EDITORIAL

ANESTHESIOLOGY IN THE PRACTICE OF MEDICINE

The practice of medicine today is quite different in every respect from the practice of medicine which existed one hundred years ago when anesthetic agents, as we know them, first came into use. There were no special fields of medicine to which physicians limited their work or even paid particular attention. Indeed, the discovery of ether and chloroform were the events which made the special field of surgery possible. Slowly, from that time on, surgery developed as a specialty but anesthesia was something that any and all physicians practiced when the occasion arose. It is significant, however, that for fifty years or more it was considered strictly a part of the practice of medicine and was rarely performed by a nurse technician. While nitrous oxide was well known about this same time it was seldom used as a total agent because of the poorly constructed apparatus available, the lack of relaxation produced by it and the danger accompanying its administration.

No new agents were developed for many years and physicians in general were not interested enough to improve their technic in giving open drop ether and chloroform. It was merely a means to an end and a sort of necessary evil, necessary when surgery was unavoidable or obstetrics required anesthesia in an emergency. Gradually as surgery progressed, the hospitals and the surgeons conceived the idea of training a nurse to render the anesthesia. I believe this was due to several factors chief among which were the poor and unreliable anesthetics rendered by the physicians, the purely mechanical nature of the procedure, the availability of the nurse in the hospital, the desire of the surgeon to direct and assume the responsibility and the general lack of understanding of the part good or bad anesthesia played in the final result. As more nurses came into the field fewer physicians were interested unless they referred the patient.

With the advent of spinal anesthesia, numerous nerve block technics, more efficient gas machines and potent anesthetic gases, it was evident that the technician was limited because of the lack of basic science, knowledge and understanding. The physician began to give some thought to the field of anesthesiology and a few began to make a study of its possibilities. The field became more attractive because it now embraced more than pouring ether on a mask, a mechanical act that it was thought could be easily mastered without much trouble. It looked to those who always liked anesthesia, but who never received much credit for their efforts, as though the field might develop some respect from the rest of the profession. There were some indications that, as anesthesia came in for its share of the scientific advances pouring into
medicine and surgery, the field might enlarge beyond the reach of the technician and offer possibilities. There was constant evidence that anesthesiology needed some leaders and disciples if it were to advance and keep pace with the needs of surgery.

The practice of medicine as a whole was undergoing a marked evolution and a complete change of face even before the period referred to in anesthesiology. Soon after the turn of the century and particularly about the time of World War I, medicine rapidly began to conform to the revolutionary changes taking place in most other walks of life. There was a more or less rapid reduction in the number of young physicians going into general practice after graduation from medical school. The trend was toward specialization much the same as that taking place in other professions and among skilled workmen. The revered family doctor was fast disappearing and in his place came the physician who did general practice but devoted much of his time to some special field of medicine, to which he felt he was best adapted by reason of his intense interest. When the time arrived, later on, that short postgraduate courses were offered, some of these men took advantage of the opportunity and others chose to train themselves. Soon the medical school graduate selected his special field during internship and, without any experience in general practice, he started his postgraduate training. This is the situation at present and probably will continue to be for a long time to come.

Anesthesiology is much like many of the other highly trained specialties in that it is in the very midst of an important transition period. Many of the leaders engaged in private anesthesiology practice, and others prominent in training programs, did have valuable experience in the general practice of medicine before going into the specialty. Most of these men did not have formal training because the opportunity was not available. A large percentage of the new men entering the field are young, recently graduated physicians who have stepped from internship, to postgraduate school, to actual practice, with 100 per cent limitation to the field of anesthesiology. Because the specialty is quite young there are also many excellent anesthesiologists in the general practice of medicine but devoting 50 per cent or more of their time to anesthesia. Those of us who are department heads, together with the help of the large number spending an appreciable amount of their time in the field, can do a worthwhile job in diminishing the mistakes which have overtaken many men in all specialties. Before our specialty becomes top heavy percentagewise in technically trained men, we have an opportunity to influence their career in the art of the practice of medicine.

I have a strong conviction that the rapid movement in specialization is largely responsible for the position the medical profession occupies in the estimation of the population at large. It would indeed be somewhat odd if the medical profession had remained in status quo while most other components of society were undergoing severe adjust-
ments in keeping pace with scientific advances. With the elimination of the family doctor and the substitution of the specialist the practice of medicine lost the most highly esteemed man of every community. He possessed virtues which even the clergyman never did attain, in his intimate relation with the average American family. His understanding of human psychology and relations was an art which was largely lost when his successor, the specialist, came along. His meager professional ability was a secondary consideration oftentimes alongside his ability to handle the over-all problem, in time of sickness. He really was a master in the art of the practice of medicine. He was an integral part of the social, political and religious life of his community. The average family regarded their doctor as their most intimate and trustworthy acquaintance. The present day evaluation is something else and, while the times are responsible to some extent, the physician could do much to improve his general position.

The anesthesiologist occupies a singular and unique position in the set-up, as medicine is practiced today. Except for the specialties of pathology and radiology there is no comparable situation. Primarily, because his practice is limited to the hospital, he does not enjoy the physician-patient relationship as does the internist, the surgeon, the obstetrician and the others who refer the patient to the hospital. His services, unfortunately for him, fall into the category of hospital service rather than private physician service in the eyes of the patient, and too often in the evaluation of the surgeon or obstetrician. This has the dangerous tendency of causing the anesthesiologist to lose his identity in the scheme of things done for the patient. Because he is not employed directly by the patient as one of his physicians, he is again liable to be soon forgotten. If he is scheduled impersonally through the institution he is in danger of being regarded as a technician rather than as a physician specialist. When a surgeon or obstetrician employs an anesthetist engaged in private practice and neglects to call him by name, his services may mean little to a patient. Thus, by reason of established custom, the anesthesiologist’s position and identity are necessarily vulnerable. I feel absolutely certain that every anesthesiologist can guard and improve his position so that he may be regarded as highly in his community as the surgeon or any other outstanding specialist. I further feel rather keenly that he has a moral obligation to the organized specialty in this behalf. He not only should, but he must control his professional conduct in a positive and aggressive manner, to retain his identity. The anesthesiologist must conscientiously avoid being grouped with the man who took a picture of the chest, the woman who applied a diatherm to the shoulder, the technician who punctured the lobe of the ear or the resident who gave a blood transfusion. The salaried hospital anesthetist is much more on the spot in this connection than is the private practitioner.

It seems to me that there are many things of importance which should be observed rather religiously as one assumes his position in the
life of his community and his rank among prominent physicians within
the profession. I am absolutely sure that, before he can expect to com-
mand and receive respect from the general public, he must be well above
average in his standing within the profession. He must be looked upon
by his county medical society and his hospital staff as competent, dili-
gent, honest and progressive. He can hardly attain that degree of ap-
praisal by his brother physicians unless he is conscientious and faithful
to a code of principles which governs his fraternal relations. Respect
and standing are never achieved accidentally, but follow a demonstra-
tion of high quality work. In his professional association the anesthesi-
ologist must keep well posted on current literature within his own and
related specialties. He ought to be the one who first brings new ideas
and technics to the surgeon’s attention rather than the one who is asked
and found wanting. If he is on his toes he will periodically inform
the membership of his staff and the county medical society of what’s
new in anesthesia. If he is able to render some service to the surgeon,
the internist or obstetrician who is in difficulty with a complication, he
should offer to help rather than wait for an invitation. Attendance at
important specialty meetings pays big dividends in maintenance of
professional standing.

Except in a rare instance, the specialist who enjoys a good reputa-
tion within his professional ranks also has a high rating by the lay
public of his home community. It is not enough, however, that he be
satisfied with a good professional standing alone. If the anesthesiolo-
gist expects to be a regular physician and live down or escape the im-
plcation that he is really only a technician, he must make up his mind
that he has a job to do. He just cannot get that job done by resting on
his professional laurels alone. There is no good or valid reason why we
should not be regarded on the same high plane as is the surgeon, the
pediatrician, the internist and others, provided we recognize our part
in maintaining that position. Because our work is referred by other
physicians, and thereby devoid of the usual doctor-patient relationship,
is no reason why our conduct and carriage should be any different from
that of our colleagues.

In the first place I firmly believe that, as physicians, we have a moral
obligation to uphold the dignity of the profession at all times. The
public has a very definite idea about things that are becoming of a doctor
of medicine in his social and professional activities. He is always con-
spicuous wherever he goes and therefore is on the spot, so to speak.
Habits and actions that are perfectly proper for most other people are
just not considered correct and becoming of physicians. I don’t think
it is possible for us to be careless off duty and then expect to be shown
a high degree of respect as we step into the hospital. Some of the im-
pressions people get when they see a doctor outside the hospital are
more lasting than those they receive in his professional atmosphere.
The more recent relaxed social standard hardly includes the conduct of
the physician. If we as anesthesiologists expect to rate equal footing with the leading specialists of our community we must protect the heritage of respect and dignity to which we fell heir when we took the oath of Hippocrates. We can and must strengthen our professional standing by pre and postoperative visits to patients. Here we have the opportunity, through dignified conduct, to acquaint the patient with the scope and quality of our work and the part it played in the entire episode.

My experience in the specialty, on a private practice basis, and my activity in organized medicine, prompt me to enumerate for your consideration some other phases of a physician’s community life. Today, with a changing social, political and economic picture, it behooves the physician to give some time and thought to his place in the new set up. Many leaders believe that it is not going to be possible for individual doctors to ignore the new-order any more than it has proved to be impracticable for organized medicine to go along as they did fifty years ago. By reason of the scientific nature of their training, and the secret physician-patient relationship in practice, the average doctor has considered himself all too little with the part he is expected to play in the new scheme of society. Here again he has been too willing to rely on his reputation and too loath to recognize other obligations. Organized medicine suddenly learned it could not exist unmolested on its great record of scientific accomplishments, but would be forced to initiate a public relations program, to sell its virtues to the public. The anesthesiologist can well afford to have an important role in such a program of physician participation in community affairs. Such activity offers a marvelous opportunity to establish his identity, to attest his civic mindedness, to afford him favorable public comment, to erase his technician status, and to place himself and the profession on the list of useful citizens.

Active participation and interest in the affairs of the hospital and county medical society committees keep an anesthesiologist in a position of prominence, more or less, within the ranks of the profession. Accepting appointments cheerfully and doing a thorough job of any assignment, tend to generate a kindly feeling and a helpful attitude on the part of the general membership. It is comparatively easy to obtain staff support for one’s own department when one justifies his position by such activity. The greatest reward for his efforts is the charitable feeling exhibited by other hospital departments, who often are jealous because they feel anesthesiology is on the receiving end of referred work and puts out little or nothing in return.

Civic clubs and chambers of commerce afford an excellent chance to develop a large acquaintance of cross sections of community personnel. Their activities take one far from professional life and diversify one’s extracurricular interests. In filling the classification of anesthesia, he frequently becomes the only anesthesiologist the membership knows. If one puts something into his club he will get much fellowship out of
it. Enthusiastic participation in a dignified manner will reflect credit and honorable mention upon the specialty and the practice of medicine at large.

If the anesthesiologist can spare the time from a busy practice, to take part in the annual community fund drive, or in the activity of one of its many agencies, he will introduce himself and his specialty to many community leaders who are worth while knowing. The same is true of membership in the church, where prominent people learn to know him as a physician first and secondly as one interested in the better community institutions. There must be no mercenary incentive behind such participations.

Interest in local politics and the affairs of the public schools are other spare time activities which help align the physician and anesthesiologist with other community leaders, whom everyone knows.

The country club offers the chance of developing a large acquaintance among business and professional people, who learn to know him as a regular fellow as well as a prominent physician and specialist of the town. These folks get to know him as they know other people and find out that he is really human after all. As long as the anesthesiologist’s conduct remains within propriety, this group of friends will hold him in high esteem. I believe strongly that if we are to be eminently successful in our specialty of anesthesiology, we must pay some attention to the art of the practice, as well as to the actual scientific rendition of anesthesia. As practitioners, we must accomplish the degree of development outside the hospital that we have attained in the operating room. It behooves us as department heads to lead the way and to set the pattern. Our instructions to those whom we train, and to those who are our subordinates, should include this second front. Anesthesiology surely deserves equal recognition with other specialties from the home town public. In some places it already occupies such a position, but in far too many localities we are scarcely known, seldom seen, and never heard. We must exercise our ingenuity to keep out of the shadow which clouded the specialty when we took over from the technicians. We have the credentials and the professional equality but as a young specialty we are not “catching up” as fast as we might. We just are not getting our story over to the patient and to the public. Let’s round out our program and make anesthesiology a part of the practice of medicine—not limit it to the operating or delivery room.

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