're termed) to determine whether they should be certified as consultant physicians in our specialty. When Dr. Evers became chairman of the department at Washington University, he created a design to be used for neckties given to visitors. I hear in those Zs a powerful engine of scientific advance, not a boring academic exercise.

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As one of the basic scientists who prepared a review article for this issue said to me, “Before I started writing, I looked through a few issues of your journal. It’s amazing how strong the contrast is between practical information and pretty basic research.” In the past few years we have expanded and will continue to expand content that can immediately guide clinical practice and serve as practical review for clinicians. And we will continue to apply innovations to better translate the importance of basic science work to the busy clinician. But this tension will remain, and we will not stop publishing important, definitive fundamental science that advances our understanding.

I will end with a thank you and an apology. Thank you to Alex Evers and his faculty, who submitted many manuscripts in all sections of the Journal that provide a clear view of one outstanding research environment. My apology is to the physician scientists who authored many of these manuscripts if my comments above suggest I hold them (and me as a physician scientist) as lesser scientists than those with a PhD degree. Nothing could be farther from the truth. I believe physician scientists uniquely combine both worlds, leading to generation of meaningful questions and solutions to our patients’ problems. Finally, like the candidates, let’s all strive to push back the point where we honestly have to say, “I don’t know!”

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References
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ANESTHESIOLOGY REFLECTIONS

Hart’s Chloroform Analgesia by “Reynolds Obstetrical Inhaler”

According to Lawrence M. Hart, D.O., of Seattle, “no more chloroform” should be added to the “Reynolds Obstetrical inhaler than will be absorbed by the gauze, otherwise a drop of the anesthetic may flow into the patient’s nostril and cause serious discomfort.” With ether or particularly chloroform, obstetrical use of this rabbit-ear-like nasal inhaler (above) peaked between 1910 and 1920. According to Washington osteopath Hart, late in the first stage or early in her second stage, a laboring mother-to-be should be prompted to “place the instrument to her nostrils at the beginning of each pain and to inhale as long as the pain lasts.” Dr. Hart considered this analgesic safe for the parturient because “the inhaler will drop from her hand at the beginning of narcosis.” (Copyright © the American Society of Anesthesiologists, Inc. This image also appears in the Anesthesiology Reflections online collection available at www.anesthesiology.org.)

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