The Anesthesiologist's View of Himself and His Specialty

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Obviously no one can, with any assurance, claim real knowledge of how several thousand people see themselves in relation to their work; any anesthesiologist is different from any other, and such abstractions as the "typical anesthesiologist" are close to meaningless. Yet there may be a certain profit in trying to generalize about some attitudes which seem to be fairly common in the specialty, and that is what I propose to do here. These attitudes seem to be held by a sizable number of anesthesiologists, at least, and seem to be important enough to have real effect upon the future development of the field.

I am required to say "seem" because there is vast quantity of research upon these matters. The investigations involved in a study reported in this journal a few years ago provided some light, as has the recent study carried out under the direction of a special committee of the American Society of Anesthesiology. I also draw, however, upon some ten years of ignorant but interested observations of anesthesiologists, including some close personal friends; some more or less systematic interviews with other members of the medical community; and doubtlessly some personal biases, hunches and intellectual idiosyncrasies. More than anything else, this is a personal essay by an interested outsider, and the occasional use of the first person singular is to remind the reader of that fact.

Any discussion of the anesthesiologist's view of himself and his specialty must begin with the observation that he almost invariably sees himself first as a physician—as a man who deals with patients, and helps sick people get well. Questions about the reasons for entering the specialty have been answered in all the studies with strong affirmation of the interest in doing something for the patient.

This is to be expected, of course, of people in all branches of medicine which have clinical application; the fact that it is expected, however, does not diminish either its force or the credit which it reflects on the whole profession. To feel that he works in a field which has genuinely high purpose should be a source of great strength to a man, and the anesthesiologists must find it so. And yet, because his involvement with patients is of an uncommon nature, this commitment also often complicates his view of his own role.

The anesthesiologist never has control of a course of treatment, from diagnosis to cure. He has a spot function, so circumscribed that he sometimes still gets that annihilating question "are you a real doctor?" He can blot out pain, maintain an airway, monitor an assortment of complex machinery. He can save life, and sometimes does so under dramatic circumstances, but primarily in unanticipated emergencies. The sense of final and complete responsibility for the process of treatment is unquestionably one of the great satisfactions of medical practice, and the anesthesiologist almost never has it. (The awe-inspiring arrogance of some internists, on the other hand, might just be related to the fact that sooner or later they lose every patient except the ones who outlive them.)

Some anesthesiologists are in the specialty, of course, precisely because of this specialized kind of patient contact. This first became clear to this writer several years ago, while conducting some interviews at a national A.S.A. meeting. Random selection procedures turned up several individuals who had begun their careers in pharmacology, or other laboratory fields, and had found these unsatisfactory because of the lack of patient contact. Several others had been in completely clinical fields and had found the intense involvement with

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patients too much to take after a time. In some ways, then, anesthesiology seems to involve just enough, but not too much, patient contact. It has been pointed out that this is true of many specialties, of course—dermatology, radiology, even ophthalmology and orthopedics, and that there are substantial numbers in these fields who find most satisfaction in limited patient contact.

Even though their work may provide just about enough patient contact for many anesthesiologists, it is not enough to secure them the unbounded respect of their colleagues in classic fields of clinical practice. Most anesthesiologists are well aware of this, and it may be set down as the second important element in the anesthesiologist’s view of his role: he feels that he works in a low-status field.

Status is not synonymous with importance; most anesthesiologists believe that their specialty is of great importance, and would not choose to be in any other field of medicine. Status describes relative relationships—and the available research clearly indicates that most anesthesiologists feel that their medical colleagues look down on them. The evidence also indicates that they are correct in this assumption.

There would be little point to reviewing, for this audience, the reasons for this attitude on the part of the rest of the profession, or to commenting on its accuracy or fairness. “The trouble with the anesthesia boys,” a professor of internal medicine said, “is that they’re over-trained for their real job, and under-trained for their pretensions.” He meant that a competent nurse can put people to sleep for surgery, and that a service-oriented two-year residency is poor preparation for research. In indicating his innocence of the present dimensions of anesthesiology, he also summarized the confluence of prejudices which accompanies the specialty; the healers see it only as a supporting service, the researchers see it as the home of people who, by going into it, demonstrated that they aren’t very research-minded in the first place.

Their deep commitment to the specialty and awareness of its relatively low status inevitably combine to produce another characteristic of many anesthesiologists: they are highly defensive, often to the point of supersensitivity.

This comment often comes from colleagues in academic medicine, in particular, and sometimes with bitterness from academic administrators.

It should be pointed out that here we begin to deal with a particular group within the specialty. Undoubtedly there are many members of the Society who have only an abstract sense of a status problem and who have no defensive psychic baggage at all. These are the members who are in private practice; whose practice is based upon referrals from their colleagues and who simply practice in a hospital setting like any other specialist. These members feel their status is reflected largely in the local medical society and in the community at large, and here they are on equal terms with any other doctor; their income may be somewhat lower than some, and their specialty a little more esoteric, but their stature is pretty much a matter of what they make it. To these members, the organized worry of some of the leadership must often seem irrelevant at best.

A rough scale of intensity on defensive attitudes would show these anesthesiologists on the bottom; those full-time on the staff of the conventional hospital somewhere in the middle; and those in the medical professoriat showing the most concern. These last are deeply involved in the pecking-order complex which runs through academia, and that order is largely related to the quantity and quality of research produced within the discipline.

The role of research, in turn, represents some rather complex attitudes. All anesthesiologists seem to agree that there is need for more good clinical research, and for more publication about its findings. Differences in attitudes center on the importance of ‘basic,’ or nonclinical research. The non-academic specialist in anesthesia seems to be little interested in it (and some of them articulately resent the space given to its reporting in the Society’s publications). The medical school anesthesiologist is the chief advocate of basic research, and its only practitioner of importance.

It is reasonable to assume that the primary reason a man does basic research is his interest in finding out things which nobody yet knows; his first drive is that of the scientist in search
of knowledge. But since this also is the man most concerned about the status of the specialty, it is also reasonable that some of his interest in basic research reflects the belief that this is the most efficient way of improving its prestige. Clinical research in medicine seems to be regarded in somewhat the same way as development work in engineering and physics; the pay-off may be in the application, both in money and popular acclaim, but it doesn’t score many points with the in-group.

Given the picture of a group committed to a profession with a high purpose but what they sense as relatively low status, given a sizable part of that group which is sensitive to this condition and highly sensitive about it, given colleagues (both researchers and clinicians) who know relatively little about the specialty’s potential and a public which knows almost nothing—given these things, you get a group burdened with a certain sense of frustration and an intense interest in self-improvement.

The drive for improvement of the specialty—in the quality of its medical care, the significance of its science, and the luster of its “image”—is another unmistakable part of the anesthesiologist’s view of himself and his work. It provides a convenient place for terminating this discussion, not because the inventory is complete, but because at this point it might be appropriate to frankly speculate about factors affecting the prospects of that improvement.

There is a close connection among the medicine, the science, and the “image” of the specialty. Perhaps most people within the specialty would agree that better medicine and better science are inextricably related; at least this seems an obvious assumption to me, as an outsider. But there seems to be considerable hope that the third part of the package can be treated separately, and that by some kind of magic the “image” can be sharply and quickly improved. This almost amounts to an American tradition, a curious and wistful confidence that the right kind of public relations man can alter almost any set of opinions. This is not true; or, at least, it is true in such small and restricted ways as to offer no real hope at all.

Since the general public has little impres-

sion of the specialty, it might be possible to increase to some extent public awareness of anesthesiology if enough money were put into the effort. Features in which anesthesiologists are heroes could be planted in newspapers and popular magazines; research papers which have dramatic implications, if stretched, can be artfully stretched; spokesmen for the Society, and the specialty, can be equipped with engaging speeches for public occasions. Keep at this long enough, hire the right agency, put enough money in it—and in time public awareness would increase. It would be a vaguely favorable awareness, too; the building of a popular image from scratch in the public mind, particularly if the public doesn’t really care very much one way or the other, is not too difficult.

I assume, however, that anesthesiologists are not really very much interested in this kind of public relations; that their primary concern is with the status of the specialty as a field of work in their own minds and in the minds of their colleagues. At this level—at the level where it matters—there is no magic unrelated to reality. Where opinions really matter, they are not subject to casual manipulation. Opinions change when things happen. Public relations men constantly point out that good public relations is not what you say, but what you do—or, to give themselves maximum credit, what you say about what you do. But the doing has to come first.

There are many case histories demonstrating this, along with countless common-sense examples. You could begin with a parade of disillusioned college presidents who, during the past thirty years, have established fancy public relations offices and instructed their tenants to convince the populace that good old Mediocre U is another Harvard. You might even include the A.M.A., which has invested heavily in professional public relations. As an outsider, I am unqualified to judge whether or not the Association has accomplished its purposes in that connection—but there is very little evidence indeed that medicine in general has increased in public prestige, and quite a lot that it has declined.

An improvement in the “image” of anesthesiology will result largely, if not entirely, from improvement of the specialty itself. This hard
fact means that it will have to be an internal process, generated within the profession and carried out by its members. This means, in turn, that the potential role of outside advisers, however specialized, well-paid, or good-hearted, will be strictly limited.

A couple of observations apparent to anyone, however, would seem to apply.

If the status of the specialty is to be improved through research, it will come about largely because anesthesiology develops a body of research which is uniquely its own. It will not come about because some of its research-minded people prove to be surprisingly good physical chemists, or physiologists, or neurologists—surprisingly good, that is, for anesthesiologists. (This writer can speak more completely about his own specialty, which has nothing whatever to do with anesthesiology, but which has some curious parallels with some of its problems. Academic journalism also has had a severe status problem; its leadership also has been concerned with improving the specialty; and more and better research has been seen by many as the best avenue. This drive has produced some surprisingly good home-made social psychologists and sociologists in journalism departments, as well as the recruiting and retreating from those fields of a few people who weren't very happy in them. But it seems increasingly apparent that real improvement in the field, both in our own minds and in our colleagues', is coming only with the development of substantial knowledge which no other academic area can provide.)

If it were possible to separate the functions of scientist and physician, one might also guess that a kind of parallel process must go on in the clinical side. Anesthesiology will grow in stature as it increasingly provides knowledge and skills which are unavailable elsewhere in the medical apparatus. As long as competent anesthesia for highly complex surgical procedures can be provided by people who are not only nonanesthesiologists, but nonphysicians, the work of necessity will have a hollow ring. Organizing a trade-union which can bring pressure to bear on the nurses back to the bed pan is, at best, irrelevant. When the time comes that certain surgical procedures, certain courses of treatment, are unthinkable without the involvement of an anesthesiologist, the status of the specialty will be on increasingly solid ground.

If this unique competence in both science and medicine does not develop, another generation of anesthesiologists may have to re-think the whole role of the specialty. They may have to learn to live with the fact that their specialty is, so to speak, engineering and not physics. If this proves to be the case, it also will be a genuine accomplishment, even if a rather melancholy one.

Meanwhile, the anesthesiologist's view of his role, and his specialty's role, is complex and in some ways ambivalent. It is compounded of a deep sense of commitment and genuine pride, conditioned by a sense of relatively low status and sensitivity about that status, fueled by a desire for improvement. Perhaps this does not sound like a description of a complacent man in a universally-honored profession, but it does sound like a specialty worth working at—and a man with a future.