EDITORIALS

Spinal Anesthesia: Our Curious Ambivalent Attitude

NOWHERE is the public's peculiar attitude toward anesthesia more evident than in its consideration of spinal anesthesia. One wonders whether this dichotomy has its roots in some atavistic fear, for it does seem strange that there is greater concern for a more durable, phylogenetically older structure such as the spinal cord than there is for a newer, more delicate structure, the brain. In part, this is an escape from the unknown summed up in the common expression "I don't care what you do to me, just put me to sleep." But more important, it is also a specific concern about the back, the origins of which are too involved for present discussion.

Unfortunately, this fear is not confined to the the laity, but appears in the medical profession as well and even among the supposed cognoscenti, the anesthesiologist. There is some regional distribution of these taboos and, like other superstitions, lack of understanding of the true situation in one area exists in others. For instance, there seems to be a belief prevalent in the East that no one in California administers spinal anesthetics. This is no more true than the belief that we still carry six guns or fight Indians.

Fortunately it is possible to trace many of these fears of spinal anesthesia more rationally. Equally fortunately, it is possible to combat them effectively. Certainly there have been and are areas in California where spinal anesthesia is used seldom if at all. In many of these locations this interdiction has been overcome by the intelligent, competent, rational, and patient application of sound principles of anesthesia and medical practice.

Spinal anesthesia has experienced more waves of popularity and unpopularity perhaps than any other anesthetic method. Within a year of its introduction by Bier, Matas in New Orleans and particularly Tait and Caglieri and Morton in San Francisco had generated considerable enthusiasm for spinal anesthesia. Then followed the bulging promotional tour by Jonnesco with its admixture of excellent and poor results. Because of the subsequent wave of disillusionment, it wasn't until the late twenties that an improved understanding of technique brought a resurgence of popularity. Concomitantly the era of the Great Surgeon occurred. Without anesthesiological help and with unbounded self-confidence he adopted spinal anesthesia—and often so abused it that White remarked: "The fact that relatively few accidents and disasters occurred in any community even during the height of this extensive use of spinal anesthesia in all sorts of hands with slight discrimination, under greatly diverse circumstances, speaks more strongly for its comparative safety than many reports of low mortality and morbidity in many thousands of cases operated upon by the most expert in the field."

Two other factors have led to the recent wave of disillusionment on the part of the lay and medical public. In the East, Foster Kennedy wrote a damaging condemnation based on a *post hoc* analysis of twelve selected cases of paraplegia following spinal anesthesia. In the West juries began to award fantastic sums in personal injury cases. The price of paraplegia from any cause was established at a quarter of a mllion dollars.

Often these are not the potentials that prevent the use of spinal anesthesia. We can find more accidents with the use of other methods which continue to enjoy popularity. Frequently technical incompetence of the anesthesiologist and unwillingness to overcome deficiencies are the actual basis for reluctance to use spinal anesthesia although other rationalizations are professed. It has become easy for the developing specialists of anesthesiology to avoid the use of spinal anesthesia because of the advent of the so-called safe non-explosive techniques. Some of these are peculiarly adapted to the lazy, the lethargic, the diffident and the poorly trained.

Unfortunately, those who profess to be consultants in anesthesiology do not always act as such. Especially in regards to spinal anes-

thesia, the proponents appear to be less active and vocal than the opponents.

It is not necessary that anesthesiologists accept this interdiction of what is perhaps our safest and most satisfactory techniques. An illustration of this occurred in a northern California county where, about ten years ago, a well-known rancher became paraplegic following administration of a spinal anesthetic by his surgeon. A judgement of $55,000 was made in his favor. This was followed by an extremely strong resistance to spinal anesthesia in that community, a resistance regularly reinforced by the sight of the paraplegic in his wheelchair. Yet, within the past two years, two well trained, personable and technically competent anesthesiologists have pioneered the practice of anesthesiology in this area. Gradually they have educated the medical and lay public, which had been complacently accepting some poorly administered general anesthesia. Now anesthetic methods including spinal anesthesia are selected on the basis of the medical requirements of each patient and operation rather than on fear of legal reprisal or emotional taboos.

In all areas of medical practice we must operate by patient requirements, physical status of the patient and the condition of the operation. Spinal anesthesia should not be singled out for local proscription any more than any other method.

Certain rules which seem obvious enough may be worth setting forth again as reminders for the safe preparation and conduct of any method of anesthesia but especially for subarachnoid block: (1) Visit the patient preoperatively. (2) Be rational in the choice of anesthestic agents and techniques. (3) Use what is medically indicated. (4) Make certain the patient understands your advice. Don't use subterfuge. (5) Write appropriate notes on the chart preoperatively. (6) Don't be shy or avoid questioning or legal problems. (7) Use meticulous technique. (8) Visit the patient postoperatively and write follow up notes on the chart.

Spinal anesthesia is well known and thoroughly understood. Its limitations are clearly defined. The indications for its use are generally accepted as are the physiologic principles underlying its application. Anesthesia should never be limited because of fear, ignorance, emotion or any reason other than responsible medical prescription.

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Education in Anesthesiology

THE PROPOSED increase in duration of residency training to three years by the American Board of Anesthesiology has led to some organized opposition. The Council on Medical Education and Hospitals of the American Medical Association has agreed to conduct an open hearing, to allow those who oppose or support the increase to present their views. A review of the background and the events leading to the Board's proposal is warranted. The American Board of Anesthesiology was formed in 1937 as an affiliate of the American Board of Surgery, with support from the American Medical Association's Section on Surgery, the American Society of Regional Anesthetists, Inc., and the American Society of Anesthetists, Inc. In 1941 independent status was granted by the Advisory Board for Medical Specialists and approved by the Council on Medical Education and Hospitals of the American Medical Association.

From the beginning the founders of the Board aimed to improve educational facilities in medical schools and practice in hospitals. In its Booklet of Information issued in 1939 the Board recommended a period of supervised instruction of at least two years prior to examination of candidates for certification. At the same time, however, the Board stated its belief that after January 1, 1942, facilities for special training would be increased and sufficiently standardized that a period of study of three years would be required. This plan of the Board was reprinted in 1941 so we must conclude that from the beginning the intent was to set a standard of three years of formal residency training. These aspirations were defeated first by the inadequacy of training facil-