THE JUBILEE YEAR OF ORGANIZED ANESTHESIA

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On October 6, 1905, a group of physician-anesthetists met at Long Island College Hospital in Brooklyn at the invitation of Dr. A. F. Erdmann (fig. 1) because, as he put it, "there are a few physicians practising anesthesia in the area, and these men ought to get together and form a society" (1). Thus was born the Long Island Society of Anesthetists. Organized anesthesia in this country stems from this Society (fig. 2). No doubt there were anesthetists in other cities who met casually on a local basis but they kept no records of the event.

The Long Island Society of Anesthetists' meeting on that historic night set down in laborious long hand, in a school-boy's notebook, the purpose of the meeting and made provision for setting up a constitution. The object of the new society was "to promote the art and science of anesthesiology" (2). Eligibility was accorded any visiting or resident hospital anesthetist or any other regularly qualified physician whose particular interests centered in anesthesiology. Plans were made for a business and scientific session. A nostalgic fee of $1.00 was set for annual dues. Thus, fifty years ago, nine men led by Dr. Erdmann pioneered the formal organization of anesthesiology in the western hemisphere.

The London Society of Anesthetists was founded in 1893. The Long Island Society of Anesthetists, the forerunner of our present organization, therefore, is the second oldest anesthesia society in the world.

The records of this infant society for the next few years are unfortunately brief because, in 1911, a fire destroyed the home and records of Dr. H. A. Sanders, secretary of the Society as well as one of the original founders.

Interest in the scientific sessions and increased requests for membership from outside of Brooklyn led the Long Island Society at their meeting of May 31, 1911, to appoint a committee to enlarge the scope of membership and to present a plan for a new Constitution. Twenty-three members were present at this meeting (table 1). The last meeting of the Long Island Society of Anesthetists, at which an informal dinner was served, was held in the old building of the New York Academy of Medicine, at 40 E. 41st Street in Manhattan. The meeting was called to order by the President, Dr. Erdmann, who gave a brief history of the Society. This was the last act of the old Society; there-

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after the name was officially changed to the "New York Society of Anesthetists." In the scientific session that memorable evening, Professor Yandell Henderson of Yale spoke on the relation of the physiological chemist to the anesthetist. On that night also, Professor Max Verworn of the University of Bonn was a guest at the dinner meeting, after which everyone repaired upstairs to hear his lecture on "Narcosis" before the Harvey Society (3).

Fig. 1. Adolph Frederick Erdmann, M.D.

At the second regular meeting of the New York Society of Anesthetists on February 7, 1912, Dr. James T. Gwathmey was elected President. The new constitution gave as the object of the Society "the advancement of the science and art of anesthesia" (4). Dues were now to be $3.00 per year, already an indication of the Society's growth. Meetings were to be held in February, May and November unless other-
wise arranged by the Executive Committee. The movement began a year before to enlarge the membership began to gain momentum. The founders had set the number of charter members at fifty, and this was accomplished within a few months after the name of the Society was changed. With the accompaniment of growing pains, plans were discussed at the May 15, 1912, meeting for the formation of a national society of anesthetists. The Executive Committee was instructed to confer with the officers of the American Medical Association about forming a section on anesthesia. It was decided to hold the meeting

**Table 1**

**Members of the Long Island Society of Anesthetists (1905-1911)**

1. A. F. Erdmann*
2. H. A. Saunders*
3. L. Stock*
4. R. O. Brockway*
5. G. L. Buist*
6. A. H. Longstreet*
7. H. F. McChesney*
8. G. F. Sammis*
9. G. W. Tong*
10. James Watt
11. W. E. Woolsey
12. Emeline C. Schirmer
13. L. D. Broughton
14. H. T. Hotchkiss
15. D. S. Macnaughton
16. F. Schroeder, Jr.
17. C. H. Watson
18. Alfred Bournmann
19. J. D. Kruskal
20. E. S. Stone
21. T. B. Buchanan
22. J. E. Lombard
23. James T. Gwathmey

* Original Founders Group.
for the contemplated organization of the national society after the symposium on anesthesia to be held at the American Medical Association meeting in Atlantic City in June. One hundred and three were present at this meeting.

In the meantime other anesthesia organizations were beginning to appear on the scene (fig. 3). A group called the "American Association of Anesthetists," who had been meeting sporadically for about five or six years, became organized at the meeting of the American Medical Association in Atlantic City on June 12, 1912. They held their first meeting in Minneapolis on June 18, 1913, during the American Medical Association's next meeting.

A real zealot for the young specialty came upon the horizon in the person of Francis McMechan (fig. 4). Until his death in 1939, he was

one of the most militant figures in the history of anesthesia. He was the first to accomplish liaison between the basic sciences and clinical anesthesia. Although a charter member of both the New York Society of Anesthetists and the American Association of Anesthetists, he believed that the former group was a more or less local organization and the latter group, being limited to 100 members, could not take care of the specialty of anesthesia for the United States. He was among the group that finally got the American Association of Anesthetists to enlarge the membership to include all anesthetists who could meet the requirements. In 1915, he organized the Interstate Association of Anesthetists (Ohio and Kentucky), acting as its organizational secretary. In 1916, he became secretary of the American Association of

![Diagram of Origins of McMechan's Societies]
Anesthetists and directed their policy from then on. This association was enlarged in 1926 to become the Associated Anesthetists of United States and Canada. At the same time, the Interstate Association of Anesthetists was changed to the Mid-Western Association of Anesthetists, becoming a regional society of the Associated Anesthetists. McMeechan helped found the Canadian Society of Anesthetists (1921),

![Fig. 4. Francis Hoeffer McMeechan, M.D.](http://anesthesiology.pubs.asahq.org/pdfaccess.ashx?url=/data/journals/jasa/931677/)

which later became the Section on Anesthesia of the Canadian Medical Association. In addition, he aided the formation of the Pacific Coast Association of Anesthetists (1922), all of which became regional societies of the Associated Anesthetists of the United States and Canada.

Since manufacturers of anesthetic drugs and apparatus and other laymen interested in anesthesia were ineligible for these societies, McMeechan, with the help of McKesson, in 1919 founded the National
Anesthesia Research Society in Cleveland to include this group. In fact, for the first few years the governing board was composed of physicians and laymen; later it became exclusively professional. Realizing that the progress of the specialty was becoming international in scope, the name of the organization was changed in 1925 to the International Anesthesia Research Society. As a result of the visits McMeechan made to other countries in which the specialty of anesthesia was developing, the Board of Governors founded the International College of Anesthetists. A plan for certification of specialists in anesthesia was arranged by this group in 1936. All this came from a man on crutches since 1911, suffering the ravages and pains of a crippling arthritis (5–8).

The Eastern Society of Anesthetists was formed on September 20, 1923. Albert Miller of Providence, a student and scholar, was one of the pioneers. This Society was composed of New York and New England anesthetists who planned to work toward a closer cooperation between the surgeon and anesthetist, as well as to regulate anesthetic practice. Later, it also became one of the regional societies of the Associated Anesthetists of the United States and Canada. The American Society of Regional Anesthesia appeared in 1923. It was composed of about four physicians who limited themselves to anesthesia, all the other members being neurosurgeons. This group was formed to honor Gaston Labat, an émigré from France then living in New York. It was Labat who developed the art of local infiltration and nerve block techniques to a high degree. He resisted all efforts to have the society named after him because, he said, "it was unethical."

Meanwhile the New York Society of Anesthetists carried through faithfully its regular programs of business and scientific sessions. Prominent men throughout the country contributed to these sessions. Some of the speakers at the May 15, 1912, meeting were, for example, Arthur E. Guedel of Indianapolis and E. M. Prince of Birmingham, Alabama. Discussion was led by A. D. Bevan of Chicago, Frederick J. Cotton, Walter M. Boothby of Boston, and S. Griffith Davis of Baltimore. To this national flavor was added the interest of adjoining states. In 1913, while Joseph S. Lombard was president, some of the candidates for membership were from New Jersey, Pennsylvania, Connecticut, Massachusetts and Maryland. The membership roll increased steadily, more particularly from the other states. By 1915 there were seventy members. In this year amendments on membership were added to the constitution. In the qualifications for active members, after the phrase "legally qualified practitioners of medicine who are members of County Medical Societies" was added "or of other medical societies in good standing" (9). There was also an "associate membership" for dentists who showed special qualifications and who had an active interest in anesthesia. These two measures helped to increase membership.
By 1916 the heightened interest in this new specialty led Dr. Gwathmey (fig. 5) to suggest more frequent clinical meetings be held in addition to the regular meetings. These clinical meetings were held at various hospitals in metropolitan New York. Each meeting was held with the strictest decorum, the superintendent or chief surgeon opening the meeting and then turning the gavel over to the President of the (Anesthesia) Society.

![James T. Gwathmey, M.D.](image)

As with other specialties, when our country went to war in 1917, the New York Society of Anesthetists adopted a resolution calling the attention of the Secretary of War and the Secretary of the Navy to the importance of anesthesia and offering their services as individuals to give instruction in anesthesia and to serve. Drs. Gwathmey, Guedel, Buchanan, Munkittrick and Booth were among those who served over-
seas, organizing training centers and contributing to resuscitative measures for poison gas patients. The highlight of this year was the address delivered at the regular meeting of November 8, 1917 by Major George W. Crile who had just returned from the war front.

With World War I a matter of history, the Society settled down to consolidate its gains. Efforts were again made in 1921 to secure a Section on Anesthesia in the American Medical Association. Letters were sent to the Secretary and representatives to the committees of the American Medical Association for the next ten years without success. By 1933, attention was directed to certifying its members in order to elevate their status. A Certification Committee made its final report in December and a constitutional amendment setting up proceedings for Fellowships was adopted. Without realizing it, this move became the spur for entrance into the American Medical Association.

In 1933-34 the Advisory Board for Medical Specialities was set up by the American Medical Association. This was the result of their attempt to satisfy the lay as well as the medical public by putting a special designation after the name in the directory of those who were certified as specialists. Unfortunately only organizations who had sections in the American Medical Association were included in the Milwaukee meeting of February, 1934. The Advisory Board did agree to meet with an Anesthesia Committee, but the latter consisted of representatives from the International Anesthesia Research Society and the Associated Anesthetists. The New York Society was excluded because of its local name, although there was representation in its membership throughout the country. Nevertheless, the requirement of the Advisory Board that its component bodies come from the related sections of the American Medical Association barred any consideration for anesthesia.

T. D. Buchanan (fig. 6), of the New York Society of Anesthetists, prophetically suggested that perhaps anesthesia could qualify under the related section of surgery, and that possibly the point might be gotten around in that way. Meanwhile he urged that attempts be made to raise their own status through Fellowships granted through their own certification by the Society. The New York Society was against the practice of the International Anesthesia Research Society and the Congress of Anesthetists who granted a certificate as a specialist in anesthesia to any physician who was able to supply proof of giving anesthesia in ten cases. The Society realized that the Advisory Council of the American Medical Association was formed for the purpose of prohibiting such improper certification. In an exchange of correspondence between Buchanan of the New York Society and McMeehan of the International Anesthesia Research Society, the latter wrote that his organization was trying to get an American College of Anesthetists started, but he felt it would take about five or six years. Furthermore, McMeehan went on, he did not want any alliance with the American
Medical Association because they were against medical men specializing in anesthesia. He wanted to follow the lead of the American College of Surgeons and the American College of Physicians who had more or less disregarded the American Medical Association.

The New York Society, however, believed it was not comparable numerically to these organizations and that they did need the help of the American Medical Association. Buchanan also felt that the purpose of certification was not only personal gratification to the individual in that he had passed a formal examination, but that anesthesia would thus be recognized as a full and distinct specialty by the American Medical Association (10). The matter of sending delegates to the meeting of the Advisory Board was therefore tabled until the meeting of the Congress of Anesthetists in Boston. At this convention an
attempt could be made to smooth out the difficulties between all the anesthesia societies, and this would work to the best advantage of the whole specialty throughout the United States and Canada.

It is not meant to imply that there was friction between McMechan and his groups on the one hand and the New York Society of Anesthetists on the other. On the occasion of the twenty-fifth anniversary of the latter society, McMechan sent the following telegram, "Congratulations of a charter member on silver jubilee and hopes for a golden anniversary. Regret illness prevents attendance. Friendly remembrance to the best of friends from the McMechans" (11).

On this twenty-fifth anniversary a two-day program was planned for October 17 and 18, 1930. The first day was devoted to clinics in the morning and to a scientific session in the afternoon. At the clinic held at Mt. Sinai Hospital, New York, a cardiotachometer was first demonstrated. Some of the titles of the scientific session were intriguing, such as "The Psyche of Anesthesia," and "The Anesthetist Himself." The second day, which fell on Saturday, was highlighted by an outing to Ossining and a general meeting at the Hotel McAlpin in the evening. This program merits recording. Gwathamuy spoke on the evolution of anesthesia; Yandell Henderson on the anesthetist as a specialist in the therapeutic use of gases; Geoffrey Kaye on the anesthetic fatalities; the Honorable Mr. Justice Riddell of the Supreme Court of Ontario, on the responsibilities of surgeons, anesthetists, hospitals and nurses in anesthetic fatalities; and the Counsel to the Medical Society of the State of New York, Lorenz Brozman on anesthesia in the laws of the United States.

We feel it is of historical interest to stand over Dr. Erdmann's shoulder when he reported the above activities as Secretary of the Society and excerpt some of the contents: "The celebration of the twenty-fifth anniversary of the founding of the New York Society of Anesthetists was a mere interposition of 'time off' between varied activities of busy men. The attendance of a group of visitors who had held the annual meeting of the united societies (Congress of Anesthetists) at Philadelphia added materially to the pleasantness and the success of the event. Wells, Sword, Evans, Miller, Bourne, Kaye from Australia, Kast, Waters, Sise and others augmented the number of the Society's members in participation. The one notable absence was that of Dr. McMechan and his wife whose recovery from a recent illness permitted him to send his heartfelt greetings even as his earlier advice contributed much to the formation of the plans. . . .

"The complimentary banquet was really the high point of the celebration. Dr. Eliasberg's toastmastership was fittingly appreciated; and Mrs. Evans' witty representation of the wives of the members was enthusiastically applauded. The Secretary briefly related sufficient of the early history to make the necessary relation of the twenty-five years.
"Two of the original members were present: Gwathmey, who read the first paper and made the first demonstration, and Erdmann, at whose invitation the first meeting was held. The celebration was concluded on Saturday with an outing to Ossining on the invitation of Dr. Robert Bloom, anesthetist to the prison hospital, and of Dr. Sweet, Surgeon-in-Chief.

"... the party was taken through the hospital and later were Dr. Bloom's guests for luncheon at the Country Club. On the way home Dr. Hammond piloted the group through the Grasslands Hospital" (12).

In April, 1932, the Society was presented with a seal (fig. 7) by its designer, Paul M. Wood. This is still the seal of the American Society of Anesthesiologists, the explanation of the significance being the pilot wheel, perfect circle, shield, stars, clouds, moon, ship, sea, and lighthouse. The motto is "Vigilance." The patient is represented as the ship, sailing the troubled sea with the clouds of doubt, and the waves of terror, being guided by the skillful pilot (the anesthetist) with constant and eternal (stars) vigilance (motto) by his dependable (lighthouse) knowledge of the art of sleep (moon) to a safe (shield) and happy outcome of his voyage through the realms of the unknown.

Late in 1934 the Committee on Certification was empowered to print application blanks. The Committee set up plans for holding examinations twice a year. There was some confusion on the part of those members not present at the earlier meetings who thought that filling
out the application blank was the only requirement for certification. The plan, however, was to hold a written, oral and practical examination in accordance with the Advisory Board for Medical Specialties which would eventually be submitted for approval to that Board.

By October 10, 1935, the Fellowship Committee was able to report that they had already received requests for certification from twenty-three states. At this meeting it was also announced that a Section of Anesthesia of the Indiana State Medical Society had held its first meeting. California, in 1920, had already formed a section in its State Medical Society which was called the "Section of Anesthesiology."

The national flavor given to the certification procedure by the representation of members from the twenty-three states re-awoke the hope of the American Medical Association's recognition of the specialty of anesthesia. Meanwhile, candidates from Ohio, Texas, Georgia, Michigan, Massachusetts, Minnesota, Oklahoma and Nevada were applying for membership in the society. Entry of most of the new members into the society was due to the efforts of the Secretary-Treasurer, Paul M. Wood. He literally embarked on a one-man crusade to increase the enrollment.

In January, 1936, the designation "Fellow in Anesthesiology" of the New York Society of Anesthesiologists was applied to the recipient of this honor. Those recommended for fellowship at this meeting included Joseph Lumbard and Moses Krakow of New York, Ansel Caine of New Orleans, Charles McCuskey of Los Angeles, Ralph Waters of Madison, Wisconsin, and Sidney Wiggin of Boston. Dentists interested in anesthesia who had joined the Society now pressed for admission to fellowship. This category was denied to them since one of the chief aims in forming the fellowship component was to be part of the Advisory Council. It therefore followed that all who are approved or certified by the Advisory Council must be members of a component part of the American Medical Association. At the same time, surgeons interested in anesthesia, and physicians like Alvin Barcha doing work in gas therapy, were favored because it showed that the profession in general was in sympathy with the Society's purposes and for the educational requirements which the Society wished to maintain.

At the meeting of January 15, 1936, further evidence of this "national" character was the recommendation of Paul Wood for a revision of the constitution to add another permanent committee, the Public Relations Committee. The Executive Committee, aroused by this new attempt to focus attention on this specialty, could contain itself no longer and, prior to the next meeting, polled the membership by postcard for their reaction to a change in the title of the New York Society of Anesthesiologists. On the night of February 13, 1936, in an atmosphere charged with tension, Paul Wood launched into an explanation of the proposed change. He stated that the motivating purpose was "to make this Society, in name, as well as in fact, a national society in
anesthesia.” Nothing would be changed in the Society except to replace the word “American” for “New York” throughout the Constitution. He reviewed for those present the unwillingness of the American Medical Association, the Advisory Board for Medical Specialties, and other national organizations to accept any local organization such as that indicated by the title “New York Society.” Finally, he concluded that in order to secure the recognition for which they had worked so long, this change should be made. Of the 124 replies received from the questionnaire, 120 were in favor of and 4 opposed to the change. Buchanan reported that other anesthesia societies, like the Associated Anesthetists, had tried to certify anesthetists but had given it up temporarily because they had not received enough applications to make it worthwhile. This therefore left to this Society an open field for certification. It followed that to assume the mantle of a national society it must have a name that was national in character. The Society would then be able to meet the requirements of the Advisory Board for Medical Specialties.

In this pulsating atmosphere, Erdmann, the original founder of the Society, rose to speak. In the hush that followed he admitted that he had been one of the men opposed to the change, but that Buchanan’s report had taken away a good deal of the opposition in his own mind. Speaking slowly, he spelled out his fear of anesthesia organizations certifying anesthetists and of the confusion it would create. He retraced the history of the Long Island Society from 1905 to 1911, when it “was swallowed up by the group of men in New York City,” and now the Society was going to change its name again and lose its identity. But, he admitted, they had gone so far that they must go farther to accomplish what they had been intending to do. “I am overwhelmed,” he concluded, “by the recognition of the changes which will take place, and by the fact of the necessity for making those changes” (13).

Thus was born the American Society of Anesthetists with the footnote added to the constitution: “All properties, memberships, rights, privileges and special honors of the New York Society of Anesthetists shall devolve upon and unto the American Society of Anesthetists.” The first business after changing the name was the appointment of John Lundy as delegate to a meeting in Chicago of the Guiding Committee of the American Medical Association and of the Advisory Board for Medical Specialties to represent the American Society of Anesthetists in speeding representation. At the scientific session that same evening, the tension lightened when Buchanan, one of the strategists, in opening the discussion of James Gwathmey’s paper on rectal Evipal®, remarked “when Dr. Gwathmey was a little boy down on the old plantation in Virginia, his mother did not let him use the front door except on state occasions, and that habit has grown up with him. And that
is fortunate, because nobody has presented more real information on colonic anesthetics than Dr. Gwathmey!” (14).

Although the horizon was brighter in the quest for a section on Anesthesia, the American Medical Association showed no enthusiasm for prompt approval. There was a possibility, however, of gaining entrance via a side door, that is, as a subdivision of surgery. E. R. Schmidt, Professor of Surgery at the University of Wisconsin Medical School, was at the time visiting in the East to amalgamate the various surgical societies in an effort to obtain a Board of Surgery. Being under the influence of the anesthesia program of Waters, he was very anxious to see anesthesia keep pace with surgery in official status. Schmidt intimated that if the American Medical Association refused to recognize any more specialties, the surgical group might appoint a subcommittee of examiners composed of anesthetists. Certification in anesthesia would therefore be accomplished within the over-all framework of surgery. “It is a long, hard fight,” said Buchanan, “but we eventually, I think, will get our place” (15).

In order to obtain recognition as a specialty by the American Board of Surgery it was necessary to have representation of the national organizations in the specialty, though not necessarily of all the organizations. The Associated Anesthetists of the United States and Canada and the International Anesthesia Research Society decided not to come in on this plan of certification. They continued with their plan to form a College of their own patterned after the American College of Surgeons. The American Society of Regional Anesthesia, however, did agree to send representatives to the Advisory Board on Medical Specialties. The American Society of Anesthetists believed their future was with the American Medical Association. The surgeons, despite the American College of Surgeons’ designation of “Fellowship,” had to go along with Schmidt’s plan within the American Medical Association to form the American Board of Surgery. By the same token, the American Society of Anesthetists felt that the American Board would be the one under which certification under the aegis of the American Medical Association would be “complete and verified.”

The farseeing minds of Lundy, Wood and Buchanan pushed through the motion to send Tovell as their delegate, in conjunction with the representative from the American Society of Regional Anesthesia, to the Advisory Board for Medical Specialties. A statement was prepared that anesthesia was a specialty and as such should be recognized, and that an American Board of Anesthesia was being formed and had representatives from the national organizations.

A second invitation to McMeechan, as Director General of both the Associated Anesthetists of the United States and Canada and the International Anesthesia Research Society, to send delegates to meet with the other national groups for the purpose of forming the American Board of Anesthesia, received the following reply: “The definite policy
of the Associated Anesthetists of the United States and Canada and its regional societies, the Eastern, Midwestern, Southern and Pacific Coast Associations of Anesthetists, as well as of (sic) the International Anesthesia Research Society, has already been (sic) decided by committee action and vote of these organizations at the Chicago Congress, and this policy calls for certification of anesthetists on the basis of essential requirements compliance which leads to certification and also to Fellowship in the International College of Anesthetists. Through the Board of Governors of the International Anesthesia Research Society such certification has been under way for several years, and is being continued at the present time and will be continued permanently. It was also decided as a definite policy that such a certification would proceed in the same manner established by (sic) the American College of Surgeons and the American College of Physicians and that such certification by the International College of Anesthetists would be entirely separate from any other larger medical or surgical organization and free from its domination or control. Under these circumstances, these societies cannot in pursuance of their determined policy send delegates to any meeting contemplating certification along other lines and under the domination and control of other organizations” (16).

A meeting was held on December 10, 1936 to consummate the incorporation of the old society with the new name. The Articles of Incorporation had been signed by a Justice of the State Supreme Court and accepted by the Secretary of New York State. This gathering, therefore, organized the new Society, the old organization then going out of existence. A new constitution and by-laws were legally adopted. Dentists were no longer eligible. It was now entirely a medical organization except for those under the classification of “honorary members.” Under the Articles of Incorporation, the offices of Secretary and Treasurer were separated. The governing and advisory body were to be a Board of Directors of eighteen members. The board was composed of the five officers and thirteen members elected in three classes, four to be elected for three years, six for two years and three for one year. The constitution likewise provided for a Committee on Fellowship consisting of nine members, three to be elected for six years, three for four years and three for two years. Annual dues were now increased to $5.00 for the 487 members on the rolls of the incorporated Society.

The membership was urged to attend the American Medical Association meeting at Atlantic City in June, 1937 and to register in the Section on Surgery, adding the word “anesthesia” in parentheses. Tovell, in the meantime, had reported that three representatives from the surgical section (general and abdominal) of the American Medical Association had been appointed to meet with representatives of the American Society of Anesthetists and the American Regional Society of Anesthetists to consider and facilitate the formation of a Board of
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Anesthesia. At this meeting, which was held in October 1936, the groundwork for the formation of this Board was undertaken. It was recommended that the anesthetists' representatives to the Board be appointed from the Section on Surgery (General and Abdominal). The first representatives were to be Fellows of the American Society of Anesthetists. With this recommendation, the surgical section accepted the responsibility of sponsoring Anesthesia as a related section. They also placed two members of the American Society of Anesthetists on the surgical program for the scientific session of 1937. At the instigation of Sise and Lahey, the American Medical Association officially invited the American Society to prepare or suggest the preparation of a scientific exhibit on anesthesia at the Atlantic City Convention.

As a final step toward approval, at the meeting in Chicago setting up the American Board of Surgery, the Advisory Board for Medical Specialties recommended that the American Society of Anesthetists apply to the American Board of Surgery for an opportunity to come in on the basis of an Affiliate Board.

The policy of the American Society of Anesthetists continued to be one of cooperation with all anesthesia organizations. Wood and Tovell met with McMeehan regarding the attitude of the International Research Society of Anesthetists and the Association Anesthetists toward the certification of Fellowships in the American Society. McMeehan expressed the greatest encouragement to the American Society's certification. While he had refused to send delegates from his two anesthesia groups to the meeting with the Surgical Board, it was on the basis that he felt the International Anesthesia Research Society should keep open the membership for dentists, scientists and foreigners. Thus the only difference between the two certifications was that the Fellowship Committee of the American Society of Anesthetists aimed toward a recognition and certification by the American Medical Association which would not be granted to anyone but members of the American Medical Association. This excluded dentists, scientists and foreigners.

Still in line with a pacifying policy to the other anesthesia groups who had not previously accepted an invitation to join because they thought the American Society was antagonistic to McMeehan, a recommendation was made to extend applications on the formative group basis until July 1, 1937. After that, any member from the voluntary excluded groups would be compelled to take examinations according to the dictates of the American Medical Association's Boards.

The plans for affiliation of the American Board of Anesthesiology with the American Board of Surgery were completed on June 2, 1937. This was the work of a general committee representing the American Society of Anesthetists and the American Board of Surgery. The plan was approved by two national Anesthesia societies (The American Society of Anesthetists and the American Society of Regional Anes-
thecia) and conformed in all respects with the Examining Boards in other medical specialties, approved by the Council on Education and Hospitals of the American Medical Association. The members and associate members of the Examining Board were selected by a Committee representing the American Society of Anesthetists, Inc., the American Society of Regional Anesthesia, and the section on Surgery of the American Medical Association (17). This gave national and regional representation to the composition of the Board.

The general committee also included in its program the purposes of the affiliate Board to the American Board of Surgery. These were:

1. To establish fitness to practice Anesthesiology.
2. To seek to increase educational facilities in medical schools and hospitals and furnish lists of these, together with lists of individual instructors who give adequate instruction and training in Anesthesiology.
3. To arrange, control and conduct examinations to determine the qualifications and to grant a certificate to those who voluntarily apply and meet these required standards.

In February 1938, the Advisory Board for Medical Specialties approved the affiliation, and the American Board of Anesthesiology proceeded with its incorporation in the State of New York. Official recognition of physicians competent to practice and teach anesthesiology as a specialty was now an accomplished fact. It might be well at this time to list the representatives from the cooperating societies which made up the American Board of Anesthesiology, an affiliate of the American Board of Surgery. In essence, it includes those who primarily carried the brunt of the momentous tasks leading to the formation of the Board:

From the Section on Surgery of the American Medical Association:
   (1) R. M. Tovell, (2) H. B. Stewart, (3) H. S. Ruth

From the American Society of Anesthetists, Inc.:
   (1) E. A. Ravenstine, (2) T. D. Buchanan, (3) J. S. Lundy

From the American Society of Regional Anesthesia, Inc.:
   (1) P. M. Wood, (2) P. D. Woodbridge, (3) R. M. Waters

On "invitation by the new Board," a Founders Group was to be chosen from the following categories:

1. Professors and associate professors of Anesthesiology in approved medical schools of the United States and Canada.
2. Those who for fifteen years prior to the formation of the American Board of Anesthesiology limited their practice to Anesthesiology.
3. Those who held certificates of Fellowship in the American Society of Anesthetists and who limited their practice to Anesthesiology.
The requirements for those having to take the examinations were graduation from an approved medical school and special training, including three years of formal training plus three years of practice limited to Anesthesiology. The first written examinations (Part I) were held in July, 1938, and the first oral examinations (Part II) were given in October, 1938 (18).

In spite of the fact that there was to be a new certification by the American Board, the American Society of Anesthetists decided to continue to issue their Fellowship certificate to those anesthetists who could not qualify for the stricter requirement of the new Board. These included those who did not limit their practice to Anesthesiology. The gap between regular members of the Society and Diplomates of the American Board could be well covered by the Committee on Fellowship. Anesthetists who had some other medical practice than anesthetin, and had some special training in anesthesia and general ability, could qualify for the examinations on recognition of the Committee if they held membership in this Society.

The Committee on Fellowship met, elected officers on October 12, 1939 and planned to give examinations leading to Fellowships. Other memorable events for the new American Society of Anesthetists occurred in 1938. Annual dues were raised to $10.00. An invitation was issued by the World's Fair Committee on Exhibits to present to the public an exhibit in the field of analgesia, anesthesia, resuscitation and inhalation therapy. The World's Fair was to be held in New York beginning in 1939. Recognition of the status of anesthesia in the United States was evident in the invitation to E. A. Ravenstine to be visiting lecturer in anesthesia at Oxford, England. He was to give a six weeks' course. The Society planned to hold combined meetings with regional societies, the first one being held with the Connecticut State Medical Society, Section on Anesthesia, at Groton in June, 1938. Local district anesthesia meetings throughout the various sections of the country became activated for scientific sessions. Thus there was formed the Cincinnati Society of Anesthetists, the Chicago Society of Anesthetists, the Southern Association of Anesthetists and the Texas State Association of Anesthetists. The Boston Society of Anesthetists enlarged its sphere and changed its name to the New England Society of Anesthesiology in 1938. Combined meetings of the Southern Association of Anesthetists and the Section of Anesthesia of the Southern Medical Association began at the same time. In 1939, the American Society held a joint meeting with the Ohio Society of Anesthetists.

There still remained a large item of the original agenda. Since 1912 the goal had been a section on Anesthesia of the American Medical Association. Gwatney repeated these efforts to have the American Medical Association establish a section on anesthesia at the Boston meeting in June, 1921. The secretaries of each county society in the State of New York were memorialized in urging that they endorse this
movement. All the efforts described above in behalf of the American Board had been instigated originally for the Section on Anesthesia. The circuitous route in obtaining the American Board had temporarily slowed the progress for the establishment of a Section. Now, in 1939, the organization began its efforts anew.

California, Indiana, and Connecticut had already established Sections on Anesthesia in their State Medical Societies. The New York State Medical Society was including a session on Anesthesia at its annual meeting in April, 1939. There was to be a session on anesthesia under the auspices of the Section on Miscellaneous Topics of the American Medical Association at its St. Louis meeting in May, 1939. To all this was added the awareness that friendly relations were beginning to be noticeable between the American Medical Association and organized medical anesthesia, as represented particularly by the American Society of Anesthetists.

In October, 1939, a Special Affiliations Committee was appointed by the American Society to determine the best ways and means of procedure for the specialty as a whole. A member of that committee was sent to the Chicago office of the American Medical Association to find out whether those who had shown interest in Anesthesia, such as members of the dental profession and research members, could be included in the American Society. He found that arrangements could be made with facility to include those members, and still work hand in hand with organized medicine, as exemplified by the American Medical Association. The committee then approached the Board of Governors of the International Anesthesia Research Society with the proposal to meet for the purpose of amalgamation. Although they received a verbal answer that the International Anesthesia Research Society found it inadvisable to meet with the American Society at this time, a great gain had been made. The inquiry at Chicago had also included the determination that the American Medical Association was apparently happy to discuss with representatives of the American Society of Anesthetists the possibility of a Section on Anesthesia at some future Scientific Assembly.

A subcommittee of the Special Affiliations Committee of the American Society of Anesthetists was now appointed to meet with the Council on Scientific Assembly on November 24, 1939 in Chicago. Their expectations were further increased by the receipt of a letter from James E. Paulin, Chairman of the Council on Scientific Assembly of the American Medical Association, in advance of the proposed meeting: "... of course I cannot speak for the entire council, but I do believe that the establishment of a Section on Anesthesiology would be for the good of the American Medical Association and I think it would help your specialty very much—a subject in which I wish to say I am enthusiastically interested" (19).

Cordial relations were being established with the various offices of
the American Medical Association for definite furtherance of the recognition of medical anesthesia in the United States. The culmination of these efforts was the notification by the Chairman of the Council on Scientific Assembly of the American Medical Association as reported at the regular meeting of the American Society of Anesthetists on December 15, 1939: "I wish to inform you that the Council agreed to give you one session this year under the section of miscellaneous topics for your section on anesthesia. We also agreed to recommend to the House of Delegates that a Section on Anesthesiology be established ..." (20). This was tantamount to victory since in the past the recommendation of the Council had always been approved by the House of Delegates. Thus, in June, 1940, at the American Medical Association's annual meeting, the House of Delegates voted unanimously to establish a Section on Anesthesiology. A telegram from the Secretary of the American Medical Association informed the Society of the list of officers selected for the new Section on Anesthesiology for 1941. This included the delegate to the House of Delegates from the new section. A mission begun thirty-five years before had been accomplished. Anesthesia was now a recognized specialty!

The Committee on Special Affiliations reported in November, 1940 that the Associated Anesthetists of the United States and Canada were uniting with the Mid-Western Society, which was the last step before they merged with the International Anesthesia Research Society. Nothing further could be done about the final amalgamation between the American Society of Anesthetists and the International Anesthesia Research Society for at least another year. Because of some most unfortunate misunderstandings on both sides, nothing further ever developed again. Subsequent events have shown that the friendly competition which may exist is good for both organizations.

Rumors were now heard that the six affiliate Surgical Boards of the American Board of Surgery were in favor of separating and becoming separate individual Boards. In 1941, the Advisory Board for Medical Specialists approved the establishment of the American Board of Anesthesiology as a separate major Board with the unanimous consent of all the participating societies and boards. In the meantime, the American Society of Regional Anesthesia, not having met for two years, asked for affiliation with the American Society of Anesthetists, and withdrawal as an active organization in the American Board of Anesthesiology. They offered the names of the Pacific Coast Association of Anesthesiology, the New England Society of Anesthesiology, and the Section of Anesthesia of the Southern Medical Association as replacements for their position on the American Board. This was approved by the two other representations on the Board.

In 1942, the American Board of Anesthesiology, now a separate major Board, made some changes in its constitution. It enlarged the
total membership from nine to ten representatives, the representation being as follows:

4 representatives from the American Society of Anesthetists, Inc.
4 representatives from the Section on Anesthesiology of the American Medical Association.
1 representative from the New England Society of Anesthesiology.
1 representative from the Section on Anesthesiology of the Southern Medical Association.

The Pacific Coast Association became defunct in 1940 (21). The American Board of Anesthesiology again made a change in its constitution in 1950. Its membership was increased to eleven representatives, who are elected only by the American Society of Anesthesiologists and the Section on Anesthesiology of the American Medical Association. Six members are elected by the Society and five by the Section. Certification of Diplomates by the American Board rose sharply following World War II and, as of June, 1955, there were 1,324 diplomats (fig. 8).

There remains now to describe another major plank from the agenda of the original founders—the formation of a journal on anesthesia. From the first meeting in 1905 a scientific session was held at each meeting. Although, by 1912, the scientific speakers sent in a written copy of their paper, it was merely attached to the minutes of the meeting. McMeechan realized early that organized anesthesia would need a journalistic outlet for its future publications and activities. He persuaded the Managing Editor of the American Journal of Surgery to establish a quarterly supplement of anesthesia and analgesia in that publication. In 1914, the "quarterly" thus became the
official organ of several of the then existing societies of anesthetists. In 1915, the New York Society of Anesthetists adopted the *American Journal of Surgery* as the organ of the Society, provided that it continued the anesthesia supplement (22). The membership anticipated that special arrangements might be made to obtain free reprints of all articles on anesthesia printed in the *Journal*. The first quarterly supplement on anesthesia appeared in the *American Journal of Surgery* in 1914 and was continued for about ten years.

After McMehan had founded the National Anesthesia Research Society and the regional societies, he provided this development of the specialty with a monthly bulletin. The first Congress of Anesthetists representing these societies was held in 1921 and the following year he enlarged the bulletin to its present official organ, *Current Researches in Anesthesia and Analgesia*. This was the first medical journal to be devoted entirely to anesthesia.

In 1927, a directory was ordered by the New York Society and printed the following year. This was the first official listing of physicians practicing anesthesia. In 1937, *Anesthesia Abstracts* was published by the Journal Club of the Section on Anesthesia of the Mayo Clinic under the editorial direction of John Lundy. This annual digest is still published.

At a meeting of the New York Society of Anesthetists on October 10, 1935, a public stenographer was used for the first time to take down the verbatim proceedings of the business and scientific session. This was then mimeographed and sent to the membership. It provided a valuable means of publishing and disseminating the latest advances in anesthesia. The following year, the *American Journal of Surgery*, having been reorganized, asked the newly named American Society of Anesthetists to support one issue of the Journal each year entirely devoted to anesthesia. The American Society, however, was preoccupied at the moment with obtaining a Section on Anesthesia in the American Medical Association and of establishing a Board in Anesthesia, and did not feel it was ready to submit sufficient material for an entire issue. A symposium on anesthetic did appear in the December, 1936 issue of the *American Journal of Surgery*, and, although not under the auspices of the American Society of Anesthetists, all the articles in it were contributed by its members.

In the Historian’s report of 1936, this issue was mentioned in pointing out the pressing need for an official organ of the Society by which its own activities could be brought before the general medical profession. In 1938, McCarthy, of Toledo, Chairman of the Committee on Public Relations, started a monthly newsletter which for a time was sent out together with the aforementioned mimeographed minutes of the meetings. The *Newsletter* included publication of reports in recognized journals, activities of the members of the organization, and any valuable lectures on anesthesia that were being given in various
parts of the country. In this year also, a change in the constitution provided that copies of the proceedings of this Society could not be sold or distributed to non-members until such time as a recognized journal would be published. Four months later, in October, 1938, a committee was appointed to look into the matter of a journal representing the American Society of Anesthetists. This was in response to a plea from the West Coast members, so situated geographically that it was impossible for them to attend the regular meetings of the Society.

Significant, in 1939, was the appointment of an anesthesia editor to the New York State Journal of Medicine, and the knowledge that the American Medical Association on several occasions had considered sponsoring an anesthesia journal. At this time the Committee on Publications of the American Society of Anesthetists recommended that it be empowered to proceed with the establishment of a journal. This recommendation was approved by the Executive Committee. The name of the journal was to be *Anesthesiology*. Early in 1940 an Editorial Board, Policy Committee, and Consulting Editors were appointed. Through the joint efforts of Henry Ruth, as Editor, and Paul Wood, as Business Editor, the first issue appeared in July, 1940 and was sent to 568 members and to 300 additional subscribers. *The Journal* has been published bimonthly since, and today has a combined circulation of more than 8,000 copies per issue. In April, 1941, a constitutional amendment provided that all presentations made at meetings of the American Society of Anesthetists becomes the property of the Society and were to be submitted to the Editorial Board for possible publication in the *Journal*.

The influence of the written word is far reaching, and this thought must have been in the minds of the early pioneers in Anesthesia as evidenced by the above efforts. In 1912, a Librarian was one of the elected offices, and attempts were begun to accumulate a library. The earliest books on Anesthesia were by John Snow (1858), V. Mott (1863), F. W. Hewitt, H. Davis and D. W. Buxton (all in 1888), A. P. Heineck (1901) and R. J. Probyn-Williams (1902). Here and there surgical textbooks and journals carried articles on Anesthesin, particularly the *Boston Medical and Surgical Journal*. These books practically comprised the extent of the literature up to the founding of the Society. For a few years most of the books were little more than the titles: "A Guide to Anesthesies" (Luke, 1905), "Anesthesies, a Practical Handbook" (Blumfeld, 1906), and "Practical Anesthesies" (Boyle, 1907). In this country the first actual textbook on Anesthesia was written by Gwathmey and was published in 1914. In 1915, McMeehan put out a "Year Book" on anesthesin and analgesia. Flagg's "Art of Anesthesia" appeared in 1916. Gueldel's "Signs of Anesthesies" was published in 1920, Labat's "Regional Anesthesies" in 1922, and Hewer's
"Anesthesia in Children" in 1923. Since then the number of books on Anesthesia has been increased tremendously.

At any rate, through individual efforts, a library was being built up. Considerable impetus was given to this project by the announcement that Paul Wood was willing his Anesthesia library of some 70 volumes to the Society. The Library would remain in his office and he was appointed Librarian for life. By 1936 there were more than 160 book volumes pertaining to Anesthesiology. In addition, several museum pieces had been received and catalogued. The Library Committee also

![Wood Library—Museum of Anesthesiology in 1937.](image)

began to have anesthesia films made in duplicate for general distribution throughout the country. By the following year there were 350 book volumes, with about five duplicates in some editions so that a loan library could be established. A Library-Museum was officially opened in the Squibb Building in New York in July, 1937, with all volumes properly catalogued according to the Library of Congress method (fig. 9).

Another purpose of organized anesthesia was to increase educational facilities in medical schools and hospitals and to make training...
in the subject available to all interested physicians. During the early years of the organization, attempts were made to have medical anesthetists assume charge of departments of anesthesia in hospitals. In 1934, the Hospital Superintendents Association of New York requested a model setup for a department of anesthesia. In 1935 the Committee on Education of the Anesthesia Society sent a questionnaire to 87 medical schools in the United States and Canada about the teaching of Anesthesia in the medical schools. Of the 75 schools which replied, 58 listed anesthesia instruction as a separate subject given by a physician; 5 listed anesthesia instruction as a separate subject given by nurses; 5 listed anesthesia instruction as part of surgery or pharmacology, and 7 gave no instruction in anesthesia at all (23).

Following this report the American Society of Anesthetists passed this resolution: "That it is to the best interest of the medical public that the departments of anesthesia in medical schools and hospitals shall be in charge of a physician who shall have direct supervision of the teaching of this subject to undergraduates and graduates. This physician shall have devoted a satisfactory time to the study of the specialty or shall have been certified as a specialist in anesthesia by a recognized national society of anesthetists."

In 1937, seven universities appended to the Educational Committee for men capable of assuming directorships of their anesthesia departments. Albany Medical College, University of Georgia, Stanford University and the University of Vermont immediately accepted the recommendation of this committee. Also in this year, a grant of $15,000 was secured to open a school of anesthesia at the University of Buffalo. By 1939, four physicians had received masters' degrees in anesthesia at the University of Minnesota.

In 1938 the Educational Committee set up a Placement Bureau for physicians desiring resident appointment in approved residency programs and announced details of short courses and postgraduate instruction in inhalation and regional anesthesia, and listed hospitals and medical schools with appointments in anesthesia available to trained anesthetists. Where four years before only four hospitals had been approved for residency training in anesthesia, now seventeen hospitals were so designated. In 1945, there were forty-nine approved residencies in anesthesia and, in anticipation of physicians returning from military service applying for training, efforts were made to increase this number. At the last listing of Approved Residencies in the September, 1954 Journal of the American Medical Association, the number had risen to 188, of which 14 were in the Veterans Administration Hospitals (fig. 10).

When the Seventy-ninth Congress passed Public Law 293, January 3, 1946, it was comparable to the signing of the Magna Carta for Medicine within the Veterans Administration. Thereafter, in terms of Anesthesiology, progress was rapid. Since 1949 the fourteen Veterans
Administration Hospitals approved for Residency Training have spawned 231 individuals eligible for Certification by the American Board of Anesthesiology. There are 77 full-time Anesthesiologists employed in Veterans Administration Hospitals. The 174 hospitals in operation have 119 Attending Physicians in Anesthesiology and 171 Consultants. The fourteen Area Consultants send their reports on teaching activities within their area to the Special Consultant in Anesthesiology assigned to the Central Office. It is not due to chance that Ralph M. Tovell holds this position. As one of the indefatigable workers who helped create the American Board of Anesthesiology, the Section of Anesthesiology of the American Medical Association, and the journal Anesthesiology, and later as consultant in Anesthesiology

Fig. 10. Approved Residencies in Anesthesiology.

for the European Theatre of Operations, World War II, he was a natural selection for this role (25).

The last questionnaire sent to the medical schools in 1954 revealed the following facts: Only 11 have autonomous Departments in Anesthesiology. The remaining departments are divisions or sections of surgery. All the Chiefs of Anesthesiology hold professional rank, but of varying status. A conclusion that emerged was that medical school instruction in Anesthesiology furnishes an invaluable stimulus for men to enter the specialty of Anesthesiology (26).

The final objective of the Founders’ Group was to bring the medical anesthetists to equality with the internist, surgeon and obstetrician. Too few interested physicians had prevented adequate numbers and
training to meet the demands of surgical practice so that non-medical anesthetists had made deep inroads. After ten years of increasing its membership and raising the standards of medical anesthesia, the New York Society of Anesthetists in 1915 worked toward amending the Public Health Law of the State of New York, "to define the administration of a general anesthetic as the practice of medicine." In 1917, the Society, at the request of McMeehan, endorsed a resolution supporting the State Board of Health of Kentucky and the Louisville Society of Anesthetists in a test case to adjudicate the legal status of unlicensed and nurse anesthetists. In 1924 the Society applied to the Compensation Bureau of the Labor Department of New York to recognize medical anesthetists in the listing of medical fees. In 1934, another bill was introduced in the New York State Legislature to limit the administration of anesthesia to physician anesthetists. This bill was not put to a test vote because of opposition and the feeling that if it did pass it would cause chaos because of the inability to replace the non-medical anesthetists immediately. At this time even the American Medical Association was slow to respond to the recognition of Anesthesia as a medical specialty. This had caused McMeehan to disavow any alliance with that organization toward forming a specialty Board in anesthesia. In 1935, the New York State Medical Society turned down the request for a Section on Anesthesia in its Society because they believed it was so closely allied to surgery that its scientific material could be handled in the Section on Surgery.

By 1939 there were many economic and legislative programs involving such matters as compensation rates for anesthesia, associated hospital insurance plans, and permission for osteopaths to administer anesthesia. There were similar difficulties in the fields of Radiology, Pathology and Physical Medicine. These bodies urged the inclusion of the specialty of Anesthesia in a "Joint Council." The American Society of Anesthetists felt that since many of the items were problems within individual states, local legal functioning organizations within each state should be set up. Such a representative section could legitimately and legally cooperate with the other specialties in these efforts. Thus the New York State Section of the American Society of Anesthetists came into existence and was approved at this time. Other states with similar problems followed suit. Scientific meetings were also included in these state sections.

These separate state units made it possible to work on the various phases of economic or legal practices on a local level. The need to establish the administration of anesthesia as the practice of medicine was vital to the recognition of Anesthesia as a medical specialty. As Krakow pointed out, "It is an unfortunate and laughable thing that the veterinarians included in their Practice Act that animals can only be anesthetized by veterinarians and physicians but anybody can put a human being to sleep" (27).
By the following year progress began to be seen at the local level. The New York State Medical Society called the attention of hospital authorities to the fact that the Directors of Anesthesia Services should have their place on the hospital medical board with all the rights, privileges, and duties of such a position. With the advent of the Blue Shield plans, the National Society came back into the picture. It went on record that it preferred to have benefits for the administration of anesthesia eliminated from hospital service contracts and included in medical service contracts. In 1947 it adopted a resolution which was sent to many organizations, including the American Medical Association, the American College of Surgeons, the American Hospital Association and the national office of the Blue Cross. The resolution was as follows:

"Whereas, the development and furtherance of modern Anesthesiology is of great importance to the welfare of patients and whereas, Anesthesiology is a component part of the practice of medicine:

Now therefore be it resolved:

That the American Society of Anesthesiologists, Inc., recommends strongly:

a. The establishment of Departments of Anesthesiology in all medical schools and hospitals under the direction of a doctor of medicine actively engaged in the practice of Anesthesiology.

b. That the Department of Anesthesiology shall bear the same relationship to the medical school and/or hospital as borne by other medical departments of the institution.

And be it further resolved:

That the American Society of Anesthesiologists, Inc., disapproves:

a. the training of persons other than doctors of medicine in the science and art of Anesthesia, for the assumption of responsibility in the care of patients where it may be necessary to exercise medical judgment, and particularly does it disapprove of the issuance of certificates for such training by its members.

b. the existence of Departments of Anesthesiology in hospitals and/or medical schools under the direction of persons other than doctors of medicine not actively engaged in the practice of Anesthesiology" (28).

Meanwhile the State Sections of the American Society of Anesthesiologists and the local offices of the Blue Cross and the Blue Shield were working together to include the Anesthesiologist within the framework of medical services available to Blue Shield subscribers. Although not completely satisfactory, advances continue to be made to maintain the physician-patient relationship.

Howard W. Haggard pointed up our problem in this respect when he addressed a meeting of the American Society of Anesthetists on October 12, 1939. Said he in part, "Thus, gentlemen, it seems to me that the future position of the anesthetist in American medicine is largely a matter of social change. The anesthetist will not establish his position by laboring and clinical research alone, or by the development of new anesthesies and new apparatus. He will establish it only when he deals with the important but often neglected social feature. Even in spite of this neglect by most anesthetists, the fact remains that
the anesthetists have during the last decade made more progress toward establishing their specialty than any other group of the professions. So far the progress has been mainly from within. It has been organization, the founding of journals and sections, and the insistence on better teaching of anesthesia. Today the public, by and large, believes that the important decision in anesthesia is what anesthetic they will be given, or possibly what method will be used. When, by propa-

![Fig. 11. Hickman Medal (Front).](image1)

![Fig. 12. Hickman Medal (Reverse).](image2)

ganda, you have changed this view to one in which the important decision is what man shall give the anesthetic, then the problem of the place of the anesthetist in American medicine will be solved’’ (29).

“Another major point in the enduring establishment of any specialty of Medicine,” said Haggard, “is that it must receive respect and prestige from the other members of the Medical profession.” One of the best examples of the recognition of the Anesthesiologist is the
tri-annual award of the Hickman Medal given by the Council of the Royal Society of Medicine to any person of any nationality for his work in the science of anesthesics (figs. 11, 12). The first award went to Wesley Bourne of Montreal in 1935; to I. W. Magill of London in 1938; to Arthur E. Guedel of Los Angeles in 1941; and to Ralph M. Waters of Madison, Wisconsin in 1945. All of the first four recipients of this honor were members of the American Society of Anesthesiologists.

During the years from 1942 to 1945 there was a curtailment of activity due to the war. A great number of members were in the Armed Forces. In the revision of the Articles of War in the regulations of the Army and Navy, the specialty of Anesthesiology had at last been recognized. At home, efforts begun several years before had resulted in 1942 in achieving standard colors for the gas cylinders. Because of the National Defense Program, all work in conjunction with the Massachusetts Institute of Technology on fire and explosion hazards had come to a halt. The major manufacturers agreed to standardize equipment. The pin index system for preventing cylinders from being attached to the wrong yokes as a safety measure was first broached at this time. Qualified dental anesthetists were permitted affiliate membership in the American Society of Anesthesiologists. Total membership in 1943 had risen to 1200, from more than 40 states and several foreign countries. The House of Delegates of the American Medical Association came out against hospital corporations engaging in the practice of medicine. The American Society of Anesthesiologists established an essay contest in which $100 was given annually to a Resident in Anesthesia submitting the prize-winning manuscript. A Research Fellowship Committee was organized to secure funds to establish a Research Fellowship in some educational institution. A committee for the study of anesthetic mortality was instituted to collect monthly reports and submit them to the Editor of the Newsletter for publication. A Committee was appointed to set up post-war plans for the establishment of departments of anesthesia and anesthesia scholarships in various hospitals (30).

In 1944, Wood proposed changing the name of the organization to the American Society of Anesthesiologists, Inc. Eight years before he had been given credit for coining this word “anesthesiology” but he disclaimed it, saying it had been in use long before he entered medical school. The lexicographers accredited its meaning as, “the study and practice of the art and science of Anesthesia in all its forms and all that pertains thereto (i.e., gas therapy, resuscitation).” Wood also made public a letter he had received from a Dr. M. J. Seifert: “In 1902, while teaching in the University of Illinois,” he wrote, “I coined the word ‘anesthesiology’ and defined it as follows: The science that treats of the means and methods of producing various degrees of insensibility to pain with or without hypnosis. An Anesthetist is a technician and an Anesthesiologist is the scientific authority on anesthesia
and anesthesiology. I cannot understand why you do not term yourself the American Society of Anesthesiologists?". On April 12, 1945, the certificate of change of name was received (31).

The Society now prepared to move its headquarters to Chicago as a more central location since many national organizations were located there. Discussions were continued about postwar plans for establishing training centers for the war returnees. Attempts were made to stimulate formation of State Sections of the Society to handle economic problems and institute scientific programs. The New York State Section of the American Society of Anesthesiologists held its first Postgraduate Assembly in Anesthesiology in 1945. It consisted of a series of panels on specific subjects and has become one of the most popular and well attended programs in Anesthesiology.

In its fortieth year as an organization, the Society established the Distinguished Service Award to be given annually (fig. 13). The inscription to its first recipient, Paul M. Wood, is a tribute to the Founders' Group itself and merited recording: "There is no one who, by his service to our specialty, is more deserving of recognition by his fellow Anesthesiologists than the one who has been chosen. He has worked tirelessly and given of himself unspuringly toward the advancement of Anesthesiology, Anesthesiologists and the societies represented by them. We are all aware that he had done these things with no thought of award or recognition other than the personal satisfaction of seeing Anesthesiology take a deserving place in modern medicine" (32). The successive recipients of this high honor were Ralph M. Waters, Adolph F. Erdmann, John S. Lundy, John Adriani, Arthur Guedel, Ralph M. Tovell, Henry S. Ruth, Charles F. McCuskey and Moses H. Krakow.

As World War II drew to a close there were 739 Society members in the Armed Forces out of a total membership of 1977. Of this number, 607 were serving in the Army, 81 in the Navy, 3 in the United States Public Health Service, 43 in the Canadian Forces, and 5 in foreign service. Complimentary letters on the importance of the Newsletter to them while they were away had been received from many of these men. All of the aforementioned developments had been faithfully reported in the Newsletter. Those who had joined the organization after becoming interested in anesthesia in the Armed Forces were particularly concerned with the plans to increase the residency programs and the establishment of Research Fellowships in Anesthesia under the auspices of the National Research Council. The Society had contributed $12,000 for a trial period of three years which would enable young Anesthesiologists to come in contact with basic sciences, increase the dignity and prestige of anesthesia, and promote specific contributions to scientific knowledge. As a further impetus, in this year, the House of Delegates of the American Medical Association declared the administration of anesthesia to be the practice of medicine.
Jubilee Year of Organized Anesthesia

There is no better way to express the contributions at the war's end and the future of anesthesia than the editorial "Postscript and Prelude," which appeared in the Newsletter in January, 1946: "Lack of fundamental knowledge during World War I proved a tremendous stimulus to scientific thinking... World War II reaped the benefits.

The

Distinguished Service Award

for the year nineteen hundred forty-five of

The American Society of Anesthesiologists, Inc.

is presented to

Dr. Paul M. Wood

for outstanding service in anesthesia

December 14, 1945

M. K. Vinson

Ralph M. Water

Fig. 13. Distinguished Service Award.

The shortcomings of Anesthesiology were by no means completely deleted during those intervening years. But advancements were effec-tual to the degree permitting life-saving surgical procedures not possible a quarter of a century ago. Returning surgeons have only praise for the accomplishments of Anesthesiologists. To the latter goes much of the credit for the restoration of thousands of casualties. The
combat experiences of the anesthetist have opened new roads. The
unobtrusive missionary work he has done by impressing the war sur-
geon with the importance of and necessity for the best possible anes-
thetic practices has inestimable presagement. The war years, of ne-
cessity, have curtailed somewhat both scientific and clinical advance-
ment at home. Despite handicaps, it is a distinct accomplishment that
the foresight shown by the leaders of the American Society of Anes-
thesiologists has so ably organized, effectively guided, and creditably
established the Society on a secure foundation” (33).

During 1946 the membership increased to 2,147. Veterans found
residencies in 63 training centers. The Council on Medical Education
and Hospitals of the American Medical Association and the American
Board of Anesthesiology granted temporary approval to hospitals
which set up residency programs to accommodate approximately 700
men who had been separated from the services. Included in these
programs were the Veterans Administration Hospitals. The first Fel-
lowship in Anesthesia by the National Research Council was awarded
in September at the University of Pennsylvania. The first medical
teaching commission sponsored by the Unitarian Service Council in
cooperation with the United Nations Refugee Relief Association
(UNRRA) went to Czechoslovakia. It included an anesthesiologist
as one of the outstanding representatives of each medical specialty in-
vited. The Morton Centennial Celebration and the Ether Centenary
were celebrated in Boston in October under the auspices of the Ameri-
can Society of Anesthesiologists.

An organization which had begun with 9 members and had now ex-
panded in 1947 to well over 2,400 members must of necessity require
full-time personnel to coordinate all activities. In 1943 the Society
began thinking in terms of an office of a Coordinator who would pre-
pare a survey of existing conditions. This officer was to receive a sal-
ary and travel expenses and was conceived for the Secretary of the
Society who had recently resigned after many years of service. The
name was changed to Field Secretary and the salary was increased.
Members of the Society who were offered this position were unable to
accept it. A layman was next considered and the term, Executive Sec-
retary, was used. He was to be a man who would work in the best
interests of the specialty throughout the country. Toward the end of
1946, Mr. Clarence G. Minus of Topeka, Kansas was appointed as tem-
porary Field Secretary to get this office started and to break in a per-
manent executive secretary. This was accomplished in February, 1947,
with the appointment of John H. Hunt. This personable young man
has been serving continuously since and has proved a most happy
choice.

One of the first steps to be undertaken in 1947 was the drafting
and adopting of a new constitution and by-laws for the Society. The
constitution finally adopted, provided for government of the Society
by an Executive Committee, a Board of Directors, representing geographical regions of the United States and Canada, and a House of Delegates composed of representatives from each of the States in the Union, the Territories of the United States, and the Provinces of the Dominion of Canada. It contained no provision for nominating Committees! All nominations for offices were to be made from the floor of the House of Delegates. As Mr. Hunt stated in his 1952 report, "this constitution and by-laws adopted by the membership, created the most democratic method of governing a medical society which at that time or even at the present time, has ever been devised" (34). It did much to dissolve sectional and personal rivalries that may have existed.

The new constitution also provided for component societies on a State, Territorial and Provincial level. Each State Society adopted a constitution and by-laws consistent with the new constitution of the parent society and upon receiving a charter was authorized to be represented in the House of Delegates. The chartering of these component societies has given the Anesthesiologists an opportunity and a means of meeting problems affecting the specialty on a local level and of solving matters peculiar to a particular region in a way that would not otherwise be possible. Minnesota became the first state to receive a charter as a component State Society under the new constitution. On July 15, 1955, Mississippi became the forty-fourth component Society of the American Society of Anesthesiologists.

Another organizational revision under the new constitution was the establishment of an American College of Anesthesiologists, under the control of the Society, to replace the Committee on Fellowship. This latter committee inaugurated in 1936 to certify Anesthesiologists as Fellows became dormant following the establishment of the American Board of Anesthesiology as an affiliate of the Board of Surgery in 1938. It was the intent to continue designating Fellows-in-Anesthesiology for those anesthetists who could not qualify for the American Board and yet deserved some type of certification. Nevertheless, disinterest on the part of the anesthetist whose practice was not 100 per cent limited almost caused the abandonment of the Fellowship in 1942. With the setting up of the American College of Anesthesiologists in 1947, the members of the dormant Fellowship Committee became the Board of Governors of the College and all Anesthesiologists holding certificates previously issued by the committee automatically became Fellows of the American College. In 1947 there were 250 Fellows, but with the revitalization process, the numbers steadily increased until, by 1954, there were some 1,280 Fellows certified by the American College of Anesthesiologists (fig. 14). Its existence has justified itself in that it encourages physicians to enter Anesthesiology, serves to stimulate them toward attaining a degree of competent safety and
provides a means of recognition for those who are qualified but do not limit their practice to the specialty of anesthesiology.

Through its Committee on Medical Schools and Postgraduate Education, the American Society of Anesthesiologists has supplied teaching outlines for anesthesia instruction in medical schools and for interns; kept a file of the American Medical Association approved training facilities; a monthly revised file of the applicants seeking a residency or fellowship; has aided anesthesiologists in securing appointments; compiled a list of short courses for physicians interested in part time anesthesia; and initiated, in 1950, annual "Refresher Courses." This series of lectures, consisting of one hour sessions,

CERTIFIED FELLOWS
THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS

![Graph showing the number of fellows certified by the American College of Anesthesiologists from 1935 to 1955.]

**Fig. 14.** Certified Fellows of American College of Anesthesiologists.

is presented at the Annual Meeting of the American Society of Anesthesiologists. The subject matter includes basic medical sciences and clinical aspects. In addition to guest lecturers of the Society membership, one foreign guest instructor is invited each year and presented with an honorarium. A list of postgraduate courses, from 110 centers of instruction, is sent each year to the American Academy of General Practice. General practitioners who take these approved courses are given credit for these by the Academy.

The Library-Museum, officially opened in 1937, has steadily increased its material until, at present, there are more than 800 exhibit pieces, 4,000 reprints, and 1,500 books available. In addition, under
instructions of the House of Delegates at the 1949 annual meeting, a non-profit corporation was formed, known as the Wood Library-Museum of Anesthesiology (fig. 15). This is located in New York, and was granted a permanent charter in 1952. It is designated as the official repository for the archives and paraphernalia pertaining to the field of Anesthesiology of the American Society of Anesthesiologists, and receives a yearly grant from the Society. It supplies books on loan to its members and material for exhibit purposes.

The first Annual Meeting in which a House of Delegates of the American Society of Anesthesiologists was instituted took place in November, 1948 at St. Louis. It heralded the coming-of-age of the Society. A Speaker and a Vice-Speaker were added in 1953. The program for the annual meetings, the refresher courses, and their scientific, business and exhibit aspects have become increasingly complex. Held in a different city each year, with an average registration of over 1,500, they are now big business. In this, the Jubilee year of organized Anesthesia, we have a Society which has grown from 9 members in 1905 to a membership of 4,887 (Fig. 16), a Section on Anesthesiology in the American Medical Association, an American Board of Anesthesiology, an American College of Anesthesiologists, a Library-Museum, a Journal devoted exclusively to Anesthesiology and the institution of teaching standards in the medical schools hospitals to elevate the status of the specialty and increase measures of safety for the patient.
The functions of this Society are reflected in the present organization of its committees: on Constitution; By-laws and rules for the guidance of the Society; Credentials for representation at the House of Delegates; Public Policy and Public Relations, to investigate matters affecting the ethics of the practice of Anesthesiology; Liaison with the Wood Library-Museum; History, to report annually all matters deemed worthy of preserving for posterity; Medical Schools and Postgraduate Education, to secure available data concerning activities, progress and needs of medical schools and hospitals with respect to the specialty of Anesthesiology, and recommend minimum standards for such sources and residencies; Annual Meetings, to provide suitable accommodations and arrangements; Membership, to encourage qualified members of the medical profession to apply for membership; Progress, to prepare and secure the scientific program for the Annual Meeting and a Judiciary to hear and consider all specific questions of ethics, discipline, professional relationships, and the right and standing of members. In addition, there are Special Committees: Honors and Awards, for the Distinguished Service Award; Clinical Records; Hospital Hazards and Standardization of anesthesia and resuscitating equipment; Motion Pictures, for review of films in respect to, or allied
to, the specialty; Placement, to match applicants to available locations in anesthesia; Liaison, with other organizations that have a direct or indirect bearing on the practice of Anesthesiology; Liaison, with the American Board of Anesthesiology; Advise, on production of anesthesiologist films; Advise, on scientific exhibits; Armed Forces needs; Insurance, such as malpractice, life, annuity and health and accident; Case Reports; Eligibility of Foreign Trained Residents for a bona fide residency appointment and licensure to practice in this country; and Operating-Room Deaths. There are also Annual Reports submitted by the American College of Anesthesiologists and the Editorial Board of the official Journal, Anesthesiology.

What of the future of Organized Anesthesia? Have we achieved the maximum effort after fifty years of striving to elevate the status of the physician Anesthesiologist and to safeguard the patient during surgery? These were the goals of the Founders' Group. Perhaps we can offer a glimpse into the future by quoting from the President's address at the annual meeting of the American Society of Anesthesiologists in Cincinnati in October 1954 (35). He stated that the various trends in our society compelled him to predict that:

"1. Our membership will double in the next decade. This is based on the ever increasing demand for Anesthesiologists, the continued expansion of the nation's medical schools, the expanding coverage of the Blue Shield and other voluntary insurance plans for the public, and the general increase in the population of this country.

2. An annual interim American Society of Anesthesiologists' convention similar to the American Medical Association due to increased membership and participation in activities.

3. The scheduling of the refresher courses apart from the annual meeting, due to the continued enthusiasm and demand, and the inauguration of a correspondence refresher course program for those who cannot attend such sessions.

4. The installing of a Board of Trustees of the American Society of Anesthesiologists with duties similar to those in many large professional organizations.

5. And lastly, and most important, the respect for the economic as well as the professional status of the Anesthesiologist will be well established throughout the country in the next decade in a manner similar to any other physician in the clinical practice of medicine.''

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Appendix to References