with his female patient. Another more serious extraneous emotional involvement occurs when the anesthesiologist feels his omnipotence threatened by the patient. This manifests itself as a resentment toward the patient who is "going sour" on the operating table. The doctor experiences the patient's actions as an attack on his training, competence, person and on the very integrity of his fantasies of being god-like.

With children it is important that parents prepare the child for operation and the anesthesia experience either by words or play, but not too far in advance. The anesthesiologist should allow himself adequate time to win the child's trust and then offer the child short, repeated, confident explanations. Ideally, the child should be asleep before being transported through the hospital corridors. In adults, for local anesthesia, a brief comment with each step should suffice. At no time should the technical aspects be over-explained. (Over-explaining reflects the doctor's own anxiety.) It is important that the patient not be engaged in weighty conversation in the operating room. We all know from personal experience that when we are anxious about an impending matter, such as an examination, our wife in labor, or the like, we have difficulty listening to what is being told us and even more difficulty in retaining what has been said. This has to be kept in mind during the preanesthetic visit when the patient is anxious and is told all the minutia of the next day's events. The most practical approach is to introduce oneself and chat for a while about anything, then ask the patient for questions, and at times raising "questions that must be on your mind."

I titled this editorial "*What* Preanesthetic Visit?" because of my concern for the patient and for those anesthesiologists who do consider this problem. The preanesthetic visit varies qualitatively and quantitatively from anesthesiologist to anesthesiologist. Some hospitals ignore the problem entirely and in others the visit is part of the routine.

In recent years there has been greater emphasis on the study of the "total person," and unfortunately, an increase in specialization. The anesthesiologist today has to approach his patient with a psychological awareness of both himself and the patient. We in psychiatry, and you in anesthesiology, face a similar problem. In our case the general practitioner, internist or surgeon knows the patient much better than we, yet turns to us for help. At times we feel that the referring physician is "dumping the patient in our lap." This applies as well to the surgeon who is familiar with his patient, yet turns him over to the anesthesiologist. I believe that this is a professional function we both must accept. In understanding the patient it is incumbent upon both of us to be cognizant of the basic problem: *that the patient has an illness with its own emotional factors, and that he brings to this illness or operation* his own *personality and* his own *anxieties.* And what about the anesthesiologist? The anesthesiologist who feels apologetic will have the most difficulty with the preanesthetic visit. The anesthesiologist who has a realistic pride in his skill, and faith in the importance of his function will communicate this to the patient for mutual benefit and satisfaction.

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The Section on Anesthesiology of the American Medical Association

ONE of the shortcomings of many democratic organizations, whether they be on a national, state, or local level, is the apathy and failure of the majority to exercise its duly endowed rights of participation. Too often this apathy and disinterest leads to control of an organization by a willing, dedicated, but at times, a misunderstood and castigated minority. This lack of interest permeates all aspects of our democratic way of life, including our professional societies.

It has been disturbing during the past several years to note the appalling lack of interest which our specialty has displayed towards

the Section on Anesthesiology of the American Medical Association. Our stake in the Section is too important to our professional existence to have the organization wither on the vine by default of the membership. The Section on Anesthesiology is the specialty's only liason with other groups which comprise the American Medical Association. We all, even though we are specialists, owe a certain loyalty to organized medicine despite the fact that we have channeled our interests into a single phase of medical practice. Many of us envision the American Medical Association as a remotely located, nebulous apparition which is organized principally to solve our economic problems. The scope of the Association extends far beyond that of staving off socialization of medicine and being the champion of the "fee for service" principle. Too few of us dwell upon the thought that the degree of excellence which American medicine has achieved has been due largely to the efforts of the Association through its Council on Medical Education. The Association has exalted the caliber of medical practice by formulating educational standards at both the undergraduate and postdoctorate level and seeing that such standards are maintained by institutions approved for education and training. The specialty boards, including the American Board of Anesthesiology, are chartered by and are under the surveillance of the Association through its Council on Education.

The American Medical Association recognizes that Anesthesiology is a phase of medical practice which is the sole responsibility of physicians. Shortly after the inception of training programs for physicians specializing in Anesthesiology, the American Board of Anesthesiology was organized under the auspices of the Council on Education and basic requirements were formulated. Almost simultaneously, largely through the efforts of Dr. John S. Lundy, a Section on Anesthesiology was created. For over twenty years the Section flourished and progressed under the strong support and leadership of Dr. Lundy, who acted as its secretary for almost seventeen years.

There has been an increasing tendency during the past five or six years to place more and more emphasis on the American Society of Anesthesiologists and to overlook the importance of the Anesthesiology Section and to relegate it into the background. The specialty needs both organizations. Each functions in a different capacity but one supplements the other in the same manner that the left hand supplements the right, neither being fully useful without the other. The folly of isolating ourselves from our colleagues engaged in other phases of medical practice should be obvious to all of us. The physician who is truly a specialist abhors such isolationism; the technician basks with self-satisfaction in its insipid glow. The specialist is readily distinguished from the technician. The specialist continues to be a physician but places especial emphasis on a particular aspect of medicine which is to his liking or for which he has talent. The technician, on the other hand, literally renounces medicine, becomes a craftsman and confines his activities to an emperic, monotonous routine within a limited sphere. The memberships of some specialty societies, regrettably, are permeated with technicians.

Whether or not a specialty advances or recedes depends, to a large extent, upon the educational and scientific standards which are promulgated in its behalf and upon whether or not the group accepts and abides by such standards. The decision for acceptance or rejection of such standards ultimately rests with the electorate of the Association as a whole or with one of its particular sections. All subgroups delegated with authority to set standards are subservient to the electorate. They are its servants and not its masters. The wishes of the majority, however, can only be expressed by participation of that majority in the organization designating such authority and responsibility. Any dissatisfaction which develops, more often than not, stems from lack of interest and default of the electorate.

Besides the responsibility of caring for patients and training our future specialists and colleagues we have, as specialists, one other responsibility—that of informing our colleagues whose primary interest is in other aspects of medicine of the advances in our own field. We are obligated to disseminate to them knowledge which they are able to use which

we have gleaned from our experiences and studies. The relief of pain is of interest to and an obligation of all physicians. The Section on Anesthesiology through the medium of its scientific programs, its papers which are published in the Journal and its scientific exhibits serves as the avenue for the dissemination of such knowledge to physicians in other specialties. Thus, if we are to serve the public in the capacity to which we are pledged, we can only do so by being good specialists. In order to be good specialists we must first be good doctors and in order to be good doctors we must be active participants in organizations and functions designed to support and advance medicine in all its phases.

JOHN ADRIANI, M.D.

Enzymes Alleviate Literary Gastritis

Wallerstein Co., a pioneer in the enzyme field, has scored another break-through. It now offers new biochemical catalysts to aid authors who seek to garnish the scientific diets of their colleagues and successors. These enzymes are available now; others are still in development stages:

Techno-amylase: An enzyme complex that removes bulky, starchy components which add unnecessary volume to reports. (Caution: this enzyme should not be used where reports are judged by weight.)

Techno-protease: An enzyme system that removes low quality, proteinaceous quagmire and allows readers to get to the heart of the subject.

Techno-pectinase: An enzyme system that clarifies reports by reducing their viscosity; thus, they become free-flowing, and cloud-producing elements settle for later rapid removal. (Techno-pectinase is contraindicated in patents and pseudotechnical sales literature.)

Techno-flavor: A new enzyme that adds flavor to reports, ensuring sustained reader interest and consumption.

Anatole France once wrote:

> Whenever you can shorten a sentence do.
> And one always can.
> The best sentence?
> The shortest.