

blood pressure was most likely due to pre-block hydration, gradual institution of a restricted block in the supine position and, perhaps, the cardiac stimulation of moderate blood levels of lidocaine. We underline Bonica's statement that extensive sympathetic blockade in arteriosclerotic patients may prove dangerous. However, the benefit of a restricted peridural block in terms of graft survival appears worthy of consideration.

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## The Anesthesiologist Unfulfilled

*To the Editor:*—In a 40-year view of the anesthesia scene, peaks and valleys of an earlier year stand out. Human nature being what it is, the valleys of little progress may be more easily remembered than the peaks of achievement. We often wondered, 20 or 30 or 40 years ago, why so few able men were attracted to our field. Among the basic reasons for this is one I have never heard mentioned: the dull, dull meetings of that time, meetings which were endlessly devoted to the affirmation of the "importance of the open airway." Of course it *was* and *is* important, but to build meeting after meeting on that obviously important but unexciting theme was not likely to attract enough stimulating candidates for training. The span from those early and dreary days to the achievements of the present represents a struggle and an advance of remarkable quality and extent not only in Western countries, but in Eastern countries as well: the development of anesthesia in Russia, for example, from 1956 to 1970. At my first visit there in 1956, nearly everything was done or attempted with local anesthesia. Ether administered through an endotracheal tube was rare. In Vischnyevsky's famous clinic pneumonectomies were done (or attempted) under local anesthesia, without either addition of oxygen or the use of positive pressure. In 1970, techniques in Russia, at least in the major cities, were similar to ours. Especially in the U.S.A., in England, and in Scandinavia, there is an intellectual climate equivalent to

that of the best specialties in medicine. The meetings are stimulating.

In almost every way the field of anesthesiology has advanced—in *almost every way but one*, standards and performance far exceed those of 25 years ago. I refer to the widespread belief that the chief can maintain his skill and his authority without himself conducting anesthesia. Anesthesia is a technical and intellectual specialty. It is true a good many chiefs spend time in the operating theater "supervising." There are endless stories of fiascos in which the chief, whose techniques have fallen away, attempts a difficult, and in the event, disastrous maneuver. If individuals wish to limit themselves to the physiologic or pharmacologic aspects of anesthesia, fine! But they should not call themselves anesthesiologists. Everybody knows what the medical world thinks of surgeons who do not do surgery; I cannot see that the non-practicing anesthesiologists are any better off. Twenty-five years ago the chief usually administered anesthesia regularly; today, this is far less common. I believe such present policies are in error.

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