THE SURGEON-ANAESTHETIST RELATIONSHIP.*

by

R.H.Orton,M.B.,B.S.,D.A.(Melb.).
(Melbourne).

The purpose of this address is to discuss the relationship that should exist between surgeons and anaesthetists and to attempt to suggest means by which the status of the anaesthetist can be improved.

Most of us have come to realize that modern anaesthesia has become increasingly complex. With the complexities have arisen new hazards for the patient. These added risks can be justified only if they confer benefits upon the patient. I believe that the added benefits which result from these methods,when employed by skilled anaesthetists,more than outweigh the risks. But the point I wish to make is that modern anaesthesia demands a very high standard of skill from those practising it. How can this high standard be realized ?

Firstly,the surgeons must be made aware of the possibilities of modern anaesthetic methods,of their dangers and of the demands which they make upon the knowledge and skill of the anaesthetist. This education can best be done by the demonstration of results. But it is useless to demonstarte results unless they are good. It is the duty of the senior members of the specialty,who already enjoy the confidence of their surgeons,to acquire skill in modern technique and to convince the surgeons that it will enable them to perform more complex operations,but with less disturbance to the patient. It is the duty of these senior members to seize every opportunity offered by postgraduate lectures and surgical sessions to impress upon the younger generation of surgeons that,if they wish to attain eminence in modern surgery,they must exploit to the full the advantages that modern anaesthetic methods can offer them.

Secondly,those anaesthetists who occupy senior posts must insist that those under them who propose to employ these newer methods should have previously acquired the necessary skill and knowledge. In the past, far too many anaesthetists have lightheartedly given new and potent drugs without so much as reading the literature wrapped around the package by the manufacturer. They have set out to employ apnoeic methods without the

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* Address by the retiring President to the Australian Society of Anaesthetists,Perth,Aug.16th,1948.

slightest knowledge of what they were doing to the physiology of their patients. As a result of these actions, many drugs and methods have suffered discredit. These unjustifiable and dangerous actions should cease and their control is in sight when we see ahead the formation of Departments of Anaesthesia, having at their head directors who can control their subordinates. I saw this method at work in Auckland, where all anaesthetics administered in the public hospitals of the city were under the control of one man, and he saw to it that the anaesthetist allotted to any particular case was capable of handling it, whether he was a staff anaesthetist or a visiting one. This means that an anaesthetist is guided along his career, starting with simple methods and gradually acquiring skill in the more complex, being at all times under supervision if necessary. Here in Perth, a step has already been taken in this direction. Melbourne has similar schemes under consideration.

Thirdly, we must bring the specialty of anaesthesia into line with other specialties by requiring that, before a person can be appointed to a senior position upon an anaesthetic staff, he must possess a higher qualification in anaesthesia. In the past, it was impossible to insist upon this, as higher qualifications were not available in the country. Today, with diplomas in anaesthesia being granted in two States of the Commonwealth, it is time that we reviewed the situation. One would not expect a general practitioner who had shown some interest in surgery in his practice to apply for, and be appointed to, a senior surgical position in a teaching hospital. Men have occupied such posts without higher degrees on rare occasions, but only after long apprenticeship. Why, therefore, if we wish to raise the status of the anaesthetist, should we continue to appoint to senior anaesthetic positions people who have shown but a passing interest in the subject ? I trust that none will take this as a personal gibe. Many of us have acquired what skill we have in the hard way and have served our hospitals to the best of our abilities. I consider, however, that the time has passed when such a haphazard approach to anaesthesia is necessary. In the future, we should aim at placing our chosen specialty on an equal footing with any other branch of medicine.

When we have educated ourselves, educated our surgeons and raised our status to that of other specialists, then and only then can we meet our surgeons upon an equal footing. Then can the surgeon say to the casual

anaesthetist who refers a patient to him,not "Would you like to give the anaesthetic ?",but "Have you qualifications which entitle you to consider that you are capable of giving this anaesthetic ?". This is the state of things today in Britain,where so many anaesthetists have taken the Diploma of Anaesthesia offered by the Conjoint Board. Surgeons demand anaesthetists with a higher qualification and no appointment is made to a senior post without the Diploma. I earnestly suggest to the younger members of this Society,for their own protection,that they consider the possibility of acquiring a higher qualification. With nationalization of medicine looming on the horizon,it is well to think of the future.

In the past,the relationship between the surgeon and his anaesthetist has been too much that of master and servant,the servant merely doing the bidding of his master. It is time that this attitude vanished and the two worked together as equally-important members of a team. To achieve this, the anaesthetist must know more of his own subject than does the surgeon. From this arises the question of what is the extent of the anaesthetist's subject. In the past,too much attention was focussed upon the actual administration of the anaesthetic and the surgeon felt,with considerable justification,that he himself could drop ether from a bottle just as efficiently as could his anaesthetist. The position of the latter was not improved when the surgeon found him to have little knowledge of what abuses he was inflicting upon the physiology of his patient. The surgeon felt that it was necessary for him to exercise considerable control over the administration of the anaesthetic. Now,however,the responsibility of the anaesthetist commences long before the patient reaches the operating-theatre. It is his duty to assess the patient and provide him with the necessary medication that will ensure a smooth approach to his surgical ordeal. During the administration,it is the duty of the anaesthetist to maintain a careful watch upon the condition of the patient and to see that all appropriate measures are taken to counter any undesirable effects. The administration of intravenous fluids should be his responsibility and with him should rest the decision as to the volume and nature of those fluids. After the administration,the anaesthetist must decide if and when oxygen is needed and the best method of administering it in the particular case. Post-operative respiratory complications should be his responsibility and he should be equipped to deal with any of these as they may arise. Th

may involve such procedures as tracheo-bronchial suction or bronchoscopy. Under these conditions,I believe the anaesthetist achieves his place in the surgical team and finds that he enjoys a status equal to that of the surgeon.

But can this be obtained under present conditions of practice ? I think the answer must be "no". How then are we to achieve the result ? I believe that the anaesthetist must be relieved of a considerable part of his financial burden if any approach to the ideal is to be made. The present system involves the anaesthetist in a great deal of unpaid work,so that,in the rest of his time,he is forced to fit in as many administrations as possible in order to eke out a livelihood. Two alternatives seem possible which will allow the anaesthetist to devote more time to each patient. Either the fee that he receives for each administration must be considerably increased or else he must be adequately paid for the work which he at present performs for charity. It seems to me that a little of each alternative is desirable. The scale of anaesthetic fees is out of all proportion to the amount of attention the anaesthetist should give to his patient. I deliberately say "should give",as I feel that he should devote more time than he does today. The second suggestion is that he should be paid for his work in public hospitals.

How does this scheme of payment work out in practice ? I think it justifiable to relate my personal experience over the past year or so,to give an idea of what work can be done by an anaesthetist under this system. In the thoracic unit in which I work,I ~~xxx~~ am employed by the hospital upon a salary basis,but have the right of private practice to the extent that I can charge fees for all private anaesthetics administered in the unit. The result is that I administer anaesthetics to approximately 250 major thoracic cases per year and carry out on these patients all the pre-operative and post-operative treatment which I have already enumerated. I find this work a full-time occupation,with very little spare time,and I feel that these patients are being reasonably well cared-for. What would be the position if I were doing this work on a charitable basis and were required to earn my living in the time left at my disposal ? The pre-operative and post-operative treatment would have to be sacrificed. A thoracic unit is,of course, an extreme example,for the post-operative attention is much greater than with general surgical cases. But the anaesthetist who deals with general surgical work would,if relieved of the burden of the honorary side of his

practice, find more time to follow up his patients and attend to their needs. Recently, I investigated the pulmonary complications in one hospital and found that no case of post-operative atelectasis had been actively treated in the past five years, except those which had occurred in the thoracic unit. Surely this is an indication that, under the honorary system, the patient is not receiving the maximum attention.

At the risk of redundency, I should like to recapitulate my opinions. I feel that the present relationship between surgeon and anaesthetist is not entirely satisfactory. It can be improved if the status of the anaesthetist in the community is raised. In order to raise it, the anaesthetist must be prepared to place himself in the same position as the specialist in other branches of medicine. Having done this, he will find that, to do justice to his patients, he must restrict the volume of work that he does. As a corollary to this, he must receive remuneration for the service that he gives at present in an honorary capacity.