WHITHER ANAESTHESIA?*

QUINTIN GOMEZ

Mr. President, Colleagues:

THE POPULAR SPEAKER or professional lecturer usually tells his audience what they would like to hear, or discusses a subject he knows is not really controversial. In this way, the listeners and the speaker go home with the feeling that "a good time was had by everyone." The verdict is, "he is an interesting speaker, let's have him back again. By the way, what did he talk about?"

Fortunately, the president of the World Federation of Societies of Anaesthesiologists cannot be re-elected, according to the by-laws; nor can he be replaced unless he dies or becomes an idiot. Being ineligible for re-election gives me the freedom to tell you what you may want to hear without being suspected of politicking; and since I have no intention of dying or turning into an idiot before 1980, I intend to discuss subjects which may not only be controversial but actually unpleasant.

The Canadian Anaesthetists' Society is a Founder Society of the World Federation and its first president was a Canadian. The Second World Congress of Anaesthesiology was hosted by the Canadian Society in Toronto in 1960. Your Society has been continuously represented in the Executive Committee and various standing committees of the Federation since its inception. Your Society has been and still is one of the pillars of our Federation. For all this I thank you and sincerely hope that in the future, much more support will be forthcoming.

All over the world today there is an increased effort to study the problems of anaesthesia and anaesthetics. As you well know, research into the physiology, pharmacology, immunology, physics, psychology, and even the legal problems of anaesthesia and anaesthetics is continuously expanding our knowledge. And yet, the statistics of the World Health Organization show that anaesthetic morbidity and mortality are still high, world-wide. Apparently good and safe anaesthesia is not as easy to deliver as we might think, or as others among us might think. In most instances it is the "apparently simple" case which gives us the most trouble.

I believe that the first and most important step to delivering good, safe anaesthesia is to admit to ourselves that there is no such thing as fool-proof anaesthesia; that there is no technique that is not potentially hazardous to some degree; that there is no drug that is 100 per cent harmless; that the intra-anaesthetic period is a period of intensive care (or "critical care" if you wish to use that term) and that the operating room is an intensive care unit.

In reality, in the majority of our elective cases, we are conducting a relatively healthy person through a short period of intensive care and returning him to his

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room in the best possible condition. As anaesthesiologists, it is our responsibility to protect the patient from the hazards of anaesthesia and surgery during this period, to the best of our ability.

Another problem I have noted is the widening gap between the delivery of good anaesthesia to patients and the scientific advances in anaesthesia. The result is that, in spite of all the research and advancement in drugs and equipment, morbidity and mortality traceable to inadequate or poorly administered anaesthesia is still high. We must do something about this before it is too late.

It has been said that the development of a medical specialty is an indicator of the culture of a nation, and the rise and fall of a specialty is influenced by the social development of that nation. That is why, as one travels from one country to the other, he finds that the status of the anaesthesiologist and the prestige of the specialty are different.

The challenges and our response to those challenges determine the development of our specialty. At a symposium on Education in Anaesthesiology in the U.S.A. some years ago, the question was asked whether anaesthesiology should exist as a specialty. Apparently the idea has grown that the only way for anaesthesia to be recognized as a specialty is in the field of research; that the problems of patient care in the operating room are not worthy of the attention of intelligent, creative men. The idea of individualizing medical benefits for the ordinary patient is of no consequence. This problem is due to what some feel is the unglamorous work of relieving pain. The saving and maintenance of life day by day is not considered important, but some technical surgical exercise almost lacking in importance can gain the attention of the medical world. This attitude must be reversed by leadership, by closer rapport with patients, and by learning to find comfort and solace from the intrinsic worth of what we do without the applause.

Fifty years ago the anaesthesiologist asked the surgeon to be his partner in order to provide better care for his patient. Today the anaesthesiologist is not only a partner to the surgeon but also to the obstetrician, the paediatrician, the internist, the cardiologist and the psychiatrist. Anaesthesiology has developed far beyond the confines of the operating room and the recovery room. This has been good, but it has also resulted, to a certain degree, in lessening the importance of the anaesthesiologist in the operating room where his principal activity in patient care still requires his total concentration and ability.

It has been suggested that anaesthesiology be made part of internal medicine, which means that an anaesthesiologist would become an internist practising anaesthesiology. We have overlapped so many specialties, especially internal medicine, that anaesthesiology no longer conforms to existing ideas of what a specialty should be.

I believe we should stand back and take a good look at our activities and our teaching. We are involved in recovery rooms, intensive care units, inhalation therapy, pain clinics, and now in critical care medicine both outside and inside the hospital. These activities have challenged us and stimulated us to develop better patient care, but, without our realizing it, less qualified people are creeping back into the operating rooms to do what we originally told the surgeons only we should do. Is this why more accidents are occurring in the operating rooms? Is this why

the surgeons are beginning to assert more control of patient care in the operating room? Has the day-to-day administration of anaesthesia become so simple or so safe that more and more nurses are utilized in operating rooms? Has the need for anaesthesia become so pressing that poorly trained physicians will now be given equal rating with Certified Fellows?

Education and training vary from region to region, but the objective is still the same, and that is to make anaesthetics and anaesthetic procedures as safe as possible. How safe we make these anaesthetic procedures is entirely up to us. One of the most important facts to remember is that the practice of anaesthesiology is the practice of medicine and medicine must be practised by doctors of medicine.

Has the leadership of anaesthesiology failed to cope with the demands of the specialty in providing training and providing inspiration for future anaesthesiologists?

Let us ponder these questions seriously because we are approaching a cross-road. We must choose the right turning or anaesthesiology as a specialty will become a "fossil of history."