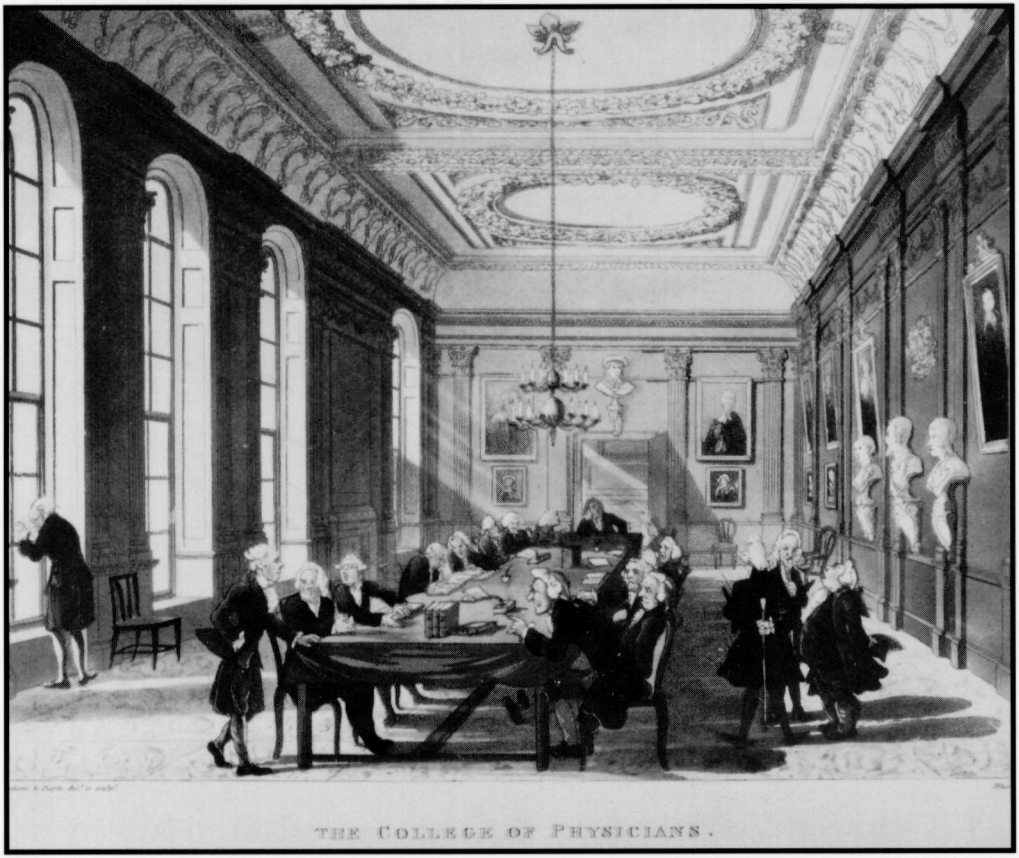
The History of Anesthesiology

Reprint Series: Volume Twenty-six

Anesthesia Organizations



"The College of Physicians"

By

Thomas Rowlandson (1756-1827)

English watercolour painter, illustrator and caricaturist.

Anesthesia Organizations

Introduction

When delving into the history of anesthesia organizations one is immediately confronted with concepts of professionalism and specialization in medicine. To begin with, in any endeavor, professionalism may be defined as a calling in which one professes to have acquired some special knowledge used by way of instructing, guiding or advising others or of serving them in some art. Inevitably, along with professionalism came specialization which has its origins in antiquity — never more evident than in Egyptian medicine, according to Galdston. As early as the middle ages in Great Britain, the need arose for specialists to establish independent bodies in order to guard professional standards. And ultimately, as prevails today, such bodies exist to promote the highest medical standards by way of education, supervision of training programs, conduction of examinations, and awarding of diplomas which grant special status to the holder. Relatedly, Ralph Waters wrote, "The foundation of any specialty is dependent, I suppose, first upon men, second upon publications and third upon organizations through which men meet for mutual development by exchange of ideas."

Thus, in the context of this introductory paragraph we offer a collection of reprinted articles for the most part applicable to the American Society of Anesthesiologists. Regretfully, for lack of space, we are not able to pay homage to the many other anesthesia groups, national and international, whose contributions rightfully deserve inclusion under the rubric of Anesthesia Organizations.

Leroy D. Vandam, M.D.
B. Raymond Fink, M.D.

Anesthesia Organizations

Selected Papers

1. Griffith HR. History of the World Federation of Anesthesiologists. *Anesth Analg* 1963; 42:389-397
2. Cullen SC. An account of the history of the journal Anesthesiology. *Anesthesiology* 1964; 25:416-427
3. Betcher AM. Historical development of the American Society of Anesthesiologists, Inc. in Volpitto PP, Vandam LD. *The Genesis of Contemporary American Anesthesiology.* Springfield, IL, CC Thomas, 1982, Chapter 14, pp 185-211
4. Haugen FP. The American Board of Anesthesiology, Inc. *The Genesis of Contemporary American Anesthesiology.* Springfield, IL, CC Thomas, 1982, Chapter 15, pp 212-221
5. Papper EM. The origins of the Association of University Anesthesiologists. *Anesth Analg* 1992; 74:436-453
6. Stephen CR. *Anaesthetists' Travel Club, 1929-1952* [The Academy of Anesthesiology], *An Historical Review.* [St. Louis, MO, Academy of Anesthesiology, 1990]

— 1 —

HISTORY OF THE WORLD FEDERATION OF ANESTHESIOLOGISTS

Harold R. Griffith, M.D.

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HISTORY *of the* WORLD FEDERATION *of* ANESTHESIOLOGISTS

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THE WORLD FEDERATION of Societies of Anesthesiologists is now generally accepted as the one officially recognized organization representing international anesthesiologists. It has been suggested, therefore, that it would be useful to record, before it fades from memory, the story of the origin and early days of the Federation. Since it fell to my lot to be chairman of the organizing committee and then to be elected first president of the W.F.S.A., it is perhaps appropriate that I should be the one to tell the story. I have received already more than my share of honors and of appreciation, so any personal references in this narrative are made only as part of the record.

Some thought of a truly international organization to promote interest in anesthesiology had been for many years in the dreams of leaders in the specialty in various countries. Indeed, the late Dr. Frank McMechan, when he organized his various anesthesia groups back in the early 1920's, gave to one of them the name "International Anesthesia Research Society." The "international" referred only to the United States and Canada, but he hoped that the whole English-speaking world and Latin American and European countries might eventually be included. In spite of arthritis which made him a helpless cripple, McMechan and his wife, Laurette, travelled up and down North America and to Europe and Australia, preaching always the gospel of better anesthesia for everyone everywhere. After Frank died in 1939, Laurette carried on, and the International Anesthesia Research Society (hereafter referred to as the I.A.R.S.) continued to hold an annual congress of anesthetists and to publish the "yellow journal" *(Anesthesia and Analgesia—Current Researches)*.

In the hope of promoting international co-operation, the Board of Trustees of the I.A.R.S. made arrangements to hold the 1951 Congress of Anesthetists in London in joint session with the Association of Anaesthetists of Great Britain and Ireland, which by that time was the representative national organization

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of that specialty in the United Kingdom. This Congress, attended by several hundred anesthesiologists from Europe and North America, was extraordinarily successful, and it was followed in two weeks by another international anesthesia congress in Paris, sponsored and organized by a group of French surgeons. This group had been responsible some years previously for the organization of the Société Francaise d'Anesthésiologie, comprised mainly of surgeons, pharmacologists, general practitioners, and the few anesthesiology specialists then practicing in France.

Although this Society was not controlled by anesthesiologists, it was at that time the only organized medical group in France whose main interest was anesthesiology, and its leaders, such as Professor Robert Monod and Dr. Marcel Thalheimer, were filled with genuine enthusiasm for the progress of anesthesiology. They planned not only to have an international congress in Paris, but also at the same time to form an international society.

Dr. Thalheimer came to the London Congress with a copy of the proposed constitution of this Society, and solicited support from British, Canadian, and American anesthetists. Leaders from these and other countries met in London to discuss the matter and again in Paris. It was the consensus of those present that the type of organization proposed by the French surgeons would not satisfactorily further the development of world-wide interest in anesthesia; that progress in anesthesia had been made most notably in those countries where the professional status of anesthetists was recognized; and that an international society to be effective should definitely be controlled by anesthesiologists and not by surgeons.

At this point Dr. Jean Delafresnaye, Secretary of the C.I.O.M.S. (Council for International Organization of Medical Societies, one of the subsidiaries of the United Nations Educational, Scientific and Cultural Organization and the World Health Organization) came into the picture with valuable advice. He proposed that a committee should be set up, consisting of representative anesthesiologists, to study the whole matter of an international society and report at another congress to be held within five years. After unanimous agreement, the

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members chosen for this committee were: Dr. Jacques Boureau, of Paris; Dr. John Gillies, of Edinburgh; Dr. Alex Goldblat, of Brussels; Dr. Torsten Gordh, of Stockholm; and Dr. Harold R. Griffith of Montreal. I was elected chairman, and Dr. Goldblat secretary. We went to our homes and got to work.

We had no definite plan, no funds, and not much idea about what kind of organization we should form. Our first task seemed to be to gather information regarding anesthesiology and the status of anesthesiologists from every country in which there was any existing organization. So Dr. Goldblat and I divided up the world between us, and gradually accumulated a great deal of information regarding national societies of anesthesiology, the status of anesthesiologists, and their numbers.

By the beginning of 1953 it became evident that there should be a meeting of the Organizing Committee, and on account of financial and travel difficulties then still existing, it was decided to meet in Europe rather than America. Dr. Goldblat invited us to Brussels. C.I.O.M.S. provided some funds for travelling expenses, and I.A.R.S. paid the balance. Indeed, at that time, and throughout the period of organization of the World Federation, it was the financial assistance of I.A.R.S. more than any other factor which made possible the whole development. The Board of Trustees of this Society provided funds for secretarial help, for travel by committee members, and subsequently for the publication of the Proceedings of the first World Congress. This proved to be intelligent vision and wise investment. In order to make the meeting more representative, the original committee was enlarged by invitations to several other leading anesthesiologists. We met in Brussels in June 1953, and those in attendance were:

Drs. Boureau, Gillies, Goldblat, Gordh and Griffith, of the original committee. Drs. A. W. Low, Geoffrey Organe, and R. P. W. Shackleton, representing the Association of Anaesthetists of Great Britain and Ireland. Dr. C. R. Ritsema van Eck, of Groningen, The Netherlands, representing the Netherlands Society of Anesthesiologists. Dr. Enrico Ciocatto, of Turin, Italy. Drs. R. J. Whitacre, A. W. Friend and T. H. Seldon, representing the International Anesthesia Research Society. Dr. Ellis Gillespie, of Melbourne, Australia. Dr. Wesley Bourne, of Montreal, who was at that time spending a year in France as visiting professor of anesthesiology at the University of Paris. Dr. Jean Delafresnaye, secretary of the C.I.O.M.S., Paris.

The meeting had four main items on its agenda:

1. To receive reports from national societies of anesthesiologists regarding the number and status of those who were practicing anesthesiology in all countries, and to hear which national societies were interested in the formation of an international organization.

2. If reports were favorable, to consider what form this international organization should take—whether a federation of national societies or a new society with individual membership.

3. To draw up a tentative constitution which would then be sent to national societies for consideration.

4. To make plans for a World Congress of Anesthesiologists in 1955.

Discussion of these items proceeded over a period of 3 days, interspersed with pleasant social entertainment. On Sunday we visited beautiful Bruges, and drove through a corner of Belgium which brought back to me poignant memories of the trench warfare days of 1914-1918, and of the friends of my youth who lay buried there.

Reports were received regarding anesthesiology activities in 20 countries. The national societies in many of these countries consisted of only a handful of anesthesiologists—in many cases newly organized and struggling for recognition. In all, we were able to count approximately 7000 anesthesiologists in the world, about half of whom were in

the United States and the overwhelming majority of the remainder were in other English-speaking countries. The strongest support for an international organization came from the powerful Association of Anaesthetists of Great Britain and Ireland; and almost all the other groups were enthusiastically in favor of going ahead with it. The American Society of Anesthesiologists withheld any official action, many members doubting the wisdom of "foreign entanglements," and it was to be another 7 years before the A.S.A. became a full participant. Indeed, if it had not been for I.A.R.S. leadership, America would have had very little part in the development of the Federation.

However, in view of widespread interest and an expression of need from many countries, the committee decided to proceed with the new organization, and it was unanimously agreed that the organization should be a federation of national societies of anesthesiologists rather than just a new medical society with individual membership. This, it was felt, would give better assurance that the organization would be truly representative of anesthesiologists and that it could not fall into the hands of any ambitious and possibly unscrupulous groups or individuals. The name of the new organization would be The World Federation of Societies of Anesthesiologists (Fedération Mondiale des Sociétés des Anesthésiologistes.)

Much time and thought was given to drawing up a Constitution, and in this regard I must pay tribute to the assistance of Dr. Delafresnaye of C.I.O.M.S., who contributed valuable knowledge regarding the experience of other medical groups, and the legalities and pitfalls of such international organizations. We followed his advice that the purpose of the Federation should be a simple one: "Better anesthesia for more people throughout the world"; or, as someone facetiously expressed it, "Better dope for more dopes."

On account of the great disparity in size between the various national societies, an attempt was made to set up the governing body of the Federation in such a way that every country, no matter how small, would have representation; and on the other hand, a national society, no matter how large, could neither completely dominate the Federation nor bear an unreasonable burden with regard to financial support. After much discussion, a plan was accepted whereby the overall control of the Federation rests in a General Assembly, which would meet on the occasion of each world congress (that is every 4 or 5 years), and be composed of delegates appointed by the member societies. Every member society would have at least 1 delegate. There would be 2 delegates for societies with 500 to 1000 members, and one more delegate for each 1000 (or fraction thereof) over the first thousand members. Financial assessment would be in proportion to the number of delegates of a member society to the General Assembly, with the proviso that no member society would be assessed more than $1 (U. S.) per annum per member. The General Assembly elects a president for each congress, and a secretary-treasurer who is to set up a secretariat and be in fact the executive officer of the Federation. The General Assembly elects also an Executive Committee, consisting of anesthesiologists representing member societies in various geographical areas, the only restriction being that the Executive Committee must always include at least 1 representative from each of the 2 largest member societies. The Executive Committee in co-operation with the secretary-treasurer conducts all the work of the Federation during the interval between sessions of the General Assembly.

This proposed constitution was subsequently distributed among the national anesthesiology societies for consideration, and formed the basis for the constitution which was finally adopted.

The final item on the agenda was a decision regarding the first World Congress. The committee was pleased to accept an invitation from the Netherlands Society of Anesthesiologists to meet in Holland in September 1955, and

arrangements for the Congress were left in the hands of Dr. Ritsema van Eck and his Dutch colleagues. The committee meeting adjourned after a vote of thanks to Dr. Goldblat and his Belgian colleagues for their extraordinarily bountiful hospitality. As we got to know our European friends more intimately, we all realized why the Dutch and the Belgians were qualified to take such an active part in the organization of international anesthesiology. Their societies were new, having been founded only after the war, and had still a comparatively small membership, but they had enthusiastic and dedicated leadership and were maintaining the highest ethical and professional standards.

It was felt that the committee should meet again before the Congress, so a meeting was held in Holland in June 1954. The sessions were held at Scheveningen, a seaside suburb of The Hague, because it was here that the Netherlands Society proposed to stage the 1955 Congress. Once again the committee meeting was not only a vital business session but also provided opportunity for delightful social entertainment. We had a preview of the touring and gastronomic delights which the Dutch were preparing for next year's Congress. I again had the honor of presiding over the committee meetings, and travelled in company with Dr. C. J. Durshordwe, of Buffalo, New York, who this year represented the I.A.R.S. There were a few other new faces at the meeting, notably those of Dr. Rudolf Frey from Heidelberg, Germany, Dr. L. A. Boeré, of Leiden, The Netherlands, and Dr. Francis F. Foldes of Pittsburgh, Pennsylvania (U.S.A.). The agenda followed the general pattern of the Brussels meeting. It was reported that there had been enthusiasm for membership in the proposed federation from almost all national societies, and approval of the general principles of the constitution. The large and powerful American Society of Anesthesiologists was still uncommitted and aloof, but it was decided to go ahead anyway with the formal organization, and to hold the door open for subsequent affiliation.

Dr. Ritsema van Eck and Dr. Boeré told of the plans of the Netherlands Society of Anesthesiologists for the 1955 Congress, which were then in an advanced stage of preparation. Everyone was encouraged by the progress, and success seemed assured.

And so the stage was set for the First World Congress of Anesthesiologists and the formal inauguration of the World Federation of Societies of Anesthesiologists which took place at Scheveningen, Holland, September 5 to 10, 1955.

It was indeed a great gathering. Formal opening ceremonies were in the "Rittersaal," the ancient knight's hall at The Hague, where the Queen of the Netherlands still comes to open Parliament. Scientific sessions, which included nearly two hundred papers on a wide variety of subjects, were held in a large auditorium at Scheveningen, and there was simultaneous translation into English, French, and German. So courteous and so multilingual were our hosts that Dutch was not even one of the official languages of the Congress. Receptions, dances, banquets, and unforgettable sightseeing trips were interspersed throughout the week. The keynotes of this wonderful Congress were friendship, mutual understanding, united effort for a common purpose, and great enthusiasm for better anesthesia. A spirit which could be described as almost a religious fervor seemed to animate many of the delegates, not just scientific calm. Personally, I was struggling under a handicap, as I had been smitten with hepatitis about ten days previously while I was on a pre-convention tour of Italy. Fortunately, we were in Turin and among friends when I collapsed. I was rushed to hospital, cared for with great skill and kindness by Professor Dogliotti and his colleagues, and, rather against the advice of these good doctors, I managed to get to Holland in time for the opening of the Congress. Our Dutch friends made us feel so much at home that I was able to carry on without further serious trouble.

Concurrently with the scientific program of the Congress, there were sessions of the Organizing Committee at which the Constitution of the World Federation was finally drafted, nominations for the executive received, and other matters settled. On Friday, September 9, 1955, the last day of the Congress, at a memorable constituent assembly, the World Federation of Societies of Anesthesiologists officially came into being. I had the honor of being chosen the first president. The vice-presidents were: Dr. C. R. Ritsema van Eck, of The Netherlands; Dr. A. Goldblat, of Belgium; Dr. R. Frey, of Germany; and Dr. M. Curbelo, of Cuba.

Dr. Geoffrey S. W. Organe, of London, accepted unanimous election as secretary-treasurer, and he continued from then to now to fill that post with great distinction and with untold benefit to the Federation.

The aim of the World Federation, as set out in the Constitution, which was legally registered in The Netherlands, on July 15, 1956, is "To make available the highest standard of anaesthesia to all peoples of the world." In pursuit of this aim, the functions of the Federation include the following: a. To assist and encourage the formation of national societies of anesthesiologists. b. To promote the dissemination of scientific information. c. To recommend desirable standards of training of anesthesiologists. d. To provide information regarding opportunities for postgraduate training and research. e. To encourage research into all aspects of anesthesiology. f. To encourage the establishment of safety measures, including the standardization of equipment. g. To advise, upon request, national and international organizations.

An Executive Committee to carry on the affairs of the Federation until the next General Assembly was elected as follows:

Dr. Alex Goldblat, Brussels, Belgium, Chairman
Dr. Jacques Boureau, Paris, France
Dr. Enrico Ciocatto, Torino, Italy
Dr. John Gillies, Edinburgh, Scotland
Dr. A. Gonzales Varela, Buenos Aires, Argentina
Dr. Torsten Gordh, Stockholm, Sweden
Dr. R. A. Gordon, Toronto, Ontario, Canada
Dr. Harold R. Griffith, Montreal, Quebec, Canada
Dr. N. R. James, Melbourne, Australia
Dr. O. Mayrhofer, Vienna, Austria
Dr. R. P. W. Shackleton, London, England
Dr. Zairo E. G. Vieira, Rio de Janeiro, Brazil

At a subsequent meeting of this Committee, the following were co-opted as members: Dr. C. R. Ritsema van Eck, Groningen, The Netherlands, and Dr. S. G. Talwalkar, Bombay, India.

National anesthesiology societies from the following countries became at that time official members of the World Federation:

Argentine	Great Britain and Ireland
Australia	India
Austria	Israel
Belgium	Italy
Brazil	Netherlands
Canada	Norway
Chile	Portugal
Colombia	Spain
Cuba	Sweden
Denmark	Switzerland
Finland	South Africa
France	Uruguay
Germany	Venezuela

Official observers were present from The American Society of Anesthesiologists (Dr. L. H. Wright) and the New Zealand Society of Anaesthetists, but these organizations did not choose at that time to accept membership. There were anesthetists present also from the following countries:

Czechoslovakia	Egypt
Greece	Jamaica
Yugoslavia	Kenya
Poland	Nigeria
U.S.S.R.	Rumania
Turkey	Hungary

Application of the Mexican Society of Anesthesiologists for membership was accepted by mail ballot shortly after the first meeting.

The International Anesthesia Research Society, as a contribution to world anesthesia, undertook to publish the Proceedings of the First World

Congress. Dr. T. H. Seldon of Rochester, Minnesota, shouldered the prodigious editorial responsibility for this 320-page volume, which appeared in 1956. All of the papers delivered at the Congress were translated into English, and the volume was sent without charge to those who had registered at the Congress, and to all members of the I.A.R.S. This represented an investment of over $10,000, and has been much appreciated.

After the Scheveningen Congress, Dr. Geoffrey Organe set up the secretariat of the World Federation in his home (17 Burghley Road, London, S.W. 19, England) and carried on the work of the organization, mainly by correspondence, from that address. There was no money for anything but some part-time secretarial help; and what travelling was done by Dr. Organe and other members of the Executive Committee was all at their own expense. Indeed, the infant Federation might have petered out in bankruptcy if it had not been for two generous donations by Dr. Oscar O. R. Schwidetsky, of the United States, who felt that the work being done was worthy of American support. An informal meeting of some members of the Executive Committee was held in London, in April 1956, and at that time it was decided to accept the invitation of the Canadian Anaesthetists' Society to hold the Second World Congress and General Assembly meeting in Canada in 1960. Hope was expressed that before that time The American Society of Anesthesiologists would join the Federation. The door was held open continuously, and Dr. Organe, Dr. Ritsema van Eck, and several Canadians visited the United States to promote the project. Finally, in 1959, the House of Delegates of The American Society of Anesthesiologists voted to accept full membership, and since then this largest of all anesthesiology societies has taken an important part in all the activities of the World Federation and Dr. Ralph Sappenfield of Miami, Florida, was co-opted as a member of the Executive Committee.

The Canadian Anaesthetists' Society decided to hold the 1960 World Congress in Toronto. An active local organization, with Dr. R. A. Gordon as chairman, was set up and plans got underway in 1957. In June 1959, a meeting of the Executive Committee was held in Edinburgh, and final arrangements were made. The Second World Congress was held at the Royal York Hotel, Toronto, Ontario, from September 4 to 9, 1960, and was in every way a memorable success. Some two thousand anesthesiologists and other friends from 34 countries were registered, and more than 150 papers were presented. Simultaneous translation service was in English, French, German, and Spanish. Sessions of the General Assembly of the World Federation of Societies of Anesthesiologists were held on the opening and closing days of the Congress. At the first session the following societies were admitted to membership:

Sociedad Mexicana de Anestesiologia
The Philippine Society of Anesthesiology
The Ceylon Society of Anaesthetists
The Anaesthesiological Branch of the Czechoslovak Surgical Society
The Greek Society of Anaesthetists
The Society of Anaesthetists of Hong Kong
The Society of Anaesthesia of Japan
The Korean Society of Anesthesiologists
The New Zealand Society of Anaesthetists
The American Society of Anesthesiologists, Inc.

Dr. Organe presented a summary of his work as secretary-treasurer for the period from 1955 to 1960. Highlights of this report were as follows:

"Dr. Organe had said that he would attempt to travel to as many countries as was possible, in order to make the acquaintance of anesthetists and to have an opportunity of meeting them as individuals and as societies. During this time, he had travelled to Norway, Belgium, The Netherlands, Finland, Switzerland, Italy, France, Spain, Canada, United States of America, Australia, Venezuela, Mexico and Eire. Sometimes he had been able to attend the meetings of the National Societies. In all cases he had had the very greatest pleasure in meeting a large number of new friends and in having very useful dis-

cussions about the work of the World Federation."

In 1956, following a visit to WHO Headquarters in Geneva, Dr. Organe had decided to recommend to the Executive Committee that we should apply for official relationship with the World Health Organization, which was duly granted. The Federation also joined the Council for International Organizations of Medical Sciences.

The Executive Committe had had no full meeting between those in Scheveningen and in Toronto. To have called a full meeting of the Executive Committee would have cost approximately $6000, nearly 2½ years, income of the Federation. However, the secretary-treasurer had met a number of members of the Executive Committee at different times and in different places and frequently, especially at European meetings, quite a number of members gathered when it was possible to have informal discussions on matters relating to the Federation.

The secretary-treasurer had travelled to Toronto in 1957 and in 1958 to meet the Organizing Committee of the Second World Congress.

In 1959, members of the Canadian Organizing Committee came to Edinburgh and arrangements were made for some of the European members of the Executive Committee to meet them there for further discussion.

Though not much appeared to have been achieved by the World Federation during the time between the two Congresses, time and energy had been put into this period of development and consolidation. We could now look forward to more activity.

Unfortunately, further activity would be limited, to some extent, by finance. The annual income of the Federation from subscriptions would be approximately $2600, which would not go very far toward organization of committee meetings, correspondence with member societies, and the publishing of reports. Our activities to date would not have been possible had it not been for extremely generous donations which the Federation received of $500 from the International Anesthesia Research Society and two gifts of $1000 each from Dr. Oscar O. R. Schwidetzky. It was only because of these gifts that the Federation had been able to carry on, and it would be necessary for member societies to devise ways of raising the money which would enable us to do more. There would be no lack of willing workers.

The report was accepted and very sincere appreciation expressed for Dr. Organe's tremendous contributions. No organization has ever had a more devoted and self-sacrificing secretary.

I felt that the time had come for me to retire from office, and also from membership on the Executive Committee, and I therefore withdrew my name from nomination. New officers and Executive Committee members were elected as follows:

President:
Dr. C. R. Ritsema van Eck, The Netherlands
Vice-Presidents:
Dr. John Gillies, Scotland
Dr. Francis F. Foldes, United States
Dr. J. Bark, Germany
Dr. Zairo E. G. Vieira, Brazil
Dr. H. Yamamura, Japan
Executive Committee:
(new or re-elected members)
Dr. John J. Bonica, United States
Dr. Luis Cabrera, Chile
Dr. Quintin J. Gomez, Philippines
Prof. O. V. S. Kok, South Africa
Dr. C. R. Ritsema van Eck, The Netherlands
Dr. Ralph S. Sappenfield, United States
(continuing members)
Dr. Jacques Boureau, France
Dr. Torsten Gordh, Sweden
Dr. R. A. Gordon, Canada
Dr. O. Mayrhofer, Austria
Dr. R. P. W. Shackleton, England

The Secretary-Treasurer, Dr. Geoffrey Organe, was unanimously re-elected.

I was honored by being named "Founder President" of the World Federation. This special title, which con-

fers the privilege of continuing to take part in the activities of the Federation, is one which I value as a very high honor indeed.

The final act of the 1960 General Assembly was to accept an invitation to hold the next World Congress in Sao Paulo, Brazil, September 20 to 26, 1964. Preparations for this next great gathering are now progressing satisfactorily under the management of our Brazilian colleagues (Dr. L. P. Machado, C. P. 330, Sao Paulo, Brazil, Secretary).

Since the Toronto Congress there has been held a most successful European regional Congress in Vienna in September 1962, and numerous other regional and national meetings.

The world of anesthesiology is rapidly expanding, and it is not too much to hope that within a few years really good, safe, and pleasant anesthesia may be available to all people everywhere. The seed which Frank McMechan planted so modestly more than 40 years ago, when he founded the International Anesthesia Research Society, has finally found fertile soil and has brought forth fruit in abundance.

The Dunes Hotel, Las Vegas, Nevada, site of the 38th Congress of The International Anesthesia Research Society—March 15-19, 1964.

— 2 —

AN ACCOUNT OF THE HISTORY OF THE JOURNAL ANESTHESIOLOGY

Stuart C. Cullen, M.D.

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An Account of the History of the Journal Anesthesiology

Stuart C. Cullen, M.D.

THE YEAR 1939 was one of ferment in the American Society of Anesthetists, Inc. Frank McMechan, a stalwart in the International Anesthesia Research Society, had recently died and serious consideration was being given by many people to amalgamation of the two societies. In a letter dated July 20, 1939, from John Lundy to Laurette McMechan, a woman devoted to her husband, to the society which they founded (I.A.R.S.), and to the journal of that society (*Current Researches in Anesthesia and Analgesia*), it was evident that Mrs. McMechan was debating in her mind the future of societies and journals in the field of anesthesia. The introduction of another journal in the field had been debated by others prior to the crisis precipitated by Frank McMechan's death. The publisher, Charles C Thomas, had heard that there was talk about another journal and in a letter dated two years earlier (December 29, 1937) and sent to both Paul Wood and John Lundy, he proposed that he publish the new journal. In a letter of reply from Paul Wood dated January 4, 1938, the idea of a new journal seemed to be limited to a few enthusiastic people such as Paul Wood, John Lundy, and Ralph Waters, and the administration of the American Society of Anesthetists was reported as being rather reluctant. In this letter as well as in other documents in succeeding years, it was evident that the existing journal and its editor posed a serious deterrent. The correspondence between Charles C Thomas and John Lundy, in particular, was active and of interest until the contract for printing the new journal was arranged in 1940 with Lancaster Press, Inc. (On March 5, 1938, publisher Thomas presented the basic items for a contract for publishing the new journal. The arrangements proposed by Thomas in 1938 are quite similar in philosophy and function as the contract finally implemented in January 1960.) Ultimately the decision was to keep the identity of the two societies and to start a new journal of the American Society of Anesthesiologists. This decision was based in part, at least, by a strong conviction held by the McMechans that there was no place in organized anesthesia for nurse anesthetists and they wanted no part of any organization that either tolerated or endorsed (as did the A.M.A.) nurse anesthetists. In addition, the McMechan organization was an international group and many in the American Society of Anesthetists believed that a national organization and a national journal were needed. There was reconsideration of this decision in later years but no change especially in relation to the two journals devoted to anesthesia.

On July 21, 1939, a meeting of the Board of Directors of the American Society of Anesthetists, Inc., was held in New York at which the principal items of business were the matters of amalgamation of the two societies and appropriate action regarding the journal of the I.A.R.S. and a publication of the American Society of Anesthetists, Inc. At this session, a letter from Philip Woodbridge dated June 30, 1939, was introduced. This letter stated among other things: "(1) That the American Society of Anesthetists approach the International Anesthesia Research Society and the Associated Anesthetists of the United States and Canada for the purpose of joining these groups into one. (2) That the American Society of Anesthetists publish a journal of anesthesia without further delay. Depending upon the results of negotiations suggested in the preceding paragraph, this might or might not take the place of, or be a continuation of *Current Researches in Anesthesia and Analgesia.*

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HENRY S. RUTH, M.D.

If the latter, this would offer a suitable opportunity to change the name and editorial policy of that journal."

From the records available, this constitutes the official introduction of the idea of a journal of the American Society of Anesthetists, Inc. although, as has been mentioned, the idea of a journal had been introduced to the society as early as 1937. There is very little evidence to indicate that Philip Woodbridge had been active in the promotion of a new journal; his letter provided the spark that fired the group into concerted action. Some of the comments in the meeting of the Board of Directors are of interest. Paul Wood, then Secretary of the A.S.A., expressed the belief that there was evidence of "sufficient demand to warrant the publication of another journal of anesthesia." Others including Harold Kelley and Robert Hammond believed that one society and one journal satisfied the demand. It was brought out also that the A.M.A. had some interest in publishing a journal in anesthesia and that there would be merit in having the A.M.A. assume the responsibility. Correspondence in 1938 indicated that it was quite likely that Morris Fishbein would be pleased not to have the responsibility of initiating a new journal. The end result of the debate was the appointment by Brian Sword, President of the A.S.A., of a committee called either the Special Affiliation Committee or the Reorganization Committee. This committee had Henry Ruth as chairman, with Paul Wood, Ralph Tovell, Cline Chipman, F. Elmore Hubbard, Ralph Waters, John Lundy and Harry Shields as members. According to a letter of notification to Ralph Tovell from Paul Wood dated August 1, 1939, this committee was charged with "(1) an attempt to arrange for an amalgama-

PAUL M. WOOD, M.D.

tion or combination of the American Society of Anesthetists with other existing anesthesia organizations, (2) to arrange for journal publication either by cooperation with the present journal or by establishment of a new journal, and (3) finally to investigate and report to the Board of Directors upon the possibility of securing the services of Mrs. McMechan for the journal and organization, if combination efforts can be effected." These objectives were reiterated in a letter sent by Henry Ruth to members of the committee on August 10, 1939. It appears from this letter that the committee was to report to the A.S.A. at its meeting on October 12, 1939.

The A.S.A. passed the following resolution at its meeting on October 12, 1939, at the New York World's Fair. The committee submitted the following report:

Dr. Wood: Mr. President: The Journal Committee finds:

RALPH M. TOVELL, M.D.

1. That a strong publication in Anesthesiology is required by Society anesthetists, librarians, medical schools and hospitals.
2. That such a journal can be made self supporting by large subscriptions or by advertising, with smaller circulation.
3. That it is thought a journal with advertising could be made available to members of the publishing organization at no additional cost over their membership dues, possibly even in the first year of publication.
4. That such a journal, with advertising and non-member subscription increases can be a source of legitimate income to the publishing organization.
5. That with the possibility a section on Anesthesia in the American Medical Association is obtainable, and if the Society has a good Journal which it desires the American Medical Association to publish, it might be arranged.

Therefore:

The Committee on Publications recommends that it be empowered to proceed with the establishment of a journal on the following plan as modified by its Editorial Board:

Name: "Anesthesiology," or "American Journal of Anesthesiology."

Edited for the American Society of Anesthetists, Inc., by a Board consisting of the Editor in Chief, Associated Editors, Foreign Editors (e.g., from England, Canada, Australia, South America), Consulting Editors (on subjects such as Surgery, Gas Therapy, Physics, Pharmacology, Engineering, Chemistry, Physiology, Dentistry), Managing Editor, and a suitable number of representative anesthetists selected by the Journal Committee.

The Editors to hold office for a period of two years, during the experimental period.

The publication to be issued with advertising.

The Editorial Policy to be established by a Committee on Policy, including the Editor in Chief, the Associate Editors, the Managing Editor and four members chosen by the Journal Committee.

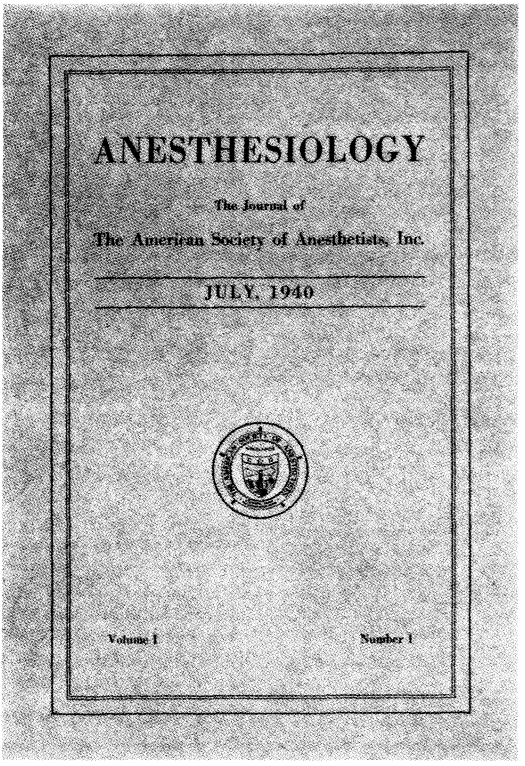
COMMITTEE ON POLICY:

Editor in Chief—Dr. Ruth
Associate Editors (2) Drs. Tovell and Rovenstine
Managing Editor—Dr. Wood
Drs. Waters, Lundy, Clement and Woodbridge

It is interesting that although the report of the journal committee which offered the resolution included the names of the Editor in Chief, the Associate Editors, the Managing Editor and other members of the Committee on Policy, these names were "not to be published" and were not officially proposed until the meeting on November 4 mentioned in the succeeding paragraph.

E. A. ROVENSTINE, M.D.

On the evening of November 4, 1939, a meeting of the Journal Committee and Publishing Committee of the A.S.A. was held and attended by Robert B. Hammond, E. A. Rovenstine, Henry Ruth, Brian Sword, Ivan Taylor, Ralph Tovell and Paul Wood. The minutes of this meeting, as kept by Paul Wood, reveal that the membership of the A.S.A. was polled in regard to establishment of a new journal and of the 498 replying, only 79 wanted a journal sponsored by the A.S.A. It appeared also that intervening discussions with the I.A.R.S. established that the society intended to continue its separate existence and maintain its own journal. As an aside to the matter of establishing a new journal, it is interesting to note the discussion in the minutes about the manner of handling the subscription cost for the journal. Serious discussion was held about whether or not the dues for the A.S.A. should be increased one or two dollars per annum to bring the total dues to $11 or $12. Apparently 10 members out of 500 dropped out when the dues were previously raised from $5 to $10. The minutes also reveal that of several publishers contacted, at least one offered to publish a new journal at no cost to the society provided he could keep the



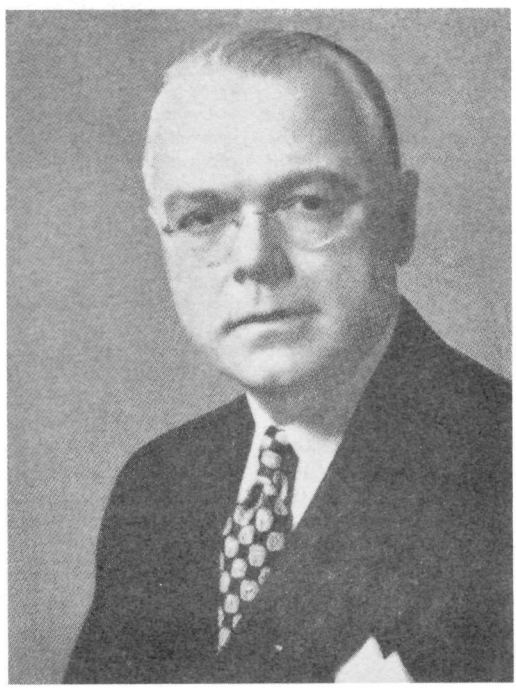
income from advertising. The minutes include official election of the editors and the policy committee, the same group listed unofficially in the report made to the A.S.A. on October 12.

A letter dated November 6, 1939, from Henry Ruth to Ralph Tovell, E. A. Rovenstine and Paul Wood outlines the results of the November 4 meeting. This letter listed the Editorial Committee "for the new journal on anesthesiology to be published by the A.S.A., Inc., as tentatively decided last night." The letter also listed Henry Ruth as Editor in Chief and Ralph Tovell and E. A. Rovenstine as Associate Editors. Paul Wood was to function as Managing Editor. In addition, the letter listed an Editorial Board of fifteen people, four Contributing Editors, and nine Consulting Editors. The letter also listed an Editorial Policy Committee with John Lundy, Ralph M. Waters, Fred Clement and Philip Woodbridge as members. The letter states "these names will not be published with the journal, but will act as the steering committee for the society to determine the editorial policy of the magazine with the major editorial board of four." The confusion associated with "editorial committee" and "editorial board" apparently started with the inception of the journal. The semantic confusion is significant because with it developed an assumption that the journal functioned independently of the A.S.A. (an assumption and a way of practice that persisted for twenty years). The letter further requests that thought be given to such things as the size of the journal, the contents, the amount of advertising, etc. Consideration

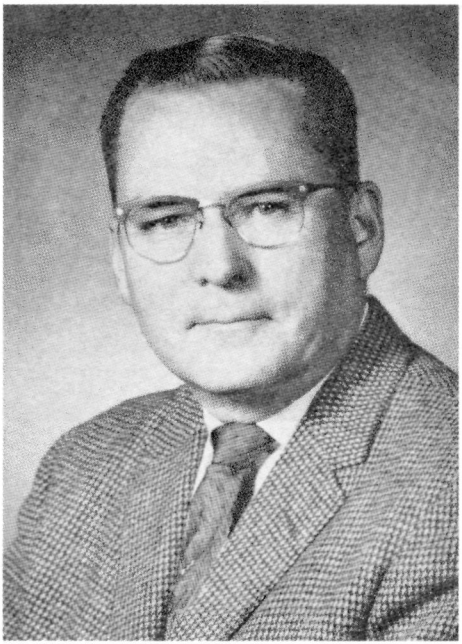
was to be given to separating the journal into sections dealing with research articles, clinical articles, review articles and abstracts. Obviously, early there was concern about the nature of articles to be published, a concern about the balance between "dog type" articles and "clinical" articles that persists to the present day. When the decision was made to use Lancaster Press is not known. There is no known official document (even in the files of the Lancaster Press) detailing the arrangements between the editorial board and the Lancaster Press. There is no document that indicates official notification of the selection of Lancaster Press as the printer. The excellent cooperation by this organization has, however, existed from Volume 1, Number 1, to the present and is evidence of a good choice by Henry Ruth who undertook the negotiations and made the decision.

In such a manner was the Journal, ANESTHESIOLOGY, started. We shall now look into the various factors that influenced the development of the journal.

Volume 1, Number 1, issue of ANESTHESIOLOGY appeared in July 1940, only nine months after the decision was made to start the new journal. The lead article was "The Place of the Anesthetist in American Medicine" by Howard W. Haggard, Director of the Laboratory of Applied Physiology at Yale University. The editorial for this issue was by E. A. Rovenstine. A letter dated April 30, 1940, accompanying the submission of the editorial contained the comment by the author that the editorial was "lousy." The first issue had a number of articles on cyclopropane; one wonders if Volume 1, Number 1, of a journal these days would not include a high proportion of articles on halothane. A letter from Paul



ROLAND J. WHITACRE, M.D.



STUART C. CULLEN, M.D.

Wood to Morris Fishbein, then Editor of the *J.A.M.A.*, mentions a problem in advertising policy in the first issue. For some curious reason, the source and validity of which were not investigated, cyclopropane could not be mentioned in advertisements in the *J.A.M.A.* Paul Wood was anxious to learn if this were true and if so what ethical problems would the fledgling journal encounter if it included advertisements for gas machines that made provision for cyclopropane administration. There is no documentation, but presumably the conflict was resolved without prejudice to a field in which such advertising seemed appropriate. Volume 1 had 368 pages but was a half-year volume. Volume 2 had 768 pages and Volume 23 had 894 pages. Of the November 1940 issue, 1,022 copies were mailed. Of the November 1963 issue, 12,603 copies were mailed to subscribers. Subscription rates per annum including postage was $6 for the first volume.

The first issue contained along with the main body of articles a section on Book Reviews and a section on Abstracts. This latter section was prompted in part by the publication, Anesthesia Abstracts, issued by John Lundy in 1937 in an effort to expand the literature available to anesthetists. Many of the abstracts were from that source or, at least, prepared by Florence McQuillan. This section later became Briefs from the Literature. The issue did not contain Current Comment. Apparently this latter section was proposed by John Lundy if a letter from Ralph Tovell to Henry Ruth on August 29, 1941, is interpreted correctly. In any event, the section on Current Comment appeared in a later issue of 1941 and presumably responsibility for the collection of some of the material was that of Fred Haugen.

In a circular letter sent out by Ralph Waters to former residents, he urged that they submit

material not only to the main body of ANESTHESIOLOGY but also to the newly established section of Current Comment. He urged, also, that they consider themselves responsible for submitting good material and suggested that they not be too critical of the Editors for being fussy about the quality of manuscripts submitted. Case reports were added to Current Comment in 1942. Technical suggestions, forerunner of the Gadget portion of Current Comment, were initiated.

The journal did very well financially from the outset as disclosed by a Financial Report prepared by Paul Wood and circulated in August 1941.

The management of the editorial review of manuscripts was at this stage of development of the journal (1942) largely a personal interrelationship between Editor in Chief, Ruth, and the two Associate Editors, Tovell and Rovenstine. Final decision on the suitability of manuscripts was left to the Editor, as it is today. Whatever system there was was flexible and workable primarily because the demand was not as great as today and there was not the urgency for as early publication as

FREDERICK P. HAUGEN, M.D.

STEVENS J. MARTIN, M.D.

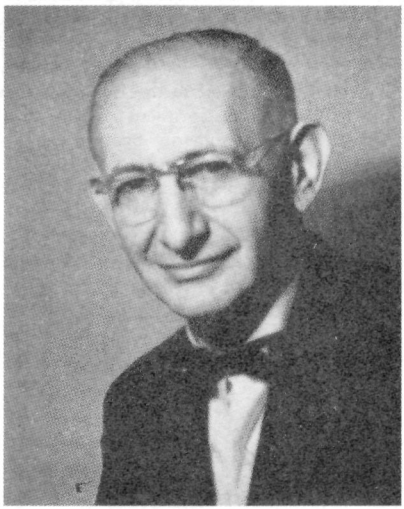
JAMES E. ECKENHOFF, M.D.

HUBERTA M. LIVINGSTONE, M.D.

JOHN W. PENDER, M.D.

possible. Each editor saw the comment of other editors at the time he made his own review.

There is an hiatus from 1942–1946 in the material available for review. The hiatus in material is due to the fact that Ralph Tovell was the major source for this account. In 1946 Ralph Tovell had returned to duty as an Associate Editor after four years in the Army even though he functioned to some extent in that capacity throughout his tour of duty with the Army. Stuart C. Cullen

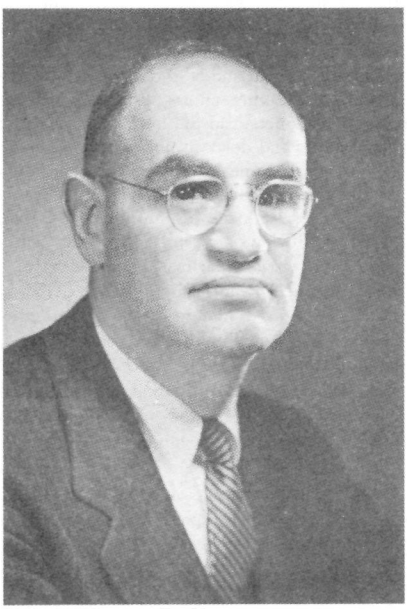


JOHN ADRIANI, M.D.

acted as an Associate Editor in the military absence of Ralph Tovell beginning in 1944. In 1946, the masthead no longer carried the temporary qualification and he became a full fledged Associate Editor. Very shortly, Roland Whitacre became an Associate Editor. Correspondence between Henry Ruth and Ralph Tovell indicated that at this stage there was beginning dissatisfaction with maintaining the huge coterie of people on the mast head on such appointments as members of the Editorial Committee, Contributing Editors, Foreign Editors, etc.

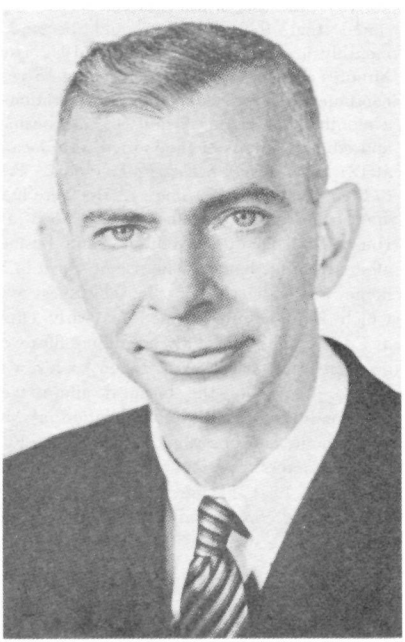
In 1947, some effort was being made to improve the Abstract Section in that a trial was made of assigning journals for abstracting to various departments of anesthesia throughout the country. This proved to be an unsatisfactory answer to the problem of providing current and useful abstracts. This year also marked the point at which there was appreciable dissociation of the journal from the society in that approval was given by the Board of Directors of the A.S.A. to establish a separate checking account for the journal from which

ARTHUR S. KEATS, M.D.



LEROY D. VANDAM, M.D.

money could be drawn for journal business by signature of two members of the Editorial Board. At this time, Fred Haugen was serving as Business Editor. Actually there was a succession of men functioning in the business end of the journal operations when Paul Wood resigned. William G. Schmidt held the position from July 1943 through 1946. Dwight Grove took over from Fred Haugen and held the position from July 1948 through June



S. G. HERSHEY, M.D.

1949. Miss Dorothea Taeffner (now Mrs. Wall) began her long service to the journal in 1947 and assumed responsibility for the business operations when Dwight Grove resigned in 1949. The separation of journal and A.S.A. was enhanced in 1948 and 1949 as evidenced by a letter from John Hunt, Executive Secretary of the A.S.A., dated October 12, 1949, in which he stated, in essence, that all funds of the journal should be kept separate from A.S.A. funds and under the control of the Editor in Chief and that the Treasurer of the A.S.A. shall not be responsible for them. This is interesting in view of contrary interpretations of the relationship of the journal and the A.S.A. some ten years later.

By 1948, as reported in minutes of an Editorial Board meeting, the circulation of the journal was 4,674 of which 2,479 were members of A.S.A. It appears that by this time, more than 79 members of A.S.A. were interested in a new journal. The minutes also contain a motion that "the journal should become a monthly at the discretion of the Editor." The "discretion of the editor" qualification must have come about as a result of failure to implement a motion at the February 16, 1947, meeting of the Editorial Board which stated that the journal should become a monthly journal with the October 1947 issue. Minutes of meetings in the succeeding 15 years continue to show evidence of consideration of a monthly publication. In 1949, the business and editorial affairs of the journal were located at 121 North Broad Street, Philadelphia. Prior to then, some of the business affairs were managed from the central office of the A.S.A. and Henry Ruth conducted editorial and business affairs from his home. The use of space in his home was indicative of the selflessness with which Henry Ruth pursued his early efforts as Editor. The constantly expanding files were an increasing source of irritation to his wife, Wodie. Some of the business affairs were also conducted, prior to consolidation, at Mrs. Wall's home and in a small cubicle in the Flint Building across the street from the Hahnemann Hospital. In 1951, circulation had risen to almost 6,000 copies, and business and editorial activities were such that the office space had to be enlarged.

For 14 years the inside front cover of ANESTHESIOLOGY carried a massive list of people comprising the Editorial Committee, Consulting Editors, Foreign Contributors, and others. In 1954 action was taken to limit official personnel to the Editor in Chief and Associate Editors.

By 1954 it was evident that Henry Ruth was in ill health and Ralph Tovell often functioned as Acting Editor. The year 1955 was one of change and enhanced activity. Henry Ruth resigned as Editor due to illness and Ralph Tovell took over as Editor in Chief. By this time E. A. Rovenstine decided for a number of reasons that he should retire from the Editorial Board. It was decided also to have a serious appraisal of the journal operations primarily from an editorial standpoint and William E. Porter was asked to do this task. His inquiries resulted in some major changes in format and editorial policies. These changes plus other efforts resulted in an appreciable reduction in the backlog of accepted manuscripts and delay in publication. Stevens J. Martin and James E. Eckenhoff were added to the Editorial Board. Huberta Livingstone was charged with the responsibility of editing the Book Reviews. In July 1955 the journal had outgrown its quarters again and a move was made to 3 Penn Center Plaza. Later (in 1956), Roland Whitacre came to an unexpectedly early death and John Pender was appointed to replace him on the Editorial Board.

In 1956, Henry Ruth died and with him ended an era in the history of the journal. In this same year, a readership survey was undertaken under the direction of William E. Porter of the State University of Iowa. The results of this survey were reported some time later, but it is interesting to note that much of the information concerning the attitudes of personnel in the practice of anesthesia obtained by the readership survey are similar to information currently being secured by the survey being conducted under the auspices of the A.S.A.

The year 1957 was one in which the journal, particularly its business activities, was brought into closer relationship to the A.S.A. At the request of the A.S.A., Clarence Munns conducted a survey of A.S.A. activities including

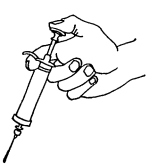
the journal. Although his concept of journal operations was influenced largely by his connection with a state society journal, he did, nevertheless, recommend that operation of the business end of the journal be more closely linked to A.S.A. business operations. This return of the journal to "the fold" was prompted by many things including an overhaul of A.S.A. functions, the sound financial status of the journal operation, some questions of tax liability, closer identification of the editorial board with the other committees of the A.S.A., etc. After much discussion and many extreme suggestions including transfer of both business and editorial operations to the Chicago office, it was finally decided to enter into a contract with J. B. Lippincott Company for the business operation and leave the editorial functions to a committee of the A.S.A. One should recall the recommendations made by a publisher in 1938.

Actually, the same office force and editorial board remained with the journal. The Medical Publications Division of J. B. Lippincott Company took over direct responsibility for the business management, and the editorial board continued to exercise sole judgment on editorial matters. The arrangement has worked satisfactorily for all parties concerned. The contract was effective January 1, 1960. Lancaster Press remained as printer.

The year 1959 marked a significant change in editorial policy in that under the Editorship of James E. Eckenhoff, a series of review articles and symposia issues were started. It is interesting that the minutes of the February 16, 1947, Editorial Board meeting contain a passed motion indicating opposition to issues devoted to one subject. The first symposium issue was in the fall of 1959 and dealt with muscle relaxants. Subsequent review articles and symposia have met with enthusiastic reception. Ralph Tovell's long and intimate association with the journal ended in 1959, years in which he put tremendous energy and thought into the development of the magazine. John Adriani was appointed to replace Ralph Tovell. James E. Eckenhoff remained as Editor until 1963. Leroy Vandam was appointed to the Editorial Board in 1961 and assumed the Editorship in 1963. Arthur Keats was appointed to the Editorial Board in 1963 and the most recent addition was S. G. Hershey.

No account of the journal would be in true perspective without including reference to a devoted staff. Mrs. Margaret Pruitt joined the staff in February 1950 and left in June of 1952. However, she returned in April 1956 and has remained as the backbone of the editorial staff since that time. Others significantly involved in the editorial end of things were Mrs. Maxine Holmes, 1949 to 1950, and Miss Margaret Baney, who had a substantial association with the developing journal from November 1951 until February 1958. Since 1951 the business matters were capably handled by Mrs. Mary Reilly and Miss Ruth Keim. Under the able direction of Mrs. Wall others dedicated to the development of the journal as a paying proposition were Miss Helen Keim and Mr. Charles Towner.

What the next 25 years will bring is impossible to predict. It is evident, however, that a journal spawned from the enthusiasm of a small group of pioneers in anesthesia has grown from a speculative venture into a substantial journal in the medical field. Its pages reflect the eagerness and devotion of the early supporters and the growth in scientific stature of the specialty. It is an example of the foresight and ambition of the first editors. As an example of modern scientific literature, it is a journal of which the specialty can be proud.



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HISTORICAL DEVELOPMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

Albert M. Betcher, M.D.

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Springfield, IL, Charles C. Thomas, 1982
Chapter 14, pp 185-121

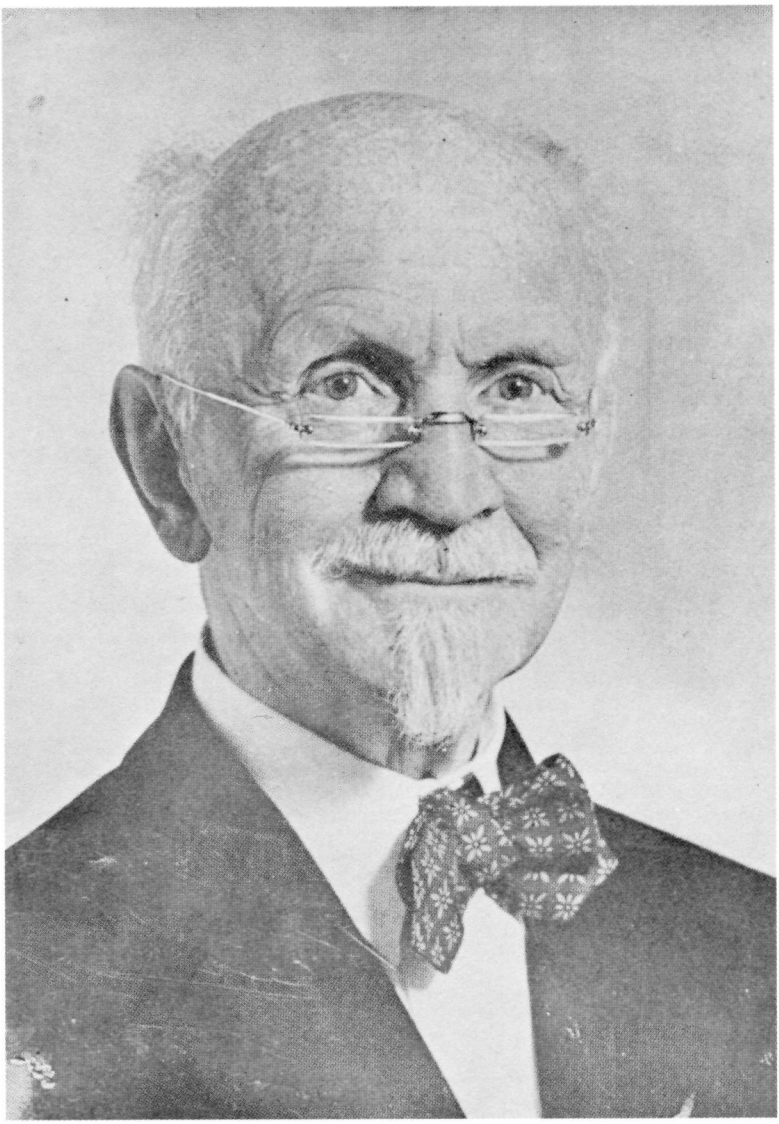

Figure 14-1. Adolph Frederick Erdmann
M.D.

14

HISTORICAL DEVELOPMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

ALBERT M. BETCHER

ORGANIZATIONAL GROWTH

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."[1] 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

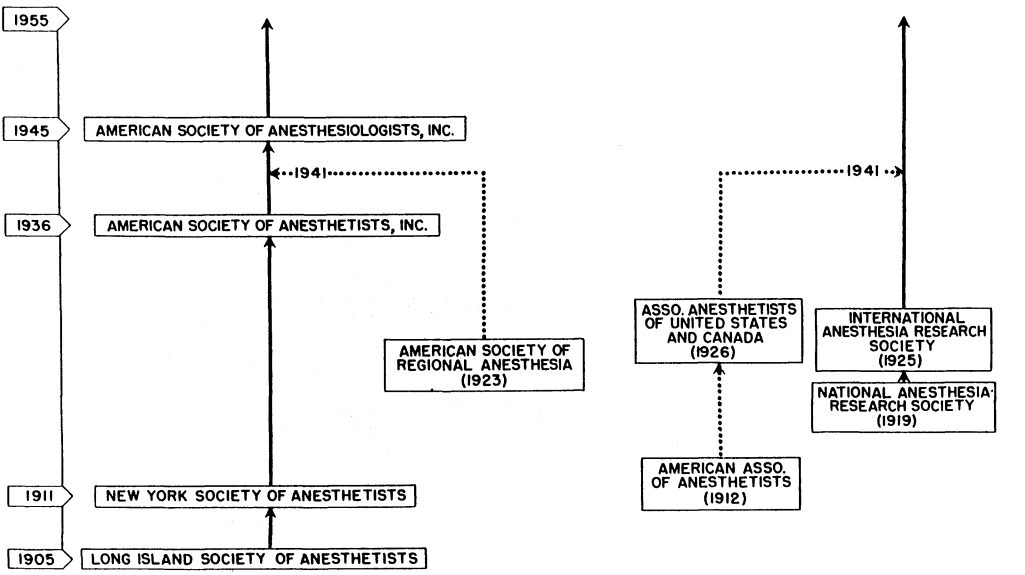

Figure 14-2. Origin of the American Society of Anesthesiologists, Inc.

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-

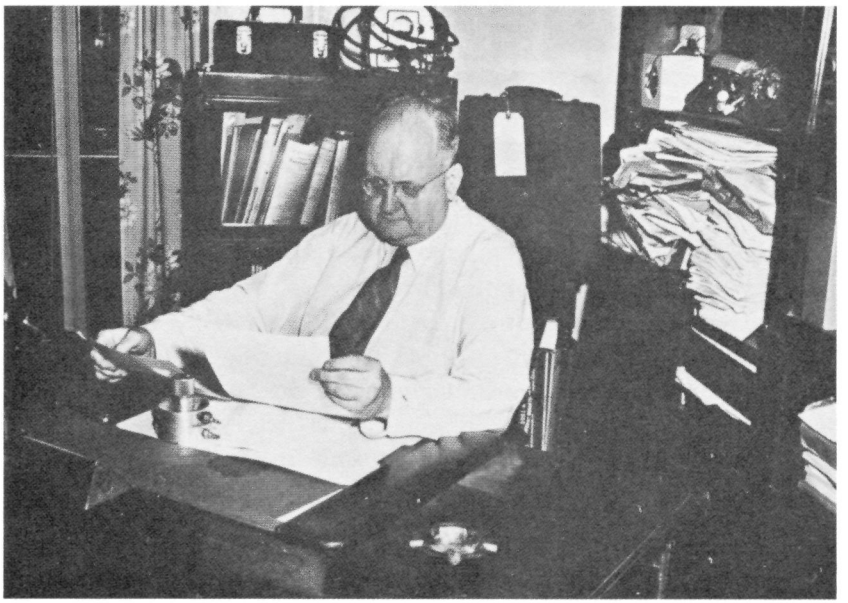

Figure 14-3. Paul M. Wood, M.D.

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

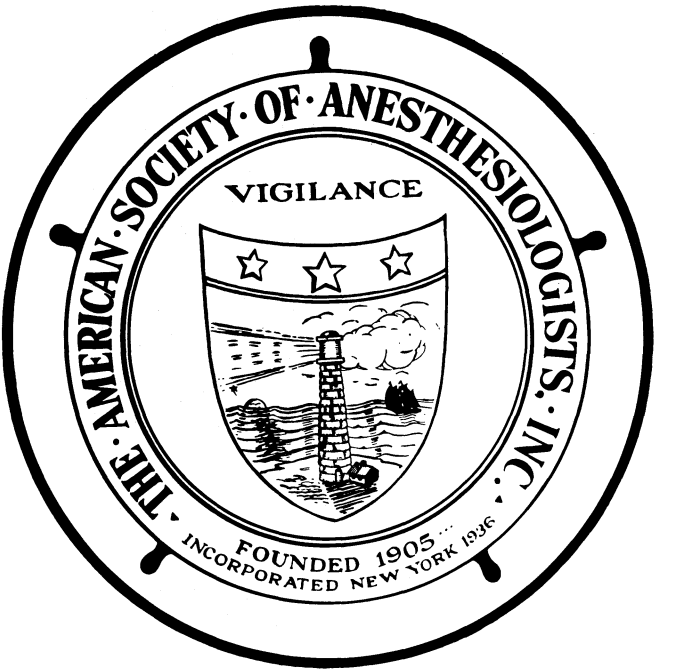

Figure 14-4. Seal of the American Society of Anesthesiologists, Inc.

Anesthesia of the Southern Medical Association.[8] 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.[9] 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.[10] It also provided for component societies on state, territorial and provincial levels, each with their own bylaws compatible with those of the national organization.

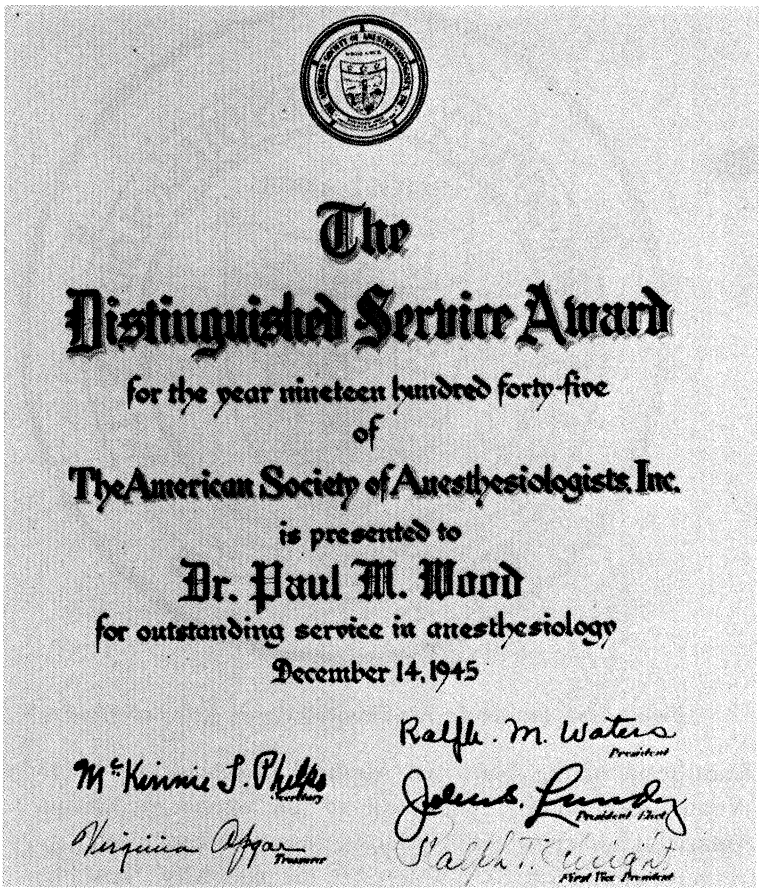

Figure 14-5. Distinguished Service Award of the American Society of Anesthesiologists, Inc. Courtesy ASA.

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.[11]

Significant new achievements, however, were few 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-

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.[12] 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.[13] A sound financial structure, and a new concept of the executive office staff were introduced that have since functioned extremely well.[14]

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."[8] 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.[19] 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.[6] 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.[8] 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 Govenors 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 anesthesiology or who had not fulfilled training requirements of the American Board.[6] 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.[20]

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.[27] 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.[28-31] 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.[32]

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.[33] 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.[34] 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.[27] 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.[35]

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,[33] and in 1960, the Society co-sponsored a National Registry of Inhalation Therapy Technicians.[36] 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.[37]

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.[13] In 1968 the committee developed a form for reporting adverse drug reactions.[38] 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.[39] In 1963, the Society approved a resolution to provide anesthesia training to residents in accredited oral surgery training programs.[40] 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.[38]

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.[41]

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."[42]

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.[43]

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."[52] A Public Education Program was approved for 1980-1981 utilizing the national media.[53]

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,[54] 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.[33,34,39,44,45] 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.[54]

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.[48] 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.[55] 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.[40]

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.[56] 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.[57]

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.[58] 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.[59]

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.[60] 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.[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.[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."[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.[63]

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.[65,67] 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.[69] 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.[70] In 1963, they amended this resolution to permit anesthesia training for residents in oral surgery.[71] 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.[26] 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."[13] 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.[72] The following year the Society was still attempting to clarify its Statement of Policy regarding employment of anesthetists other than Doctors of Medicine.[36]

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.[73] 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."[74]

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.[35] 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.[75]

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.[76]

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.[77] 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.[78] 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."[79]

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.[80] 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.[81] 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.[82]

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.[83] 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.[13] 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.[39] 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-

sional Liability, testified before the Senate Subcommittee on Health, on the escalating malpractice crisis.[84] 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.[81] 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.[85]

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.[86-88]

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.[89]

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 anesthesiology 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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THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.

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15

THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.

FREDERICK P. HAUGEN

A STRONG MOVEMENT TO ESTABLISH STANDARDS OF FITNESS for practice in the various specialties was underway in the mid-thirties. By 1933 in the United States, five specialty boards had been formed to certify as diplomates those physicians who satisfied their criteria. An Advisory Board for Medical Specialties was organized under the auspices of the Council on Medical Education and Hospitals of the American Medical Association. The purpose of the Advisory Board was to coordinate the activities of the specialty boards, and to advise in matters of graduate education.

One of the requirements of the Advisory Board was that its component bodies come from related Sections within the American Medical Association. Inasmuch as Anesthesia did not at that time have a Section, it could not qualify for membership. It became apparent that two courses were open for obtaining national recognition of the specialty. One pointed toward obtaining a Section on Anesthesia from the American Medical Association, then proceeding with the establishment of an American Board of Anesthesia. The other course was to attempt to develop a Board through the

Section of Surgery. As it turned out, both routes were followed. The first was slow in developing owing to lack of enthusiasm on the part of the American Medical Association. The other, aided by vigorous support from Dr. Erwin S. Schmidt, Professor of Surgery at the University of Wisconsin Medical School, materialized. He was greatly influenced by his association with Dr. Ralph Waters, Professor of Anesthesia at that institution. While Dr. Schmidt was seeking an amalgamation of surgical bodies to create an American Board of Surgery, he gave encouragement to the leaders of the New York Society of Anesthetists to seek an affiliation with that Board when it became operational.

The New York Society of Anesthetists was the only truly national professional group restricted to physicians in anesthesia. Dr. Thomas Buchanan and Dr. Paul Wood were the strong figures who emerged from this organization, and Dr. Wood, as Secretary, actively recruited membership throughout the country. During that era, plans were afoot for a certifying body within the structure of the New York Society. Drs. Wood, Lundy, Ruth and Buchanan were among those active in that endeavor. In an interview, Dr. Lundy said that at that time they thought there should be a certifying body as a College. Quote, "We would practice (asking questions and giving examinations) in this College and when we got the Board to work and could certify them for practicing anesthesia 100 percent, this College could certify that they are competent to practice anesthesiology, but don't give 100 percent of their time to it."

The Committee on Certification of the New York Society of Anesthetists proceeded then with plans for a nine-man board, and invited applications from its membership. By the end of 1935, physicians from twenty-three states had filed application. This widespread interest, together with the need for a national organization to sponsor formation of a Section on Anesthesiology in the American Medical Association, impelled Dr. Wood to propose that the New York Society change its name to the American Society of Anesthetists; this was accomplished in February, 1936.

In an editorial appearing in the *Journal of the American Medical Association* in March, 1936, it was stated that "residencies in specialties are of special importance at this time, when certification of specialists is being rapidly developed through the formation of

special examining boards, which will determine by an examination the fitness of a candidate to practice his specialty." That year there were eleven hospitals offering residencies in anesthesia, almost double the number of the previous year. Anesthesia was attracting more and more physicians to the field, and enthusiasm ran high.

The leaders of the newly formed American Society of Anesthetists grasped this as the time to push for recognition. John Lundy was appointed as delegate from the Society to represent it at a meeting of the Guiding Committee of the American Medical Association and the Advisory Board for Medical Specialties. Through his friendship with Dr. Fred Rankin, Secretary of the Section on Surgery, it was hoped that a favorable atmosphere would prevail. To quote Lundy, "I got acquainted first at the Clinic with Dr. Fred Rankin who was then Secretary of the Section on Surgery of the American Medical Association. He claimed that he ran it, which is pretty true of most Section secretaries, or it (the Section) won't go if they don't run it." It was a successful conference, and on October 21, 1936, a special committee of the Section on Surgery met to deal with the formation of an American Board of Anesthesia. Drs. Floyd Romberger, Boyd Steward and Ralph Tovell represented the Section, and they together with representatives of the American Society of Regional Anesthesia and the American Society of Anesthetists laid plans for a special meeting with representatives of the American Board of Surgery to be held the following spring. The meeting was held in Hartford on May 15 and 16, 1937, where the groundwork was laid for affiliation. On June 2, 1937, a second meeting was held in New York with the entire Board of Surgery. Representing the Section on Surgery of the American Medical Association were Drs. Tovell, Stewart and Ruth. The delegates from the American Society of Anesthetists were Drs. Rovenstine, Buchanan, and Lundy, and the American Society of Regional Anesthesia was represented by Drs. Wood, Woodbridge, and Waters. And so, at long last, the specialty of Anesthesia had formulated an Examining Board that conformed to the criteria established by the Council on Medical Education and Hospitals of the American Medical Association.

In February, 1938, the Advisory Board for Medical Specialties of the Council approved the affiliation with the American Board of Surgery and the American Board of Anesthesia became a reality. As

Lundy remarked, "We did this thing so quickly that we didn't have time to get any practice in this college thing, as a matter of fact, the American College didn't get going until really after the Board did, or almost the same time."

The first announcement of the newly formed board appeared in the *Journal of the American Medical Association* on May 21, 1938. It is of interest to recount this announcement in its entirety.

> ANNOUNCE ESTABLISHMENT OF NEW BOARD OF ANESTHESIOLOGY. The American Board of Anesthesia has been organized as an affiliate of the American Board of Surgery in response to many requests to establish official recognition of physicians competent to practice and teach anesthesia as a specialty. The affiliation was approved by the Advisory Board for Medical Specialties in February, 1938. Cooperating societies include the Section on Surgery of the American Medical Association, American Society of Anesthetists, Inc., and the American Society of Regional Anesthesia, Inc. The term of membership on the new board will be six years. Present members are Drs. Thomas Drysdale Buchanan, New York, president; Henry S. Ruth, Philadelphia, vice-president; Paul M. Wood, New York, secretary-treasurer; John S. Lundy, Rochester, Minn.; Emery A. Rovenstine, New York; Harry Boyd Stewart, Tulsa, Okla.; Ralph M. Tovell, Hartford, Conn.; Ralph M. Waters, Madison and Philip D. Woodbridge, Boston. Two groups of candidates are recognized for qualification by the board: those who have already amply demonstrated their fitness as trained specialists in anesthesia, the Founders' Group, on invitation by the board, may be chosen from (1) professors and associate professors of anesthesia in approved medical schools in the United States and Canada, (2) those who for fifteen years prior to the board's organization have limited their practice to anesthesia and (3) those who hold the certificate of fellowship in the American Society of Anesthetists, Inc. All applications for the Founders' Group must be received by January 1, 1939. No candidate will be considered after that date. Requirements for those to be qualified by examination will be: 1. Graduation from a medical school of the United States or Canada recognized by the Council on Medical Education and Hospitals of the American Medical Association or graduation from an approved foreign school. 2. Completion of an internship of not less than one year in a hospital approved by the Council or its equivalent, in the opinion of the board. 3. Special training: a further period of graduate work of not less than three years devoted to anesthesia taken in a recognized graduate school of

medicine or in a hospital or under the sponsorship accredited by the American Board of Anesthesia for the training of anesthetists. The period of training shall be of such character that the relation of the basic sciences to anesthesia shall be emphasized. Adequate clinical experience in which the candidate has assumed the whole responsibility will be required. An additional period of not less than three years of study or practice limited to anesthesia. 4. The candidate must present to the board sufficient evidence of good moral character and that he has limited his practice to anesthesia as a specialty and that he intends to be so engaged.

The qualifying examination will be divided into two parts: Part I will consist of a written examination covering such topics as anatomy, biochemistry, physiology, pharmacology, physical diagnosis, therapeutics, pathology and public health, in relation to anesthesia. Part II is oral and practical, which may cover similar topics and in addition such questions on physics and mechanics as are important in anesthesia, especially those dealing with electrical theories and the proper handling of high pressure gases and inflammable agents. The practical examination will consist of actual observation of clinical work in the applicant's own operating theater when possible, and it may consist of cadaver demonstration of regional block, sites for alcohol injection and procedures for resuscitation or inhalation therapy and clinical experimentation.

The fee for Group A, Founders' Group, shall be $25.00. The fee for Group B shall be $50.00, payable $25.00 on application, which shall be returned if the candidate is not accepted for examination, and $25.00 on taking the examination. Reexamination within two years may be had, if necessary, without additional fee. Once a candidate has become qualified he will have no further financial obligation to the board.

The board postponed its first examination (Part I, written), which was scheduled for July, 1938. Part I and Part II will be held in New York City October 21. Requests for booklets of information and application blanks should be addressed to the secretary, Dr. Paul M. Wood, 745 Fifth Avenue, New York.

Dr. Buchanan, the first president and holder of the first certificate issued, was one of the pioneer physicians in the specialty. At the time of his election to the Board, he was Professor of Clinical Surgery (Anesthesia) at the New York Postgraduate Medical School and Clinical Professor of Anesthesia at the New York Medical College. Dr. Buchanan was forced to retire from the Board during the first year of his term because of coronary disease, and he died on

March 21, 1940. Dr. Henry Ruth succeeded Dr. Buchanan as President of the Board. The first meeting took place on March 23, 1938. The agenda consisted of long discussions of details of the Constitution and Bylaws, the Founders' Group and their qualifications for membership, and the meaning of the affiliation with the American Board of Surgery. Minutes of later meetings in 1938 disclosed a growing feeling that the Board of Surgery was pressuring the Board of Anesthesia to embrace the national organization of nurse anesthetists and to put the two groups into "happy relationships." It was pointed out that no other specialty board was functioning as a supervisor of the training of technicians and the Board of Anesthesia was convinced that it should not become involved in the matter. During the formative meetings of the Board, representatives of the American Board of Surgery met with it; the relationship was irksome because of the differences in viewpoint. A quotation from the minutes — "we can't buy a postage stamp with the other Board's approval" — sums it up.

The first year was a busy one. Nine meetings were held, in four of which the full Board was in attendance. In all, the Board received 115 applications for certification, issued forty-seven certificates and examined fifty-four candidates. During 1939, the Board met in July and October, the October meeting being with representatives of the American Board of Surgery. The disagreement between the two Boards over nurse anesthetists continued, and the Board of Anesthesia expressed a desire to become an independent organization. At this time, the original three-year residency requirement was under discussion and two years of training for entrance into the examination system were proposed. The requirement was officially changed in June, 1940. Dr. Charles McCuskey was elected to fill the vacancy left by the death of Dr. Buchanan.

In an interesting sidelight on the type of discussions that went on in the early years, Dr. Lundy said, "Paul as secretary wanted to record everything, and then the wire would get off the spool and get on the floor. I recall that many times it was two o'clock in the morning before we could get away from him, and our wives were frantic about this. Paul had so many virtues and was such a hard worker that we would go along with him until we were completely fatigued."

The route by which the American Board of Anesthesia became a reality had been a circuitous one, and attention was again directed

toward obtaining representation on the Advisory Board for Medical Specialties through establishing a Section on Anesthesia of the American Medical Association. Once this was achieved, an independent Board could be proposed. Negotiations were opened between the American Society of Anesthetists and the Council on Scientific Assembly in November, 1939, and a favorable attitude was demonstrated toward formation of a Section. In June, 1940, at the annual meeting of the American Medical Association, the House of Delegates voted to establish the Section on Anesthesia. This was a most important landmark in the recognition of our specialty. In February, 1941, a letter was circulated to all members of the Board, stating that the Advisory Board for Medical Specialties had recommended that the American Board of Anesthesia be released from its affiliation with The American Board of Surgery, pending approval of other participating boards. This approval was given and the ABA achieved independence February 16, 1941.

During the years from 1941-45 the activities of the Board were limited, but there was a great deal of attention given to the status of anesthetists serving with the Armed Forces. At the June, 1943, meeting it was reported that there were now 185 diplomates, forty in the Army and seven in the Navy. Thirty-four residencies were approved for training. It is evident from the minutes of those years that the certification process was a highly subjective affair, with the Board bending over backwards to do what they thought best for the individual candidate in view of circumstances. An absolute level of competence was not sought. Dr. Meyer Saklad, who had been elected to represent the New England Society of Anesthetists when the membership of the Board was increased to ten, acted as a strong force to establish a "stiff examination for everyone who comes here, and then stick to it."

Changes had taken place in its organization. The American Society of Regional Anesthesia withdrew from the list of sponsoring organizations owing to its own inactivity. The New England Society of Anesthesia (formerly the Boston Society), the Section on Anesthesia of the Southern Medical Association, and the Pacific Coast Association of Anesthesia were considered as representative groups for representation on the American Board of Anesthesia. The Pacific Coast Association was no longer active in 1942 when revisions were made in the Constitution of the ABA, but the other two

were recognized. The members were now to be elected as follows:

(1) One member from the New England Society
(2) One member from the Section on Anesthesia of the Southern Medical Association
(3) Four members from the American Society of Anesthetists, Inc.
(4) Four members from the Section on Anesthesia of the American Medical Association.

It should be noted that the members of the ABA during the formative years spent much time at their own expense attending meetings, often working into the small hours to develop that wherewith we have today.

The immediate postwar years were marked by a great increase in the number of candidates. Ninety-four presented themselves for the oral examination in October, 1946, whereas previously the greatest number had been thirty-six. There were many problems in relation to residency programs. Sixty-four hospitals now had the approval of both the American Board of Anesthesiology and the Council on Medical Education and Hospitals, but the responsibility for granting of approval was not clear, and the Council felt that it should remain under its control. The matter finally was resolved in this as well as other boards by the development of joint committees on residencies called Residency Review Committees.

In the early 1950s, another revision of the Constitution was proposed and adopted. Provision was made for an eleventh member to serve on the Board. The organizations with representation were reduced to two: The American Society of Anesthesiologists (officially changed from The American Society of Anesthetists on April 12, 1945) and the Section on Anesthesia of the American Medical Association. Considerable discussion took place as to the number of representatives each should have, as the Council on Medical Education had a rule that required as much representation from the Section as any of the other organizations that sent representatives to a Board. The ABA took the position that the assignment of the representation could be made after selection of the nominees, and this compromise was acceptable to the Council and the Advisory Board.

The problem of upgrading residencies took much time. Several

attempts were made to increase training to three years as a requirement for entrance to the Board examinations, and one year residencies were abolished. Survey committees made up of diplomates living in various parts of the country came into vogue as a means of determining the abilities of a candidate prior to taking the oral examination. This system was continued for several years, then abandoned.

Changes in the operation of the Board often met with considerable opposition from other organizations, including our own Society. Some of the members of the American Society of Anesthesiologists thought that a function of the ABA was to discipline diplomates and candidates for certification who practiced contrary to its economic policy. Surgical organizations hastened to condemn the Board for presumably assuming the role of disciplinarian in this regard. Others feared that it was becoming a self-perpetuating autocracy. These were times of major upheaval. As the founding members' terms expired, new and younger men stepped in, and fortunately the ABA remained steadfast in its prescribed role of certifying candidates as to their academic qualifications and granting certificates attesting to their proficiency. Liaison committee meetings between the American Society of Anesthesiologists and the ABA resulting in a better understanding of the points of dissension and relations improved steadily during this decade, although the Board no longer made membership in either the American Society of Anesthesiologists or the American Medical Association a prerequisite for certification.

As the third decade of its existence draws to a close, the Board is a smoothly running organization. The problem of selecting Directors has been quite satisfactorily solved by establishment of a joint committee, consisting of representatives from the Section on Anesthesiology of the American Medical Association, the American Society of Anesthesiologists, and the American Board of Anesthesiology. The committee meets annually to consider nominations from various parts of the country, and selects a slate of approved nominees to the Board for final decision as to replacements for directors whose terms are ending. By 1969, the total number of applications received by the Board since its beginning in 1938, was 8,418. Final action had been taken on 6,423, the balance either in the examination process, or declared ineligible. Physicians number-

ing 4,739 have been certified as Diplomates of the American Board of Anesthesiology, making this one of the most active certifying bodies among the specialties. And so, because of the energies and vision of its founders, the Board now faces its fourth decade as an active, vital organization, dedicated to the maintenance of high standards of scholarship and skill in the practice of anesthesiology in the United States.

Physicians who have served as Directors of the American board of Anesthesiology, or still serving are as follows:

T. D. Buchanan	1938-1940	S. C. Cullen	1950-1962
R. M. Tovell	1938-1950	S. M. Smith	1950-1960
H. B. Stewart	1938-1946	E. B. Tuohy	1952-1955
H. S. Ruth	1938-1951	M. C. Peterson	1954-1967
E. A. Rovenstine	1938-1948	A. Faulconer	1956-1969
J. S. Lundy	1938-1955	F. E. Leffingwell	1956-1969
P. M. Wood	1938-1948	E. M. Papper	1956-1965
P. D. Woodbridge	1938-1948	R. D. Dripps	1956-1967
R. M. Waters	1938-1947	R. H. Barrett	1960-
C. F. McCuskey	1940-1953	J. Adriani	1961-
M. Saklad	1943-1956	D. M. Little	1961-
R. J. Whitacre	1947-1956	W. K. Hamilton	1963-
J. W. Winter	1947-1949	J. H. Matthews	1963-
C. B. Hickcox	1948-1959	R. T. Patrick	1963-
D. L. Burdick	1948-1962	J. E. Eckenhoff	1966-
F. P. Haugen	1949-1962	A. M. Betcher	1968-
H. C. Slocum	1950-1960	A. S. Keats	1968-

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THE ORIGINS OF THE ASSOCIATION OF UNIVERSITY ANESTHESIOLOGISTS

E. M. Papper, M.D.

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SPECIAL ARTICLE

The Origins of the Association of University Anesthesiologists

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Conceived in turbulent times but born in optimism at facing a brave new world, the Association of University Anesthetists (AUA, as it was called at its inception) is an interesting and important manifestation in medicine of the rapid intellectual and societal changes that were taking place in the United States in the immediate post-war (World War II) period. That this new organization was put together in a tumultuous environment is documented by the parting note of the first secretary, who was one of the eight founders of the Association, Austin Lamont. In 1957, he attached two interesting paragraphs to all of the correspondence that he had kept from those who worked to organize the group. On his presentation of the correspondence to the archives of the Wood Library and Museum in Chicago, Lamont wrote (1):

> This folder contains correspondence dealing with the formation of AUA and with the so-called Hingson Report. In both these matters strong personalities were involved. I believe the individuals concerned trusted my discretion, for they would write or tell me things they would not say to each other. There are, therefore, in this folder personal letters not intended for public view.
>
> But someday it may be of interest to a mature organization to look back on these matters. I think it would be a mistake to permit this folder to be opened until 1965 or 1970. By then the persons involved will have mellowed, the controversial issues will have been settled, and the personal references contained in many of their letters will no longer carry the sting they originally had.

Some consideration, however brief, of the environment in which the AUA first appeared as a structured force in academic anesthesiology is needed to understand the background information important to the story of this new organization's beginnings.

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Academic Anesthesiology Before World War II

Before World War II, academic anesthesiology was characterized by many healthy accomplishments. The important academic presence in that era begins with and is centered around the first recognized academic department in the United States at the University of Wisconsin chaired and led by Ralph Waters. From the inception of the Wisconsin Department in 1927, Waters and his large coterie of distinguished followers, including E.A. Rovenstine who brought the academic message from the Midwest to the East at New York University and Bellevue Hospital, were engaged in studying the scientific bases of the important clinical problems of that era. Their skillful research in the anesthesiology of that period was a strong beginning. Equally important and interesting was the establishment and subsequent development of an academic arm, with respect to research and teaching at the Mayo Clinic under the leadership of the founder of anesthesiology in that institution, John Lundy. At the same time there were discrete and important burgeonings of interest in intellectual and other scientific matters that dealt with the anesthetic process. There were individuals who came from other disciplines like surgery, internal medicine, and pharmacology to study the biology of anesthetized humans with great foresight and clarity. Among these people was the young and able Henry K. Beecher who combined a scientific rearing with Professor Krogh in Copenhagen with clinical interest in anesthesia at the Massachusetts General Hospital. Beecher's book, *The Physiology of Anesthesia*, published in 1938, ranks among the landmark developments of the academic strength of anesthesiology. Despite these activities, there was insufficient time and opportunity to develop scientific researchers and teachers in anesthesiology, to say nothing of clinicians, in adequate numbers to have made a major mark upon all academic enterprises in the United States before the War.

The needs of World War II produced a rapid

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development of marginally educated physicians in anesthesiology to meet the critical exigencies of injury and disease resulting from massive warfare in all parts of the world.

The Academic Scene in Anesthesiology After World War II

At the end of World War II, the still young but seasoned veterans who had academic interests and talents saw these skills reinforced and greatly extended by the enormous clinical experience brought to them by the unfortunate results of institutionalized killing and wounding that is modern warfare. These young physicians in military anesthesiology were often, and in substantial numbers, attracted to a permanent career in this relatively new discipline; and, as was fortunately the case, a sufficiently strong cohort of this group opted for academic work. The education required for research and teaching careers was, for those days, rigorous. Today, in view of the enormously more complex problems to solve, the adequate clinical and scientific education of the immediate post-war era would be viewed charitably as evolutionary in character and accurately as floating on the margin given the problems to be resolved. Between the end of the war and the end of the decade of the forties, there was enough opportunity to accomplish the establishment of new independent departments of anesthesiology devoted to academic purposes of research, teaching, and complex patient care. There were enough individuals with investigative and educational talents devoting their entire career to academic pursuits to become a force mostly of youthful enthusiasm and of raw ability who wished to make anesthesiology the scientifically based discipline that it deserved to be. They worked hard to extend the benefits of those investigations to the care of patients who needed and deserved these attentions. There was a spirit of buoyancy, of powerful hope, and of great energy. There was also an important characteristic that marked many of the young leaders of the immediate post-war period. They had courage. Risk taking was known to be necessary and was entered upon with realistic reflections of the possible outcomes. Great success can be gained but equally great failure can ensue if the risk-taking results in an adverse outcome. In assessing his tenth anniversary as Columbia University's President, Michael Sovern quoted a favorite passage of his from William James on the subject of risk-taking (2):

> Not a victory is gained, not a deed of faithfulness is done, except upon a maybe; not a service, not a sally of generosity, not a scientific exploration or experiment or textbook, that may not be a mistake. It is only by risking our persons from one hour to another that we live all. And often enough our faith beforehand in an uncertified result is the only thing that makes the result come true.

There was ample evidence of the willingness to take the risks, because the past did not exist for most of the then young academicians in an important sense. Their future was one of brimming optimism, and their leaders were young, vigorous, and committed to a future boundless in scope. There was no possibility that the academic anesthesiologists of the immediate post-war period would be lulled into contentment with their present condition because of a good past. It simply did not exist in a serious way for them and, therefore, there were no weighty impediments to thinking ahead for the future.

This environment of optimism among a relatively small group of academicians had its counterpart among the clinical practitioners of anesthesiology but was differently arranged in priority and differently organized with respect to functions and goals. Practitioners in anesthesiology came back from the war finding a society in which their services were required far beyond the possibilities of numbers to satisfy. Young surgeons and others were deeply impressed by the contributions to patient welfare that could be provided by skillful clinical anesthesia. It is possibly because of the fact of short supply of competent anesthesiologists that an extreme position began to be noticed and apparently adopted as functional policy, if not official policy, by the controlling establishment in anesthesiology (although there were those who claimed it to be official). The practitioners of anesthesiology could use their new-found shortage of supply and high desirability as market forces to rectify the injustices of their economic oppression (as they viewed it) in the pre-war period by hospitals and similar institutions. An expression of these clinical market forces was a decision made to adopt a document known as the Hess Report of the American Medical Association (3) as policy. This report stated in part (chapter III, Article VI, Section 6):

Economic Bases Between Academic Anesthesiologists and Anesthesiologists In *Private Practice*

> A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever named called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned.

This section was interpreted by the officers of the American Society of Anesthesiologists (ASA) and the Directors of the American Board of Anesthesiology (ABA) in such a way that salaried forms of the practice of anesthesiology were deemed to be unethical. Attentive reading of the approved Hess Report does not support this interpretation so clearly.

Further on, the American Medical Association's (AMA's) House of Delegates report states under "additional guides," in teaching hospitals where there is research and education, that "the financial arrangements if any between the hospital and the physician properly may be placed on any mutually satisfactory basis" (3). Adjudication of conflicts, if needed, was recommended to be performed, where possible, on a local level.

Little recognition was given then or, for that matter, now about the dangerous irrelevancy of linking ethical behavior of a physician in practice to the manner in which he or she earned a living as a matter of principle. It is *how* these practice patterns are used that determines whether the method leads to inequities and to abuse of patient care rather than the process itself. Whatever the elements were, it was strongly believed by the University group that earning a living on a salary was the most agreeable arrangement to them at the time (despite dreadfully low salaries in many institutions). They behaved in this manner because there was a concomitant freedom from the necessities of schedules that impacted negatively on their time for scientific research and for education in favor of meeting the exigencies of a clinical schedule designed always by someone else and never under the control of anesthesiologists. Practitioners, who were vastly in the majority then and now, were of a different mind. They intended to retain the money that they believed they had properly earned, rather than have it distributed into the general coffers of a hospital or institution that may have profited by their efforts.

So intent were the practitioners of that period on enforcing this change that they attempted to require of every anesthesiologist who sought certification by the ABA that he or she be a member of the ASA and conform to the requirements of fee-for-service methods of earning a livelihood. The actual statement was that an applicant to the ABA must "be a member in good standing in the American Medical Association, the state and local county medical society or comparable national medical society approved by this Board. He (the applicant) must be a member in good standing of the American Society of Anesthesiologists, Inc." (4). This requirement was omitted in the booklet of information published on November 1, 1953, eliminating the matter that appeared to be of serious concern to university anesthesiologists. In fact, there never was secession from the ASA by the University group, although there were many problems between the practitioners' views and those of the academicians from 1950 until the AUA was organized in 1953.

The Gathering Storm

The matter achieved some considerable notoriety as well as serious concern on the part of academic anesthesiologist in that one of their number, a person of distinguished military performance in anesthesia during the war, as well as possessing a strong academic background in having come from the academic environment of the Mayo Clinic (Lloyd Mousel), was threatened with the loss of his Board certificate because he was working on a salary (5). There were other academicians who were prevented from joining the component societies of the ASA for similar reasons. One such example occurred in the component societies that comprised Maryland, Virginia, and the District of Columbia, in which an anesthesiologist from Johns Hopkins' Anesthesiology Division was refused membership in the component society and, therefore, the ASA for accepting a salary. The gathering storm was aggravated by extremists of the anesthesiology practitioner establishment of that period as well as by the excessive reactivity of some of the academic people.

An irony that is obvious, even to the passing observer, is the fact that the fee-for-service system modified by group practice features has actually prevailed even in most of the universities today, whereas it was viewed with dangerous alarm by the academicians at that earlier time. The current system, in turn, has led to other serious abuses in that instead of hospitals exploiting anesthesiologists, some anesthesiologists are now engaged in the dubious distinction of exploiting each other. The closed contract between the central power structure or the leadership of a group of anesthesiologists with an institution and the subsequent imposition of unfair and poor salaries on junior anesthesiologists (more common in private clinical practice than in academic organizations today) is the hallmark of how the human condition seems often to opt for base behavior given an opportunity of free choice. This observer recognizes that these comments are perhaps too cynical, a problem generated because one becomes attached to one's biases. As Alexander Pope, the distinguished 18th century poet, put it (6):

> To observations which ourselves we make
> We grow more partial for the observers sake.

These and other forces that molded the conception of the AUA and its ultimate delivery and birth are best understood by examining the correspondence that most of the featured players of the formative period had with and through Austin Lamont who functioned as a collecting center for a vast correspondence as well as, as he puts it, "the placing of confidences in him that would not otherwise be told." Lamont would probably feel some of those confidences should never have been breached. It seems to me that the story is better understood if both the actual statements of the players, where appropriate and useful, are studied at this time, some 38 years later, and are, to the degree possible, interpreted in the rather strong light of those turbulent times.

The Lamont File of Correspondence Leading to the Formation of the AUA

People of stern conviction are often afflicted with the inability to engage in a dialogue. At the time when they are neither talking nor writing, they are neither listening nor reading but simply waiting for the next opening to talk or write. This characteristic was true of all participants in an activity as fraught with controversy as was the genesis of the AUA. However, lest there be undue stress upon the fact that the AUA's beginnings were only the reaction to heavy-handed enforcement of a relatively archaic issue even then, i.e., the way one earns a living, it is essential to examine all the other issues and needs, especially the positive forces of university work, to understand how it all began. In the mind at least of this observer, there is little question that the AUA would have been organized sooner or later without the stimulus that was provided by the practitioner element in anesthesiology in insisting on a fee-for-service basis as one of the requirements of holding an ABA certificate. There was, after all, a modest-sized (compared to the present) but growing group of individuals interested and curious about the scientific underpinning of clinical anesthesiology. Many of them wished to have the opportunity to study important physiological and other functional changes in the human organism during the massive effects wrought by the powerful drugs and chemicals that are anesthetic agents. There was also a sufficiently strong group of people who were interested in imparting the knowledge that they or others had accumulated in a systematic way, i.e., teaching. They strove hard to improve the education of new people coming into the field of anesthesiology. These pressures were increasingly apparent and these aspirations were increasingly legitimate, as more and more people became interested in the science and education needed in anesthesiology.

Despite these positive and healthy factors, there is an opening salvo of anger in the Lamont correspondence by Henry K. Beecher. In due course, as will become evident, the formation of a group of friendly colleagues, at first groping their way to a solution of their common problems and later providing clear and powerful leadership for their goals, emerged from the mixture of conflict with external forces and the salutary responses to internal needs.

On November 17, 1950, Henry K. Beecher wrote to Austin Lamont at the University of Pennsylvania about his anger and discouragement about the pressures put against academic anesthesiology. Part of the emphasis of Beecher's interest and accomplishments is reflected in the title on this letterhead where he is self-characterized as the Dorr Professor of Research in Anaesthesia and Anaesthetist-in-Chief. Research is what the occupant of the Dorr Chair did in his work. After attending two meetings on anesthesiology (one in Miami Beach and one in Houston), he says to Lamont (5):

> It is perfectly clear that a tight little fascist dictatorship is being set up while the rest of us with any liberal views whatsoever stand idly and helplessly by.

Later on in the same letter, Beecher writes (5):

> Surely more important is the legislation designed to club all individuality into a mold. I find it impossible to believe that the ardent campaign against salaried individuals will not be turned against those in university positions when earlier battles are won, etc. etc.

Beecher concludes his letter by suggesting to Lamont that the latter lead a group in the form of a loyal opposition that could be made effective "in an organization to be called something like Association of University Anesthetists" (5). Beecher, thus inspired by the anger against what he believed to be philistinic behavior of the practitioner power structure, advocates a loyal opposition, but views it, perhaps paradoxically, to be expressed in the form of a new association that will become the AUA.

Some of the change in attitudes over the last 41 years toward academic anesthesiology may be seen in the change of title of Beecher's successor, Richard J. Kitz. The latter uses the title of Henry Isaiah Dorr Professor on his letterhead. Dr. Kitz views himself as the head of an enterprise that encompasses research, teaching, and patient care directly in the way his title is expressed. This larger view is a reflection of the change of the times. It is one of the successful stories of evolution probably aided by increased substantive recognition of the values of academic anesthesiology. The AUA played an important role in this transition

ANESTH ANALG
1992;74:436-53

from then to now throughout the country, symbolized by a letterhead change of title.

The Sense of Urgency Developing in Academic Anesthesiology

All of the Lamont correspondence reads, if one studies datelines, as though the correspondents sensed a high level of urgency to communicate. No time is allowed for lapse between letters. Lamont replies to Beecher on the November 21, 1950, 4 days after Beecher's letter was written, not counting time to be mailed and received. Lamont agrees with Beecher that the news of economic pressures on anesthesiologists in universities is deplorable. At the time of his first reply to Beecher, Lamont believes that all of the commotion is exaggerated and he does not, at first, think that an organization of university anesthetists would be necessary or wise. His views, of course, were to change rapidly in the next few months. In fact, Lamont's initial reaction was to say in effect that it was possible to satisfy the economic pushes of the power structure of the ASA by establishing what he called "partnerships in universities." It was an attempt to "window dress" (in his words) the salary question, which he later withdrew.

There appears to have been a lull in activity, judging from the Lamont correspondence, in that there are no further communications during 1950 and there are no letters amongst the principals, Beecher, Dripps, Lamont, and Papper in all of 1951. Clearly, there must have been some form of action during this interval of some 14 months, perhaps by telephone or conversations during medical meetings, as the resumption of the correspondence reflects that there was interim thinking about the problems of university anesthesiologists. My own files and notes and my recollections do not cast any further light or information upon this period during which no letters appeared in Lamont's files.

Letter writing was resumed with the letter of February 15, 1952 from Dripps to Papper in which Dripps proposes a modest model of the Society of University Surgeons for university anesthesiologists in which a small group of institutions could get together to discuss scientific research, either alone or in collaboration with basic scientists. He suggests a group consisting of Harvard, Columbia, Hopkins, Washington (St. Louis), and Pennsylvania as a beginning. He indicates that his thinking at that time was tentative and he would be happy and willing to have suggestions of other activities (7). In rapid reply, on the 19th of February, Papper's response to Dripps reflects his opinion that a larger group is a much better one for anesthesiology. He is strongly in favor of a group of academic anesthetists rather than one in association with surgeons. Papper comments about having seen Beecher just before this exchange of letters, and he also urges the establishment of a university group (8). The correspondence from this point on continues at a hectic pace and with unabated vigor. A principal advocate of a new association in some form is seen in a letter from Beecher on February 26, 1952, to Lamont (9):

> nevertheless my telephone continues to ring with discordant wails from all over the country. The most recent funny business has been going on at the University of Utah where apparently Scott Smith is involved on the side of union tactics.

He concludes his letter with being willing to form a travel group rather than a new society and to collaborate with others in opposition to the heavy-handed tactics he observes in the power structure of the ASA. Beecher's inclination, at that time, was to seek alliance with powerful groups in surgery whose views he thought would be most supportive of the positions and the needs of academic anesthesiologists against the heavy-handed "oppression" of private practitioners in anesthesiology. On Leap Year Day on 1952, Papper, in a short letter to Dripps, reaffirms his position in support of a larger, rather than a smaller, group for a new association, citing the real needs of a society to work on the mutual problems of research and teaching (10).

An Early Agenda for the Formation of the AUA Proposed by Beecher, Dripps, Lamont, and Papper

On March 3, 1952, Lamont writes to Beecher and presents to him an 11-point program in draft form with which he and Dripps are in agreement and for which Beecher's support is sought. Papper's views were also put forward as being in essential agreement with the major goals of our group of four (Beecher, Dripps, Lamont, and Papper) but repeating his desire to have a rapid evolution to a national organization. Lamont, in his letter of March 3, 1952, presents the proposals (11):

1. An organization composed of the anesthetists in some of the universities would be desirable.
2. Such an organization should start in a very small and informal way, perhaps as a travel group, as you (Beecher) suggest.
3. As a start, these might be included—Harvard, Columbia, Pennsylvania and two or three others who conduct effective research.

4. The primary purpose of such a group is the exchange of information regarding research.
5. For this reason membership in the group should be rather limited.
6. The consideration of other matters of interest (e.g. socio-economic relations, residencies, teaching, etc.) should have no place in the programs of the group's meetings. There is no reason, however, why the members of the group should not decide informally among themselves to stay over an extra day to discuss these matters if they wish. (This view was later abandoned.)
7. Should the members of the group eventually prove to be sympathetic and congenial and should the matters mentioned above in number 6 be still of moment at that time, consideration should then be given to enlarging the purposes of the group. (This view prevailed later.)
8. But, at least as regards socio-economic matters, it seems likely that any stand this group might adopt would be supported by a considerable number of anaesthetists (university or otherwise) who would not be eligible for membership in the group. (A reflection of the need to address real issues faced by all academicians.)
9. Consideration of these other matters and action upon them can at present be affected as we are now doing.
10. Formation of a group interested in research should not be postponed simply because there may be opposition.
11. As far as organizational matters are concerned, if such a group is formed, its first job should be to define carefully standards of eligibility for membership and procedures for election.

Clearly, Lamont's and Dripps' points of view emphasized the importance of small size of the group, a concentration of research activity, and an unwillingness to include teaching or other matters unless, later on, the group feels that attention should be given to them. There is, nonetheless, open-mindedness about the possibilities of including such matters as teaching and education, as well as considering what are lumped together as "socio-economic matters." As time goes on, the correspondence gets more and more crystallized toward what eventually became the AUA. Its initial interests in teaching and research were expanded to include items properly included under the aegis of university problems and issues.

One day later, on March 4, 1952, Dripps writes to Papper, still wanting a small research group rather than a larger group. He also advocates as much informality as possible and wishes to keep the organizational structure streamlined and simple, and the meetings relatively compact and short. He also impresses upon Papper his own need to be in Philadelphia and working with his Pennsylvania research program more closely. He says, therefore, he would be jealous of any time he would have to spend upon a much larger enterprise than the original thoughts of the small research group of interchange of experiences. He suggests, tactfully and parenthetically in a sermonette to Papper, that as the latter's responsibilities increase, he will face the same problems. He writes (12):

> I believe that as your responsibilities grow outside of your own department and university, you will appreciate why I take such a strong stand on this. As soon as you have to go to Washington for various committee meetings, leave the country on Army inspection tours and so forth, you will realize that additional meetings have got to offer you something, for you just will not have the time and energy to devote to them otherwise.

However, Dripps had a more open mind about the objectives of anesthesiologists concerned with research states when he says in the concluding paragraph of the same letter: "Perhaps you, Beecher, and I, plus a few others should meet during the Federation meetings in New York City and talk this whole problem over again" (12).

In keeping with the speed and developing force of the correspondence, Beecher responds to Lamont on March 7, 1952, about Lamont's and Dripps' memorandum of the statement of purposes. In a conciliatory opening paragraph, Beecher is very accommodating by agreeing to the approaches that Lamont and Dripps recommend to begin small and possibly enlarge later if things go well as Papper advocates. However, the short letter ends with anger. He says "I know anesthesia will suffer from the maneuvers of the unionists. All medicine too. It is a pity" (13).

Beecher's letter to Lamont of agreeing to think seriously about forming an association that would be small at first and then gradually grow also supports Papper's idea to include problems other than research, such as teaching, and "socio-economic matters" (not precisely defined nor limited).

There were lively discussions at meetings and by telephone among the various people who were members of, but not necessarily representative of their organizations, i.e., the American Society of Anesthesiologists, the American Board of Anesthesiology, and a group of active and vocal university people.

Some of the voices now being heard were new in the discussions over whether a university group needed its own organization to satisfy its important concerns about its activities and responsibilities. These individuals eventually were elected to AUA as "first rounders" in Boston in 1954.

ANESTH ANALG
1992;74:436–53

Failure of Efforts at Conciliation Between the University and Practitioner Groups

In the autumn of 1952, Dripps wrote to Ralph T. Knight, the Chairman of the Department of Anesthesiology at the University of Minnesota and the then sitting President of the ASA, in an effort to improve relations between university and practitioner anesthesiologists. Dripps believed that it was a useful opportunity to clarify the needs of the University people and to persuade the ASA to address their grievances and concerns about being isolated from the mainstream establishment of anesthesiology. He, therefore, wrote directly to the President, who could have been very helpful as he was also a member of the university fraternity. It was a reasonable way to attempt reconciliation between the two groups.

Knight was an individual who had worked hard and conscientiously to establish modern anesthesiology at the University of Minnesota in an environment that was difficult for anesthesiology. However, it was an important institution as the surgical activities at Minnesota under the leadership of the distinguished Professor of Surgery, Owen Wangensteen, presented many opportunities for significant progress in both fields. There are those who, at the time, believed that the reason Knight was appointed Professor of Anesthesiology was because he would cause no undue commotion against a tough and strong leadership in surgery. Unfortunately, comfortable collegiate relationships between surgeons and anesthesiologists were still evolving at the time in some hospitals and medical schools. The role of the anesthesiologist as handmaiden had not yet died, nor was it replaced everywhere by mutual respect. Certainly, if one looks at Knight's contributions to academic anesthesiology, they belong to that transition period between the early significant academic contributors like Waters and his "offspring" Rovenstine and a few others and the new wave of strongly scientifically oriented academic anesthesiologists that was beginning to be evident after World War II. In short, Knight, while a university faculty member, thought and believed more like the mainstream establishment of practitioners in the ASA. Therefore, Dripps' representations to him were doomed to be unsuccessful, but they are summarized and considered here.

On October 3, 1952, Dripps wrote to Knight stating that he needed to put in a letter the points he wanted to make because he thought that he might be too busy in Philadelphia to be able to join him in a quiet face-to-face talk. He represented his views as being typical of a small group, not identifying the rest of us in his letter. The letter is, on the whole, conciliatory and recognizes the importance of economic and political justice for our specialty, which was the central concern of the ASA at the time. He then states that the ASA's preoccupation with economic matters precludes its interest in anesthesiological science. Dripps writes to the ASA President (14):

> We do not believe that the ASA is taking advantage of those individuals interested in and capable of attacking the scientific aspects of the specialty.

and further:

> In the past there have been abortive thoughts of an organization such as the Association of University Surgeons. In other words, we would form an Association of University Anesthesiologists. There is in such an organization danger of a real rift and I, for one, have not been willing to be too enthusiastic until other possibilities were explored.
>
> I wonder if it would not be possible for some of us to discuss this matter with the Executive Committee of the ASA in an attempt at working out a solution and in avoiding a head on collision? In my opinion the ASA will be better if it is strong in all phases of its activities, not just in some. I would appreciate your thoughts on this matter.

In keeping with the speed of reply by letter in those days, on October 10th (1 week after the date of Dripps' letter) Knight arranged an agenda position for Dripps and any others who wished to come to meet the ASA's Executive Committee in response to Dripps' request to do so. Knight then goes on in his letter to support and defend the position of the ASA, whose program, some 2–3 years old at the time, concentrates on economic matters to rescue physicians from the position of being economically "oppressed" by hospitals. This was said to be the motivation of anesthesiologists in the ASA to establish fee-for-service practice patterns among its members. Knight, while speaking of the emphasis on economic matters, also supports ASA's interest in science by writing: "This should not nurture, and I do not believe it has nurtured a lessened interest in scientific development" (15). He says that the ASA meeting should have something for everybody in the membership and that means diversity of program. Knight does not oppose the establishment of an organization for academicians and he writes in the same letter to Dripps (15):

> It is certainly understandable that University Anesthesiologists might want to have meetings or an organization of their own. I do not think it would be detrimental to our society to do so and I do not think it would cause any rift. I do, however, believe it would be much better if their programs were within or continuous with the ASA meetings so that the whole membership could have the benefit of listening and learning.

This conciliatory message seemed to state that the practitioner establishment wanted to continue to have university people in ASA's programs or, if that was not reasonable and in the best interest of university scientific development, they (ASA) could accept a separate organization. There was hope for improved relationships and tolerance with healthy mutual understanding. The quarrel between university academicians and clinical practitioners in anesthesiology, therefore, seemed to have been peacefully and comfortably resolved without further ado. Such, however, was not to be the case. The meeting between Dripps (and others he might invite) and Knight with the Executive Committee of the ASA was postponed because Dripps left for Korea on October 30th to conduct field studies of plasma expanders for the Surgeon General of the Army of the United States during the Korean War. No substitute date was suggested for Dripps to meet with the ASA's Executive Committee, and that meeting evidently never took place. I do not recall being invited to such a meeting nor attending it.

Not long after this cordial exchange of letters, conflict seemed to have been rekindled by events that suggested that the ASA's position was going to remain tough despite the apparently conciliatory views of its President. Beecher, on November 17, 1952, in a letter to Lamont, discusses the matter of Georgetown University in Washington, D.C., where the ASA took a position declaring that the members of that Department were "unethical" because they worked for a salary. Beecher was considerably exercised about that incident and viewed it as serious. For the first time, there was some disagreement among the original group of four about the importance of an external matter. Beecher writes (16):

> I went to New York for the express purpose of seeing Papper. I was dismayed to hear him say that he did not think the matter was very important, at least as far as Georgetown was concerned. That matter was and is important to me because it was the first time the unionists had attacked a university hospital which had had the salary system. You will recall that they had said that they would not do this.

Beecher then proceeds to state that there has been a return of agreement among the original four, in the light of further discussions, and he writes to Lamont: "I am extremely pleased that Papper believes that these matters are important and he is, as I understand it, eager to do something about them" (16). Beecher then reiterates the need for a separate university organization once again and urges that Papper and Dripps come to some agreement about their present differences of view with respect to the size of the prospective organization. Dripps favored a smaller organization and Papper, a larger one. In the same letter, Beecher sought outside support for the position of the university anesthesiologists from a strong figure in academic surgery and from the AMA. He describes his activities (16):

> Because I thought the matter was so urgent and because nothing else seemed to be happening, I wrote a letter to a surgical friend of mine (Evarts Graham). He was much agitated and took the matter up with the Board of Regents of the American College of Surgeons, with the American Surgical Association and with Donald Anderson of the American Medical Association. . . . The end result of this is that we have a strong body of support in other quarters of medicine.

Beecher furnished Lamont with a copy of the letter that he had written to Dr. Graham, which describes in part the great concern that Beecher had about how things were going with respect to viewing a salary position as being unethical and, therefore, not acceptable to the establishment in anesthesiology. In a letter that is undated but presumably was written in the autumn of 1952, he writes (17):

> A good many prominent anesthetists have decided that it is unwise for any man to accept a salary "from a lay corporation", i.e. a hospital or a university. They are busily imposing this curious point of view. Their chief weapon is a threat that the young man will never be certified by the Board if he takes a salaried position. These anesthetists have said they had no intention of altering university arrangements already in effect. Frankly, I never believed this statement. Proof is now at hand that it was not sincere.

The Role of Distinguished Surgeons and the AMA

Beecher's very strong efforts to seek outside help from people prominent in medicine and surgery resulted in the agreement by distinguished surgeons to support the university anesthesiologists' positions. There was also a conciliatory letter to Beecher from Dr. Donald Anderson, then the Secretary of the Council of Medical Education and Hospitals of the AMA, that the Council and the ABA were in agreement that there can be no economic pressure on the Board's Diplomates relating to the issue of salary vs. fee-for-service practices.

In a letter dated October 13, 1952, Anderson wrote to Beecher (18):

> The Council made it clear that it would not tolerate being a party even indirectly to such activities (i.e. economic pressures). The representatives of the American Board stated that the Board had not been a

party to such activities and viewed them in the same light as did the Council.

A joint statement from the Council and the Board was subsequently issued to this effect.

Four days later, on October 17, 1952, Beecher replied to Anderson. Beecher, in effect, stated that he did not doubt the position of the Board officially nor that of the AMA Council, but he maintained that individuals in the power structure of political anesthesiology were using their Board Directorate positions to undermine the joint statement. He states his disbelief in the efficacy of the joint statement in this fashion (19):

> I do have reason to believe that men who are active in the politics of the Board and of the American Society of Anesthesiologist have been responsible for threats being made that certain individuals would not be certified by the Board if they took salaried positions. . . . I do not believe it or any such statement will get to the root of this serious problem. It might help if the Board members were asked to sign the statement as applying not only to joint Board action but as representative of their own beliefs. I strongly suggest that this be done.

It is interesting that the Hess Report, which was the foundation document of the ASA establishment's economic pressures, was not in the opinion of Anderson, the document that ASA alleged it to be. In a letter to Beecher on October 24, 1952, Anderson says (20):

> The history of the Hess Report is a long and confusing one. Perhaps I can best sum it up by saying that three or four years ago certain specialty groups endeavored to stampede the American Medical Association into enforcing certain rigid economic practices favored by these groups. From the start the issue was hotly debated with the more mature and responsible leaders of the AMA opposing this move.
>
> At one stage, a version of the Hess Report was adopted which did place the AMA in such a position. However, no action was taken by the AMA to implement this feature of the report. Rather the responsible leaders of the AMA worked diligently for the adoption of a new version of the report which would not put the AMA in the position of enforcing economic practices. This new version, a copy of which is enclosed, was adopted in 1951 and I believe will stand as the AMA's policy in the relationships of hospitals and physicians. (No copy was found in the Lamont files. A copy of the 1950 action of the AMA on the Hess Report was supplied by Dr. James Todd, the current Executive Vice President of the AMA.)
>
> I think you will agree that the report in its present form does not in anyway justify those who would disrupt university departments, although it is possible that there may be individuals or groups who are attempting to misinterpret the report to further their own ends.

The Discussion With the AMA

At the conclusion of this exchange of letters between Anderson and Beecher, the latter almost in the finality of discouragement does not accept Anderson's views even though he understands that Anderson did the best he could. He writes to Anderson (21):

> I would be less than honest if I led you to believe that I thought it would accomplish a single thing. I know the men on the Board very well indeed and I cannot believe that a single one of them will be deterred in their individual actions by this joint statement. However, please do not construe this letter as harshly critical. I know that these problems are complex and I do not doubt that you are doing the very best that you can to solve them.

That is where the conflict over salaries and fee-for-service practice stood on October 29, 1952.

At the end of this period of exchange of letters between Beecher and Anderson, which resulted in any uneasy impasse, Lamont collected a summary of current views from Beecher, Papper, and perhaps others whose names are not mentioned to provide a memorandum for Dripps who was still in Korea with the Army.

In the memorandum that Lamont prepared for Dripps on November 17, 1952, he described the joint statement by the AMA Council on Medical Education and Hospitals and of the American Board of Anesthesiology. Among the points mentioned in a reading of the joint statement by Roland Whitacre (an ABA Director) were (22):

> The Council and the Board consider the matter of the financial arrangement that may exist between the hospital and its anesthesiology staff one that is not within their proper purview, provided the relationship between hospital and physician conforms to the policies and the Principles of Medical Ethics of the American Medical Association.

It was on this statement that the issues of conflict were to be drawn, as many in the university group, Beecher most emphatically, neither trusted nor accepted the integrity of the commitments made in the joint statement. Our group of four continued to receive evidence that salaried practice was unacceptable to the ASA power structure. In his memorandum to Dripps, Lamont states that Whitacre affirmed the fact, in response to a question posed to him, that if an anesthesiology staff is not in conformity with the principles of the Hess Report its residency would be disapproved. Whitacre's reply was inflammatory un-

der the circumstances, and thus began the heat of conflict once again. In the memorandum for Dripps, Lamont describes the negotiations that Papper had been carrying on with Drs. B. B. Sankey and R. Whitacre of Cleveland, Ralph Knight of Minneapolis, and others with respect to the position of university departments. Lamont says (22):

> He (Papper) thought he was making good progress towards an arrangement that would satisfy everyone, and he had made plans to have Sankey meet in December or June with a number of representatives of university departments. These conversations had been continued up until twelve hours before Whitacre's statements to the Delegates. Papper was therefore very surprised and upset by W's (Whitacre) statement. He is sure that W knew of his conversations with Sankey because the two are very close professionally and socially (their wives are sisters).

Lamont proceeds to summarize the views of those present. He writes (22):

> Papper now feels that the university people should get together to discuss the matter. . . . He feels that whatever we do should be perfectly open and that probably a larger group would be better than a smaller one. . . .
>
> Beecher, as you know, has been convinced for some time that these men (Whitacre et al.) are determined to do as much mischief to the specialty as they can. He thinks we should get together to discuss the matter and he also believes we should get on with forming of a group of university people, as I have suggested under A. below.

The Decision Is Firmly Made to Establish the AUA

In summarizing all of these discussions and the status quo for Dripps, Lamont writes (22):

> A. We would proceed forthwith to organize a small group of university anaesthetists (and please let's not call them University Anaesthesiologists!) which will meet at least once a year to present papers and to discuss research projects in progress. These would be closed meetings.
>
> Either just before or just after each meeting the heads of departments who wish to do so could meet to discuss administrative and other matters of interest to them.
>
> B. . . . Another principle is that a private organization like the Board should not have such power as it apparently seeks, to interfere with and to exercise coercion in regard to those aspects of our life which we Americans have always held to be our own business so long as we obey the law of the land.

Under Item C of the memorandum, Lamont believes that we should set up our own certifying examinations under joint university auspices if the Board takes steps to approve the residencies in anesthesiology. He even perhaps somewhat wistfully adds if all else fails we should seek external help.

> Perhaps we could join with the surgeons in certifying anaesthetists (22).

The Lamont memorandum concludes, finally, with a behavior pattern recommended to university people in forming the new association (22):

> C. Because the university people tend to be more individualistic and because we probably each have our own idea of the proper path for the specialty, it would not surprise me to find considerable areas of disagreement among us (evidently still present!) in so far as we can we must assume that everyone of us is acting solely with the good of the specialty in mind. We must try to look at the matter in the round and not just from the view point of our individual situations. . . . This is not a matter of ethics nor of religion, but rather something that history has proved many times. By giving up ourselves to something greater than our selves, we ourselves become something greater.

Lamont cannot resist his return to earth in a slightly self-mocking deprecation of his lofty principles as he says (22):

> When I hear my grandfather talking I know it is time to stop.

The next day, on the 18th of November, Lamont resumes his correspondence with Beecher and gently reproves the latter for his excessive vehemence and perhaps his impulsiveness. He writes (23):

> I think we must be very cautious about making charges we cannot prove. I haven't heard recently of any threats, though I knew of at least one in this city some years ago that I could prove. If we hear rumors of threats let's try by every means to track them down and get the facts, preferably in writing.

Two days later, on November 20, 1952, Lamont, in another letter to Beecher, provides him with a small list of suggested people for membership in the new association. Unfortunately, the actual list was lost and it cannot be determined who Lamont may have had in mind for initial membership beyond the group of four then working on the problems of university activities.

Evidently, the problems were becoming more widely known. It is certain that Dripps and Lamont discussed these matters with their colleagues in the Pennsylvania Department. On November 21, 1952, in a letter to Lamont, Eckenhoff, then a senior colleague of Dripps' at the University of Pennsylvania, advocates the formation of a small informal group consisting of the departments of anesthesiology at Harvard, Columbia, and Pennsylvania to meet without any formal structure. The activity he thought should be entirely research oriented and informality should be the keynote of the pattern of the meetings. Eckenhoff valued the plan of informality in dealing with research matters, but also felt that this structure would minimize, if not eliminate, objections by others to the activities of the university groups mentioned (24). On December 1, 1952, after receiving Lamont's memorandum of the points made by Eckenhoff, Papper agreed to the idea of informality of the organization at its beginning, consisting of the three institutional departments that were recommended by Eckenhoff. He goes on to describe his vision of a larger organization by writing (25):

> However, I have been among those who felt that a larger group of people interested in research in anesthesiology was desirable. I believe that Bob (Dripps) and Harry (Beecher) are not in accord with this thought for reasons we have all discussed previously. However since a beginning must be made somewhere, I would like to go along with your thought that we meet in Philadelphia on April 3rd from just the three departments, to discuss at large among other things, what form such a group should take. I should like to consider that an open question at the present time.

Papper's reluctance to go along with the informal, small group began, in a short time, to be shared by others as events began to mount in frequency and intensity. On December 10, 1952, Lamont prepared a memorandum report of conversations and correspondence for the Pennsylvania Department. His opinions of the issues at the time are illustrated by a few excerpts from his report. The quotations illustrate not only the intensity of feelings at the time, but the fact that individuals of the original group of four, otherwise thought to be strong and determined and even stubborn in their views, show evidences of accepting the need for change with the evolution of events. There is also a clear reflection of some of the volatility and instability of the times in that these otherwise determined individuals seemed to be movable occasionally from previously fixed positions. Lamont, among other statements made to the Pennsylvania Department, says (26):

> Papper thought a small group might be open to charges of snootiness, oligarchy, etc. But he will go along with (the) small group idea to see how it works.

Lamont, in relating these relationships to the other organizations in anesthesiology, writes (26):

> Papper emphasized that the only long term solution of our problem within the existing frame work lies in our seeing to it that men of high standards are elected to the Board and to office in the ASA. . . . It will take a lot of work and results will be slow in appearing. Papper is unwilling to consider any solution that lies outside the existing framework.

Papper's attitude apparently changed several times and appeared to be one of vacillation between accepting the established framework and rejecting it. This indecision evidently was a reflection of his uncertainty of the time, as to whether the long-term benefits accruing to academic anesthesiology would best be served in a separate organization or within the existing establishment. Papper may have responded to the ironic observation of Jacques Barzun who was and is his mentor and close friend (27):

> . . . The simplest way to stop the transacting of business and split the ranks is to appeal to a principle.

He might also have been persuaded by the comment of Oscar Wilde in retrospect (28):

> Experience is a name everyone gives to their mistakes.

Were we doing something unproductive in our obsessions with the hostile forces of the ASA? There was little doubt as events unfolded by the end of 1952 that the best course for university development in anesthesiology in the post World War II period was to establish an independent organization. Beecher's view in the Lamont memorandum of December 10, 1952, although stated with excessive force, was one that was quite appropriate to the events of the time. Lamont cites Beecher as follows (26):

> Beecher would like us to be a band of brothers sworn to find the solution even if it is meant going outside the existing framework.

In terms of self-reliance, the principles important to a society that had become entrepreneurial were also relevant to the now evolving new organization (26):

> Beecher and Papper felt that we should not seek support outside the specialty unless it becomes evident that we cannot make real progress on our own.

The Rapid Gathering of Support Among University Anesthesiologists for the Formation of the AUA

This is a change of view for Beecher in view of his previous seeking of support from powerful individuals in the field of surgery.

As the correspondence was beginning to crystallize more definitely on the need for a separate association with other questions being left open for further consideration, there existed, almost simultaneously, a similar but not very vocal group of younger people in anesthesiology who were thinking also that they had need of each other professionally and perhaps personally as well. Harmel, on December 23, 1952, wrote to Lamont (who was one of his close friends and former mentor at Hopkins) that some of the discussions in our group of four, whom he termed "Old Turks" had become known to the anesthesiologists on the Board of Directors of the New York State Society of Anesthesiologists. Dr. Harmel, who, at that time, was Chairman of the Department of Anesthesiology at Downstate Medical Center in New York City, reflects on the possibility that there may be a split between the university group of anesthesiologists and the larger numbers in the specialty who are engaged in private practice. He does not seem overly concerned about any risks that may be involved. He believes that some of the problems we are seeing in academic anesthesiology are part of the problems of the world at large. He thinks (29):

> The cloister of the University is invaded and I think we must prepare, in some manner, to open our doors to new ideas, new approaches and an interchange of ideas which goes beyond the jealous guarding of secrets. Therefore, I think that this small movement amongst the "Young Turks" (Harmel and Artusio among others) to exchange ideas and confidences concerning the work and teaching is significant. It is a step toward the establishment of a University idea which goes beyond the archways of the campus.

These groups of Old Turks and Young Turks were to become unified without any difficulty in the Association of University Anesthetists that was now destined to emerge in a matter of months.

After the Christmas Holidays and the settling into the new year of 1953, Lamont's files of correspondence take on a cast in which it seems more and more obvious that the conversations between the practitioner establishment in anesthesiology and the university groups were to be fruitless in achieving a compromise. It began to look as though Walter Gropius may have had us in mind in examining both groups when he said (30):

> Specialists are people who always repeat the same mistakes.

Possibly, even John Kenneth Galbraith was thinking of people like us, although he addressed a more universal phenomenon when he wrote (31):

> Meetings are indispensable when you don't want to do anything.

Beecher, in his letter of January 22, 1953, to Lamont reflects the impasse with respect to reaching an accommodation with ASA and ABA officials. He writes (32):

> I thought this was a terribly depressing conference (with ABA Directors in Cleveland). I could not see that a single thing was accomplished in three hours in any constructive way. I came away with a heavy conviction that the only reason "they" consented to meet with us is because they believed they could "explain" the situation to us so that we would embrace their point of view and stop being so troublesome.

He concludes (32):

> I should think we had better proceed quietly and straightforwardly with the plans for the university anesthetists.

The decision to establish the AUA was, therefore, all but completed. There was no longer a possibility of finding a compromise approach to furthering the needs and interests of university anesthesiologists with respect to their practitioner colleagues.

The emerging pattern of increasing firmness among the group about the need to form AUA because of the external pressures that were highly negative and were imposed by the practitioners in anesthesiology is reflected in a letter of March 2, 1953, from Dripps to Papper. He writes (33):

> I suggest that we form a Society of University Anesthetists, as we have all been discussing and believe that we should form it at once.

The Problem of Selecting Charter Members for the AUA

Dripps was a person of firm convictions and often appeared to possess black-and-white views of issues and people—a quality that was very appealing to me and to many others, but sometimes could be disconcerting. In that letter from Dripps to Papper he is very specific about people that should *not* be invited and others that should. As the correspondence is open to

anyone who chooses to read it, those individuals that care to study Dripps' opinions about people are urged to have a look at this letter. He thought that the creation of the AUA would see widespread receptivity in most of the then departments or divisions of anesthesiology at universities, and he named some specifically. On the negative side, Dripps suggests that because of the hostile leadership in those institutions it is pointless to expect favorable replies from the Departments at Utah, Iowa, Oregon, Minnesota, and Hahnemann. Dripps does not expand on his reason for noting the expectation of refusal by some, and he also states that he does not believe that they should be invited in any case. Some of the opponents to the idea of the AUA were to be found in those institutions; but at least in two instances, Dripps' views were possibly personal rather than professional. Those were in Iowa led by Dr. Stuart Cullen and in Oregon whose chairman was Dr. Frederick Haugen. There is nothing further in the correspondence that explains Dripps' attitude about those two institutions. My own recollections cast no further light on the subject. In point of fact, as will be seen, Cullen and Haugen attended the meeting of the first round of elected members and were always supportive of the AUA from the beginning (33).

Dripps also, in the same letter to Papper, drafts a proposed letter to those who will be invited to join in the first round. The AUA's purpose is now clearly articulated as events became more and more definite in the march toward association formation. The draft letter proposes in part (33):

> A number of us in university departments of anesthesia have decided to form an organization concerned with problems of particular interest to individuals in academic life. We believe that members of such departments differ from other organized groups of anesthetists since in addition to caring for patients, they must evaluate teaching techniques, teaching facilities and foster sound programs of research. The development and financing of their complete program also poses unique problems.

It was now becoming apparent as the discussions pushed forward that the original purpose of small size and collegial informality, concentrating only on research, was gradually enlarging and taking the form that deals with an entire academically oriented constituency. Papper's reply, almost by return mail, to Dripps supports the position of setting a first date for a meeting and hoping that he, Beecher, Lamont, and Dripps will be able to agree at once on the initial steps. First soundings were made of individuals like Drs. E. A. Rovenstine and Joseph Artusio in New York and Drs. Benjamin Etsten and Julia Arrowood in Boston whether they would join in support of the idea of establishing an association. By March 20, 1953, things had progressed even more rapidly and a proposed constitution modeled on that of the Society of University Surgeons was put together by Lamont, plus a tentative list of possible future members and also a suggestion to enlarge the founding membership to eight. It was decided to get things prepared as rapidly as possible and, as Lamont puts it to the other members of the group of four in his letter of March 20, 1953 to Beecher with copies to Dripps and Papper (34):

> Since Papper thinks that an announcement before the AMA meeting in June would have a vulnerable psychological effect, could we not make such an announcement for the larger group in time for the June meeting if we were to write fairly soon to most of the members of the larger group, enclosing a copy of the constitution and asking each whether he would accept membership if he were elected. In this way we could send out notices of announcement immediately after the meeting May 9th.

The Group of Founders Is Expanded to Eight

There is no indication in the correspondence as to how the decision was made to increase the original group of four of Beecher, Dripps, Lamont, and Papper to eight by adding Etsten, Faulconer, Orth, and Robbins. Each of them was evidently contacted by Lamont and agreed with alacrity to serve as founding members of the newly created Association. They were the group that was to meet in Philadelphia on May 9th to formulate some of the basic issues to be presented at the meeting of invited members, which was to be the second official meeting of the AUA and was scheduled to take place in Boston in early 1954. The composition of the letter to those to be invited to attend the first meeting after the founders' meeting in Philadelphia was the subject of some discussion among the original group of four. For instance, in the letter of March 26, 1953, from Papper to Lamont, Papper urges the elimination of the words that characterize the original group as belonging to what Lamont called "the Eastern Seaboard." He prefers a national structure (35):

> We (or at least I) want the first flavor to be intellectual, but also *national.*

This was another effort to push toward a national scope for the new Association. The idea had by now become acceptable to the founders and to the first elected group.

On March 26, 1953, the die was definitely cast to establish the new Association. In a letter from Lam-

ont on behalf of the original group of four in which he signs himself Secretary Pro Tem, Association of University Anaesthetists, he writes to Faulconer, Etsten, Orth, and Robbins describing the establishment of an association of university anesthetists and invites each of them to become one of the founding members now enlarged to eight in number. The broadening of the founding group to include at least one southerner, one additional northeasterner, and two midwesterners was believed at the time to be symbolic of national involvement as well as the need to deal with our own peculiar and important problems more effectively Lamont says in part (36):

> What we need is an opportunity to present current and contemplated research projects in an informal (or formal) manner and to subject them to intimate, informed, friendly, and constructive criticism and discussion. We believe that a meeting of university anaesthetists would prove to be much better suited to our needs than anything now available.

Lamont now also supports the activities beyond research alone and indicates (36):

> We also consider that such a group might be helpful in improving methods of teaching and in solving problems of organization in university departments and of their relations to the university as a whole.

A copy of the proposed constitution was also enclosed with his letter of invitation to the additional four founding members who were to meet in Philadelphia in May. As a cordial and pleasant added touch to the invitation, Lamont invited each of the four to stay at his beautiful home rather than at a hotel. All four accepted promptly within a week's time of the invitation and the founding membership was then established. A list of prospective "first-round" members was also sent to each of the four. The number consisted of 55 names, including two individuals from the United Kingdom (Mushin and Pask) and one Dane (Mörch). The origin of the 55-name list is unclear at this time. It may have been a collection of all the names submitted by the original group of four or it may have been compiled by Lamont and Dripps. In the absence of more definite information and as it differs rather sharply in both directions (i.e., some on Lamont's list were not elected and others not on the list were elected), it is best simply to speculate that the results of sending out a list to the additional group of four may have been the stimulus that settled on the list that was finally formulated. Another inconsistency in the correspondence is the fact that in all of Lamont's letters to the group of four and to others, he consistently refers to a group of 26 names suggested to be first-round members and not 55. The group of 26, one can only imagine, must have been the result of the deliberations either at the May meeting of the founding group or in another manner not apparent in the correspondence collected by Lamont.

Acceptance of Membership by Charter Members Is Rapid and Enthusiastic

Letters of acceptance of election by "first-rounders" were all dated prior to the time of the May meeting of the founding group. The acceptance of election was prompt, enthusiastic, and almost 100%. One must, therefore, conclude that the final list of the 26 had been agreed upon before the May meeting of the founding group. Whether the second group of four of the founders had any voice in it is impossible to determine with certainty. Knowing the individuals and the degree that memory is not totally faulty, my opinion is that they must have had input into the choosing of the 26 additional names to be added to the eight founders. Most of the replies were characterized by the enthusiasm and support expressed by Artusio in his letter of acceptance to Lamont dated April 13, 1953. He says in part (37):

> I wholeheartedly agree and am one hundred percent behind the formation of a group of university anesthetists. I wish to signify my willingness, without reservation, to accept election if I am elected.

Some of the letters, although almost always enthusiastic, raised a few questions of substance and some of detail. There was an interest on the part of Stephen, for example, to explore further whether there should be affiliation with the ASA in some form. Stephen, like the others, was not as yet informed of all the discussions that had already taken place with the ASA officers and with the ABA Directors. Others, like Virtue, raised some questions about the details of the Constitution that were validly helpful. These suggestions were accepted by Lamont and incorporated into the official documents. Still other suggestions were typified by those of Adriani who suggested an age limit of 45 or at most 50 to be sure that bright young people doing active research would always be in control of the AUA's meetings. It is interesting to note that this issue of age, fixed numbers, and the idea of preserving the youthful vigor of the membership has always been present for consideration, even before the AUA's actual formation. The problem, if it is a problem, has not gone away and probably never will. A few of the first group may not have sent letters to Lamont, and at least two interpretations are possible. It is conceivable that some letters were lost or not deemed to be

important. It is also possible that acceptance was accomplished by telephone or in person without notations for the record. I suppose a third alternative may exist. Two or three of the more dubious and conservative first-round members were not sure that they wanted to be elected until they had a look at what the first meeting was like. Whatever the explanation of a few missing letters of acceptance is, all of the first-round invitees accepted membership, were supportive from the outset, and appeared at the Boston meeting in 1954.

After the receipt of letters of acceptance from the invitees, the original four were asked by Lamont to react to those letters that presented suggestions or other views. Beecher's views, on April 21, 1953, in his response to the material sent by Lamont to the three of us, can be summarized by wholehearted support for the new venture, but he is consistently extreme in the statement of his position. He writes (38):

> I think it would be disastrous for our little group to be affiliated in any way with the ASA. We are not in competition with the ASA and, in fact, are probably everyone of us members of the ASA. It seems to me that any official affiliation with the ASA would promptly nullify any prospect of us rescuing the anesthetist from the political and financial morass which threatens to engulf him, at least to separate him from all others in medicine.

Even before the Philadelphia meeting of the eight founding members, knowing that the organization would be a success or believing it would be from the start, Beecher, in a letter of April 21, 1953, to Lamont, invites the Association to meet at Harvard in 1954, at a date to be arranged, for a scientific and business meeting. The meeting of the founders group in May of 1953 in Philadelphia was to be entirely business and no scientific papers at all were to be presented. At about the same time, in a letter of April 23, 1953, from Rovenstine to Lamont, the former happily accepts membership in the AUA and makes two strong suggestions for its activities. In addition to research, he stresses the importance of teaching and educational activities for the new AUA—an activity that he always found congenial and important to his own mission. He also warned against domination by an inner small group of powerful people that could detract from the scientific value of the meetings. He also felt that social activities, incidental to the meeting, should be minimal. April 23rd seemed to be a day of letter writing for the group of four and Papper, in a letter to Lamont on that same date, seems to waffle temporarily from a previously consistent position with respect to the issue of affiliation with the ASA. He says in part (39):

> I wrote just yesterday that I thought the Association of University Anesthetists ought to be an independent organization. However, I suppose we should consider seriously affiliation within the ASA providing the things we wish to accomplish will be officially accepted policy. That is to say the goals we attempted to accomplish in Cleveland might possibly be accomplished in the manner Stephen suggests.

He makes further suggestions that membership in the ASA should not be required for Board certification and similar provisions, and concludes by saying (39):

> If these positions were accepted by the ASA I would have no objection to affiliating our association with the national society.

Evidently on further reflection, thinking that these suggestions were ones of weakness rather than of conviction, he writes in a hand-written postscript to the same letter (39):

> These are rambling thoughts—conditioned by the first sunny day in NY in a long time. I'd like to think more about.

He did think more about these matters subsequently and returned to his original more tenable position that the AUA needed to be an independent organization.

The Question of Age Limit Surfaces Early

The age limit was addressed by Beecher in his comment to Lamont on April 28, 1953. Beecher objects to Adriani's position about retiring to senior status or some similar academic heaven despite his obvious conflict of interest, as Beecher was 49 years old at the time of his writing. He stated that anesthesiologists do not have a comfortable place to retire to like surgeons do, which for them is the American Surgical Association. He concludes by stating (40):

> I think we ought to look very sharply at this question (age limitation) before we make any easy assumptions that the group ought to be kept young, vigorous, etc. etc.

Apparently, on a less sunny day in New York or the firm establishment of springtime in that city, Papper got over his indecision about the independent structure of the AUA and in a letter of April 29, 1953, to Lamont, he writes (41):

> I am delighted that everybody feels that we should not tie the new association in with the ASA. My second letter on that subject was written in a bloom of

> optimism. I know full well the ASA will not make the two concessions that I felt were a prerequisite to the Association being affiliated with the ASA.

Quiet optimism then prevailed in Papper's mind as he concluded his letter by saying (41):

> We should have a pleasant future ahead for all of us.

For those readers interested in some of the specific details of the correspondence among the founding members and the group of first-rounders, on the 30th of April, Lamont summarizes all of the points that were raised in the exchange of information about the formation of the AUA by using a combination of excerpts from letters and notes from his own files. As these main points have already been summarized in this essay, it is suggested that further detailed information, if desired by the reader, be sought from the Lamont file. Lamont's summary of all the material was not only useful to the original group of four but was especially useful in briefing the second group of four, now firmly established as the founding members of the AUA, and eventually the group of 26 elected on the first round.

The AUA's First Meeting in Philadelphia Is Organizational and Attended Only by the Founding Group of Eight

On May 9, 1953, the Philadelphia meeting of the founding members took place. All were present except for Orth who could not attend at the last minute, but he sent his views by letter. The Constitution and By-laws were discussed and appropriate suggestions for change were made. Lamont states in his notes of the meeting (42):

> It is fair to say that no substantial changes were made, that the changes were in the direction of greater precision and simplicity.

The minutes of that meeting included the names of the first 37 members (including the original group of four and the recently established founding membership of eight). They were Adriani, Allen, Apgar, Arrowood, Artusio, Beecher, Brewster, Bunker, Converse, Cullen, Van Deming, Dripps, Eastwood, Eckenhoff, Etsten, Faulconer, Greene, Greifenstein, Hampton, Harmel, Haugen, Holaday, Keats, Lamont, Landmesser, Morris, Orth, Papper, Pender, Proctor, Robbins, Rovenstine, Stephen, Van Bergen, Vandam, Virtue, and Volpitto.

The AUA Consists of All University Leaders in Academic Anesthesiology: The Second Meeting Including All Charter Members Is Held in Boston in 1954

The second meeting of the AUA was scheduled to take place on January 16, 1954, at the Massachusetts General Hospital in the Ether Dome. The founding group of eight appointed themselves as Executive Council under the new Constitution until the Boston meeting. Lamont was appointed Secretary Pro-Tem also until that meeting. The first group of officers were, therefore, to be elected in Boston.

This meeting took place on January 9, 1954, at the Massachusetts General Hospital. It was chaired by Beecher and consisted of two groups of laboratory studies that were very well received and the first major presentation of the important subject of measurement of subjective and pain-related responses to come from Beecher's Department and Laboratories. The evaluations of hypnotic power, the placebo response, and the relative and comparative actions of analgesic substances, especially the narcotics, were presented in a group of most interesting papers. There are no notes available on the nature of the business meeting in detail except that officers were elected.

The first Council consisted of E.M. Papper, President; Austin Lamont, Secretary; James Eckenhoff, Treasurer; and the Councilmen-at-Large were Stuart C. Cullen, C. Ronald Stephen, and Frederick Van Bergen. The 1955 meeting was scheduled to take place at Duke University on the invitation of Stephen. Those were the facts that brought to a happy and successful conclusion the struggles of the formative period of the AUA.

Epilogue

What does not appear in the Lamont file were the serious reservations of a few of the influential people in academic anesthesiology. Their views were to determine whether the infant AUA was to be a national organization representative of the academic community or whether it would become, in effect, a pleasant and regionally dominated social club of, to use Lamont's characterization, the "Eastern Seaboard." Their reservations were earnest and serious, and they had to do with being sure that the AUA's positive purposes far outweighed in importance the negative pressure thrusts that stimulated its organization. It was felt, predominantly by a midwestern and western group of academic anesthesiologists, that there had to be staying power in the importance to the academic community of research, teaching,

and those common interests in the university to justify and support the development of the new Association. The response to the negative pressures of the ASA were not enough reason, in their view, to form a new group. The leaders in these concerns were Cullen, Haugen, and Faulconer. They were satisfied by free and frank discussions of the issues after dinner at the end of the meeting that the AUA was to be an important positive force in fostering the interests and goals of academic anesthesiology.

Each of the founding members was given the task of conducting small, informal group discussions, and the candid answering of questions transpired. These discussions were effective and were a major positive force in the launching of the AUA. It is important to state that Dripps was a major figure in the persuasion of those few leaders who had reservations that needed to be satisfied, despite his initial wariness of even including some of them in the AUA. There is still in my mind a vivid memory of seeing him about to depart from the site of the discussions wearing a hat, a coat and having removed his shoes, possibly as an aid to inspired cerebration, talking earnestly with Cullen and with Haugen about their reasonable and understandable reservations. When Dripps put his shoes on to leave, it seemed that all had been satisfactorily explained and that the group of 37 were now on their way to the very important role of pleasant guidance of the academic community in anesthesiology to a new way of looking at their problems together. They were ready to enhance their personal and professional relationships so important to the development of the intellectual aspects of the specialty.

Therefore, at the Boston meeting, the Association was started under the best of auspices with a high spirit of enthusiasm for common goals that were destined to become important in the development of academic anesthesiology.

Although born in political controversy and enveloped in economic pressures, the important positive elements of commonality in the intellectual and educational aspects of anesthesiology became powerful forces for the development of a strong Association of University Anesthetists. The name would be, in due course, changed to the Association of University Anesthesiologists when the sting of names and the spelling of anesthesia became less important symbolically. Lamont's adherence to conservative naming and the use of the diphthong in the spelling was eventually to disappear.

The quarrel with the ASA rapidly and unemotionally disappeared to the point where AUA members were, in effect, the editors and publishers of the two major journals in anesthesiology and were also the principal providers of the scientific parts of the ASA's annual meeting. AUA members became elected officers in the ASA, and a feeling of mutual tolerance rapidly evolved to mutual respect and then to coordination of activities. The ABA became, in turn, dominated by the academic community and all restriction and threats associated with its previous political behavior disappeared and were no longer negative factors. The AUA, therefore, was rid, in fairly rapid time, of the negative forces that encouraged its development. It was able to pursue the positive purposes of attention to research, to education, and to the commonality of university problems without the need of dealing with serious hostile forces. The AUA quickly became a success in function. The goals of academic anesthesiologists now included election to membership in the AUA.

However, even at the beginning, despite these great successes, there were signs of potential problems and troubles that were to surface in the future. Anesthesiologists, especially academic ones, seem to be excessively introspective, at least as compared to their colleagues in other fields. They seem to react and, perhaps, overreact excessively to negative forces with too much vigor. Their language is, in general, more extreme than that of many others. They don't appreciate sufficiently their own or their colleagues' talents. They underappreciate and underreact to positive strengths. They are constantly trying to find out why they are often uneasy and engage in constant efforts of "reform." Excessive aloofness was once a criticism against the AUA, directed especially against some of its more influential members. As understanding and friendships developed, the AUA began to brood about the excessively social behavior of some of its members. They criticized themselves and their Association of becoming a pleasant inactive status-seeking club where perhaps excessive drinking took place too often. These concerns then were replaced in time by the question of whether democracy, defined as more numbers in the AUA, was healthy for an organization or whether only merit should be the standard for membership. If the latter, how was it to be defined and measured? The subject of age limitation raised its head from the beginning and has continually confronted the membership. How does one decide when a person is no longer as vigorously productive as previously, and in what fields, and by what standards? These are all besetting questions to academic anesthesiologists. They are not really unique to our specialty, but we worry about real and phantom difficulties more than most.

However, the AUA is fortunate in a very important respect. It is charged, generally, by its founders with engaging in common and coordinated efforts in teaching, research, *and all other matters that concern the university community.* Its charter, therefore, gives it

free reign to engage in any aspects that the current membership believe important to the work and responsibilities of the academic anesthesiologist without the obstruction of the heavy hand of the past or the reaching out from the grave to dominate current thinking.

The search for renewal of excitement goes on and has from the beginning. Much of it is healthy. However, some of it must be a form of combat with what most generously might be characterized as boredom with peace. The AUA was begun in an environment that included passion. Passion grafted onto intellectual strength will never lose value for the human condition. Each generation must and will decide for itself where the margins are and what issues they need to address. The founders did not have the gift of prophecy, but they recognized the need to address central issues and to permit the felicitous quality of flexibility and responsiveness to constructive change in a future without limitations.

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— 6 —

ANAESTHETISTS' TRAVEL CLUB, 1929-1952

AN HISTORICAL REVIEW

C. Ronald Stephen, M.D.

ACKNOWLEDGEMENTS

I am indebted to many members of the Academy of Anesthesiology for help and assistance in preparing this historical review. Drs. John Adriani and Scott Smith during their lifetime transcribed some of their recollections of the Travel Club members, and Drs. Fred Van Bergen, Bill Pender, Al Betcher, Roy Vandam, B. B. Sankey, Dick Barrett, Rod Gordon, Joe Buckley and John Steinhaus, among others, were most helpful in catching the flavor of the Travel Club. Supplying encouragement and stimulating initiative at all times was Dr. Elliott Miller. Transcription from the handwritten word would have been impossible without the flitting fingers of my loving wife, Joan. Financial support for the printing has come from the Academy of Anesthesiology.

Many thanks to one and all.

Charles Ronald Stephen,
M.D., C.M., F.F.A.R.C.S.

CONTENTS

Inkster is a small town in the eastern part of North Dakota and it was near there, on a farm, that John Silas Lundy was raised and attended high school. His undergraduate work was done at the University of North Dakota, and he completed his medical training at Rush Medical College in 1920. He then went west to Seattle (to which he returned in his later years) and began the practice of anesthesia. A momentous event happened in his life in 1924. This event is best expressed in the words of Dr. Will J. Mayo. "Six years ago, in January, I was going to Australia and New Zealand and I stopped in Seattle to attend a medical meeting and banquet for several hundred persons. Across the table from me sat a young and handsome man who interested me immediately in his talk about anesthesia. When the meeting was over, I asked him to walk to the station with me, as I was taking the train to Vancouver. He said he thought research ought to be done in anesthesia. He was not situated so he could do research. I asked him how he would like to come to Rochester, and he said he would like nothing better, and when I returned from Australia, he was here. Since then the Section on Anesthesia in the Clinic has been in the hands of Dr. Lundy."

One does not have to imagine some of the thoughts that were coursing through Dr. Lundy's mind as he arrived at the Mayo Clinic. He expressed them in this way. "I had the experience of a feeling of isolation in being a member of this special field of medicine. Coming to the Mayo Clinic on the 27th of March, 1924, I found myself to be the only doctor interested in anesthesia, other than those who had encouraged me to come there. This meant Dr. W. J. Mayo and Dr. D. C. Balfour, at Dr. Mayo's suggestion. On arrival, I had no office or secretary, and my prospects were only those I could visualize in my imagination. On the 29th of January, 1945, Dr. Charles F. McCuskey arrived from the state of Washington and was interested in joining me in this effort I was trying to make. If it had not been for the strict discipline exercised by Dr. W. J. Mayo, I would have spent more than the casual existence that I did. I had set certain goals for myself, realizing that I would only have 35 years of opportunity at the Clinic if I lived to 65, and I had hoped to develop one new idea each of those years. Having been raised in a farming community, I knew that one had to plant several crops in order to gain one or more harvests, so I tried to keep about five projects going all the time."

We do not know if Dr. Lundy was aware of the "publish or perish" doctrine; perhaps he invented it. In any event, by December of 1929, a total of 39 papers had appeared under his name in a variety of journals. Topics ranged from the use of ethylene, barbiturates and tribromethanol in anesthesia to the value of various regional blocks and "balanced anesthesia". Beginning to emerge, was a dedicated man, ambitious, disciplined, a workaholic, and at the moment, professionally lonely. By early 1929, he had come to the conclusion that the distribution of anesthetic information in the United States and Canada could be improved by an annual meeting of a small group who

shared his enthusiasms.

In some respects, Lundy's idea was not original. On October 6, 1905, a group of nine physician-anesthetists met at the Long Island College Hospital at the invitation of Dr. A. Frederick Erdmann because in his words, "There are a few physicians practicing anesthesia in the area, and these men ought to get together to form a society." In this manner, the Long Island Society of Anesthetists was born, which in 1911 became the New York Society of Anesthetists, and eventually, the American Society of Anesthesiologists.

Following World War I, numerous societies devoted to anesthesia were formed, most of them regional in nature. In 1919, the National Anesthesia Research Society was founded by Dr. Frances H. McMechan, and in 1925 its name was changed to the International Anesthesia Research Society. In 1922, the first issue of the I.A.R.S. journal, *Current Researches in Anesthesia and Analgesia,* was published. It is interesting that through 1929, five papers written by Dr. Lundy appeared in this journal. The Boston Society of Anesthetists was founded in 1920, and in the same year the California State Medical Association recognized a Section of Anesthesia. The Southern Association of Anesthetists and the Pacific Coast Society of Anesthetists were formed in 1922. The Eastern Society of Anesthetists made its debut in 1923, and the Midwestern Association of Anesthetists in 1926. In 1923, the American Society of Regional Anesthesia was founded to honor Dr. Gaston Labat.

Dr. Lundy's concept was somewhat different and unique compared to the above burgeoning groups. His idea was to invite a small group of anesthetists, not to exceed 15 in number, from important centers a considerable distance from each other on the continent. By bringing the group together once a year there would be quick distribution of the knowledge which was rapidly escalating in this young, vibrant specialty. By keeping the group small, the hosts each year could easily lead a tour of the hospitals and clinics involved, and demonstrate ongoing techniques, as well as present topics which could be discussed freely. (It has been said, perhaps facetiously, that the group should be kept small enough that they could all get into an elevator together). On return home, it was hoped that each attendee would gather with his local group to discuss with them the new knowledge which had been gained at the meeting.

So it was that in 1929, after obtaining advice through correspondence with Dr. Ralph Waters in Wisconsin, and after having made arrangements with the authorities at the Mayo Clinic, Dr. Lundy mailed invitations to a select group of anesthetists to meet with him at the Mayo Clinic on December 29, 1929. In a recollection of the Club's beginnings, Dr. Lundy indicated that he wished those invited to be of approximately the same age, and it is interesting that at the first meeting, that wish was fulfilled. In spite of all the vicissitudes of travel in the winter and rather long trips involved by train, at least compared with today's plane travel, they all came. The hosts for the meeting

were Dr. Lundy, Dr. McCuskey, and Dr. Ralph M. Tovell, the latter two being at the Mayo Clinic at that time. Those attending were: *

Dr. Jack A. Blezard	London, Ontario
Dr. W. Easson Brown	Toronto, Ontario
Dr. Ansel M. Caine	New Orleans, La.
Dr. Arthur E. Guedel	Los Angeles, Ca.
Dr. Robert B. Hammond	Mayo Clinic
Dr. Charles H. Robson	Toronto, Ontario
Dr. Henry S. Ruth	Haverford, Pa.
Dr. Harry J. Shields	Toronto, Ontario
Dr. Lincoln F. Sise	Boston, Ma.
Dr. Charles C. Stewart	Montreal, Quebec
Dr. Brian C. Sword	New Haven, Cn.
Dr. Ralph M. Waters	Madison, Wi.

At this first meeting, a formal program was presented in which, among others, the Drs. Mayo participated, expressing their appreciation for the endeavors of those physicians administering anesthetics. A tour of the hospitals and operating room clinics was arranged and the visitors were encouraged to make notes along the way which, if given to the accompanying secretary, would be typed that evening and then placed in the hotel mailbox. The proceedings of this meeting were published as Supplement No. 1 and Supplement No. 2 of the "Proceedings of the Staff Meetings of the Mayo Clinic".

Supplement I, Volume 4, No. 51, is dated December 18, 1929. It begins with some "Remarks on Anesthesia" by Dr. Charles H. Mayo. After reviewing the beginnings of anesthesia in America, he describes his own introduction to the specialty. "I began my work in anesthesia at the age of eight or nine years. I remember a physician whom father used to call in to give anesthesia. One time a patient with a large ovarian tumor was going to be operated on. They never used to operate for an ovarian tumor in those days until it weighed 80 or 90 pounds. On this occasion, the physician was giving the anesthetic, and Dr. Will, who was older than I, was called in to help across the table from father, and I was sitting disconsolately on the doorstep. The door opened and the physician came out and reclined on the lawn, giving a good exhibition of seasickness. I was called in to give the choloroform. Father told me when to stop and when to start."

Then "Phases of Heart Disease" was discussed by Dr. F. A. Willins, Section on Cardiology. After outlining the various forms of cardiac disease, he concludes as follows: "In the giving of an anesthetic, it is always important to

(* Brief biographies of the members of the Travel Club are in Appendix I.)

prevent cyanosis and it should be realized that a degree of anoxemia may occur, even in the absence of apparent cyanosis."

W. M. Boothby, M.D., Section on Clinical Metabolism, discussed "Treatment by Oxygen". He states, "For several years, at the Clinic, oxygen chambers and oxygen tents have been used in treatment of postoperative bronchopneumonia, and it has been found that in those cases in which there is a rise in temperature with slight cyanosis, either with or without definite physical signs of consolidation, oxygen treatment often affords considerable benefit."

Next, W. C. Foster, M.D., Section on Anesthesia, presented a paper on "Certain Anatomic Aspects of Spinal and Sacral Anesthesia." After discussing the physiology of cerebrospinal fluid, he discussed the anatomy of the vertebral column and then that of the sacrum in relation to sacral block anesthesia.

"Headache Following Diagnostic Spinal Puncture" was the topic of H. L. Parker, M.B., Section on Neurology. Following a diagnostic puncture, headaches, lasting an average of three to seven days, develop in about 20 percent of patients. The essential feature in the development of the headache is the assumption of the erect posture.

J. L. Bollman, M.D., Division of Experimental Surgery and Pathology, discussed "The Effect of Anesthetic Agents on the Liver." This treatise in large part describes the functional aspects of the liver. "Perhaps the most significant function of the liver is regulation of the sugar content of the blood. Most of the common anesthetics cause increase in the glucose content of the blood of the normal animal. This does not occur, however, in animals in which the hepatic glycogen has been reduced by fasting or by various experimental procedures. Obviously, the increase in sugar of the blood is at the expense of the hepatic glycogen. We have been inclined to consider the elevation of blood sugar as evidence of good hepatic function. Certainly, also, in animals in which the concentration of sugar in the blood fails to rise, degeneration following anesthesia is of frequent occurrence. This effect can usually be minimized by the administration of glucose in the preoperative and immediate postoperative periods."

Finally, J. S. Lundy, M.D. discussed "The General Anesthetic Tribromethyl Alcohol (Avertin: E-107): Review of the Literature on its Rectal and Intravenous Use." This review was indeed extensive, citing a total of 176 references. He concludes: "A review of the literature does not leave one with a very definite opinion concerning the value of tribromethyl alcohol as a general anesthetic. --- It probably must be used only as a basic anesthetic."

In Supplement 2, following a few remarks by Dr. Will J. Mayo, the first paper, "A Study of the Minute Volume of Respiration in Experimental Anesthesia: The Effects of Combinations of Procaine, Sodium Iso-Amylethyl Barbituric Acid, Morphine, Scopolamine, Ether and Carbon Dioxide", was presented by R. M. Isenberger, M.D., Associate Professor of Pharmacology,

University of Kansas. Dogs were used in this comprehensive study of the interaction of drugs. With a small dose of morphine, a moderate dose of sodium iso-amylethyl barbituric acid (Amytal), and a general anesthetic such as ether, full anesthesia could be easily established and adjusted. This combination allowed a higher degree of respiratory reserve than when ether alone or ether preceded by morphine was used to a similar degree of anesthesia. A combination of morphine and Amytal only produced a definite reduction in the minute volume of respiration, comparable to that seen in dogs in normal sleep. The state produced has been called "basal narcosis", which is characterized by complete unconsciousness and analgesia.

The final paper in this Supplement, titled "Review of the Literature on the Derivatives of Barbituric Acid: Chemistry; Pharmacology; Clinical Use," was authored by John S. Lundy and Arnold E. Osterberg in the Division of Chemistry. No fewer than 13 derivatives were discussed in this far-ranging review which quotes 466 references. It is apparent that the stage was being set for the introduction of thiopental sodium.

Lundy ruled the Travel Club more or less with an iron hand. As he himself says in a "Rough Draft of the History of the Academy of Anesthesiology," written in 1963 at the request of Dr. Bill Pender and Dr. Steve Martin, "I think I made the rules." At each meeting, it was decided where the next meeting would be, and the host would be responsible for arranging the details. Invitations were extended to the original group, and if anyone could not attend, the host would have the privilege of inviting someone of his choice to that meeting. Group photographs were made at each meeting: Figure I (see page 6) was taken in 1935 at the meeting held in New Orleans (photo courtesy Dr. Leroy Vandam).

A sense of camaraderie soon prevailed at these annual meetings which blended a unique degree of formality and informality. Early on, an autograph book became evident to record the signatures of those present. It also became the practice of the host to present each guest with a souvenir of the occasion. Dr. Lundy records that one was an ampule holder and another was a metal ruler having a gauge for needles on it, as well as a gauge for endotracheal tubes. Often the gift represented gadgets used in early anesthesia practice. Thus, the Travel Club thrived due to the untiring efforts of its members, while other anesthesia organizations were developing. The general format of the Club remained the same until World War II interrupted its annual gatherings.

Subsequent Meetings

The 1930 meeting was hosted by Dr. Ralph M. Waters and held in Madison, Wi. Additional invitees to this meeting were Dr. Wilmer D. Baker,

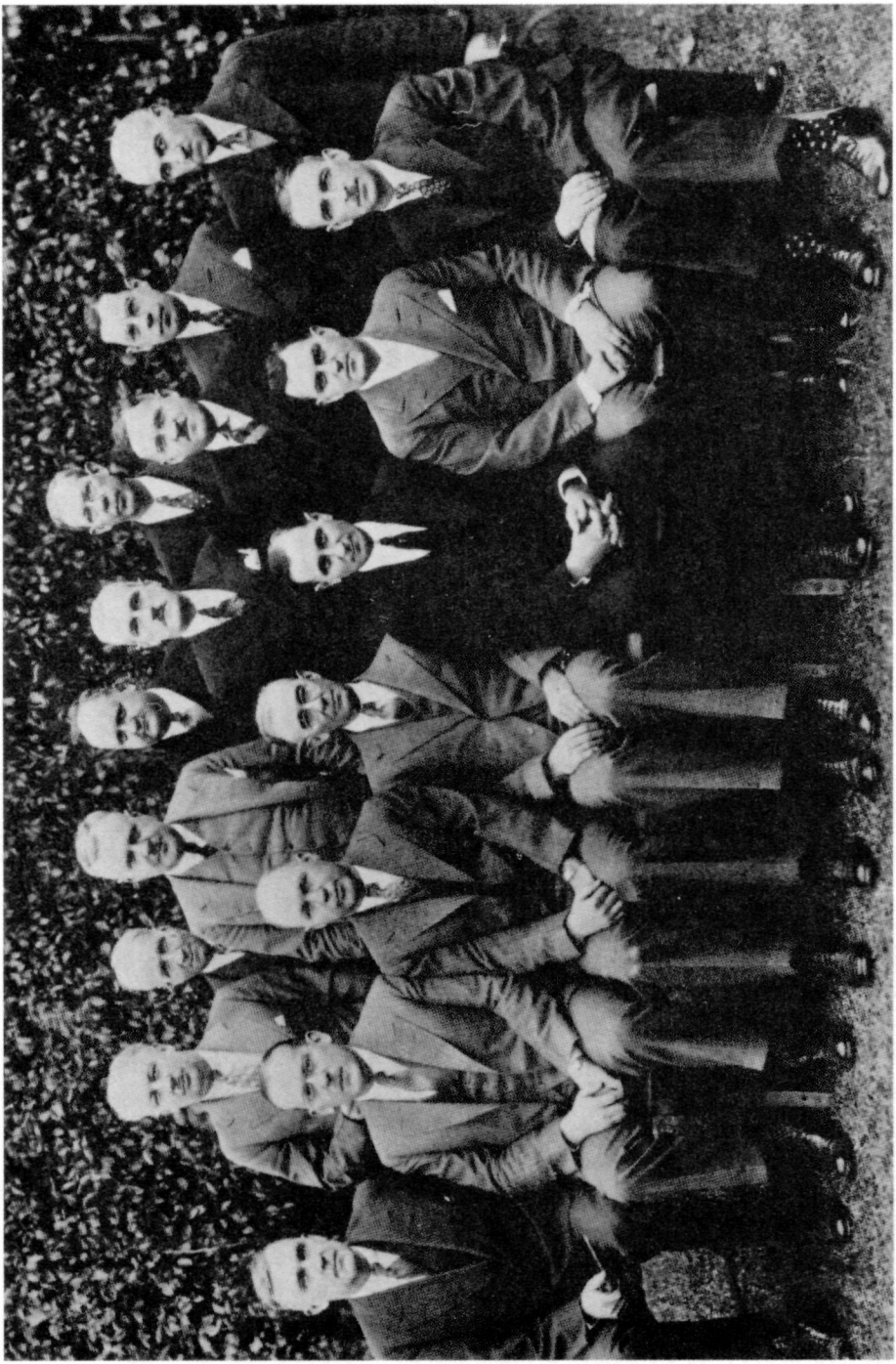


Figure 1 (photo at left)

Although group photographs were probably taken at each meeting of the Travel Club, this one in 1935, at the sixth meeting in New Orleans, is the only one it has been possible to resurrect.

In the photograph, from left to right (standing) are:

Brian Sword, New Haven, who devised a circle absorber system in collaboration with Richard Foregger;
T. D. Buchanan, New York, a New York pioneer;
W. Easson Brown, Toronto, Canada;
Paul M. Wood, New York, founder, American Board of Anesthesiology and Wood Library-Museum of Anesthesiology;
Wesley Bourne, Montreal, Canada, to be Professor and Chairman, Department of Anaesthesia, McGill University ;
T. J. Collier;
Harold R. Griffith, Montreal, who introduced curare and became the first President of World Federation of Societies of Anesthesiology;
Robert B. Hammond, New York;
John A. Blezard, London, Ontario.

Front row, sitting, left to right, are:

Ralph M. Waters, Madison, Wisconsin, first residency program, introduced cyclopropane clinically;
Henry S. Ruth, Philadelphia, Professor Hahnemann Medical School, first editor of *Anesthesiology*;
C. F. McCuskey, Los Angeles, Chief, University of Southern California;
Ansel M. Caine, New Orleans, pioneer in anesthesia and co-host of meeting;
Wilmer Baker, New Orleans, co-host of meeting;
John S. Lundy, Rochester, Minn., Chief at Mayo Clinic, primary organizer of Travel Club;
Charles C. Stewart, Montreal, Chief at Montreal General Hospital.

(continued from pg. 5)

New Orleans, La., Dr. T. Drysdale Buchanan, New York City, Dr. John J.Buettner, Syracuse, Dr. Harold R. Griffith, Montreal, and Dr. Philip D. Woodbridge, Greenfield, Ma. No records are available of the transactions at this meeting.

The 1931 meeting was hosted by Drs. Easson W. Brown, Charles H.

Robson, Harry J. Shields, Charles C. Stewart, Harold R. Griffith, Wesley Bourne and Charles LaRocque, and was held in Toronto and Montreal. New Invitees were Dr. Wesley Bourne, Montreal, and Dr. Charles LaRoque. No records are available of this meeting.

The 1932 meeting was hosted by Drs. Henry S. Ruth, Lincoln F. Sise and Philip D. Woodbridge, and was held in Philadelphia and Boston. An invitation was extended to Dr. Everett Tyler of Island Heights, N.J. No records are available of this meeting.

The 1933 meeting was hosted by Drs. Ralph M. Waters, John S. Lundy, and Ralph M. Tovell, and was held in Madison, WI, Minneapolis and Rochester, MN, on October 2-7. New attendees were Dr. Ralph T. Knight, Minneapolis, Dr. Edward B. Touhy, Los Angeles, and Dr. Paul M. Wood, New York. Records show that 15 attended, an indication that the original stipulation regarding numbers was being adhered to. The first day was spent in Rochester, with the morning being devoted to operative clinics. In the afternoon, a series of lectures were given, primarily by members of the Mayo Clinic. They included:

1) Death from the delayed effects of chloroform, by Drs. P.F. Olson and D. C. Beaver.
2) Lesions in the spinal cord of dogs produced by a dose of procaine sufficient to cause permanent and fatal paralysis, by Drs. J. W. Kernohan and J. S. Lundy.
3) Quantitative effects of subarachnoid injection of procaine on the sympathetic, sensory and motor nerves, by Dr. J. L. Emmett.
4) Untoward blood reactions to amidopyrine and the barbituric acid derivatives, by Dr. C. H. Watkins.
5) Hypersensitivity to procaine, by Dr. G. W. Waldron.
6) The effect of carbon dioxide on the blood pressure, by Dr. M. Hardgrove.
7) Clinical and experimental evidence of aspiration during anesthesia, by Dr. W. S. Lemon.
8) The theory of oxygen therapy, by Dr. W. M. Boothby.
9) Anesthesia study records, by Dr. R. M. Tovell.

In the evening, an informal dinner was held at the University Club.

The next day was spent at the University of Minnesota in Minneapolis. The following lectures were presented by the Department of Pharmacology.

1) A quantitative method for the study of alterations in sensation in experimental animals: its application to analgesic and hypnotic drugs, local and general anesthesia, by Drs. A. D. Hirschfelder and A. H. Ridges.
2) The therapeutic coefficient of various spinal anesthetics in

frogs and rabbits, by Drs. R. H. Bieter, A. H. Ridges and J. W. Brown.

3) Practical importance of variations in blood magnesium, by Drs. A. D. Hirschfelder and V. G. Haury.

4) Effect of renal insufficiency in the action of barbitals, by Drs. A. D. Hirschfelder and V. G. Haury.

The Department of Surgery presented the following lectures.

1) Current practices in the employment of anesthesia at the Minnesota General Hospital by Dr. R. T. Knight.

2) Inhibition of respiration after operations, by Dr. H. A. Carlson.

3) Lobular atelectasis, by Dr. R. W. Koucky.

4) The decompression of intestinal distension by suction, by Dr. O. H. Wangensteen.

5) The blood loss factor in strangulation obstruction, by Dr. H. C. Scott.

6) Gas bacillus infections, by Dr. M. H. Manson.

The following day, October 4, was spent back in Rochester, where operative clinics were conducted in the morning, and in the afternoon, the following lecture-demonstrations were held at the Institute of Experimental Medicine and Surgery.

1) The technique and use of the heart-lung preparation in physiology, by Dr. H. E. Essex.

2) Chemical methods of determining the presence of procaine in the blood plasma, by Dr. J. G. Dunlop.

3) The effect of certain anesthetics on the blood flow in the femoral artery of the dog, by Dr. J. F. Herrick.

4) Chemistry of certain new anesthetic agents, vasoconstrictors and ischemic agents, by Dr. A. E. Osterberg.

5) Experiments with certain anesthetic agents of recent development, by Drs. J. S. Lundy and H. E. Essex.

The next day, the group travelled to Madison where, in the evening, there was a round table discussion on "Teaching Methods", led by Dr. A. E. Guedel.

On Friday, October 6, the morning was spent in the operating rooms where there were demonstrations, among other things, of ether-carbon dioxide apnea and a new intravenous barbiturate. In the afternoon there were lecture-demonstrations on the following:

1) Scopolamine - amomorphine - case report.

2) Ether convulsions.
3) Record system and sorting machine of anesthesia department.
4) Demonstration of permeability of rubber to anesthetic gases.
5) Closed chamber for oxygen-carbon dioxide studies in animals, and animal feeding (drug addicts), by Drs. Tatum and Seevers.
6) Electrocardiograph - effects of cyclopropane to complete respiratory paralysis, by Drs. Meek and Seevers.
7) Anesthesia with so-called pure methyl ether, by Dr. Sohmid in the Experimental Surgery Laboratory.

On Saturday, October 7, there were demonstrations in the operating rooms of the use of cyclopropane for anesthesia. In a paper titled, "Cyclopropane Anesthesia: a clinical record of 350 administrations:" (Can Med Assoc J 1934; 31:157-60), Dr. Griffith pays fitting tribute to Dr. Waters for introducing cyclopropane into the operating room in 1933. In the afternoon, the group was entertained at an intercollegiate football game, followed by a buffet supper at Dr. Waters' home.

The sixth meeting in 1934 was hosted by Drs. Brian C. Sword, Paul M. Wood, Emery A. Rovenstine and Robert B. Hammond, and was held in New York, White Plains and New Haven, from October 8 to 13. The new attendee was Dr. Rovenstine, New York City.

The first three days of the meeting were spent in New York City. The first day was at Columbia University Medical Center. The group was welcomed by Professor Allen O. Whipple and the following papers presented by the Department of Surgery:

1) Gas analysis associated with production of lung collapse, by Dr. R. L. Moore.
2) Pontocaine and spinal anesthesia, presented by Dr. C. B. Esselstyn.
3) Comparison of spinal anesthesia and Avertin, by Drs. L. Sloan and T. Stevenson.
4) Discussion of complete extirpation of the gland in thyroid disease, by Dr. W. B. Parsons, Jr.

From the Department of Medicine, the following paper was presented:

1) Role of oxygen treatment in a proposed department of gas therapy with illustrative clinical problems, by Dr. A. L. Barach.

In the afternoon, the Department of Physiology presented a

demonstration by Dr. Williams, and this was followed by three lecture-demonstrations from the Department of Pharmacology.

1) Comparison of effects of chloroform and ether in the isolated rabbit heart, by Dr. Lieb.
2) Effect of morphine and atropine on the intestine of intact dogs and its possible application to postoperative distension, by Dr. Raiford.
3) Effect of certain so-called respiratory stimulants in the unanesthetized and narcotized dog.

In the evening there was a social hour at the home of Dr. and Mrs. Paul Wood.

The Cornell University Medical Center hosted the second day, and the following lectures were presented during the day:

1) Respiratory accidents and resuscitation: discussion of the rate of exchange of different gases in the lung, by Dr. P. N. Coryllos.
2) Peripheral effects of respiratory drugs, by Dr. H. Gold.
3) Liver function test applied to Avertin and barbituric acid compounds, by Dr. A. Quick.
4) Heart risks in anesthesia, by Dr. M. J. Raisbeck.
5) Local anesthesia at site of fracture, by Dr. J. H. Mulholland.
6) Artificial pacemaker, by Dr. A. Hyman.

A visit to the Empire State Building was followed by a buffet supper with Dr. and Mrs. T. D. Buchanan, and there was a visit to Radio City to view a broadcast by Ed Wynne.

On Wednesday, the third day, there was a visit to Police Headquarters, not to bail out any of the group, but to listen to a discussion of "Anesthesia used for criminal purposes with case reports." Then Bellevue Hospital was visited and a lecture titled, "Degree of anesthetic and alcoholic toxicity as revealed by brain analysis," was presented by Dr. A. Gettler, city toxicologist. Following lunch at Paddy's Clam House, the following papers were presented at the Post Graduate Hospital:

1) Anesthesia in diabetics, by Dr. H. O. Mosenthal.
2) Case of carbon tetrachloride poisoning, by Dr. Poindexter.
3) Oxygen carrying power of blood, by Miss Mattice.
4) Case of addiction to Amytal, by Dr. Greene.
5) Prevention of postoperative nausea and vomiting by caffeine injection, by Dr. K. Miller.
6) Drug habitues and their tolerance, by Dr. Brenner.

In the evening there was a formal dinner at the Hotel McAlpin.

Thursday, October 11, the group travelled to the Grasslands Hospital in White Plains, and in the afternoon visited Sing Sing prison where the hospital, laboratories and prison itself were viewed.

Yale University and Grace Hospital in New Haven, in conjunction with the Boston Society of Anesthetists, were the hosts for the final two days of the meeting, the host being Dr. Brian Sword. On Friday morning there were clinical demonstrations of anesthesia, including endotracheal cyclopropane, nitrous oxide analgesia with air, nitrous oxide-oxygen, ethylene-oxygen, ethylene-oxygen ether sequence, spinal anesthesia with procaine, pontocaine and metycaine, and caudal and trans-sacral blocks with procaine.

In the afternoon, the Department of Pharmacology presented:

1) Benzol and chloroform syncope, by L. H. Nahum.
2) Fever and antipyretics in rats, by P. K. Smith.
3) Anemia in swine, by L. S. Goodman and A. J. Geiger.
4) Pharmacology of the isolated mammalian heart, by A. J. Geiger, W. E. Hambourger and L. S. Goodman.
5) Absorption of drugs in fish, by A. Z. Gilman.
6) Analysis of morphine excitement, by E. W. Hambourger.
7) Morphine and metabolism, by J. Andrews.
8) Methods of determining blood concentration, by J. Trace.
9) A two-way fluid shift produced by posterior pituitary, by A. Z. Gilman.
10) Heat regulation and the hypothalamus, by H. G. Barbour.
11) Changes in the blood and serum under morphine and ether, by P. H. Twadle.

On Saturday, following clinical demonstrations at the Grace Hospital, the Club were guests of Professors Yandell Henderson and H. W. Haggard at the Department of Applied Physiology.

In the afternoon, a football game between Yale University and Pennsylvania was followed by a dinner at the New Haven Lawn Club as guests of Dr. and Mrs. A. J. Mendello.

This meeting is worthy of special comment for two or three reasons. It was the first time, of which there is a record, at which the wives were specifically invited to some of the social functions. One must recall that the country was just emerging from the Great Depression that had affected all economic levels, so that in previous years travel may have been difficult for spouses. In any event, the red carpet was laid out for the guests. To be able to attend a live radio broadcast of Ed Wynne was certainly a unique event in those days. Likewise, a formal dinner at the Hotel McAlpin, then the focus of social life in New York, must have been a shining occasion.

As noted above, the first two days of the meeting in New York were held at Columbia University Medical Center and at Cornell University Medical Center, while the third day there was a visit to Bellevue Hospital. Whether Dr. Rovenstine knew at this time that he was being considered for the Professor at New York College of Medicine (he assumed the post a year later) is unknown, but it may have placed him in a somewhat embarrassing position as an attendee of the Travel Club from the University of Wisconsin. On the other hand, it allowed him to see the caliber of the work then going on in New York.

It is perhaps a coincidence that the group attended a police lineup in New York and then later visited the Sing Sing prison. There is no reason to believe that a view of law and order was necessary for the group!

It is noteworthy that the meetings in New Haven were held in conjunction with that of the Boston City Society of Anesthetists. There is a suggestion in the notes available that the Travel Club travelled on to Boston from New Haven, but whether this was actually so is unknown. Apparently such a visit was not a formal part of the meeting.

The 1935 meeting was held in New Orleans from December 30, 1935 to January 3, 1936, the hosts being Drs. Ansel M. Caine and Wilmer D. Baker (Figure 1). The new attendee was Dr. Thomas J. Collier. An attractive program was designed for this meeting, and in it notifications were listed of a forthcoming meeting in March, 1936, of the Eau Claire and Associated Counties Medical Society in Wisconsin, and of the fifteenth annual meeting of several anesthesia societies in Philadelphia in October, 1936, to honor Dr. E. I. McKesson.

Considered on the basis of previous meetings, this one could be considered to be less formal, perhaps because of the holiday season. On the first morning, Monday, there were demonstrations of "routine work" at the Touro Infirmary and the Southern Baptist Hospital. In the afternoon, Tulane University work at the Touro Infirmary was reviewed, and in the evening a dinner was tendered by a group of surgeons. On the following morning more clinical demonstrations were available, and in the afternoon work at the Louisiana State University Medical Center was reviewed, followed by a reception at Dr. Baker's home. Being New Year's Eve, the evening was left open.

On New Year's Day, the group was entertained at the Sugar Bowl football game, followed by a buffet supper hosted by Dr. and Mrs. Caine.

On January 2, there were more clinical demonstrations at Touro Infirmary and the Southern Baptist Hospital, followed by a visit to the U. S. Marine Hospital. In the afternoon the group were guests of Dr. John T. Halsey and his staff in the laboratories of Tulane University. In the evening Drs. Caine and Baker hosted a dinner at Antoine's.

On Friday, the concluding day, there was a business session followed by a discussion of interesting cases presented by each member of the group.

In 1936, the eighth meeting was held in Los Angeles and San

Francisco, the hosts being Drs. Arthur E. Guedel, Charles F. McCuskey, Jack G. Dunlop and William W. Hutchinson. New guests were Drs. Jack G. Dunlop and William W. Hutchinson, Glendale, CA. Unfortunately, there are no records available of this meeting.

In 1937, the meeting was held from October 18 to 23 in Montreal and Toronto, the hosts being Drs. Charles C. Stewart, Harold R. Griffith, Wesley Bourne, W. Easson Brown, Charles H. Robson and Harry J. Shields. New attendees were Drs. John C. Dessloch, Rochester, N. Y. and Sidney C. Wiggin, Boston, MA.

The first three days were in Montreal. On Monday morning there were clinical demonstrations at the Western Division of the Montreal General Hospital by Dr. Stewart, followed by a reception and lunch at the City Hall hosted by Mayor Adhemar Raynault. In the afternoon, the Osler Library at McGill University was visited, the host being the librarian, Dr. W. W. Francis, and this was followed by a reception at the home of Dr. and Mrs. Stewart.

On Tuesday morning there were clinical demonstrations by Dr. Bourne at St. Mary's Hospital, and in the afternoon clinical work was demonstrated by Dr. Griffith at the Homeopathic Hospital. In the evening there was a formal dinner for the men at the Montreal Hunt Club and a dinner for the ladies at the University Club, followed by theater.

On Wednesday morning there were clinical demonstrations by Dr. Bourne at the Royal Maternity Hospital, followed by a trip to the Laurentian Mountains. In the evening a buffet supper was hosted by Dr. and Mrs. Griffith at their home, followed by entrainment to Toronto.

During Thursday morning Dr. Robson conducted clinical demonstrations at the Hospital for Sick Children, and in the afternoon there were demonstrations in the Department of Pharmacology under the aegis of Professor V. Henderson. In the evening Dr. Philip Woodbridge spoke at a meeting of the Section of Anaesthesia of the Toronto Academy of Medicine.

The next day clinics were conducted at the Toronto General Hospital by Drs. Shields and Brown, with a demonstration of blood transfusion apparatus. In the afternoon there was a demonstration at the Banting Institute of the Department of Physiology by Dr. C. H. Best, followed by a formal dinner at the Esquire Club.

Saturday morning there were clinics at the Toronto General Hospital and then a lecture by Sir Frederick Banting at the Banting Institute. In the afternoon the group watched the Toronto Argonauts vs. Ottawa football game, followed by an informal dinner at the home of Dr. and Mrs. Robson.

It is interesting, as this chronology is being written in 1990, that football was as major an attraction in the 1930's as it is today.

The 1938 meeting was held at Madison, WI and at Rochester and Minneapolis, MN, the hosts being Drs. Ralph M. Waters, John S. Lundy, Edward B. Tuohy, R. Charles Adams, and Ralph T. Knight. New guests were Drs. R. Charles Adams, Rochester, MN, David C. Aikenhead, Burlington,

Ontario, and Beverly C. Leech, Regina, Saskatchewan.

The only available record of this meeting is the program for October 10 and 11, which was held in Madison. On the first day, Monday, there were operating room demonstrations of three chest cases, a first stage thoracoplasty with apicolysis, a revision thoracoplasty with possible extrapleural pneumothorax, and a lobectomy for actinomycosis. Simultaneously in gynecology there was a Cesarean Section, an ovarian cystectomy with nitrous oxide by the carbon dioxide absorption technique, a D & C with nitrous oxide-ether by the absorption technique taught to a student by Dr. Waters, and a D & C with cyclopropane by the absorption technique taught to a student by Dr. Waters. In the afternoon there were the following discussions:

1) Circulatory effects of anesthetics, by Dr. Meek.
2) Oxygen-carbon dioxide transport in the blood, by Dr. Bauman.
3) Blood-gas studies during anesthesia, by Mr. Stormont.
4) Urea clearance following cyclopropane anesthesia, by Dr. Orth.

Then there was tea, discussion and a buffet supper at Dr. Waters' home.

On the following morning demonstrations were held in the operating suite:

1) A McBurney's appendectomy under nitrous oxide anesthesia.
2) An upper abdominal operation using procaine in the rectal sheath with cyclopropane as the inhalation anesthetic.
3) Open drop ether for a hernia taught to a student.
4) Demonstrations of apparatus for taking respiratory tracings.
5) Tour to demonstrate equipment by Dr. Conroy.
6) Demonstration of brain rest and thoracoplasty braces.
7) Tracheobronchial toilet demonstration by Dr. Yerdy.

In the afternoon there was a staff meeting to allocate assignments, followed by demonstrations of all remaining equipment and gadgets. Following dinner all the films on hand were shown.

On reviewing this program, it is fascinating to see the stress that was laid on the aspects of teaching. There were even two practical sessions on how to teach students. If one ever doubted Dr. Waters' role in his dedication to teaching, it was no longer in question.

In 1939, the eleventh meeting was held in Hartford and New York from October 9-12, the hosts being Drs. Ralph M. Tovell, Emery A. Rovenstine and Paul M. Wood.

The first morning was spent in clinical demonstrations at Hartford

Hospital. In the afternoon the following lectures were presented:

1) Annual report of Department of Anesthesia for fiscal year 1939, by Drs. L. J. Miller, A. D. Milligan and Ralph M. Tovell.
2) Report of Committee for Hospital Investigation, by Professor J. W. Horton, Massachusetts Institute of Technology.
3) Intravenous therapy - a hospital problem, by Dr. R. Patterson.
4) An apparatus for transfusion of blood, by Dr. Jacob Fine.
5) Report on spinograms, by Dr. Curtiss Hickcox.
6) Case report: Muscular spasms occurring during the administration of cyclopropane, by Dr. Alice McNeal.
7) A new incubator for premature infants, by Drs. Prior and Tovell.

Later there was an exhibition of historically interesting books and pamphlets, with explanations by the librarian, Dr. Walter Steiner, at the Hartford Medical Society building.

On the following morning there were clinical demonstrations at the Hartford Hospital, followed by entrainment for New York.

The program for the ensuing two days was under the direction of Dr. Rovenstine. It is interesting that at this time on his staff were three Assistant Visiting Anesthetists, namely, Dr. C. L. Burstein, Dr. John Adriani and Dr. S. J. Martin; three Resident Physician Anesthetists, including Dr. Mary Lou Byrd; and nine Assistant Resident Physician anesthetists, including Dr. R. S. Sappenfield and Dr. D. H. Batten. All of these people were to become prominent in anesthesia circles and several became members of the Academy.

During the first morning there were operating room clinics, and in the afternoon the following demonstrations and exhibits were presented:

1) Nitrogen therapy for schizophrenia, by Dr. Adriani.
2) Circulation time tests, by Dr. Doud.
3) Therapeutic nerve blocks for (a) infra-orbital neuralgia, (b) angina pectoris (stellate), (c) tic douloureux, (d) carcinoma pelvic/pain, by Drs. Lyons and Suffin.
4) Exhibits in the chemistry laboratory of the Anesthesia Department, by Dr. Adriani.
   a) methods for quantitative determination of gaseous and volatile agents in blood and air;
   b) blood gas analysis methods;
   c) detection of barbiturates;
   d) characteristic chemical response of some anesthetics.

The final morning was spent in the Laboratories of Experimental

Surgery, followed by the following demonstrations and discussions:

1) Apnea in the dog during anesthesia, by Dr. Burstein.
2) Effects of certain barbiturates on rats treated with sulfanilimide, by Dr. Suffin.
3) Effects of cyclopropane on intestinal activity, by Dr. Lyons.
4) Effects of cyclopropane on reptilian and amphibian heart tissue, by Dr. Adriani.
5) Studies on the protection against ventricular fibrillation induced by epinephrine during cyclopropane anesthesia, by Dr. Burstein.
6) Oxygen, carbon dioxide and cyclopropane concentrations in maternal and fetal blood during cyclopropane obstetrical anesthesia, by Dr. Sappenfield.

The 1940 meeting was held in Boston, the hosts being Drs. Philip D. Woodbridge and Sidney D. Wiggins. New guests were Dr. H. Boyd Stewart, Tulsa, OK., and Dr. Roland J. Whitacre, Cleveland, OH. No records of this meeting are available.

The 1941 meeting was in Montreal, with the hosts being Drs. Charles C. Stewart, Harold R. Griffith and Wesley Bourne. New attendees were Dr. Urban H. Eversole, Boston, and Dr. Frank J. Murphy, San Francisco. No records of this meeting are available.

From 1942 through 1951, no meetings were held due to World War II. However, there may have been an effort to revive a similar format beginning in 1945 in Boston. In a letter signed by Drs. Morris Nicholson, Urban Eversole and Leo Hand and dated April 18, 1945, there are details regarding a meeting, which represented no formal organization, which was held at the Lahey Clinic on March 23 and 24, 1945. The attendees were chosen more or less randomly and it was hoped that the group would be somewhat permanent, with future meetings. Apparently, this meeting resulted from discussions by Drs. Eversole, Curt Hickcox, Major Harold Bishop and Rolland Whitacre at the AMA meeting in 1944. Those attending this meeting included Drs. Meyer Saklad, Curtiss Hickcox, Milton Peterson, Major Harold Bishop, Fred Haugen, Burdell Sankey, Rolland Whitacre, Harvey Slocum, Austin Lamont, Jacob Fine, Robert Richardson, Major Steven Martin and Sidney Wiggin. Invited, but unable to attend were Drs. R. Charles Adams, Major Lloyd Mousel, Ed Tuohy, Digby Leigh, Arthur Wilkinson, John Adriani, William Cassels and Melvin Kilbourne.

Clinics were held in the mornings and lectures in the afternoon, a format similar to that conducted by the Travel Club. Among the papers presented was one by Dr. Morris Nicholson, who reviewed the literature on permanent postspinal neurologic sequelae, followed by a case report. Dr. Walter Jetter of the Department of Legal Medicine at Harvard Medical School

discussed "Pathological Changes Seen in Patients Who Die Under Anesthesia in the Operating Room." He indicated that the most frequent underlying cause was hypoxia (times have not really changed!). The well-known hematologist, Dr. Lewis Diamond, then talked about transfusion reactions, with particular reference to the importance of the Rh factor.

In the evening there was a dinner at the Harvard Club followed by a general discussion on what was needed to improve the status of anesthesia, ranging from further organization, elevation of standards, improving residencies, to the economic difficulties of anesthesiologists. It was generally agreed at this gathering that there should be another meeting and three members were appointed to select the host and arrange the time.

The next afternoon, following clinical demonstrations in the morning, Dr. Hurxthal discussed heart disease and the problems of the patient with hypertension as an anesthetic risk. In his presentation he noted that patients with angina often had a blood cholesterol of 350 to 500 instead of the normal 150, and that while a low fat diet tended to lower the cholesterolemia, he did not hold out much hope for it as a cure. (Even after 45 years, this problem is still being debated!).

A second meeting was held in Cleveland, the host being Dr. Whitacre, with the format being similar to the first. The third meeting was held at the University of Iowa, with Dr. Stuart Cullen being the host. According to a letter written by Dr. Morris Nicholson on March 11, 1986, further meetings of this group were somewhat obscure in his memory.

In a letter written to Dr. John Adriani in April 1986, from Dr. Curtiss Hickcox, he refers to the above meetings as the "Junior Travel Club", which he indicates had no intention of challenging "Lundy's Club". Nevertheless, Lundy "took great personal offense at this upstart movement and raised quite a fuss."

In December of 1952, the fourteenth and final meeting of the Travel Club as such was held in Rochester, MN, the hosts being Drs. Lundy and Adams. Fifteen members were able to attend this meeting, but fourteen were not. There is no record of the program of this meeting, but some annotations are available from memoirs written by Dr. Lundy and by Dr. Frederick H. Van Bergen, the latter in 1970. It became apparent at the meeting that a decision had to be made regarding the continuance of the Travel Club. The active membership had increased to 30 and it was becoming physically difficult to continue the personal observations within the operating rooms of the various medical centers. The increased membership also added to the financial burden of the host. The general consensus favored the idea of continuing the effort in a somewhat different arrangement. With Dr. Lundy's impetus and Dr. Whitacre's parliamentary abilities, the two drew up a constitution and bylaws for an Academy of Anesthesiology. It was explained that the members of the Travel Club could continue as founding members of the Academy. Adoption of the constitution and bylaws was unanimous.

At this gathering, the members elected a slate of officers: R. J.

Whitacre, President, Harold R. Griffith, First Vice-President; Charles F. McCuskey, Second Vice-President; R. Charles Adams, Secretary; H. Boyd Stewart, Treasurer; and Henry S. Ruth, Historian. John S. Lundy was made Honorary President; Harry J. Shields, Honorary First Vice-President; Paul M. Wood, Honorary Second Vice-President; Charles C. Stewart, Honorary Secretary; and Charles H. Robson, Honorary Treasurer. In this way the flavor of the Travel Club was preserved.

The initials of the Anaesthetists' Travel Club and its founding date were coupled with the initials of the Academy of Anesthesiology and its founding date to form an emblem which today represents the official insignia and crest of the Academy. In this way the Academy of Anesthesiology was founded at the site where, nearly a quarter of a century earlier, its parent organization, the Travel Club, had first met.

To complete the record of the transition, one cannot do better than quote from the memoirs of Dr. Van Bergen in 1970. "The inaugural meeting of the Academy was held at the Netherland Plaza Hotel in Cincinnati, Ohio, in October, 1954. The meeting was devoted to discussions of the aims, purposes, policies and concepts of the new organization. It was obvious from the start that the founders of the Academy wished the organization to function in the same spirit as the old Travel Club and for that reason the active membership was limited to 60. As in the Travel Club, membership could be gained only through invitation; thereafter, members were not allowed to miss more than two consecutive meetings without being formally excused by the Executive Committee, with approval by the voting membership.

"Initiation fees and annual dues were established at this meeting to defray expenses. A substantial portion of income was to be contributed annually to the Anesthesia Foundation, an organization devoted to providing financial assistance to worthy students pursuing careers in anesthesiology.

"It is of interest to note, as we currently flounder in an increasingly polluted environment, that the principal address delivered at the inaugural meeting by Dr. Clarence A. Mills dealt with the subject of the effect of weather and atmospheric conditions on the health of human beings." (Twenty years later, we are embroiled in the same problems, with the terms acid rain, ozone layer, and urban smog creating more havoc than ever).

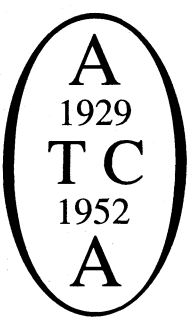
At this meeting, Charles Adams was instructed to begin work on a Directory of the Academy, which he did until his untimely death in 1956. Dr. Scott M. Smith succeeded as Secretary and was responsible for the completion of the Directory, so cherished by each member today. In Lundy's words, "It is a model of its kind."

Also, through the Secretary's efforts, a unique annual program was instituted, which contains not only the names of the active, senior and honorary members and their wives, but also the names of deceased members with the dates of their deaths.

Unfortunately, none of the original members of the Travel Club

survives today in 1990. But the legacy which they have transferred to the present generation will serve to make an indelible impression. Of the original members of the Travel Club, no fewer than eleven were honored by the American Society of Anesthesiologists by receiving the Distinguished Service Award: Paul M. Wood, 1945; Ralph M. Waters, 1946; John S. Lundy, 1948; Arthur Guedel, 1950; Ralph M. Tovell, 1951; Henry S. Ruth, 1952; Charles F. McCuskey, 1953; Rolland H. Whitacre, 1956; E. A. Rovenstine, 1957; Harold R. Griffith, 1959; and Ralph T. Knight, 1960. In addition, a total of twelve deceased or present members of the Academy have been honored by receiving the Distinguished Service Award: John Adriani, 1949; C. Walter Metz, 1958; Forrest E. Leffingwell, 1969; John J. Bonica, 1973; Albert M. Betcher, 1975; Daniel C. Moore, 1976; Leroy D. Vandam, 1977; M. T. "Pepper" Jenkins, 1978; David M. Little, Jr., 1979; C. Ronald Stephen, 1981; John E. Steinhaus, 1982; and Robert M. Smith, 1987.

As a reflection of their leadership abilities and dedication to the advancement of Anesthesiology, a total of thirteen members of the original Travel Club were elected to the Presidency of the American Society of Anesthesiologists: Henry S. Ruth, 1938; Brian Sword, 1939; Ralph M. Tovell, 1941; Wesley Bourne, 1942; E. A. Rovenstine, 1943-44; Ralph M. Waters, 1945; John S. Lundy, 1946; Edward B. Tuohy, 1947; Charles F. McCuskey, 1948; H. Boyd Stewart, 1949; Rolland J. Whitacre, 1950; Urban H. Eversole, 1951; and Ralph T. Knight, 1953. Furthermore, twenty-five deceased or present members of the Academy have served as President of the American Society of Anesthesiologists: C. Walter Metz, 1952; Stevens J. Martin, 1954; B. B. Sankey, 1955; Scott M. Smith, 1956; Ralph S. Sappenfield, 1958; Daniel C. Moore, 1959; Leo V. Hand, 1960; J. Earl Remlinger, 1961; Forrest E. Leffingwell, 1962; Albert M. Betcher, 1963; Oliver F. Bush, 1964; John J. Bonica, 1966; Carl E. Wasmuth, 1969; John E. Steinhaus, 1970; Robert G. Hicks, 1971; M. T. "Pepper" Jenkins, 1972; David M. Little, Jr., 1974; John W. Ditzler, 1976; Jack Moyers, 1978; Jess B. Weiss, 1979; Eli M. Brown, 1981; Louis S. Blancato, 1982; Robert T. Capps, 1983; Ellison C. Pierce, Jr., 1984; and H. Ketcham Morrell, 1985.



No historical narrative of the Anesthetists' Travel Club would be complete without a look at some of the personal characteristics of these men who gathered annually to show practically what their particular group was doing and to enhance their knowledge of each other by swapping stories, trading ideas for the future, and being entertained by their hosts. There was an air of informality in these meetings, and yet from them emerged the specialty of Anesthesiology as it is seen today.

John S. Lundy exerted his influence and made his mark by sheer determination. Probably while still in Medical School in Chicago he attended a lecture by Dr. Heidbrink who was demonstrating his nitrous oxide apparatus. Certainly, he administered anesthetics at the Presbyterian Hospital while in Medical School. Following graduation he moved to Seattle and gave his first anesthetic there on October 20, 1920. The following year, he bought a Gwathmey anesthesia apparatus, carrying it with him to as many as nine hospitals as he built his practice. However, he was not content with this work and jumped at the chance in 1924 when Dr. Will Mayo offered him a position at the Mayo Clinic. Four or five years later, craving exchanges with colleagues having interests similar to his, the concept of a Travel Club of anesthetists evolved. There were letters written to Ralph Waters, who encouraged the idea, and so in 1929 the Travel Club was born at the Mayo Clinic.

This midwesterner was tireless in his pursuit of obtaining official recognition of anesthesia as a distinct specialty. He travelled a good deal and exerted influence on Paul Wood to change the name of the New York Society of Anesthetists to the American Society of Anesthetists, which the latter proposed in a momentous meeting on February 36, 1936, and which became a fact in December of that year. Lundy was appointed to attend a meeting of the Guiding Committee of the American Medical Association (AMA) and the Advisory Board of Medical Specialties to seek approval of a specialty board in anesthesia. In due time, with the backing of the American Society of Anesthetists, the American Society of Regional Anesthesia, and the Section on Surgery of the AMA, the American Board of Anesthesiology was incorporated in 1938 as an affiliate board of the American Board of Surgery. In 1941 it became completely independent.

For a number of years, Lundy had been pressing for a Section on Anesthesia within the AMA. In his own words, "I deliberately went to Chicago at every opportunity and went to AMA headquarters and called on the Secretary, Dr. Olin West, and kept after him until out of sheer desperation he made the necessary arrangements through Dr. Paullin", then Chairman of the Council of Scientific Assembly. The first meeting of the Section was in 1941. Lundy remained Secretary of the Section "until it was on its feet, which took 17 years."

These numerous accomplishments in the organization of Anesthesiology did not come at the expense of taking a back seat to anyone. His aggressiveness led to bruised feelings among some of his peers. It was

said that one agreed with him or he was your enemy. However, as one looks back at the 1940's, it is apparent that Lundy was almost always a constant manipulator of what transpired in the American Society of Anesthesiologists and the American Board of Anesthesiology. Such was John Lundy, never shy about stating opinions and an expert in the conduct of meetings.

Ralph M. Waters was in many ways the antithesis of Lundy, which is perhaps why the Travel Club thrived and flourished. Waters was primarily an "inhalation" man, whereas Lundy promoted intravenous and regional techniques, as exemplified in his coinage of the term "balanced anesthesia". The story goes that, at an ASA meeting in New York, someone asked Lundy at what minimum age one could give Pentothal safely. Lundy said he would not use it for patients under the age of ten. Waters stood up immediately and commented that he did not think Pentothal should be used for anyone under the age of 100.

They differed also about the use of nurse anesthetists for administering anesthetics. Lundy supported the concept, but Waters was much opposed to the idea. The tale is told that sometime after Waters was appointed Professor of Anesthesia at Wisconsin in 1927, he was approached by the Dean concerning the feasibility of training nurse anesthetists. The discussion developed to the point where Waters threatened to resign if this idea were to become a reality. Obviously, Waters won.

There was also the general belief that Lundy's program was more clinically oriented than that which was instituted at Wisconsin. Certainly, Waters early sought to bring the Departments of Pharmacology and Physiology into a close working relationship with Anesthesiology, but Lundy tried to rectify the situation by establishing the postgraduate Fellowship program, with the Fellows spending time in the basic science laboratories.

The characteristics of the two men were dissimilar. Waters did not seek publicity and he was not a driving, forceful personality. He was fair at all times, personable, level-headed and a sound thinker, exemplified by his love of smoking a pipe. Teaching was a prime motivation in his life, and his residents idolized him and for what he stood.

At times there were hints of a rivalry between Lundy and Waters, but if so, one has to believe that it was a friendly rivalry based on mutual respect. Each in his own way contributed uniquely to make anesthesia what it is today.

Paul M. Wood is probably the least understood character in the Travel Club. While in college, he was Director of a summer camp for the underprivileged and taught summer courses in a Bible Teaching Training School. One summer, while in medical school, he served as a companion to a psychotic patient. After graduation, he worked as a pediatrician with the Grenfell Mission for several months. During World War I he served as Commanding Officer of an Aid Station on the Italian front.

While a surgical house officer at the Roosevelt Hospital in New York in 1924, he had nine months of instruction in anesthesia, and this experience

decided his vocation for life. His exploits in furthering the cause of organization in anesthesia are well known. It must have been an emotionally charged evening when Paul Wood, at a gathering of the New York Society of Anesthetists in 1936, rose to propose to "make this society, in name as well as fact, a national society in anesthesia - - - to change New York to American."

In the meantime, Paul Wood was becoming a collector, a repository of anything and everything associated with this new developing specialty. He kept all the material, papers, gadgets, anesthesia machines, in his apartment until there was literally no place for his family to live. Dr. Lewis Wright came to his rescue and persuaded the Squibb Company to provide space for the mounting collection. Eventually this area became no longer available, and Dr. Richard Foregger, the anesthesia instrument designer, loaned the use of a boathouse to store the equipment. For a number of years, later, there was no real resting place for this accumulating goldmine, it being spread over a number of locations. In 1949 the House of Delegates of the ASA established a non-profit corporation known as the Wood Library-Museum and designated it as "the official repository for the archives and paraphernalia pertaining to the field of anesthesiology." Now there was an entity but still no home. Not until 1962 did the House of Delegates authorize the ASA President "to take such actions as he may deem necessary or proper to construct, complete, furnish and place in operation a Library-Museum addition to the Headquarters building". At long last, Paul Wood's dreams were to be fulfilled. The Wood Library-Museum was dedicated on November 3, 1963. Unfortunately, as fate would have it, Paul Wood had passed away some six months previously. However, his spirit still echoes amongst the book stacks and in the museum artifacts.

Charles F. McCuskey was a Mayo man, working with Lundy from 1925 to 1933. Then he went to Los Angeles, where he spent the rest of his career in leadership roles in academic anesthesia and participating in national anesthesia affairs. During World War II he was a Consultant in Anesthesia in the Pacific theater. Although he was soft-spoken and a most attractive individual to engage in conversation, he possessed all the attributes of a leader and creator.

Ralph M. Tovell has been described as the martinet type, small in stature, militant in bearing. He was no doubt influenced by Lundy, having spent several years at the Mayo Clinic before moving to Hartford Hospital in 1936 to organize a department as Chief of Anesthesia. He possessed major organizational abilities, even in adversity, as witnessed by the fact that there was an anesthetic explosion in his hospital in 1939. Not to be daunted, he set about to develop new safety standards, assuming a leading role in the National Fire Protective Association. During World War II he was a Consultant in Anesthesia to the U. S. Army Overseas, returning to Hartford Hospital to create one of the outstanding residency training programs in the East. In his leading role as Editor of the journal *Anesthesiology* in the 1950's, he did

much to improve its status. He is a prime example of what could be accomplished in anesthesiology in a non-academic atmosphere.

John A. Blezard was a Canadian member who served in World War I before heading the Department of Anaesthesia at the University of Alberta. Later, in 1937, he went east to become Professor and Department Head at the University of Western Ontario in London. He was of small stature but tall in developing academic anesthesia in Canada.

W. Easson Brown never sought after prominence and served faithfully in the Faculty of Medicine at the University of Toronto for 38 years. A jovial man, he was usually the life of the party. The story goes that at one of the Travel Club meetings, he became embroiled in an altercation at one of the local pubs which, because of his physical size, was not lost to the cause. He loved and enjoyed life, as his tribute to himself indicates in his biography.

Ansel M. Caine, whose son Curtis is still practicing anesthesia in Jackson, MI, was an anesthesia pioneer in New Orleans. Reputedly, it was at the urging of Rudolf Matas that he became interested in anesthesia. Along with Wilmot Baker, they organized the private practice of anesthesia in the deep South. They welcomed John Adriani to their city, the story being that Caine, a staunch Baptist, even attempted to lure him to his faith.

Arthur E. Guedel, one of the more distinguished names in developing anesthesia, lost three fingers in an accident while a youth, but this disadvantage never deterred him in his practice. During World War I he taught the rudiments of anesthesia on the western front to anyone who would listen. He became known as the flying anesthetist, tearing up and down the front lines on a motorcycle, at considerable risk to himself, providing pain relief to the wounded. His notable description of the signs and stages of anesthesia was adopted worldwide and rivalled the circulation of his textbook, "Inhalation Anesthesia, A Fundamental Guide", which became a standard for students.

He had a lifelong, close relationship with Ralph Waters, letters and ideas being almost constantly exchanged between Wisconsin and Los Angeles, where Guedel practiced in his later years. The development of the cuffed endotracheal tube was a symbol of this friendship.

It has been said that Guedel had no acquaintances, only friends. Any and all who visited him in Los Angeles were struck by his genial warmth, good humor, kindliness, and expert knowledge.

Robert B. Hammond was a New Yorker who exemplified the private practice of anesthesia in that area. He became known as the toastmaster in the Travel Club.

Charles H. Robson, another Canadian, was probably the first pediatric anesthetist on the continent. His career was spent at the Hospital for Sick Children in Toronto where he guided many a budding anesthetist in the intracacies of anesthetizing infants and children.

Henry S. Ruth, an erudite scholar, contributed much to the

organization of anesthesia as a distinct specialty. He was the first Editor of the journal, *Anesthesiology,* serving in that capacity for a number of years beginning in 1940. Along with the surgeon Bailey and one of his distinguished residents, Kenneth Keown, he promoted some of the early work in providing anesthesia for surgery on the heart.

Harry J. Shields, after serving with the Canadian Army Medical Corps in World War I, became a leading exponent of the development of anesthesia in Canada, serving as Chief of the Department of Anesthesia at Toronto General Hospital for almost 20 years. His likable personality endeared him to those who trained under him.

Charles C. Stewart, a dour Scotsman with a matching sense of humor, was, with Wesley Bourne, one of the first physicians to practice anesthesia full time in Montreal. A private person, he nevertheless provided stability and respect to the specialty in its developing phases.

Brian C. Sword, with his jovial personality, provided a degree of balance in the Travel Club. With the help of Dr. Foregger, he devised in 1930 one of the first practical circle absorption systems with which so many American anesthesiologists became so enamored, particularly with the advent of cyclopropane.

Harold R. Griffith. In the dim and distant future, if an anesthesia practitioner anywhere in the world were to be asked who was a true pioneer, one of the names he would probably recall would be Harold Griffith. The reasons would be two-fold: first, the revolution in anesthesia practice he caused by the introduction of curare; and second, his dedicated work in bringing to fruition the World Federation of Societies of Anesthesiologists in 1955, of which he was the Founding President.

Those of us who had the privilege of working with him as a student and a colleague remember him as a kind, gentle, humble gentleman with sparkling humorous eyes, but always with one aim in view, the furtherance of anesthesia as a distinct specialty in medicine. He would have enjoyed the story of the famous person who said, "Flattery is like chewing gum: it tastes very pleasant, but don't swallow it."

Wesley Bourne and Harold Griffith were the best of friends and, working together as a team, they established the Department of Anaesthesia at McGill University in 1945. However, Bourne was in many respects, the antithesis of Griffith, just as Lundy and Waters tended to be opposites in character. Bourne was a firebrand in nature, always on the move. He carried two watches with him, to be sure that he would be on time at his next destination. He drove his car at breakneck speed, often ignoring red lights. At night, he studied such writers as Pushkin, and his mastery of the English language is reflected in his collection of lectures and addresses, "Mysterious Waters to Guard." It is interesting that both Bourne and Griffith were awarded the coveted Henry Hill Hickman Medal of the Royal Society of Medicine, the only time two physicians practicing in the same area have been so honored.

Philip D. Woodbridge, a graduate of Harvard Medical School, spent his life as a leader in anesthesia circles in the eastern part of the country, first at the Lahey Clinic and then as Professor of Anesthesia at Temple University Medical School. With the advent of the muscle relaxants, he became interested in the problems of potential awareness during so-called balanced anesthesia and devised a system of classification, published in 1957, based on the Greek word, nothria, which means torpor. Unfortunately, the several terms which he used derived from nothria confused the readers to such an extent that the concept was never embraced. This problem, incidentally, is still with us, but one suspects that drugs such as midazolam will do much to eradicate it.

Ralph T. Knight, the father of anesthesia teaching and practice in the Minneapolis area, served in the U. S. Army during the first World War and in 1920 became Director of Anesthesia at the University of Minnesota School of Medicine, a position which he held for 34 years. He was a prime instigator of academic anesthesia in the midwest, contributing among many other advances the Knight mixture, a combination of pentothal and curare in the same syringe, to facilitate induction of anesthesia. A stately gentleman, he commanded recognition in any assembled group.

Edward B. Tuohy, a brash, outspoken midwesterner, was a product of the Mayo Clinic who became Professor of Anesthesiology first at the Georgetown Medical School (1947-51) and then at the University of Southern California School of Medicine. One of his primary interests was in regional analgesia, his contributions including the development of the Tuohy spinal needle and the introduction in 1945 of the ureteral catheter for continuous spinal analgesia.

Lincoln F. Sise, a Harvard graduate, served in the U. S. Navy Medical Corps during World War I, following which he was Anesthetist to the Lahey Clinic for 17 years beginning in 1923. A devotee of regional analgesia, his claim to fame, and it is indeed worthy, was the introduction of the Pontocaine-Glucose solution for spinal analgesia in 1935. This technique has withstood the test of time admirably through the next 55 years.

Emery A. Rovenstine, many would agree, was the outstanding protege of the many who studied under Ralph Waters. His lifetime was spent in New York where he was Professor of Anesthesiology in the New York University College of Medicine and Director of Anesthesia at Bellevue Hospital. Many of his residents, including John Adriani and Stuart Cullen, went on to become leaders in the specialty in their own right.

Rovenstine travelled extensively, lecturing in such varied places as Oxford, England, the University of Rosario, Argentina, South Africa and Japan. In 1946, he was a member of a Teaching Mission to Czechoslovakia. At home, he was not always so welcome. Apparently some of the native New York anesthesiologists resented his coming in their midst to assume his academic role. A sketch in the New Yorker magazine tended to accentuate the

problems, although such has been refuted recently by Dr. E. M. Papper. Be that as it may, there is no doubt that Rovenstine left a legacy which it will be difficult to duplicate.

Sidney C. Wiggin, a true New Englander, was a dapper, articulate, cultured gentleman. Educated at Harvard, he was an anesthesia instructor at Harvard Medical School for 19 years and then was an Assistant Professor at Tufts University Medical School for six years. He was extracurricularly a first-rate sculptor and a founder of the Art Society in Boston. He brought a special dimension to the Travel Club.

R. Charles Adams, a Canadian by birth, was a Lundy protege and succeeded him as Head of the Section of Anesthesia at the Mayo Clinic in 1952. For a few years before his untimely death in 1956, he was Secretary of the newly-formed Academy of Anesthesiology. For most of his career, he was overshadowed by the dominance of Lundy.

David C. Aikenhead, after serving in the Canadian Army Medical Corps during the first World War, spent his academic career at the University of Manitoba Medical College for 27 years. A quiet, unassuming man, he did much to foster the specialty in the western part of Canada.

Beverley C. Leech was almost as much of a military man as he was an anesthetist. During World War I, he was a Lieutenant in the Canadian infantry, and during World War II he served as a Colonel commanding a Canadian General Hospital overseas. He continued in the Reserves, maintaining ties with the military for 32 years. He served as an Honorary Aide de Camp to the Governor-General of Canada from 1952 - 1957. Following the war, he was Director of Anesthesia at the Regina General Hospital for 27 years. As a "spit and polish" man, he brought a sense of order to the Travel Club.

Of special interest today is the pharyngeal airway which Leech developed in 1936 which provided an airtight means of providing ventilation without subjecting the patient to endotracheal intubation (Leech BC. The pharyngeal bulb gasway: a new aid in cyclopropane anesthesia. Anesth Analg 1937;16:22-25). It is similar in concept to the laryngeal mask, first described in 1983 (Brain AIJ. The laryngeal mask - a new concept in airway management. Br J Anaesth 1983;55:801-805), and which is proving to be of increasing interest in Great Britain. It is an example of the adage that everything runs in cycles.

H. Boyd Stewart was the southwest representative to the Travel Club. A dapper, friendly gentleman, he became President of both the ASA. and the American Board of Anesthesiology while working as Chairman of the Department of Anesthesiology at St. John's Hospital in Tulsa.

Rolland J. Whitacre, a suave, smooth organizer, was the nearest to being a politician that there was in the Travel Club. Working closely with Lundy, he was the prime architect in converting the Travel Club to the Academy. A strong believer in the private practice of Anesthesiology, he was Director of the Department of Anesthesiology at Huron Road Hospital in

Cleveland, organizing the first residency training program in Ohio. He was elected to leading roles in anesthesia organizations, including the World Federation of Societies of Anesthesiology. He also served on the Joint Commission of Accreditation of Hospitals. Unfortunately, he met an untimely death in 1956.

Urban H. Eversole, a native Missourian, became a staunch New Englander, serving as Director of Anesthesia at the Lahey Clinic beginning in 1941. He was an organization man, being President of the ASA in 1951. His hero was Napoleon and throughout his life he became an avid collector of books and artifacts associated with this figure in history.

F. John Murphy, a native of Alberta, served in U. S. Naval hospitals during World War II, being Chief of Anesthesia at Pearl Harbor from 1944-46. Following the war, he was Chief of Anesthesia at the Harper Hospital in Detroit and then at the University of California in San Francisco from 1946-57. In his later years he continued to practice in Billings, Montana, where ranching was his favorite pastime.

These, then, were the men who made the Travel Club what it was. A diverse group they were, from all sections of the continent, bound by the concept of improving the status of anesthesia and forging it into a distinct and honorable specialty. All of them in their own ways were leaders, many using their organizational abilities without stint, and all of them assuming leadership roles in their own communities. That they succeeded in their objectives no one can deny. That they made the road to be travelled by succeeding generations smoother and straighter is a sina qua non.