

## Presidential Message

### *Challenges in a Changing Medical Environment*

The medical profession has a guiding goal—the welfare of mankind, which it implements through medical education, the application of research findings to man, superb individual patient care, and concern for the health of the entire nation. In accomplishing this goal today, the key word throughout organized medicine, and reiterated by individuals in government positions, is manpower. Certainly manpower is a major problem and a major responsibility for the specialty of anesthesiology.—M. T. JENKINS, *Chairman's Address, A.M.A. Section on Anesthesiology, 1969*

IN ASSUMING LEADERSHIP of ASA for the coming year, I have accepted the traditional invitation of the Editors of ANESTHESIOLOGY to present my views of the immediate problems facing our specialty. I must reflect that the two-year-old statement cited above is even more with us now. In subtle or overt ways, the manpower problems cast their shadows over our other concerns for guiding policies of practice and ethics, for changing patterns of medical practice, for the growing dimensions of continuing education, and for the anxiety engendered by peer review and medical audit.

#### Manpower

At present there are 28 schools of allied health professions in the United States, and it is estimated that 70 new community colleges will be operational this year. Many have training courses in the nursing arts, and several are adding schools for training allied health personnel. Substantial sums are available now through federal grants for these programs, and anesthesiologists are eligible to formulate programs and apply for support.

The Committee on Manpower of the ASA has embarked upon an ambitious demographic study to review manpower and to define the elements of the anesthesia care team and their relationships. This study can provide valuable data to support or to study the establish-

ment of more training programs for physicians' assistants in anesthesiology. Two programs well conceived and supervised already exist for training allied health personnel in anesthesiology (Case-Western Reserve and Emory University).

Recognizing the risk of anesthetic morbidity and mortality for all patients, young and old, healthy and sick, the ASA will accept a grave responsibility if it recommends training of technicians with less background experience in patient care than that of nursing school graduates to administer anesthetics. If our demographic study shows that more physician assistants' programs in anesthesiology should be established, I recommend that the ASA follow the guidelines developed by the AMA Council on Health Manpower for the development of new health occupations. In interpretation of these guidelines, the ASA House of Delegates should indicate that the specialty has documented a need for physicians' assistants in anesthesiology. Then it should describe and identify their specific roles and functions. Problems of their employability, their licensure or certification will come under consideration, as will the burdensome worry of who assumes their legal responsibility.

I personally believe there are many tasks related to the conduct of anesthesia that the trained anesthesiologist's assistant can perform,

but that his final role will be that of an assistant. The anesthesiologist's background of training and foreground of medical conscience is necessary for quality medical care. Some, only superficially informed, believe anesthesiologist's assistants can provide skilled anesthesia care in the absence of anesthesiologists or nurse anesthetists. It should be made universally clear that an assistant can expedite the completion of a day's schedule in a specific hospital, but this does not automatically assure that a significantly greater number of patients can be cared for in a hospital with limited facilities.

With conscientious concern for the nation's health care, we cannot endorse a thesis that a physician's assistant in anesthesiology can work independently in the community hospital. The anesthetized state, produced by drugs with lethal potential, is a dangerous one with inherent morbidity and possible mortality even for the healthiest patients. There is no moral or ethical justification for training an allied health technician for independent practice, nor should the thoughtful surgeon be willing to accept legal responsibility for the independent technician. Although technicians may have some expertise in common with the professional, it is recognized that we advance medically and technologically through the efforts of our professional men. The technician may do difficult work, and in a routine manner, but it should be under the specific supervision of his professional superior whose ultimate goal is to enlarge upon knowledge in anesthesiology and devise new methods of putting it to practical and safe use.

Until the role of the physician's assistant is defined by experience, I view the concept as experimental and evolutionary. Until roles are defined, I do not believe that the physician's assistant should be granted licensure or certification.

At the predicted rate of growth, by 1980 there will be more employees involved in the delivery of health care—the so-called health industry—than in any other industry in the United States. And by 1980, if our medical schools continue to increase enrollment, and if patients will be treated in specialized centers (not every Hill-Burton hospital will qualify as

a center), will there then be a collision of interests and space between M.D.'s and allied health personnel? Will the allied health personnel, the physicians' assistants, cease to work under the direction and supervision of the physician and band together as independent health personnel, setting up external business organizations to negotiate with physicians and hospitals? These are rhetorical questions which are instinctively answered in the negative, but still there are compelling reasons why they are asked.

### Guiding Policies

In this changing medical environment, the ASA finds itself in a highly advantageous position compared with most other specialties in that it has established three important documents: *Statement of Policy*, *Guidelines to the Ethical Practice of Anesthesiology*, and *Standards for Patient Care in Anesthesiology*.

To maintain viability in changing times, these documents need review, and perhaps a section of *Guidelines to the Ethical Practice of Anesthesiology* needs revision. This section concerns the ethical relationship of anesthesiologists and nonphysician personnel. As it stands, the section is neither entirely contemporary nor quite anachronistic in defining the ethical relationships of anesthesiologists to nurse anesthetists. This would be a necessary preliminary to defining the ethical relationships of anesthesiologists to allied health personnel, should such personnel be developed as anesthesiology assistants.

These three documents apply to the anesthesiologist as an individual and give him guidelines for practice. Now perhaps we need a fourth statement, "Anesthesiology Health Care," to voice the concern of the specialty organization to provide quality anesthesia throughout the nation despite a shortage or disparate distribution of anesthesiologists. It is not immediately possible to attain the ideal of nationwide quality anesthesia because of the many hospitals located in small communities where they fulfill vital roles but where medical specialists are limited or absent. Studies could conceivably show sufficient numbers of anesthesiologists now if all patients were

treated in specialized medical centers, but there are insufficient anesthesiologists today to serve all community hospitals. Consequently, beyond our immediate environs we must be willing to consult with physicians of these hospitals and with nurse anesthetists working with those physicians. Further, we should be willing to accept the family practitioner or any other physician for preceptorship training in anesthesiology for any length of time he can commit. With some training in anesthesiology, reinforced and extended yearly through ASA refresher courses, he can make a significant contribution to this aspect of community health.

### Trends in Education Affecting Anesthesiology

Many forces now applied to medical education may diminish the numbers seeking specialty training in anesthesiology as well as have a deleterious effect upon the qualifications of those who enter residency training.

Contributing to this is the trend in medical schools toward development of a core curriculum which relegates anesthesiology entirely to a postgraduate role. In these schools, students have no association with an anesthesiology teaching service. Since about one out of fifteen of our population is anesthetized each year, medical students need some knowledge of anesthesiology, gained best from clinical clerkships and intelligently applied to later clinical practice, whatever discipline they follow. Most physicians seeking training in anesthesiology do so because of an earlier stimulating experience in which they recognized the anesthesiologist as an active and informed scientist, and it is imperative that we offer elective or required clerkships in the medical school and increase the number of student preceptorships.

A second force affecting the character of anesthesiology is the change in the requirements for postgraduate training. Based on the premise that the medical student today has opportunities for great clinical experience during his medical school training, the AMA House of Delegates has voted to abolish internships entirely by July 1975, with the strong admini-

stration that they be discontinued even sooner wherever feasible. Coupled with changing medical school curricula, this leads to my concern that future residents in anesthesiology will not have time sufficient to develop mature medical judgment by the end of their required formal training periods.

Thirty-six medical schools have already restructured their curricula to three-year formats, in some cases with one to one and a half years devoted to elective courses. It is possible, therefore, for a student to go through this straight 36 months of medical school with a minimal number of medical disciplines included in his elective time. Without an internship he could complete the residency training requirement in anesthesiology in an additional two years. Is this sufficient time, in terms of the quality of the total education of the anesthesiologist and maturation of his medical judgment? Will he have had adequate opportunity for development of critical judgment which is vitally dependent upon time for its ripening?

Although the ASA does not establish requirements for training in anesthesiology, it does express the opinions of the specialty. When the internship is eliminated, I favor the Society's recognition of the values of a three-year postdoctoral continuum of education in anesthesiology, which still requires 24 months of clinical anesthesia, and with 12 months of other medical education and experience as agreed upon by the program director, his resident, and The American Board of Anesthesiology. Should the ASA endorse in principle the three-year continuum in education, the AMA Council on Medical Education would know that the specialty has genuine concern for high standards of education as a requisite for quality health care.

Postgraduate training in anesthesiology today is producing excellent young anesthesiologists. The Residency Review Committee for Anesthesiology, representing both the Council on Medical Education of the American Medical Association and The American Board of Anesthesiology, has introduced quality controls in training programs which have made these programs extremely effective. Recruitment stands at an all-time high, partially

through the effects of the superb Preceptorship Program and other educational activities of the ASA, and partially through the day-to-day efforts and examples set by our members. The anesthesiologist today has broadened his scope of professional practice. He is now a familiar and valued physician in the areas of acute medicine, intensive care, the respiratory ward, and the coronary care unit, as well as in the recovery room and in the operating suite. Indeed, in many hospitals, because of the special interests of the anesthesiologist, he is the leader in these other spheres. These leaders developed from a conventional medical education of four years, a year of internship, and either two or three years of residency training. We must be careful that we do not sacrifice these major gains toward better patient care by untested innovations in education designed only to shorten periods of training and to gamble on the product. (One wonders why so little thought has been given to the shortening of pre-baccalaureate training, considering the quality of the high school graduate today.)

### Continuing Education

In a discussion of the maturity of the anesthesiologist, it is appropriate to recognize our personal obligations for continuing education. The journal *ANESTHESIOLOGY* especially, the self-evaluation examination, refresher courses, ASA scientific programs, postgraduate seminars, and even the medical audit and peer review each give one dimension to continuing education. The self-evaluation examination can give us insight into our individual academic knowledge and needs. A recent guest editorial in the *ASA Newsletter*<sup>2</sup> notes that some state medical societies and at least one ASA component society have already established minimum requirements of postgraduate study for continued membership. The author asks, should the ASA be the first specialty society to develop a national policy for continuing education requirements? If we should document the registration at the many special conferences throughout the nation, I believe we would find that a majority of ASA members attend one or more each year.

At the annual meetings of the ASA, the refresher courses are generally oversubscribed, attesting to their popularity as well as to the desires of the membership for continuing education. I believe we should offer our membership a series of regional refresher courses on selected week-ends during each year in various areas of the nation, not to compete with other postgraduate courses but rather to make this unique educational opportunity more widely available.

### Peer Review

The term "peer review" has stirred an unnecessary protest because some physicians interpret it only as a review of professional services, particularly fees, by non-physicians. In the true concept of peer review, physicians review other physicians' quality of patient care, ethics, and conduct. Charges are also considered if there is a reason. This is not a new aspect of medical practice, since county medical societies for many years have maintained adjudication, insurance review, and public grievance committees. At the hospital level, morbidity conferences and case reviews serve anesthesiologists in place of tissue committees. Other aspects of peer review, such as utilization and medical audit, have been implied for years in recommendations of the Joint Committee on Accreditation of Hospitals.

Emotionalism over peer review has been stirred by some governmental agencies and by health insurance associations which have magnified claims reviews out of proportion to professional care. Peer review as a concept should not be confused with "Professional Services Review" or "Professional Standards Review Organizations," which by definition embrace review of a physician's activities by non-physicians.

In concert with other medical specialties, I feel that the ASA should recognize that peer review as applied to the survey by physicians of the care rendered represents a mechanism for improving quality. This, in effect, is an educational endeavor.

We must not forget that anesthesiologists and surgeons have always exercised a form of

peer review—the daily mutual consultation and approbation of each other's medical practice.

*Compelling forces bearing upon the practice of anesthesiology today include the manpower problems, our guiding policies vis-a-vis peer review, and changing trends in the entire field of medical education. These forces may be compared with those of a smoldering volcano—impossible to tell in which direction it will erupt next, so that little direct prophylaxis can be applied. As failure is not necessarily fatal, so success is not final. Success can only be measured by how well we cope with problems*

*as they arise without diminishing our devotion and dedication to patient care.*

M. T. JENKINS, M.D.

President

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#### References

1. Jenkins MT: Anesthesiology: Some of its problems and responsibilities. JAMA 211:282-285, 1970
2. Larson CP: Continuing education requirements for the ASA. ASA Newsletter 35:June 2-4, 1971

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#### Poem

Lights without shadows line the ceiling—  
the doors to inner earth suck shut behind my stretcher.  
I know as I think "run," the paralyzing nightmare impotence  
of the attempt.  
Layers of loneliness and fear separate my body from the blankets.  
I'm cold.  
I've lost the sun.

Then voices: "Why the trembling dear—  
don't worry, you will just drop off to sleep."  
Oh god that dreamless sleep, a drop into a void of gray,  
a wedge of death.  
How will my wounded body find its soul  
without a memory of what that death has been.  
I want to run.  
I can't.  
I'm cold.  
I've lost the sun.

—SUSANNE J. LAMDIN, M.D.