EDITORIAL

SOCIOLOGIC OBLIGATIONS OF THE ANESTHESIOLOGIST

SOBER reflection, unbiased by political plerophory, cannot help but lead to the realization that a need exists for the development of plans to facilitate the provision of self-supporting medical and hospital service to the low income group. The low income group is defined as that group which in normal times has an income of $3000 or less per year. The physician's natural aversion to domination and the implications of political chicanery in Senate Bill 1161 becloud his insight into the social trends which fostered the bill. It is not in the best interests of all concerned for the physician to assume a negativistic attitude or behave like the ostrich when confronted with this contemporary problem in social evolution.

The physician must have long been aware of the need for making it possible for the low income group to support its own medical costs. He has, for ages, given service to individuals who have been unable or unwilling to pay for it. Medical care of these individuals has been rendered without a fee or for a fee reduced below the established value of the service. To compensate for the lack of adequate remuneration from this group, some physicians have charged certain of their clientele a fee which was in excess of the value of the service. Although, by some sophistry of economics peculiar to the practice of medicine, this has been a necessary and established custom, it seems unfair and unwarranted because the low income group is capable of paying for medical care if the costs are distributed by means of an insurance plan. By distribution of costs through installment buying, it has been possible for persons in this group to purchase automobiles, electric refrigerators, radios, etc.

If one is convinced of the need and if one believes that the low income group can, without subsidy, pay for medical care, the problem, then, is in evolving some plan under which a budgeting of medical costs can be facilitated. This may be done on a voluntary or a compulsory basis. The healthy growth of voluntary non-profit hospitalization insurance plans is evidence of the willingness and ability of a sizable portion of the American public to pay its own way when a convenient, inexpensive and trustworthy means of doing so is provided. There is, however, a distressing lack of interest in these plans by individuals with minimal incomes, and there is a pronounced tendency to gamble on medical and hospital expenses by those people who can least afford to gamble. There are a number of prepayment plans for medical and surgical services which have been in operation for the past few years

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Most of these plans are experiencing difficulty in obtaining participants and a few have failed because of lack of subscribers. This lack of interest may be due to the tendency to gamble or possibly to lack of education in the advantages of budgeting medical expenses. Is it not also conceivable that many individuals consider their bills for medical service a long term loan, with no interest, which can be paid off at their convenience? The current increase in national income, a major portion of which is centered in the group under consideration, may also be a factor. In considering this latter factor, one must not forget the situation ten years ago and recognize that such a state may recur within the ensuing ten years. Recognition of the certainty of recurrence of drastically reduced incomes in the post-bellum period should serve to emphasize the urgency of instituting preparations now.

It seems likely that voluntary plans will not be a solution to the problem and that some means of compulsory insurance against costs of medical and hospital service will be needed. The operation of any compulsory scheme of medical and hospital insurance will entail the collection and disbursement of tremendous sums of money. The physician should not aspire to participate in the business management of the plan. His function is to dispense medical care. He should, however, be intensely interested in and be allowed a voice in the management of these funds to the extent that there is no interference with the rendering of his services to the patient and that he receive remuneration commensurate with the value of his services.

A skilled laborer is paid according to his proficiency, training and experience. Is there any reason why a physician should not also be paid on a scale which recognizes his training, experience and proficiency? Fixed benefits are essential to the safe operation of an insurance plan. The insurance benefit should, then, serve only as an indemnity payment on the regular fee. In the group which should be most concerned with this type of protection, the benefit will, in most instances, cover the actual value of the service.

If one's political philosophy is such that federal control of compulsory insurance is satisfactory, then Senate Bill 1161 provides the solution to the problem. If one's political philosophy does not countenance the federal domination of these matters, then it is essential that some other plan be constructed.

Perhaps we should give voluntary medical service and hospital service plans a longer trial. Perhaps the state should compel individuals in certain income groups to purchase medical and hospital insurance, but allow them to buy the insurance where they like. Perhaps there is some other means of solving the problem. Any scheme, however, that does not allow free choice of physician, that interferes with the rendering of care, and that does not compensate the physician commensurate with the quality of service rendered, is against the best interest of the patient and the physician. The medical profession has contrived, under

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the present system, to provide high quality service. Is it not possible, though, that even higher standards can be attained with more equitable distribution of costs?

Anesthesiologists are, in the main, a group of young physicians. It is their responsibility to acquaint themselves with the trends in the economic aspects of medicine and to participate actively and positively in the formulation of a suitable plan for the provision of self-supporting medical service to the low income group.

For the information of anesthesiologists who are contemplating application for certification by the American Board of Anesthesiology, Inc., or who are training physicians for the specialty, the following questions have been employed for Part I (written) examinations in the past in *Anatomy:*

1. Concerning continuous caudal anesthesia:
   a. To what sensory level (in terms of spinal segments) must anesthesia be produced to give relief from pain in labor and delivery?
   b. To what level (in terms of spinal segments) does sensory anesthesia usually rise when uterine contractions are stopped by the anesthesia?
   c. What are the landmarks used in introducing the caudal needle?
   d. What anatomic structures must the anesthetist avoid injuring or piercing, when using the caudal needle to effect caudal anesthesia?
2. Sketch roughly the larynx, trachea and main bronchi going to to each pulmonary lobe on each side, showing approximate levels against vertebrae, ribs. (Note: Be sure to show the difference in the angles which the right and left main bronchi make with the trachea.)
3. Concerning brachial plexus block:
   a. What are the landmarks used?
   b. What structures near the brachial plexus should the anesthetist avoid injuring or piercing with the needle?
   c. What area of anesthesia can be expected?
   d. Why might intradermal and subcutaneous block around the arm, midway between shoulder and elbow, be a helpful addition to the block of the brachial plexus?
4. Briefly describe the technic involved in performing an injection for relief of disturbed circulation of blood in a case of "immersion foot."
5. What intercostal nerves must be blocked, and at what points, in order to produce anesthesia of the abdominal wall?
6. What are the landmarks for blocking the tibial nerve at its highest point (where it leaves the sciatic nerve)?

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