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Presidential Message

The Achievements of the Past and Challenges of the Future

IT is universally agreed that Anesthesiology as a medical specialty has evinced dramatic growth and demonstrated its capabilities as a vigorous, and progressive discipline. Many factors have been responsible; among the most important has been the way the many challenges have been met, vigorously attacked, and solved. It is true that after a promising beginning when the original challenge to the concept of anesthesia was met by Simpson, Snow and a few others, anesthesia passed through its own "dark ages" because the medical profession abdicated responsibility in favor of nonphysicians. However, during the first three decades of this century a few pioneers recognized the legacy of Snow and Simpson, accepted the responsibility and thus initiated the "renaissance" of anesthesia. During these formative years, the challenges consisted mainly of convincing the medical profession that it was the business of physicians to administer anesthetics, to develop training programs, to organizing a scientific society and finally to form a certifying board. These challenges were met by a few who contributed much in terms of time, effort, personal sacrifice and financial contribution. The Second World War presented a greater challenge provoked by the experience with anesthesia at Pearl Harbor and other military installations during the early part of the war: to train quickly a large number of physicians and nonphysicians to care for the needs of our armed forces. The magnificent way in which the challenge was met made history. But this led to new challenges, new problems and new goals. An unprecedented number of physicians, whose interest in anesthesia had been whetted by war experience, sought formal training. The dramatic threefold increase in anesthesia training programs from 69 to 213 during the years 1946 to 1950 and a commensurate increase in the number of anesthesiologists in the years that followed is impressive testimony of the fact that the young specialty measured up to its responsibilities.

With growth came a degree of maturity—a sense of responsibility to provide more patients with better care and the realization that anesthesiologists must practice in the same fashion as other physicians. However, tradition, lack of perceptiveness, and perhaps ulterior motives led many American hospitals to challenge these ideals. Thus, the young specialty found itself in a struggle for legitimacy, nay, its very survival. Again, it met this challenge with vigor, determination and a unity which provoked the respect of other disciplines. The American Society of Anesthesiologists Inc., enunciated its lofty goals (Chapter I of the Bylaws), adopted a Statement of Policy, and embraced the principles of ethics of the American Medical Association, all of which helped to reorient and encourage the members in pursuit of these goals. The result: 85 per cent of American anesthesiologists practice as private practitioners. A major conflict had been won!

During the ensuing decade the American Society of Anesthesiology, the American Board of Anesthesiology, the Association of University Anesthetists, and the International Anesthesia Research Society became more sturdy, dynamic, and influential; scientific programs improved, our Journal became one of the more highly regarded publications, medical schools began to nurture truly academic programs in anesthesia, and more and more anesthesiologists indulged in basic research. These achievements have helped to establish anesthesiology firmly as a medical discipline and earned wide respect. However, these gains notwithstanding, many leaders of anesthesiology suspected that all was not well—that deficiencies still existed. This prompted several surveys pertaining to the practice of anesthesia in this country. Of these, that by Henry Beecher and Donald Todd and later those by Otto Phillips and by Vernon Thomas are noteworthy; but certainly the analyses of broadest scope was suggested three years ago by Albert Betcher when he assumed the Presidency of the American Society of Anesthesiologists. Through the foresight and support of the officers, Board of Directors and House of Delegates of the Society, and as a result of a fantastic amount of effort and thought on the part of Robert Dripps and the other members of the Anesthesia Survey Committee and by Henry Skeele and his associates of ODM, the initial phases of the Survey have been completed. The reports of the Survey rank among the more important documents pertaining to anesthesiology. I am convinced that these reports will influence the course of anesthesiology as much as the Flexner Report influenced the course of medical education.

The Anesthesia Survey has produced benefits, not the least of which is that it represents still further proof of maturity and sense of responsibility; only in this way are intensive soul-searching and self-appraisal possible. The survey has, of course, confirmed past achievements and placed them in proper perspective, but more important, it has re-emphasized and brought into sharp focus our problems and shortcomings. These are lucidly described in the several reports of the Anesthesia Survey. I urge every anesthesiologist to read them.

Patient care is a major area of deficiency. The latter embraces: (1) Too few physicians to care for the ever expanding population. (2) Neglect and indifference on the part of some anesthesiologists to participate in the total care of the surgical patient by avoidance of preoperative and postoperative care and in other ways abdicating their responsibilities as physicians. (3) Unwillingness on the part of many anesthesiologists to participate in obstetric anesthetic care. (4) Lack of availability of some for any anesthesic service after 5 P.M. (5) Lack of drive in some to make the most of their talents and thus contribute to medical service as broadly as possible—as consultants on problems pertaining to pulmonary function and therapy, resuscitation, management of intractable pain, and other medical problems for which they have specialized knowledge and skills. (6) "Splendid isolation" from nurse anesthetists, with no attempt made to improve the quality of their work. (7) By their actions some anesthesiologists indicate that patient care is secondary to personal and professional advancement. (8) Indulgence in sharp monopolistic practices by a few.

Teaching of anesthesiology to medical students, interns and residents leaves much to be desired. Exposure of students to anesthesiology in American schools of medicine ranges from good to mediocre, with the average on the low side. Teaching staffs are thin, budgets inadequate, and curriculum time is slipping away. Trends in medical education toward the straight internship and early choice of a specialty have reduced the opportunities for giving anesthetic training to interns. This lack of exposure has deprived anesthesiology of the opportunity to contribute its full share to medical education. Many of the anesthetic residency programs fare little better: In some cases the clinical material is inadequate; in others the residents are not supervised and are used merely to get the case load done. These circumstances produce inferior anesthesiologists. There is particular concern with our failure to attract more good people, thereby to ensure growth in numbers and stature.

The professional image of anesthesiology is not admirable. Students, interns, and others who should consider anesthesiology as a field

for specialization, have serious doubts as to whether it measures up to the standards of a physician's work. There is a tendency to view it as a boring, narrow, unchallenging and merely technical field. Some surgeons and other medical colleagues, while readily accepting the benefits of our knowledge and skills, view the anesthesiologist as someone less than equal. There is also strong evidence that the public does not fully appreciate the value of anesthesiology and that many people today are unaware of its existence or do not know the mission of the anesthesiologist. These observations make it obvious that we have been deficient in our public and professional relations program. In this regard we have failed to follow the urgings of Howard W. Haggard, who 25 years ago had presented in the first pages of our Journal an eloquent speech given to the American Society of Anesthesiologists on "The Place of the Anesthetist in American Medicine." After pointing out that it is not enough that good anesthesia be afforded to a fortunate few, but that all anesthesia should be the best, and available to all people, he stressed the need for the anesthetist to shape public opinion. He pointed out that ". . . the sound and enduring establishment of any specialty of medicine is predicated by three major points: (1) It must be an intellectual as well as a manual operation. (2) It must receive respect and prestige from the other members of the medical profession. (3) It must have public comprehension and must receive public respect and prestige. In short, it must appeal to the public." He then went on to emphasize the importance of what we now allude to as public relations program, but he bluntly called it "propaganda."

It is apparent that the problems which anesthesiology faces are inter-related and pertain to every aspect of our function in a society. Indeed, they strike at the heart of the matter, the very *raison d'etre* of the anesthesiologist, which is to contribute to the welfare of mankind by teaching and providing progressively better anesthesiologic care, by adding to scientific knowledge through research and by discharging his sociologic responsibilities. It is also apparent that many of these problems are inherent in anesthesiology, others are related to the practice of medicine as a whole, and still others are products of the scientific, humanistic, technologic and social revolution which is taking place. Nevertheless, they are *our* problems, and we must find solutions to them. This, then, is the great challenge which faces anesthesiology today.

Anesthesiology must meet this challenge if it is to control its development, practice and destiny, lest others do it for us. The right response will require a shift in emphasis away from contesting merely for the rights of the specialty toward the obligations of care, teaching and research.

I believe there are practical, reasonable and productive activities the specialty can undertake to meet the challenge. However, this will require a maximum effort on the part of *every* anesthesiologist to discharge his responsibilities as a physician. It will also demand that the American Society of Anesthesiologists formulate long range plans and implement whatever actions necessary to correct existing deficiencies. In this national effort, our Society must receive the full support and cooperation of component, regional and national groups, but particularly the American Board of Anesthesiology, the Association of University Anesthetists, and the Section on Anesthesiology of the American Medical Association. There is urgent need for closer liaison among these groups and with other medical societies.

Mine are not original recommendations. They were alluded to by my immediate predecessors during their terms of office, and spelled out by the firm that carried out the Survey. My purpose here has been to publically endorse these recommendations and to have the opportunity to assure all anesthesiologists that during the coming year I will spare no effort, time or personal sacrifice to help anesthesiology realize these objectives.

JOHN J. BONICA, M.D.
President, *American Society of Anesthesiologists, Inc.*