

## EDITORIAL

### ANESTHESIOLOGY—A CONSULTATIVE PRACTICE

With the exception of a relatively few patients who come directly to the anesthesiologist because of persistent pain or because they are in need of pneumatologic therapy, the practice of the anesthesiologist is limited to those patients referred to him by other physicians, usually surgeons. This consultant type of practice is somewhat unique in that the anesthesiologist not only evaluates the status of the patient and suggests therapy, but also administers the therapy in association with the surgeon. This is in contrast to the usual type of consultation in which the consultant examines the referred patient, makes a diagnosis and suggests therapy, which is then applied by the patient's physician.

In this age of great specialization, there is a strong tendency to shift patients from one specialist to another in attempts to arrive at diagnoses and therapeutic procedures. Frequently, this approach to the practice of medicine results in accurate diagnosis and appropriate therapy. Perhaps more often than is warranted, this approach results in confusion, inaccurate diagnoses and scrambled therapy. There is considerable merit in the fundamental principle that one physician is responsible for the patient's welfare. This physician may enlist the aid of others, but the ultimate decision that influences the patient must be his. The decision of the patient's physician to accept or reject the suggestions of the consultant depends upon a number of factors. The patient's physician is in the most favorable position to determine the ultimate therapy because he is most familiar with the background of the patient and his disease; he knows the progress of the disorder, the reactions of the patient to the situation, and he knows that he will be responsible for the results of the therapy. The extent to which the patient's physician uses the advice and professional service of consultants depends in large measure upon the confidence he has in those consultants. His confidence is the natural product of favorable experience over an extended period of time.

The physician entering the specialty of anesthesiology often overlooks this important aspect of the practice of medicine. He fails to remember that he is in a consultant capacity and cannot make the diagnosis or administer to the patient independently unless given that privilege by the patient's physician. Usually, as in the case of other consultants, this privilege is not extended until the patient's physician has developed complete confidence in his consultant. This confidence is not established automatically. The anesthesiologist who has re-

ceived approved training of the required length or who has the distinction of certification by the American Board of Anesthesiologists may not expect immediate, unqualified recognition.

Confidence is developed during the relatively unique, close association of anesthesiologist and surgeon under circumstances of stress. Confidence is developed by the consistent demonstration by the consultant that he is familiar with the patient's disorder, that he is well versed basically and clinically with the practice of anesthesiology, that he is alert to changes in the patient and in the demands of the surgical procedure, that he is genuinely concerned with the patient's welfare and evinces interest in the progress of his disorder.

Discussion with the surgeon in the preoperative period, during the operation and in the postoperative period of all problems relating to the consultant's interest in the patient will help to establish confidence. In practical manner this means the imparting of pertinent information throughout these periods. For example, if significant changes occur in the patient's condition, such as a fall in blood pressure, this information should be imparted to the surgeon. There is an unfortunate tendency on the part of some anesthesiologists to consider that what they are doing and what is happening to the patient are none of the surgeon's business. Some anesthesiologists believe that they degrade themselves and assume the position of a lackey if they do not maintain this independent attitude and secrecy. There is also a tendency among some surgeons to fail to impart to the anesthesiologist important information regarding the surgical procedure. For some unaccountable reason, the anesthesia screen seems to be a barrier to communication.

These unfortunate attitudes are not compatible with the best interests of the patient. Communication and cooperation are essential. The status of the anesthesiologist as a consultant to the patient's physician is a stable and natural position and conducive to the welfare of the patient. The consultant status and subservience are not synonymous. Interchange of information and open discussion of problems will make it possible to practice anesthesiology under circumstances of mutual confidence with professional dignity.