EDITORIALS

Hallmarks of Maturity

Oh wad some power the giftie gie us
To see oursels as others see us! —Burns

About eight years ago one of America's prominent surgical specialists (he later became President of the American Medical Association) was drawn into an informal discussion of problems facing the specialty of anesthesiology. "You people are suffering from growing pains," he said. "Yours is a young and virile specialty, which is still lacking in maturity."

Upon being pressed to further explain this hackneyed observation he stated, "a demonstrated willingness to accept and discharge his responsibilities constitutes a hallmark of maturity in a doctor." Recently another prominent man, one of our own colleagues, was overheard to remark that within our ranks are some of the most irresponsible men in medicine.

Accurate or not, these indictments are not unique. Brand them if we will as unwarranted disparagement born of cynicism or irascibility, but ignore them we can't, because there is evidence that they have basis in fact. Rather, it behooves us to inventory our practices and behavior which in part determine our reputation.

Anesthesia was born more than a century ago, yet we admit, even lay claim, to being a young specialty. The scientific and technical advancements, the breadth of interest in both clinical and scientific medicine and the individual contributions made in the field of pain relief bespeak of maturity, yet collectively we exhibit attributes of adolescence. We administer some of the most potent drugs known and our procedures involve alterations in physiology which court sudden disaster; anesthesiology challenges the abilities of the most capable of physicians, yet the specialty is so subject to under-rating and disparagement by the uninformed that it is often difficult to convince potential trainees that it is a desirable and dignified pursuit for a physician. This has been ascribed to the fact that in America surgical anesthesia was first successfully introduced by a dentist and later entrusted largely to non-physician technicians and even today a majority of the anesthetics administered in this country are the immediate responsibility of other than doctors of medicine. However, comments similar to those quoted above suggest that we ourselves could be largely responsible for the light in which others view us. Perhaps our principal concern is not the technician, but rather those physician anesthetists who abdicate their responsibilities and relax into the role of technicians.

Probably the most important responsibility of those who administer anesthesics is to preach and practice the gospel of constant vigilance and good patient care. This requires that the anesthesiologist be fully informed in all aspects of the patient's medical history and that he conduct the anesthesia in such a way that he can apply that knowledge instantly in meeting complications should they arise. He must maintain enough contact during the postanesthetic period and convalescence to observe the effects of his ministrations.

There can be no greater sin than that of falling into a casual approach to what appears to be a routine anesthetic problem. The potent agents, refined techniques and narrow margins of safety of modern anesthesia demand skill, mental alertness and taut reflexes to avoid mortality and morbidity. Today, surgeons routinely correct defects in vital organs under circumstances which would have been unthinkable a decade ago. We use mechanical devices, intricate electronic instruments and robots to care for the patient and to measure his vital functions. There is no intent to
under-rate these aids nor decry their use, but robots are no substitute for reason, and it has never been shown that a stream of electrons can be endowed with good clinical judgment. The demands of today's anesthesia are such that anything less than continuous attention and management by an alert anesthetist may be adjudged as akin to abandonment.

Physicians in general and anesthesiologists in particular are being confronted with what is called the “malpractice menace.” Those who have occasion to review medico-legal actions are struck with an inescapable conclusion—far too many disclose some degree of carelessless or other evidence of the “casual approach.” Courts are aware that good anesthesia practice demands a careful and thoughtful preoperative evaluation, continuous attendance throughout the anesthetic and evidence of continuing interest in the patient's welfare in the postanesthesia and convalescent period. Such practices as simultaneously conducting two (or more) anestheias, inducing anesthesia and relinquishing the care of the patient to a technician, leaving an anesthetized or unconscious patient unattended for any cause are not defensible and cannot help but discredit our specialty.

Anesthesiologists are in short supply and the demand is increasing more rapidly than the supply. We often find ourselves in monopolistic positions and the temptation is great to indulge in sharp monopolistic practices. In such situations the heavier loser is apt to be the patient. Under normal circumstances we are called in as consultants by the surgeon, or at least with his consent. Any physician who serves as a consultant should be familiar with the limitations as well as the prerogatives of a consultant. The most elemental limitation is that the referring physician must have the final choice as to any course of action or treatment proposed for his patient. As a member of a team the anesthesiologist should be slow to assume dogmatic and arbitrary positions on the choice of anesthetic procedure, take unilateral actions in the cancellation of operation, be openly critical of a surgeon's actions or judgment, or otherwise compromise his consultant status. The fact that the surgeon may have little leeway in his choice of consultant in no way lessens the obligation to act within normal limitations. Since a surgical procedure is a team effort, differences of opinion should be settled jointly by members of the team. A position of monopoly makes it possible for the anesthesiologist to pursue a course of belligerent independence, but a climate of controversy cannot be expected to raise the standard of patient care and inevitably the status of the specialty will suffer.

If we accept the thesis that maturity is measured by a willingness to accept and discharge responsibilities then our mandate is clear. Our responsibilities appear as a montage of obligations to patients, to associates, to institutions, to our specialty, our profession and to our community. Our actions set the “standards of practice” for the specialty of anesthesiology. This term has various interpretations. In forensic medicine a standard is defined as that set by the common practices of the majority of a like class in a given community, and in the courts one is judged by these nebulous criteria. In the medical profession our behavior and practices are assessed less generously by colleagues, and their “standard of practice” for us is much more exacting and critical. This is the standard to which the specialty will be held, and if we are to be adjudged professionally mature then we must meticulously meet our responsibilities. In so doing we will provide better patient care and elevate anesthesiology to a new level of prestige and indispensability.

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