CURRENT COMMENT AND CASE REPORTS

CURRENT COMMENT is a new department in Anesthesiology. In it will appear invited professional and scientific correspondence, abbreviated reports of interesting cases, material of interest to anesthesiologists reprinted from varied sources, brief descriptions of apparatus and appliances, technical suggestions, and short citations of experiences with drugs and methods in anesthesiology. Contributions are urgently solicited. Editorial discretion is reserved in selecting and preparing those published. The author's name or initials will appear with all items included.

CORRESPONDENCE

A SURGEON LOOKS AT ANESTHESIA *

To the Editor of Anesthesiology:

Since the beginning of this century, several anesthetic agents have been introduced with varying success and the refinements in the administration of them have materially increased the margin of safety.

The aim has been to produce anesthesia with less risk and more comfort to the patient and at the same time to secure a relaxation which was conducive to good surgery. With a choice of intravenous, spinal, basal and the various gases, and even rectal anesthetic agents, selection of anesthetic for every type of surgery has been possible. With the multiplicity of anesthetic agents, there has developed a specialization in the anesthetic field.

It was the custom some years ago to delegate the anesthesia in both major and minor surgery to the most inexperienced intern or even to undergraduates. Fortunately this practice has been eliminated, so that the well-trained anesthetist occupies a place on the staff of every hospital. Remarkable as the progress has been in anesthesia, we feel that a great opportunity has been missed by those who specialize in this branch of medicine. The status of the anesthetist, at present, in some locations, approaches that of a highly trained technician. It is our conviction that the anesthetist should be a consultant and, as such, consider the selection of an anesthetic prior to an operation—particularly those of a serious nature. It has long been the custom, even in this day of selective anesthesia, to have the patient or the surgeon select the type of anesthetic desired. It is our contention that the selection of the anesthetic should be left to the anesthetist after he has seen the patient and obtained a comprehensive history of the case and a description of the operation contemplated. In no other way can the patient possibly obtain the maximum benefit in this particular branch of medicine. It is an unwritten law that a surgeon selects the anesthetic and it is presumed that he uses his best judgment. However, many surgeons are unqualified to select an anesthetic because they have not had sufficient training in this field. They view the anesthetic, no doubt, from the point of safety, but somewhat colored by the desire to have complete relaxation and, occasionally, by the item of expense. While in a majority of instances their judgment is sound, there is an infrequent case where they are in error and the patient suffers the consequences.

Choice of an anesthetic often becomes routine, but a certain flexibility is imperative if the best results are to be obtained. How much better it would be if the surgeon would ask the anesthetist to see the patient after the diagnosis is made and the type of operation is indicated. If the patient is seen only immediately prior to the administration of the anesthetic it is not only very impersonal but, to him, seemingly indicates indifference on the part of the anesthetist.

In our humble opinion the interest of

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the patient would certainly be enhanced if the anesthetist would visit the patient, introduce himself, make an examination and leave some cheerful thought. In this manner, a certain feeling of confidence is established which helps to prepare the patient for what might be, in many cases, a dreaded ordeal.

The anesthetist should visit the patient routinely, both on the day of and the day after operation and at any subsequent time that he believes it would be to the interest of the patient. Should complications develop, particularly involving the respiratory system, the anesthetist could be of definite assistance as a consultant. The administration of oxygen and carbon dioxide, often a postoperative therapeutic measure, is best controlled by the anesthetist. In other complications during the convalescence, such as vomiting, distention, retention of urine, thrombosis and shock, the anesthetist should be vitally interested, both from a prophylactic and curative angle. There is no substitute for first hand information.

I do not feel that the anesthetist’s responsibility ends when the operation is concluded but should extend through the period of convalescence.

When one speaks of an anesthetist, I believe he has in mind a person who is devoting practically all his time to the specialty of anesthesia. Unfortunately many good anesthetists have to devote a considerable part of their time to general practice in other fields of medicine. Consequently, their time for visiting patients before and after operations is somewhat limited. One would like to visualize the anesthetist as one who devotes all of his time to anesthesia and all of its ramifications.

There is no good reason why a group of anesthetists should not establish themselves as other medical groups and take up anesthesia in all its branches to be prepared to furnish their services any time during the twenty-four hours for any type of anesthesia or for the use of gas therapy. They should be prepared to assist in the treatment of some postoperative complications. I believe that such an association could give superior service and, at the same time, spread the work much to the advantage of the anesthetist. Bronchoscopic treatments should be seriously considered as a part of their work.

At the present time, much of the work devolves upon a few men, and there is duplication of much expensive apparatus. In the present arrangement, anesthetists are kept unnecessarily close to the telephone, whereas, in the group system, much more leisure would be afforded and much overhead would be deleted. We do hope that such a plan will be made operable in the not too distant future.

The anesthetist’s fee is a subject which should be discussed frankly, and not be obviously avoided. Unquestionably there are many complaints about the fee. As a rule, I should say the fee is well earned but the patient usually pays it with a feeling of having been fleeced and, in many instances, he does not see the anesthetist at any time before, during or after the anesthesia. His only connection with the patient is a statement which is submitted or attached to the hospital bill.

In some instances the surgeon is to blame in not informing the patient in advance that there will be an anesthetist’s fee of an approximate amount. It might be assumed that a patient’s mind is so occupied with the operation that some financial details are overlooked, but the patient should be acquainted with all the additional charges outside of the hospital room, including the surgeon’s fee. If the anesthetist made it a part of his duties to see the patient before and after the operation, I believe much of the controversy over the fee would be eliminated. In this way, the patient would know that this is a specialized service with a highly trained consultant, for which he should expect to pay. Anesthetists, by such a contact with their patients, justify the payment of proper charges, establish themselves as specialists and undoubtedly increase their prestige so that in the future a demand will be created for their services. This side of the practice of anesthesiology is sadly neglected and we trust there will be enough farsighted anesthetists who will appreciate these important facts and adapt their practice to such modern methods.

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