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Editorial Views

Anesthesiology Comes of Age

THE SPECIALTY of anesthesiology appears to be evolving in phases that are characteristic of other specialties and can be described in terms of the human maturation process . . . birth, infancy, young childhood, adolescence, mature adulthood, and, lastly, old age. There is increasing evidence in recent years of our specialty's finally coming of age and assuming many of the rights, privileges and, most important, responsibilities of maturity. A few examples that immediately come to mind are the independent status of most academic departments, the elevation of anesthesiologists to positions as Vice Presidents or Deans of Medical Schools, the election and appointment of some of our members to high positions in Federal, State and Commonwealth governments, greater representation in the National Institutes of Health, and the evolution of the anesthesiologist's relationship to nurse-anesthetists.

Another manifestation of this stage in the evolution of our specialty is the trend toward sub-specialization by young men and women in anesthesiology. Recent years have witnessed a sharp increase in the amount of time an anesthesiologist spends in the care of patients outside the operating room. As a result, we have seen significant numbers of our colleagues devoting much if not all of their time to such fields as obstetric anesthesia, perinatology, chronic pain, and respiratory and critical care. The expertise that anesthesiologists exercise during the administration of anesthesia and during surgery makes them particularly capable of assuming prime responsibility in these and related areas. In addition, more and more anesthesiologists are developing specialized interests within the operating room, such as pediatric, neurosurgical, and cardiovascular anesthesia. We even have examples of anesthesiologists restricting themselves to electroconvulsive therapy, ophthalmologic anesthesia, and ambulatory anesthesia.

A natural extension of this trend is for people with a common interest to come together, exchange ideas, and perhaps form a society that would help promote their objectives. Excellent examples of this are The Society for Critical Care Medicine and The Society for Obstetric Anesthesia and Perinatology. The latter has grown in a few short years to a membership of almost 400. Most recently, I have learned of the formation of a society devoted to pain, The International Association for the Study of Pain.

A philosophical conflict has arisen as a result of this greater and greater specialization. On the one hand, we have the ardent disciples who feel that only through devotion of their full-time efforts to a given field can major progress be made in their areas of special interest.[1] On the other hand, there are those who feel equally strongly that we are anesthesiologists first, last, and always, and as such must spend at least some of our professional time practicing all forms of anesthesia. Indeed, to still others, full-time subspecialization represents abandonment of anesthesiology.

As recently as seven years ago, at a Macy Conference devoted to education in anesthesiology, it was concluded that although the anesthesiologist's expertise qualifies him admirably to provide unique medical services to patients elsewhere, his primary duties must always be in the operating room.[2]

I disagree fundamentally with the latter point of view, although I must also admit that I participated in the Macy Conference. It would now appear to me that an anesthesiologist serving on a full-time basis in a special unit, in or outside of the operating room, should not have to revalidate his credentials as an anesthesiologist by occasionally administering all forms of anesthesia. As a specialty, we should not insist that these young men and women constantly pledge or demonstrate their continued allegiance to anesthesiology by serving in areas outside of their sub-specialty. Our specialty, similar to others in the past, has matured to the point where we can stop being defensive about ourselves and instead take pride in the major contributions to medicine made by some of the sub-specialties within our discipline. Therefore, we should encourage rather than discourage these special interests.

The advantages of such an approach are self-evident. These physicians, armed with the unique knowledge and skills of the anesthesiologist supplemented by in-depth training in specific areas, could provide patients with benefits not readily available through other physicians. Such specialization would be conducive to meaningful clinical and laboratory research and to the greater growth of knowledge in the field. Major advances in our knowledge, understanding and clinical care of patients have been made by those who devoted their full time to a specialized area.

The advent of more complex operations, organ transplantation and implantation, and more sophisticated instrumentation requires each member of the surgical team to have even greater competence. These highly specialized anesthesiologists will be as informed, as skillful, and as experienced as other members of the team. Clearly, this will have significant impact on our image as a specialty and hence on recruitment of medical students.[3]

The potential dangers of sub-specialization by anesthesiologists are similar to those of overspecialization in other areas—fragmentation of a specialty, tunnel vision, and further dilution of the efforts of an inadequate number of anesthesiologists. Obviously, what is gained in depth in one area, is lost in breadth in the rest of the field. There is even the danger that some enthusiasts may abandon the field entirely and, in effect, renounce their roots and heritage in anesthesiology. In this regard, I am in complete accord with David Little, who called for balance and perspective in the matter.[4] The specialty cannot abandon the administration of anesthesia as our fundamental wellspring of strength and expertise. However, there is room, manpower, and need for full-time subspecialists within the discipline of anesthesiology.

What about sub-specialty boards? I will not get into that argument. However, I am told by friends knowledgeable in this field that the American Board of Medical Specialties has made it clear in the last few years that only with the greatest reluctance will it sanction new sub-specialty boards. My prediction: there will be sub-specialty boards (or their own equivalent certification) in anesthesiology within ten years.

I am personally indebted to one of these sub-specialties, since it was through obstetric anesthesia that I first made my mark in anesthesiology. However, I have always considered myself first and foremost an anesthesiologist, and proud of it. I hope that our young colleagues entering these special fields will share these sentiments. I am equally confident in our future, and see no difficulty in attracting adequate numbers of anesthesiologists to provide surgical anesthesia. The specialty of anesthesiology has come of age and can take great pride in the work of these dedicated and highly qualified subspecialists.

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