A Wide-angle View of Anesthesiology:

Emory A. Ravenstine Memorial Lecture

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Emory A. Ravenstine was a man I knew reasonably well. I often think of him for reasons additional to the attributes and contributions listed in your program. In the 1930's he accepted what must have been the most formidable position extant, that of organizing a department of anesthesia in one of the largest hospitals in the world—The Bellevue Hospital. Few would be willing to tackle such a task today even after 40 years of development.

The stories Roy told of those days were beyond imagination, but any of you can share in them by talking with Perry Volpitt, who was Roy's first instructor, and John Adriani or Stu Cullen, who were among Roy's earliest residents. In spite of the awesome service obligations, he developed a program in the 1940's that was one of the country's outstanding residencies.

I am honored to be asked to speak in his memory.

With your permission, I would like to inspect the progress of anesthesiology from its beginnings in the middle 1800's to its present position. At that point, I would like to pause and look at what is happening to medical practice and medical education. The position I have held for the past seven years has given me a particularly good vantage point from which to make that inspection. Finally, I would like to look ahead and speculate as to what I see as future problems for anesthesiology. Since I've never yet planned ahead or speculated about anything that resulted in total approval, I doubt that this audience will change my batting average. Nonetheless, if what is said stimulates thought and suggests resolutions to problems, then my purpose is fulfilled.

It has always puzzled me that the discovery of anesthesia eluded a host of brilliant minds when all of the ingredients were at hand. Physicians as well as scientists rubbed elbows with anesthesia but failed to recognize what was in their grasp. Even the minds of the medical professors of the time weren't attuned to what was in front of them. Vandyck has pointed out that acute pain was not common in those days and that the clinical application of anesthesia therefore was obscure. Obviously this must have been the explanation in the case of general practitioner Crawford Long, who didn't think enough of his first application to write or speak of it for several years. But what of the learned societies and groups of physicians around the world that are alleged to have met periodically for discussion? Strange! It remained for dentists needing a painless method of extracting teeth thus to apply patented dental appliances to make the discovery. Today, perhaps, the search by Wells and Morton would be called project-oriented; others might more cynically call it profit-oriented, since the dentist with a painless method of extraction should attract more patients and also apply more of his own patented appliances. Emphasis is added to such cynical analysis by the early attempts to patent ether as well. Two conclusions arise from study of that period: first, communication among physicians and scientists wasn't very good, and second, a goal-oriented approach, with monetary profit expected, proved successful.

The remainder of the 19th century was a period of relative anesthetic quiescence. Ether remained dominant in this country. Because of the built-in safety features of driving rather than suppressing respiration and supporting the circulation rather than depressing it, particular expertise in administration of anesthetics was not envisioned as a requirement for being an anesthetist. Also, during this era, the surgical procedures being performed required little more than unconsciousness and immobility. Nor was the occasional death during anesthesia of great moment, because death associated with or following operation was commonplace. Surgery, however, was making progress, particularly in control of sepsis and in technique. Nowhere are the progresses of anesthesia and surgery so vividly compared and contrasted as in Thomas Eakins' two powerful portraits, the Gross Clinic, painted in 1875, and the Agnew Clinic, commissioned in 1889. The open-drop anesthetic techniques are the same, the anesthetist in one

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a urologist and in the other an intern, while technique in surgery has appreciably advanced.

Not only did the complexity of the operation not demand specialists in anesthesia, neither did the volume of surgical procedures justify specialization. The minds of most surgeons were occupied elsewhere; only an isolated voice or two was heard about the need for someone trained in anesthiesia at the head of the table. Few, if any, thought physicians were needed, but only someone accustomed to giving anesthetics. The nurse was asked to fill that void near the end of the century. One could perhaps characterize the period as one of lack of advancement, failure of demonstration of need for specialization, and failure of surgeons to appreciate the future of their own specialty, thus comprehend the need for anesthesiologists.

The third period in our development, as I see it, began in the early years of the 20th century. Admittedly, the boundaries of my periods are fuzzy and the periods overlap. Surgical procedures were becoming more complicated and were invading the body cavities with some regularity. All must not have been well, with the relatively inexperienced administering anesthetics, and presumably even the training of nurse anesthetists of the period lacked structure or depth. In 1901, John B. Murphy, the famous Chicago surgeon, was to write:

As to the future of anesthetization instead of present haphazard methods of administering anesthetics, proper methods will be taught by those competent to teach, not by any means the surgeon. He is not an anesthetist, but a surgeon. To follow his teaching in this subject would certainly be decidedly bad for the patient in many instances. More thought will be given to the selection and administration of anesthetics and no patient’s life will be jeopardized by the use of one anesthetic when danger might be avoided by the proper selection of another.

The hospital only can lay the foundation for the skilled anesthetist as it does for the surgeon. The anesthetist will not be considered a mere satellite of the surgeon, but recognized as one of a distinct class. There will be an incentive to men to give their best energies to the perfection of anesthetics, the old cry for a safer anesthetic will become a thing of the past, anesthetics used will not so often be blamed for results which are really due to their abuse—then there will be a supply of skilled anesthetists throughout this country sufficient to meet the demand.

The matter of the anesthetist’s fee has always given trouble and hindered the development of the specialty. There is but one way of deciding this part of the question and that is to have the anesthetist’s account rendered directly to the patient and not to the surgeon.

I find such a strong statement from Surgeon Murphy fascinating, considering the fact he was a Professor of Surgery at Northwestern University when he wrote it, and later Chairman of Surgery. Yet progress in Anesthesia at Northwestern moved at a pace quite different from what one would suspect from such words of support. None of the succeeding chairmen until the present incumbent gave much support for anesthesia; in fact, one chairman publicly degraded it as a specialty for physicians. Sixty-five years were to pass after Murphy’s statement before anesthesia was to be recognized as an academic discipline rather than a hospital service activity and be granted departmental status at Northwestern.

There is little question that in the early 1900’s surgeons set the pace so far as the future of anesthesia in academia was concerned. In 1908, interns and junior surgeons administered anesthesia at the University of Pennsylvania until Senior Surgeon White went to the Mayo Clinic for an operation. He was so impressed with the anesthesia given him by a nurse that he returned to Philadelphia and instituted nurse anesthesia. Nurses continued to provide all anesthesia there until 1938, when a surgeon of vision, I. S. Ravdin, insisted on a Section of Anesthesia directed by an anesthesiologist. On the other hand, in 1909 at Temple University, Surgeon Babcock, depressed at the death rate associated with general anesthesia given by interns—one in 500 administrations, turned to spinal anesthesia given by the surgeons, the practice to continue for the duration of Babcock’s tenure.

Outside of academia some physicians were recognizing the need for physician anesthetists and were effectively pleading its case. In 1905, the Long Island Society of Anesthetists, precursor of the American Society of Anesthesiologists, was formed. F. H. McMechan arranged publication of the American Journal of Surgery Quarterly Supplement of Anesthesia & Analgesia in 1914, and several years later, the Yearbook of Anesthesia & Analgesia, to be followed in 1922 by Current Researches in Anesthesia and Analgesia. E. I. McKesson, another Ohioan, devised anesthetic apparatus, wrote extensively on the subject of anesthesia, and was influential in the lives of physicians who became anesthesiologists. It is interesting that the Mayo Clinic opted to appoint John Lundy director of anesthesia in the early 1930’s when its nurse anesthesia program had been so successful, but I’m told that John accidentally met Will Mayo in Seattle and persuaded Dr. Mayo to hire him. At the University of Wisconsin, surgeon E. R. Schmidt happened to meet Ralph Waters because of Water’s interest in the pharmacologists at Madison, and was so impressed with him that he asked Waters to come to Wisconsin and form a Section of Anesthesia in 1926. There is
little question that these two appointments accelerated the growth of the specialty. Considering what was happening to the expanding horizons of surgeons in the 1915 to 1930 period, it is surprising that the growth of anesthesia was not encouraged more vigorously by the surgeons, but, as Long put it in 1915, "If the administration of anesthesia were not looked upon as a trivial matter by the majority of surgeons and hospitals, and if the expert anesthetist were accorded the same recognition as a consultant, as were men in other specialties, there would be no anesthesia problem for solution."

From my point of view, the fourth period in anesthesia in this country began with the appointments of Waters and Lundy. These two men systematically taught good anesthetic techniques, challenged the intellects of young physicians, and trained a new breed of specialists, who spread around the country to start their own teaching programs beginning in the mid-30's. Shortly thereafter, World War II broke out and the need for both physician and nurse anesthetists in the services escalated appreciably. Nurse anesthetists provided the principal anesthetic needs of the civilian population. As their technical skill improved with experience, many surgeons were loath to switch to physicians, since some were of lesser technical experience, nor were they pleased with the prospect of another specialist in the operating room sharing responsibility for patient care, so the "Captain of the Ship" controversy surfaced. The end of the War released into civilian life hundreds of physicians and nurses variably trained in anesthesia. The supply of anesthetists in civilian hospitals increased markedly, the demand for training in anesthesiology burgeoned and, as Betcher has pointed out, the number of training programs quintupled in four years. Many physicians exposed to anesthesia in the service for the first time realized the opportunities, recognized the need for basic knowledge in the field, and joined the academic movement.

At this time more than a few hospital administrators looked upon nurse anesthetists as a source of inexpensive service, the income from which helped to defray the expenses of other areas of hospital care that did not pay. They were not enthusiastic to see physicians move in with higher salary demands or desire to generate income for development of new departments. The resulting conflict had three effects. It led to a concerted move by organized anesthesia for "fee for service," it caused many hospitals to resist the move toward anesthesiologists and it alienated nurse anesthetists and physician specialists. Given surgeons unconvinced of the need for anesthesiologists and hospital administrators openly opposed to anesthesiologists, the young specialty faced an uphill battle. Nor were things peaceful in academia. Most medical faculties saw little evidence that anesthesiology was an independent discipline and were reluctant to create autonomous departments or give faculty appointments of stature equal to those in surgery, medicine or the basic sciences. Many anesthesiologists didn't help the situation by their demands of establishment of equality by fiat rather than by demonstration of equality by knowledge or practice. The non-medical faculty of universities watched these goings on with amusement; they considered medical schools to be trade schools and didn't understand what anesthesia had to offer anyway—a condition that continues to exist in too many universities today.

Nonetheless, the period between 1930 and the mid-1960's can be characterized as one of growth, ending in the unmistakable signs of maturation. By 1965 a high point had been reached in numbers of training programs, and in fact these were diminishing in number as the standards were elevated and some weak programs deleted. Recognition as a discrete specialty was assured by the fact that nearly every hospital and medical school had an autonomous department and anesthesiologists had appropriate faculty status. Neither powerful surgeons nor hospital administrators could any longer obstruct the specialty; in fact, in many locations they became strong supporters of anesthesia. The sphere of influence of anesthesiologists had broadened; instead of confinement to the technical aspects of administering anesthetics, they were now active in recovery rooms, intensive care units, pre- and postoperative care, outpatient clinics, and pain clinics. Areas of special interest had appeared, and some confined their activities to pediatric, obstetric, cardiothoracic or neurological anesthesia.

Numerous national organizations with large memberships gave effective forums for education, clinical standards, publications, and voice on the medical as well as governmental scene. The American Board of Anesthesiology had established itself as a leader among certifying bodies, and anesthesiologists commonly appeared in prominent positions in the medical and educational world. Many departments of anesthesiology had developed strong research units, the output from which was accepted without question by peers. By the end of the 1960's, anesthesia was well into a period of stability and comfortable acceptance by all.

Since becoming a medical school Dean, I've become acutely aware of some of the trials and struggles of other specialties as they seek to establish or retain their
own places in the sun. I’ve lived through most of the period of growth just described and, in fact, was intimately involved with most of it. Many of us acted as if anesthesia alone was the discipline trying to gain recognition, so we never paused to realize what might be going on in other peoples’ houses. There are a lot of other specialties and subspecialties today that are not stable and are just as uneasy as we used to be. Protection of territorial rights is the order of the day. One could point to a surprisingly large list of problem areas. As examples: the attempt of oral surgery to be recognized. Try sometime to get a plastic surgeon, an oto-laryngologist and an oral surgeon to define their own specialties and compared with those of the others. Listen to the growing pains of physical medicine; it sounds like anesthesia 30 years ago, with difficulty in recruitment of high-quality trainees, conflicts with other specialists, and even indulging in the mistakes some of us made in trying to gain recognition by fiat rather than by demonstrated ability. Remembering the pleadings for promotion of some anesthesiologists with skimpy curriculum vitae and bibliographies, I find old experiences recalled as I hear many psychiatrists explaining why they should be promoted with fragile evidence of scholarly activity. Even among the basic sciences, there are those having difficulty gaining or retaining status as a discipline.

What of the period that we are now in, which I have characterized as one of stability and recognition? It would be wrong to imply that in this period there have been no changes, or that there will not be more in the next few years. We are experiencing profound changes that can severely impact anesthesia, although not necessarily altering either stability or recognition. In recent years societal demands and federal government have forced significant changes on medicine. A few are mentioned to make the point: The first is the pressure applied on medical schools to expand their student bodies, leading to a near-doubling of the output of physicians in the past decade. This has increased the supply of American graduates going into anesthesia, and in that sense has been good for the specialty. However, on the opposite side of the coin are the constraints imposed on medical education by government, the unreliable funding provided for programs mandated, and the surfeit of physicians being graduated, all causes for alarm. Many of us do not believe that a shortage of physicians ever existed, but readily agree that there is maldistribution and that physician services are often inefficiently used. A surplus of physicians is not going to diminish the cost of health care; it will increase it, just as too many anesthesiologists will raise the cost of anesthesia. The attempts of government to dictate who can or cannot go into medicine must be viewed with alarm. If successful in medicine, why not in every other walk of life?

Not withstanding the doubled output of physicians, pressure is still being applied to increase the numbers of students and of medical schools. Proposals for new schools appear from nowhere and overnight. Some are urged by legislators who do not understand the medical educational process and are less interested in quality of physicians graduated than in quantity. Other new proposed medical schools, it may surprise you to learn, are fly-by-night money-making schemes. Several are enrolling students without having classrooms, laboratories, hospital affiliations, or libraries, or, I might add, accreditation. One such “institution” wrote and asked whether its students could use our library, and would we please send a complete list of all of our volumes. No one seems willing to challenge the impetus for more schools, more students, and more doctors. The losers in the end will be the public, in tax dollars, and patients, in the lower average quality of their physicians. Anesthesia must be conscious of what is happening, encourage its training programs to retain high standards, and resist erosion by external forces.

During the last 15 years, anesthesia in this country has had an enormous influx of foreign medical graduates; in fact, for a few years more foreign graduates than American graduates entered first-year graduate training programs in the United States. Anesthesia received a significant proportion of them. There is nothing strange in this; were I a foreign medical graduate, immigrating here, I would be likely to have opted to go into anesthesia because the opportunities have been so great. But, in my estimation, many American anesthesia programs did not provide good training for foreign doctors, often using them only as pair of hands to get the daily work done; in fact, some hospitals became completely dependent upon them.

This is in the process of changing. The laws are now revised, making it more difficult to immigrate, and a limit has been placed on the proportion of foreign medical graduates that may be in training in one institution. This will have a serious effect on some hospitals, where difficulty will be experienced in obtaining anesthetists to get the surgical work done. The result will be, in some situations, to sharply upgrade programs to attract American graduates; in others, nurse anesthetists will be substituted for resident physicians, and in still others, the case load will be redistributed to improve efficiency of utilization of anesthesiologists’ time.

The final outcome is difficult to visualize for two
other reasons. While the number of foreign medical graduates may diminish, the number of American graduates will increase over the next few years, the exact increase dependent upon governmental pressures. It is doubtful that the increase in American medical graduates will match the decrease in foreign medical graduates. The second reason is the movement by governmental agencies to control hospitals and health care activities, including building new hospitals, number of beds, location of tertiary-care surgical services, renovation of old facilities, and purchase of expensive equipment. Some small hospitals may be forced to close, finding it fiscally unfeasible to continue operation. There are likely to be many urban hospitals that will have to reduce the numbers of their beds, and institutions involved in tertiary-care surgical procedures failing to meet minimal annual limits will be forced to cease these activities. In general, federal regulations will require centralization of many medical care programs. Let me give some examples that will clarify what has been said. The National Guidelines for Health Planning released within the last three weeks by the Department of Health, Education and Welfare state, among other things:

There must be fewer than four short-term hospital beds per 1,000 population;

There should be at least 2,000 deliveries annually in any hospital in an area with 100,000 or more population;

A pediatric facility of 80 or more beds must maintain an average occupancy of at least 80 per cent;

A neonatal intensive care unit must have at least 20 beds;

At least 200 procedures must be done annually in any institution doing open-heart operations, and no new open-heart unit may be opened unless every other such unit in the service area is doing at least 350 procedures annually.

The guidelines go on and on, but I think that you can see what is meant. These regulations will have appreciable impact upon the daily activities of many anesthesiologists, may force some to relocate and others to change what they have been doing for years. At this juncture it is hard to predict the effect on numbers of anesthesiologists that may be involved. Do not take refuge in the thought that it won't happen; it has already happened! Ask any hospital director who wants to build, renovate, or order a new expensive piece of radiologic equipment.

Finally, in regard to the period we are currently in, what of the federal regulations mandating the areas of practice that medical graduates must go into? The current Health Manpower Act requires that by July 1979, 50 per cent of the graduating physicians must enter family practice, general internal medicine, or general pediatrics. It also significantly diminishes the movement of graduate physicians out of those disciplines for the three years beginning July 1978. This is a nationwide quota and is likely to remain one, although if not reached in July 1979, the quota will then revert to each medical school to meet. All of us interested in anesthesiology have wondered how much this Act would affect the recruitment of physicians into the specialty. My appraisal is that it will have only a transient effect, if that, for reasons to follow.

First, I don't believe the law will remain in effect for more than a few years. Many universities are refusing to comply with the Act because it grants the secretary of HEW the right to determine who will be admitted to medical schools and takes that right away from medical faculties. Unless all or nearly all universities comply with the Act, I don't think that it is workable. The government could, I suppose, direct that all must comply under penalty of losing total federal support, not just capitation grants, but that seems unlikely.

A second reason is that the Act is more likely to affect specialties other than anesthesiology, to wit the surgical specialties. If there are fewer surgeons in the future, there should be less demand for anesthesiologists.

A third reason is a personal prediction. I don't believe that more than 50 per cent of young physicians graduating today will be content to remain in family or general practice for the remainder of their lives. Medical knowledge is too extensive, and I cannot imagine 50 per cent of physicians being satisfied with knowing less and less about more and more. I suspect many will ultimately seek additional training in order to confine their practices to an area of medicine where they believe they can be adequately prepared and up-to-date. Many are likely to select anesthesiology. The basis for my suspicion is not germane to this presentation.

So much for the present and the immediate future. While enormous problems face medicine, I don't see these as immediate threats to anesthesiology, or as interfering with its growth as a medical discipline. In the background, however, loom questions that are worrisome, that require careful thought and deliberation, the solutions to which may well dictate the stature of anesthesiology as we move into the last decade of the century. I will pose seven questions, not in order of importance, because at this moment I have no idea of what the order should be, but they are all of paramount importance to us.
1. The education of anesthesiologists: This seems a logical place to start with the questions. The Anesthesiology Residency Review Committee and the American Board of Anesthesiology have done a creditable job of improving the standards of training in the specialty, perhaps better than have most specialties. Long before outside pressures, the number of training programs was decreased by deletion of those with unacceptable standards. But are we doing enough? Are we carefully looking inside the individual programs? Residency review committees and specialty boards can do just so much from the outside. Are the universities or corporate boards under whose jurisdiction residency programs are conducted looking equally carefully? Are we sure that the products of the programs are adequately prepared for assuming their role in patient care, integrated fully with other medical and health care services to the ultimate best advantage of the patient? Are the educational programs truly integrated with other specialty training programs and not fiefdoms serving their own purpose? A very broad question, and deliberately left so.

Monitoring the professional activities of anesthesiologists: Who continues to monitor an anesthesiologist and his/her competence once training has been completed? Who really monitors any physician once practicing? One of the complaints registered against physicians is the lack of internal monitoring of competence. But then, where is the evidence that the legal profession monitors its membership? The standards by which the press controls its releases often leaves one aghast. Nonetheless, the fact remains; because others haven’t done it doesn’t mean we shouldn’t tackle the problem. There are in excess of 6,000 physicians actively practicing today, classifying themselves as anesthesiologists, who have not passed a certifying examination. While this is only about 5 per cent of all uncertified physicians, shouldn’t it be examined? If physicians don’t become involved with this activity, then others will. I am a member of four hospital boards of trustees, and all are discussing this point. One has already appointed a board professional standards committee, and another has appointed three board members to sit with and observe the staff executive committee meetings.

3. Anesthesiologists and malpractice: The need for a resolution of this problem is obvious. I’m not sure that some of the malpractice actions haven’t been appropriate, because many litigations I’m familiar with have exposed gross negligence and incompetence— for the most part by uncertified physicians practicing anesthesia. There are two points in this matter that require more thought than the specialty as a whole has given. First is our attempt locally and nationally to provide qualified witnesses to courts. In too many litigations “expert” witnesses have been physicians who administered anesthesia only as an intern or who have practiced anesthesia the same way for 20 years, never attending a meeting or reading a journal. The second is the willingness of some among us to become an expert witness for either side just for the pecuniary gain. Anesthesia must determine and record who will speak for it in the courts. It must be prepared vigorously to defend anesthesiologists where appropriate, or appear for plaintiffs with equal force when indicated.

4. Anesthesiologists and nurse anesthetists: The divergent histories of nurses and physicians in this field have already been mentioned. The divergence is regrettable but understandable. Nonetheless, a separation of these two groups is unthinkable, and any attempt to equate a nurse anesthetist with an anesthesiologist is absurd. The expansion of knowledge and technique in anesthesia once the physicians really got into the field should be apparent to any discerning person. However, it is easy to understand how a competent nurse through years of diligent practice and study can be equated with a physician who permits him/herself to fall into a technician role, failing to participate in extra-operating-room activities and not keeping up with recent advances. It was a pleasure to me when some years ago the American Society of Anesthesiologists began overtures to the nurse anesthetists for a corroborative venture. It is unfortunate that a common understanding hasn’t been reached. I must congratulate Dr. Ament for his recent forthright statement to the nurses, and I hope a change in the attitude of their leaders results. Nurse and physician anesthetists must work together—if they don’t, the field of anesthesia will be a public laughingstock. I do not believe that every anesthetic will ever be given by anesthesiologists, so let’s not wait for the problem to go away. Nurse anesthetists are needed and are here to stay. We must work in symbiosis. Above all, anesthesiologists should not allow themselves to get “painted into a corner,” thus being forced to divorce a relationship.

5. Distribution of anesthesiologists: As stated earlier, the paramount problem of the supposed physician shortage is really maldistribution. The government’s approach to this problem is to saturate the market with primary care physicians, hoping that they will go to small communities, rural and underserved areas. I doubt this approach will work, and am sure it will
not help regional shortages in anesthesia. What plans are being laid by the specialty to cope with mal-distribution? Do some of our large urban institutions need all of the physicians they have? If we don’t come up with a solution, don’t be surprised if the government develops a formula for assignment.

6. The economics of anesthesia practice: From a position of being “poor cousins,” anesthesia has moved into the ranks of the better-paid specialties. In some instances, it would appear that incomes are becoming excessive considering relative work loads, hours worked, risks involved, and stresses and strains on the psyche. Rather than what is the service really worth, the attitude too often is, what will the market bear. Further, one senses an indifference to the costs of equipment, agents and supplies used in our daily practice. In most practices, these costs are charged by the institution, not the anesthesiologist. It is interesting to watch a private practitioner of anesthesia who purchases his/her own equipment and supplies. The manner of practice is very different. Anesthesiology, as well as all other specialties, must become more cost-conscious and develop a realistic approach to income guidelines. More time should be spent teaching the economics of practice in residency training programs.

7. Research in anesthesiology: For nearly 20 years the government pumped money into research and into training programs. Training grants have disappeared, and are unlikely to reappear. Research dollars, on the other hand, are not likely to disappear, but they are also not likely to increase. This stable state means competition for research dollars will increase; unimaginative, unrealistic and poorly or inefficiently done research will fall by the wayside. When adequate funds were available, some research done by anesthesiologists was excellent and knowledge in the specialty was vastly improved. We must find ways to continue to support research in departments of demonstrated excellence. My personal bias is that a closer union between basic science and clinical disciplines in universities provides the most likely route for success in this area. I perceive the days of the autonomous self-supporting research unit in clinical departments to be disappearing.

This concludes my list of concerns. The list is formidable and the answers are not readily available. But the problems must be kept in plain sight, on the table in front of us, for open discussion.

In my development of the history of anesthesia in this country, it was pointed out that during the period ending in approximately 1905, no one in medicine was looking to anesthesia’s future, and apparently not even the surgeons were projecting their own future, because if they had, the need for development of anesthesia would have been realized. With the next period, characterized by the first stirrings of physician interest in anesthesia, some thought of the future was applied by a few surgeons, but principally by physicians outside surgery. Academia played no appreciable part in either period, but things changed beginning with the appointments of Waters and Lundy, culminating with the seeding of training programs all over the country and an outpouring of well-trained anesthesiologists and completion of important research. Maturity has arrived, and it would appear that able leadership from both the academic faculties and the private sector is guiding the specialty well. The problems are now, however, becoming more complex, more difficult of solution, more global in character, and perhaps more consuming in time, energy and thought.

Medicine is castigated for failing to provide adequate health care for the nation, yet at the same time most accept that the caliber of the care available is excellent. As our ex-Secretary of Health, Ted Cooper has said, “How can anything that is so good, be considered to be so bad.” Should the blame be placed on physicians or on medical education? What is government’s responsibility in this alleged failure? Wasn’t the ball dropped decades ago when Washington failed to project the future of health care needs and properly plan for long range health care? It is interesting to speculate where we might be today if a president of the United States at the turn of the century had appointed a blue-ribbon task force to study health care needs for the country and propose a plan for meeting those needs. The maldistribution and inefficient use of physicians and of health care facilities would probably be different today. We cannot repeat the failures of the past periods in anesthesia, nor those of the country in health care. We must plan for our future.

With a faculty of 1,500, I’ve come to know that the most successful way to deal with complex problems is to appoint a group of thoughtful faculty members, administrators and students representing all aspects of the problem to be solved, and charge them to recommend solutions. Perhaps a president of the American Society of Anesthesiologists might find it profitable to appoint one or more advisory groups with appropriate representation from within and without the specialty to make recommendations to its Board of Directors. Such groups could consist of
anesthesiologists from both the private and academic sectors, hospital administrators, surgeons and other physicians, nurse anesthetists, attorneys, businessmen, and perhaps government or consumer representatives where appropriate. Care must be exercised to select unbiased people, avoiding those who want to protect their territorial rights. Few outside of medicine think that physicians alone can deal adequately with health care problems, because physicians have too many vested interests. Therefore, you must consider only those who can deal with the facts and recommend what is best for all.

I know the Society is dealing with several of these problems, but doubt that all are under the active and broad consideration that seems to me to be necessary. As a member of the executive committee of the National Board of Medical Examiners, I am impressed how readily that Board can call on prestigious individuals from all walks of life to advise solutions to problems and project for the future. We should be able to do this, too.

By careful selection of advisory committees, appropriate charge by the president or board of directors, and thoughtful discussion over a realistic time frame, it should be possible for the Society to deal satisfactorily with these seemingly insoluble problems. We should be able to avoid the crisis management that has become so characteristic of medicine today.

Remember: physicians want someone who will level with them, whether it be about TV sets, automobiles, stock investments, or housing. The lay public wants the same sort of information about physicians and hospitals.

Thank you for the privilege of delivering these observations on behalf of the memory of Emory A. Rovenstine.