HISTORICAL DEVELOPMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

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Figure 14-1. Adolph Frederick Erdmann
M.D.
A GROUP OF PHYSICIAN ANESTHETISTS MET at the Long Island College Hospital in Brooklyn, New York, on October 6, 1905, at the invitation of Dr. Adolph Frederick Erdmann (Fig. 14-1), a practicing anesthetist there. These physicians practiced anesthesia in Brooklyn and Dr. Erdmann thought they should meet to discuss common problems, so they formed the Long Island Society of Anesthetists. Organized anesthesia, as we know it today, stems from this Society (Fig. 14-2).

The object of this first formal organization in the Western Hemisphere was "to promote the art and science of anesthetics." Hospital anesthetists and other qualified physicians whose special interests were in the field of anesthesia were eligible to join. Dues were $1.00 per year and scientific sessions followed the business meetings each month. By 1911 membership had increased to twenty-three physicians, primarily from other sections of New York.
City, particularly Manhattan. These included such venerable names as James T. Gwathmey, Thomas D. Buchanan, Joseph E. Lumbard and William E. Woolsey. At the October 28, 1911 meeting with Erdmann as President, the Society emphasized its cosmopolitan nature by changing its name to the New York Society of Anesthetists.\(^2\)

In the following years, with Gwathmey as President, a new constitution was adopted, stating the Society's objective as "the advancement of the Science and Art of Anesthesia."\(^3\) Dues were increased to $3.00 per year and membership increased to fifty, including anesthetists beyond New York. This growth and broader geographical representation encouraged the membership to consider a national society and to confer with the officers of the American Medical Association about forming a Section on Anesthesia. However, nothing developed from this interchange.

The Society continued to grow in size and interest. By 1916, more frequent clinical meetings were held in the New York City hospitals in addition to regular business meetings. Prominent speakers, who subsequently became members and increased the membership to seventy, included Arthur E. Guedel of Indianapolis,
Alfred D. Bevan of Chicago, Frederick J. Cotton and Walter M. Boothby of Boston, and Samuel G. Davis of Baltimore. All of these anesthetists perpetuated their names in the anesthetic equipment they devised and also served their country overseas during World War I. In fact, the classic stages and signs of ether anesthesia were developed by Arthur E. Guedel while serving as consultant to the American Base Hospitals in France.4

The New York Society of Anesthetists continued to advance the art and science of the specialty during the ensuing years and the first two-day scientific program on October 17 and 18, 1930 coincided with its twenty-fifth anniversary. The first day was devoted to "WET" clinics, where a cardiotachometer was on display. The second day's program consisted of general and scientific papers. James T. Gwathmey spoke on the evolution of anesthesia; Yandell Henderson on the anesthetist as a specialist in the therapeutic use of gases; and Geoffrey Kaye on anaesthetic fatalities. Other topics included "The Psyche of Anesthesia," "The Anesthetist Himself," "Anesthesia in the Laws of the United States," and "The Responsibility of the Surgeons, Anesthetists, Hospitals and Nurses in Anesthetic Fatalities."5

In 1932, Paul M. Wood (Fig. 14-3), then Assistant Secretary to A. Frederick Erdmann, the Society's perennial Secretary, presented the Society with a seal he had designed which became the official seal of the Society, remaining intact today except for a change in name. The motto is "Vigilance;" beneath is a pilot wheel, perfect circle, shield, stars, clouds, moon, ship, sea and lighthouse. "The patient is represented as the ship, sailing the troubled sea with the clouds of doubt, and the waves of terror, being guided by the skillful pilot (the anesthetist) with constant and eternal (stars) vigilance (motto) by his dependable (lighthouse) knowledge of the art of sleep (moon) to a safe (shield) and happy outcome of his voyage through the realms of the unknown"6 (Fig. 14-4).

At a meeting in January 1936, Paul Wood, now Secretary of the Society, suggested that a Public Relations Committee be formed to focus attention on the need for national recognition of the specialty. To facilitate this, the Executive Committee polled the membership for permission to change the name of the Society to the American Society of Anesthetists. Of the 124 replies received 120 were in favor of the change. Then at the regular meeting on Feb-
ruary 13, 1936, the members agreed that in order to assume the mantle of a national society, the society should have a name to meet the requirements of the Advisory Board for Medical Specialties.

In December 1936, the Society completed its change of name by the act of incorporation. A new Constitution and Bylaws were adopted which proscribed dentists from membership. Officers of the Secretary and Treasurer were separated and a Board of Directors of eighteen members was declared the governing body; this Board consisted of five elected officers and thirteen members elected for staggered terms. The new Constitution also provided for a Committee on Fellowship consisting of nine members, also to be elected for staggered terms. There were now 484 members in the Society and dues were increased to $5.00 per year.7

In the ten years following change to a national name, the Society broadened its efforts to advance anesthesia as a specialty. It held joint meetings with local societies such as the Section on Anesthesia of the Connecticut State Medical Society, the Texas State Association of Anesthetists, the New England Society of Anesthetists, the Ohio Society of Anesthetists and the Section on
Anesthesia of the Southern Medical Association. In 1944, Paul Wood proposed that the name of the Society be changed to the American Society of Anesthesiologists, in keeping with the increased usage of that term to characterize the specialty. "Anesthesiologist" was now used to designate a physician who had received formal training in the specialty. The Society established its Distinguished Service Award in 1945 with Paul Wood as the first recipient (Fig. 14-5).

In 1947, it created the office of Executive Secretary, moved its headquarters to Chicago and revamped the Constitution. This instrument introduced the present structure of a Board of Directors representing geographical regions of the United States and Canada, and a House of Delegates composed of representatives from each of the States and Territories of the United States and each Province of Canada. It also provided for component societies on state, territorial and provincial levels, each with their own bylaws compatible with those of the national organization.
At the celebration of its Golden Jubilee year in 1955, the outgoing President, Scott M. Smith, reviewed the accomplishments of the Society that had been directed toward the advancement of the art and science of anesthesiology to date and proposed that the Society set its sights a little higher for the future. He concluded by predicting that there would be an overwhelming demand for increased services to patients far greater than was realized.\textsuperscript{11}

Significant new achievements, however, were far fewer compared to the previous years, and the Society attempted to consolidate its earlier gains. Members were primarily concerned with their economic status, the continuing struggle for universal accept-
Historical Development

ance as specialists by surgeons and hospital administrators, and the public’s confusion between the professional services of an anesthesiologist and payment of fees through Blue Cross contracts.

More than a few of the Directors’ and Committee reports and annual meeting discussions dealt with anesthesia fees and fee schedules as related to health insurance payments. This was ten years after World War II, and many returning veterans had entered the specialty and were engaged in a struggle to establish a status equivalent to that of other specialists. One index of this equivalence was income. Joseph Failing of California introduced a method of setting fee schedules called the “Anesthetic Unit Value.” His formula included such variables as anesthetic risk, surgical problems, skill required of the anesthesiologist and time involved. This method of establishing anesthetic fees, now called the Relative Value Guide, was adopted by the Society in 1962 and has since been accepted by several component societies as well as insurance carriers and other organizations.

During its transition years the Society was slow to adopt modern business methods of handling administrative matters. Financial dealings were conducted loosely without budget or auditing control. As a result, in 1958, following cancellation of the annual meeting in Pittsburgh owing to a hotel strike and consequent financial losses, the Society was faced with deficit spending. Thus it was forced to raise dues, vote an assessment of $10.00 per member and introduce an austerity program, in order to make the Society financially sound. A sound financial structure, and a new concept of the executive office staff were introduced that have since functioned extremely well.

ESTABLISHMENT OF ANESTHESIOLOGY AS A SPECIALTY

When the Long Island Society of Anesthetists had changed in name to the New York Society it had conferred unsuccessfully with the officers of the American Medical Association regarding consideration of a Section on Anesthesia. In 1921, the Society again failed to establish a Section on Anesthesia of the American Medical Association. For the next few years efforts in this direction were fruitless. The era of medical specialization began in 1933 with formation of the Advisory Board for Medical Specialties.
Unfortunately, the requirement that the parental bodies of any Specialty Board must include a related Section in the American Medical Association, precluded establishment of a Specialty Board of Anesthesiology. The New York Society therefore directed its attention to certification of its members in order to secure the status of anesthesia as a specialty. A Certification Committee was formed in December 1933 and reported a procedure for certifying fellowships, which was adopted by the Society.¹⁵

This Committee followed the format established by the Advisory Board for Medical Specialties, i.e. written, oral and practical examination. Applicants for examination came from at least twenty-three states. The first “Fellows in Anesthesia” were so designated by the New York Society of Anesthetists at the January 1936 meeting and included Joseph Lumbard and Moses Krakow of New York, Ansel Caine of New Orleans, Charles McCuskey of Los Angeles, Ralph M. Waters of Madison and Sidney Wiggin of Boston.¹⁶ But at the next meeting, as we have seen, the Society again adopted a new name, the American Society of Anesthetists. John Lundy was then sent to Chicago as delegate to the Guiding Committee of the American Medical Association and of the Advisory Board for Medical Specialties, to achieve representation for the American Society of Anesthetists. These two organizations, however, exhibited no corresponding enthusiasm for recognition of the new American Society.⁶ Efforts of the American Society of Anesthetists were weakened by the failure of other national anesthesia organizations, such as the Associated Anesthetists of the United States and Canada and the International Anesthesia Research Society, to join in a statement supporting the recognition of Anesthesia as a Specialty. These two organizations, led by Frances H. McMechan, did not wish to subordinate their identity to any other medical organization.¹⁷

The leaders of the American Society of Anesthetists devised an ingenious method to muster support from a second national organization. The American Society of Regional Anesthesia, originally organized to honor Gaston Labat, the father of regional anesthesia in this country, had become more or less inactive. Emery A. Rovenstine, acting as Secretary, sent out meeting announcements to the membership and wrote up minutes of supposedly held meetings.¹⁸ They were now able to state that “two”
national organizations favored establishment of a Specialty Board of Anesthesia. In conjunction with the Section on Surgery of the American Medical Association, the two anesthesia organizations evolved a plan to include the American Board of Anesthesiology as an affiliate of the Board of Surgery. The Advisory Board for Medical Specialties approved this affiliate Board in June 1937.

In 1939, the American Society of Anesthetists became aware of increased friendly relations with the American Medical Association. Again in October the Society appointed a Special Affiliation Committee to determine the attitude of the American Medical Association toward establishment of a Section. This Committee met with the Council on Scientific Assembly on November 24, 1939. In advance of the meeting, the Society received a letter from the Council Chairman that included the statement, "... of course I cannot speak for the entire Council, but I do believe that the establishment of a Section on Anesthesiology would be for the good of the American Medical Association and I think it would help your specialty very much — a subject in which I wish to say I am enthusiastically interested." Following the meeting, the Council on Scientific Assembly agreed to permit the American Society to hold a session on anesthesia in the Section on Miscellaneous Topics. The Council also agreed to recommend to the House of Delegates that a Section on Anesthesiology be established, a recommendation unanimously approved by the House of Delegates at its June 1940 meeting. Thus, a goal established thirty-five years earlier was achieved. Anesthesiology was a recognized specialty.

Immediate benefits of having its own Section in the American Medical Association were soon realized. The surgical specialties, which were affiliated Boards of the American Board of Surgery, desired to separate into individual Boards. In 1941, along with these specialties, the American Board of Anesthesiology was approved as a separate major Board by the Advisory Board for Medical Specialties with the unanimous consent of all participating Societies and Boards. A more detailed account of the evolution of the American Board of Anesthesiology is presented elsewhere in this volume.

Although certification of specialists in anesthesia had been accomplished, the American Society of Anesthesiologists continued to
grant Fellowship certificates. The only qualifications for Fellowship were evidence of some special training in anesthesia, some practice of anesthesia and membership in the Society. The first examinations were given in 1939. In 1947 the new Constitution established an American College of Anesthesiologists within the Society to replace the Committee on Fellowships. In the new organization members of the Fellowship Committee became the Board of Governors of the College. The 250 members with Fellowship Certificates automatically became Fellows of the American College. In 1954, there were 1,280 Fellows certified by the American College of Anesthesiologists; by 1970 they numbered over 5,000. The College was developed to encourage physicians to enter the specialty, to stimulate them toward attaining competence and to provide a means of recognition for qualified physicians who did not limit their practice to anesthesia or who had not fulfilled training requirements of the American Board. Since then, the Society has sponsored a self-evaluation program under the aegis of the American College of Anesthesiologists. All members of the Society, including those still in training, can participate with the assurance of complete anonymity.

MANIFESTATIONS OF GROWTH AND MATURITY

The Journal Anesthesiology

In 1936, the Society's historian reported the pressing need for an official organ of the Society as an outlet for its activities as well as for scientific articles. Through the joint efforts of Henry Ruth, as Editor-in-Chief, and Paul Wood, as Business Editor, the first issue appeared in July 1940.

The Wood Library-Museum of Anesthesiology

The Constitution of the New York Society of Anesthetists of 1912 provided for the election of a librarian to develop a library, despite the fact that books devoted to anesthesia were then very few. The major impetus for the library came from Paul Wood. By 1936 he had collected more than 160 books and journals devoted in some degree to anesthesia. Anticipating in time a museum of anesthesia, he also
accumulated memorabilia in his home until there was no longer enough space. In 1937, he was given free space by the Squibb Company in their office building in New York City. From these beginnings grew the library-museum of the American Society of Anesthetists that was incorporated in 1950 as the Wood Library-Museum of Anesthesiology.21,22

Permanent Society Headquarters

The concept of a permanent headquarters, necessitated by inadequate space in the Chicago office building, was introduced by the incoming President (Daniel C. Moore) in November 1958 and then approved by the House of Delegates.13 In 1959 the Board of Directors approved purchase of land in Park Ridge, Illinois, eighteen miles from downtown Chicago, and an edifice to cost $225,000.00.23 Dedication of the new headquarters building took place on May 21, 1960.24 In 1962 the Society purchased the remainder of the available adjacent land and built a two story addition to house the Wood Library-Museum. The equity derived from these purchases and building placed the Society on a sound financial basis. In 1970 plans were inaugurated to include permanent offices for other organizational bodies of the American Society because of their expanded activities.25

EFFORTS TO IMPROVE THE SPECIALTY

Standards of Equipment and Patient Care

Beginning in 1955, the expanded activities of the Society were reflected in the formation of new committees to carry out programs approved by the House of Delegates. The Committee on Anesthesia Equipment recommended that a national committee be formed of representatives from manufacturers and suppliers of material plus anesthesiologists to consider the overall policy of standardization of equipment.11

In 1957, the Society approved administrative sponsorship of the American Standards Association Sectional Committee, Z79 on “Standards of Anesthetic Equipment.”26 The Committee's progress was slow in coming, although in 1960 it was able to recommend that
the Society approve a draft of American standards specification for anesthetic equipment, endotracheal tube connectors and adaptors. However, it was unable to adopt the international classification on colors of medical gas cylinders opposed by some manufacturers and the Compressed Gas Association. Various other proposals were adopted over the following years, including standards on pediatric and adult anesthetic circuit adaptors, sterilization of anesthetic equipment and supplies, and evaluation of performance characteristics of artificial ventilation apparatus. In 1969, the Board of Directors instructed the President-Elect to appoint a Committee to consider all aspects of the Society's involvement in setting standards.

The Society was also involved in efforts to improve the quality of patient care. In 1957, it studied the problem of inadequate physician coverage of obstetric anesthesia. In an effort to reduce maternal and infant mortality rates, it fostered lectures to medical students and interns and inaugurated special postgraduate courses in obstetric anesthesia. The following year, the Committee on Maternal Welfare met with similar Committee of Obstetricians to consider mutual problems, including development of adequate twenty-four hour anesthesia coverage by trained personnel and establishment of minimum standards of obstetric care in hospitals. Three years later, the Committee on Maternal Welfare conducted a survey of obstetric anesthesia in 439 hospitals and noted some gains, particularly in larger hospitals, where 31 percent had an anesthesiologist in hospital at all times. In 1965, the House of Delegates approved recommendations of the Committee on Maternal Welfare to provide anesthesia training for obstetric residents and obstetric anesthesia training for anesthesiology residents, and to prepare an outline and standards for obstetric analgesia and anesthesia, and newborn resuscitation measures.

In 1953, a survey of oxygen therapy practice in New York revealed little uniformity in the kinds of personnel administering oxygen, their training, if any, or their supervision. In joint action with the Medical Society of the State of New York, a committee of the New York State Society of Anesthesiologists established minimum standards of therapy, defined essentials of acceptable schools of inhalation therapy and formulated a basis for certification of technicians. These steps were implemented through a resolution sent to the
House of Delegates of the American Medical Association in 1956. The American College of Chest Physicians and the American Society of Anesthesiologists became sponsoring bodies for a new organization, the American Association of Inhalation Therapists. They developed standards for acceptable schools, a Board of Registry and certifying examinations, and in 1960, the Society co-sponsored a National Registry of Inhalation Therapy Technicians. The Society appointed four anesthesiologists to the Board of Trustees of the American Registry of Inhalation Therapists, and two members as representatives to the Board of Schools for Inhalation Therapy.

Through its Committee on Clinical Anesthesia Study, the Society had been involved since 1957 in the investigation of anesthesia mortality and morbidity, and the revision of anesthesia and recovery room records. In 1968 the committee developed a form for reporting adverse drug reactions. In 1959, the Society recommended a joint policy with the American Dental Society to encourage dentists desiring to do dental anesthesia, to take postgraduate training. In 1963, the Society approved a resolution to provide anesthesia training to residents in accredited oral surgery training programs. The Society will provide when requested qualified anesthesiologists as consultants to directors of training programs. It also sponsors annual prize-giving for research papers by anesthesia residents.

A Handbook of Hospital Facilities was made available to the membership, including information on electrical hazards, operating room lighting, operating room utilization and waste gas scavenging systems.

Education

Another goal of the Society was to increase the educational facilities of medical schools and hospitals to make training in anesthesiology readily available to all interested physicians. In 1935, the Committee on Education of the Society sent a questionnaire concerning teaching of anesthesia to the eighty-seven medical schools in the United States and Canada. Of the seventy-five replies, fifty-eight listed anesthesia instruction by a physician, as a separate course by nurses, as part of surgery or pharmacology and seven with no instruction at all. The Board of Directors approved a resolution in
1936 "that it is to the best interest of the medical public that departments of anesthesia in medical schools and hospitals shall be in charge of physicians who shall have direct supervision of teaching of this subject to undergraduates and graduates. These physicians shall have devoted a satisfactory time to the study of the specialty or shall have been certified as specialists in anesthesia by a recognized national Society of Anesthetists."

In 1937, seven universities appealed to the Education Committee to recommend directors for their anesthesia departments. They received prompt responses from such leaders as Ralph M. Waters and Emery A. Rovenstine who suggested some of their own graduating residents. In the same year, the Committee also set up a placement bureau for residency appointments. Four hospitals were approved for residency in 1937; seventeen in 1938 and forty-nine in 1945. The greatest impetus to the increased number of residencies was the interest of veterans returning after World War II. This also coincided with increase in Society membership from 1,200 in 1943 to 2,147 in 1946. Residency programs increased to 188 in 1954 and as of 1970 there were 193 programs offering 1,919 resident positions.

Refresher courses were begun in 1950 and became so successful that they now occupy the two days preceding each Annual Meeting. At the Annual Meeting of 1957, 114 lectures on sixty-seven different topics were given, attended by 1,100 physicians.26 Also in the early fifties, the Society attempted to establish liaison with the American Academy of General Practice to offer postgraduate courses in anesthesiology for general practitioners.44 Booklets were prepared containing reviews and listings of courses for training the part-time anesthetist.

In 1956, the Subcommittee on Medical Schools again circulated a detailed questionnaire concerning teaching programs in medical schools. The information obtained showed that the professor of anesthesiology had contact with the freshman class in 25 percent of the schools; with the sophomore class in 50 percent of the schools; and in most schools there were some anesthesia assignments in the third and fourth years ranging from three to sixteen hours. One-fourth of the schools had no clinical anesthesia teaching of any kind.45 In 1959, the Committee reported that in those medical schools with anesthesiology divisions only half had departmental status.39 In 1960, the Committee now designated "On Medical
Schools and Residencies" noted that there were 217 anesthesiology residency programs and 1,150 physicians in formal training.46

Nevertheless, the 1960 President's report (Leo V. Hand) listed some of the disappointments during the five-year period which followed the Society's first half century of growth. Chief among these was the field of medical education. No appreciable progress had been made toward incorporating anesthesiology into the curricula of medical schools, many still having no independent departments of anesthesiology. The report also noted that during this era the Society had concentrated on administration, organization, economics and ethics with efforts to increase the Society's strength in membership.46

For the next two years efforts in the direction of medical education produced only minimal results. The Committee on Postgraduate Education recommended establishment of standards for education and development of motion pictures relating to anesthesiology, the latter to receive a seal of approval upon meeting certain standards.47

In 1962, the Society approved an amended classification of Physical Status.48

The Society notified the Council on Education of the American Medical Association, in 1962, that it had adopted a resolution requiring training in anesthesiology during the internship in order to maintain residency approval. It also charged the Committee on Public Relations and the Committee on Medical Schools and Residencies to produce films under the auspices of the Society, one for medical students and one for premedical students. A brochure entitled "Your Future in Medicine-Anesthesiology" was distributed to vocational counselors in approximately 32,000 high schools across the country.49

A Joint Council on In-Training Examinations of the American Board of Anesthesiology and the American Society of Anesthesiologists was formed in 1975 to prepare In-Training Examinations, on an annual basis, of the highest possible quality, reliability and accuracy.50 Anesthesia subspecialty organizations then began to emerge, including the Association of Cardiac Anesthetists, the respective societies of Critical Care Medicine, Neurological Anesthesia, Obstetric Anesthesia and the Section on Anesthesia of the Academy of Pediatrics.51 In 1978 the Section on Clinical Care conceived the idea of "Anesthesia Advisories." The first two published were entitled "Infection Control by Anesthesia
Personnel” and “An Advisory for Recovery Rooms.” A Public Education Program was approved for 1980-1981 utilizing the national media.

The Survey

The Society undertook new responsibility for the Specialty of Anesthesiology when the 1963 President (Albert M. Betcher) convinced the House of Delegates of the need for an exhaustive three-year study to determine the status of anesthesiology in the areas of practice, research and teaching, an idea previously voiced by others. In 1955, President B. B. Sankey expressed the Society’s need to take a close look at itself; in 1956, President Scott M. Smith noted a membership growth requiring a new approach to the Society’s activities; in 1957, President Irving M. Pallin stressed the importance of recruitment efforts; in 1958, the latter was echoed by the Committee on Residency Programs, which advocated vigorous efforts to recruit exceptional physicians and frequent contact with interns and medical students; and lastly as suggested in 1959, by the Committee on Medical Schools and Postgraduate Education to survey the current status of anesthesiology in accredited medical schools of the United States. President-Elect Betcher’s address noted that other Committees also had sought to determine various aspects of the status and growth of anesthesiology in annual reports; but the Society rarely had undertaken such studies.

The survey approved was to be preceded by a pilot study to define the objectives of the major study. It would be accomplished by an outside organization that could bring to the Society a fresh, unbiased approach, with an Advisory Committee of the Society membership, chaired by Robert D. Dripps. At the interim meeting of the Board of Directors in April 1963, the pilot study had already proceeded extraordinarily well. The survey organization urged that the Society’s goals of improved practice, teaching and research not be allowed to proceed haphazardly, but that each step be carefully calculated to contribute efficiently to those goals. The study carried out in Philadelphia’s five medical schools enabled the survey group to develop an image of anesthesiology as related to potential new members. The Board of Directors responded by making available additional funds for further study.
Phase II of the pilot study expanded the Philadelphia survey across the nation. At the annual meeting of the House of Delegates, a special Reference Committee was appointed to handle the volume of material submitted both by the Advisory Committee on Anesthesia Survey and the private Survey Organization. The pilot study had reached into every conceivable area of the specialty and, as Dripps pointed out, "Outsiders . . . have recognized many things which we have known about, but have in a sense ignored, hoping I suppose that 'they would go away'!" The House of Delegates approved the Reference Committee's unanimous recommendation to inaugurate the major study, to provide funds, and to utilize existing Committees and organization of the Society to carry out the goals and activities suggested.  

The major study conducted by the private survey group ran for three years, as originally proposed, and each succeeding President adopted and expanded activities suggested. Thus, in 1964, President Oliver F. Bush appointed a sub-committee on Training and Recruiting with responsibility for developing and carrying out projects in this area. These included a seminar on teaching anesthesia, material on training interns, information on research fellowships and medical school teaching programs, and special training in anesthesiology for general practitioners. The Committee's most important contribution was to stimulate the creation of summer Clinical Fellowships in Anesthesiology for medical students to be offered by leading private practitioners in community hospitals.  

In the following years, President Perry P. Volpitto appointed a coordinating Committee on Anesthesia Practice to advise and coordinate activities of the Committees on Maternal Welfare, Patient Welfare and Training and Recruiting. The latter, acting on a regional basis, assisted and encouraged medical schools to increase and improve educational programs in anesthesiology, expanded the summer Clinical Preceptorship Program, and supported the Section on Anesthesiology of the American Medical Association in its effort to increase anesthesiology training for interns.  

When in 1966, the survey was completed, President John J. Bonica presented a comprehensive report on the Society's past achievements and challenges for the future. The Society adopted his ambitious program of action, beginning with the development of a Council on Education consisting of six Committees: Medical.
School Residencies, Medical Student Preceptorships, Internships, Anesthesia Residencies, Postgraduate Education and Paramedical Personnel. In addition, Bonica organized ASA-sponsored conferences on the teaching of anesthesiology with participation by authorities on medical education from various specialties. He appointed additional Committees on Patient Care and a Special Committee for Planning Professional Activities. The Reference Committee that studied the plans felt that the latter could assure continuity of the proposed program by consolidating progress made by individual Committees, avoiding duplication of effort in successive years and planning for long-range responsible conservation of the budget. The House of Delegates voted overwhelmingly in favor of the program and allocated 96,000 dollars in support, almost 20 percent of the annual budget.\(^\text{61}\)

The Preceptorship Program for medical students has been the most important contribution of the anesthesia survey. Merel H. Harmel, Chairman of this Committee in 1969, traced its beginnings and progress in an editorial in the ASA Newsletter, noting that one of the principal findings of the Anesthesia Survey was the negative image of anesthesia among medical students. The survey group recommended creation of a fellowship program to expose medical students to the scope and practice of the Specialty. As a result, an imaginative and vigorous Preceptorship Program was established in 1966. Since then, 1,164 students from over 2,000 applicants have participated in this educational venture.\(^\text{62}\)

Analysis of these students' reactions by an outside consultant, J. H. Bruhn, Professor of Sociology in Medicine at the University of Oklahoma Medical Center, indicated the program's unequivocal success in creating an awareness of the place and potential of anesthesia. A by-product of this educational program has been stimulation of recruitment, resulting in a threefold increase in the number of students entering anesthesiology as a Specialty. As of 1970, the Society had pledged $275,000.00 to the Preceptorship Program, a figure more than matched by the support of individuals, local anesthesia societies and industry. Harmel concluded "In many ways we are on the brink of a new and challenging opportunity to compete for and capture the interest of students of anesthesia. This will take time, further funds, and a faith in our objectives."\(^\text{62}\) The American Society of Anesthesiologists believes the Preceptorship
Program worthy of continued support, as is evident in the findings and recommendations of the Ad Hoc Committee on Preceptorship Review submitted to the House of Delegates at its October, 1970 annual meeting. The membership's enthusiastic endorsement of the Preceptorship Program led the Ad Hoc Committee to recommend its continuation with the necessary modifications to adapt to changing medical school curricula.  

**Manpower**

Various sources have estimated the total number of anesthetics administered annually in the United States. Based on a projected increase to 22 million anesthetics by 1975 and a projected figure of 26 million in 1979, medical manpower needs by 1980 were estimated at the "astronomical" number of 44,000 anesthesiologists. The growth rate of membership in the American Society of Anesthesiologists would hardly cover these manpower needs. Even with increased numbers of physicians entering training programs, the best available figure for 1975 reached a total of 14,400 anesthesiologists. Thus, all available categories of personnel would be needed to provide anesthesia.

The Society thus initiated efforts to establish relations with certified nurse anesthetists; misunderstandings had kept the two groups apart for many years. In 1947, the Society’s Board of Directors had disapproved the training of persons other than doctors of medicine in the science and art of anesthesia. In 1963, they amended this resolution to permit anesthesia training for residents in oral surgery. Officially, neither the Society nor the American Association of Nurse Anesthetists attempted to communicate with each other after the 1947 resolution. Instead, attention was directed toward the relation between anesthesiologists and nurse anesthetists in the operating room. In 1957, the Committee on Clarification of Ethics wrestled with the problem of employment of nurse anesthetists by anesthesiologists. The Committee was careful to make no condemnation of nurse anesthesia or of the physician working with a nurse anesthetist. They considered only the situation in which the anesthesiologist charged for the nurse’s administration of anesthesia without a patient’s knowledge that the nurse was involved in management of the case.
A difference of opinion within the Committee regarding the wording of the resolution to be presented to the House of Delegates resulted in submission of a minority report. The majority report primarily dealt with the ethics of rendering bills for services of nonmedical personnel in the employ of an anesthesiologist; the minority report considered the ethics of supervision of anesthesia service. The House of Delegates accepted a substitute resolution of the Reference Committee, which tried to incorporate both concepts.

In the following year, 1958, the Committee on Clarification of Ethics recommended the explanation that supervision as it applies to administration of anesthetics means direct and personal supervision implying “the physical presence of the anesthesiologist in such manner as to make possible the continuous exercise of his medical judgment throughout the entire conduct of anesthesia.” The report of the Committee, however, was referred back for further study and clarification.

The House of Delegates, at its 1959 meeting, approved the Committee's recommendation that the original 1957 resolution be included in a Statement of Policy of the Society, and urged all members to implement this policy as soon as practicable. It also considered possible working agreements between members of the Society and hospitals, and the ethical aspects of establishing Nurses Training Schools in Anesthesiology but made no definite decisions. The following year the Society was still attempting to clarify its Statement of Policy regarding employment of anesthetists other than Doctors of Medicine.

An Ad Hoc Committee on Non-physician Anesthetists reviewed nurse anesthetist-anesthesiologist relations in 1963. It noted that the ethical relationship between the two groups had been covered by previous actions of the Society’s governing bodies and recommended no further action until a survey then in progress was completed. The then President (Albert M. Betcher) unofficially explored the possibility of a dialogue between the American Society of Anesthesiologists and the American Association of Nurse Anesthetists. The President of the latter organization replied, “The question that we discussed has been brought before the officers of this association on several occasions and we have been individually approached on the same subject. With 11,526 members in the association, many of whom have been subjected over the years to
quite opposite attitudes from the one that is now proposed, it may take many years before the Board of Trustees could adopt the suggestions that have been made. This is not to say that we will not watch every avenue by which we will continue to cooperate in all matters that pertain to patient welfare.”

In the following years, the House of Delegates adopted a resolution permitting members to assist in the curriculum and teaching of registered nurses studying anesthesia. The first joint meetings between officers of the two organizations were held in Chicago on March 6 and June 25, 1966. Among the subjects discussed was the development of an ethically satisfactory relationship between physicians and nurses trained to administer anesthetic agents, resulting in better utilization of personnel, more comprehensive anesthetic care and a proper physician-nurse-patient relation.

In 1967, the Committee on Paramedical Personnel sent a questionnaire to the Society membership. Of the 3,047 responding anesthesiologists, 78.9 percent favored more cooperation between anesthesiologist and nurse anesthetist; 82 percent believed that the nurse should be under the direct professional control of an anesthesiologist when providing anesthetic care to patients; and 82.6 percent agreed to participation by anesthesiologists in training nurses.

Meetings between representatives of the two organizations have continued their attempts to put aside past problems and to assume responsible attitudes of mutual trust and understanding. In 1968, The Society approved the recommendation of the Committee on Paramedical Personnel to actively promote liaison and cooperation with the American Association of Nurse Anesthetists and to apprise both organizations of the membership's support of such cooperation. This led to activation of an ASA-AANA Liaison Committee, reciprocal invitations to annual scientific meetings, and a speaker's bureau of anesthesiologists made available to AANA national and regional programs for assistance in their educational ventures and to provide speakers and instructors for nurse anesthetist workshops. On May 11, 1970, both groups agreed to implement a closer liaison, particularly on a local level and recommended to their organizations approval of a “Memorandum of Understanding.”

All seemed well as the ASA sanctioned appointment of anesthesiologists as regional consultants in 1974. Their names would
be made available when nurse anesthetists would encounter professional or administrative problems. However, in 1975 a series of letters from John W. Ditzler, ASA President, and Bernice O. Baum, CRNA Executive Director, to the Subcommittee on Health, U.S. Senate Finance Committee, tended to muddy the situation because of insinuations by Mrs. Baum that there was no evidence to indicate any difference in the quality of anesthesia service between the two groups. This unfortunate public confrontation between the two Societies again resulted in strained relations. On March 6, 1976, the ASA Board of Directors redefined the concept of the Anesthesia Care Team with the anesthesiologist in a leadership role.

**Relation to the World Federation of Societies of Anesthesiologists**

Despite its activity in the United States, the Society was slow to participate in efforts of the World Federation of Societies of Anesthesiologists to aid underdeveloped countries in the development of anesthesiology as a specialty. In 1953, the Society's Board of Directors approved the World Federation in principle, with its only action to send an official representative to the meeting of the Committee of the World Societies held in Holland in June 1954. It endorsed the principles and objectives of the World Federation of Societies of Anesthesiologists in 1958 and approved voluntary formation of a supporting group to attend the 1960 meeting. In the following year, the House of Delegates approved a resolution to apply for membership in the World Federation and appointed an Ad Hoc Committee to serve as delegates to the meeting in Toronto and to report to the House of Delegates at the next annual session. Thus the Society dropped its passive attitude and since then many of its members have served as Chairmen of important committees. Francis F. Foldes, a Society member, was elected the third President of the World Federation Organization in September 1968.

**PROBLEMS COMMON TO ALL OF MEDICINE**

All medical specialties including anesthesiology are faced with problems in relations with the Federal government. Thus in April 1975, J. Gerard Converse, Chairman of the Committee on Profes-
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sional Liability, testified before the Senate Subcommittee on Health, on the escalating malpractice crisis. Awards for anesthesiology liability were running second only to neurosurgery. In December 1975, an inquiry was received from the Federal Trade Commission concerning the Society's statements of ethical principles. They objected to the guidelines to "Ethical Practice of Anesthesiology" and more specifically as to salaried arrangements with hospitals. After several hearings between the Commission and the Society's officers and counsel, a special meeting of the House of Delegates was convened on June 3, 1978. The delegates voted to accept a proposed settlement of the F.T.C.'s current investigation. In substance, it prohibited the American Society of Anesthesiologists and the Component Societies from restraining anesthesiologists in practice other than a fee-for-service basis.

Also in 1975, the Department of Justice filed a civil antitrust suit against the Society, alleging that both it and its members and Component Societies conspired to raise, fix, stabilize and maintain fees charged by members rendering anesthesia services. They were opposed to the use of the ASA Relative Value Guide. A trial held in New York lasted two weeks (November 20 - December 4, 1978). On June 22, 1979, the court handed down its decision finding that the Relative Value Guide did not violate antitrust laws, and ordered the government suit dismissed.

THE FUTURE OF ANESTHESIOLOGY

A specialty that was created 145 years ago when William T. G. Morton first demonstrated the use of ether has finally come of age. Since the original event occurred in this country it might have been anticipated that it should develop an organization of anesthesiologists with the largest membership the world over. Through the years the Society has striven to carry out the purpose of the Society as set forth in its Bylaws.

The Society has striven to alter its image, to plan ahead and to investigate avenues of cooperation with allied fields of medicine and paramedical groups, and to provide better anesthetic care for more patients. It has attempted to establish minimum standards for personnel and equipment for departments of anesthesia including operating room utilization, recovery rooms, inhalation therapy and
acute medicine. It has conducted workshops and symposia on clinical care, in continuing education, the role of anesthesia in the changing patterns of internship, administrative affairs and electrocardiographic interpretation.49.90-93

The present posture of the American Society of Anesthesiologists was last stated by Stuart C. Cullen in an oration accepting the Distinguished Service Award, "Everyone of us (should) lend our individual efforts toward individual excellence as professionals, as physicians in the true sense of the word, as members of the most distinguished and most productive scientific discipline in the world — the practice of medicine."56 This was echoed in 1981 by the Society's continuing Medical Education Accreditation Program. "The American Society of Anesthesiologists is dedicated to elevating the standards of the Specialty by fostering and encouraging education, research and scientific progress in anesthesiology."

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