measure those parameters which will tell him the status of his patient for whose respiration he has accepted responsibility. It follows further that the anesthesiologist who accepts this responsibility must be aware of all the complications of carbon dioxide retention and of anoxia. This means that in addition to the knowledge of respiratory function, he must be aware of other changes in the body which follow the derangements produced by apnea as well as the changes produced by controlled respiration. He must test his apparatus and be responsible for its function.

Assuming that he can see the patient safely through these difficulties or avoid them, the anesthesiologist must have the clinical acumen and the scientific knowledge to restore the patient's breathing to normal before he is left to his own devices and his own defenses. The anesthesiologist, in short, must be familiar with the breeding of apnea and the cyclic changes which keep it going. He must be aware of how to separate red herrings from facts. He must understand how to terminate the apneic state. During the transition period he must maintain effective breathing for his patient. His responsibility does not cease until the patient is completely normal and well.

It appears as though the apneic state and controlled respiration, like so many good things, have been abused. The phenomenon itself deserves the praise it has received. But the people who use it must be alert to their responsibilities. An anesthesiologist has to be something more than his brother's keeper. He has to be his brother's breather.

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Service Through Self-Sacrifice

Among the articles appearing in this issue of the Journal is one entitled "The Art of Preparing the Patient for Anesthesia." The author includes in her paper some of the basic tenets of all religious philosophies, and certainly of Christianity. The thought of service through self-sacrifice is evident throughout the beliefs of most enlightened races. An example in the Christian religion is the prayer of St. Francis of Assisi, which is as follows:

"Lord, make me an instrument of Your peace.
Where there is hatred . . . let me love.
Where there is injury . . . pardon.
Where there is doubt . . . faith.
Where there is despair . . . hope.
Where there is darkness . . . light.
Where there is sadness . . . love.

O Divine Master, grant that I may not so much seek
To be consoled . . . as to console.
To be understood . . . as to understand.
To be loved . . . as to love.

For
It is in giving . . . that we receive.
It is in pardoning . . . that we are pardoned.
It is in dying . . . that we are born to eternal life."

Doctor Rodger is actually proposing that much of this prayer be carried out in pardoning the patient's bad behavior and in sowing faith and hope. She advocates consoling and understanding but, most of all, she suggests that the anesthesiologist give of himself more than is necessary.

The anesthesiologist can't wait in the doctor's dressing room or in his office until "they" are ready in the operating room and then offer the self-sacrificing service shown in this author's practice. It is a sacrifice to be instantly available and in observing those needs pointed out. Only through service are we able to exist in society; although one may be a selfish physician or a selfish carpenter, the laws of the land and the mores of society are sufficient to force service enough from the individual in most instances so that he functions in his profession to the extent of earning a living for himself and in performing his task acceptably. His success is not because of his selfishness, however, but in spite of it; and although he may serve society for many years with a selfish philosophy, he never serves himself sufficiently to find happiness in

his work. His self-centered attitude automatically forces his mind to think of the patient as a burden imposed upon the physician, so that the patient for emergency operation is sandwiched in between cases on a busy schedule, bringing about a feeling of self-sacrifice in the anesthesiologist and self-denial through the loss of an appointment or other personal goal. The result is to charge the frightened or insecure patient with poor behavior, with childish demands, or with not being brave, interpreting the same actions as impositions which the author interprets as patients' needs.

Actually, these needs of the patient could equally well be taken care of by the surgeon, nursing supervisor, or circulating nurse in the operating room. It is true, however, that the anesthesiologist has a greater opportunity than many because of his unique position in the medical world. Just as there are many seeming paradoxes in religion, such as "it is more blessed to give than to receive" or "it is in giving that we receive," so the anesthesiologist's position in the medical community offers a similar paradox. It is often said that he must have a unique personality; that he works with so many demanding individuals, some of whom are unreasonable; but the real truth is that he is uniquely able to serve. The emotional needs of the patient can be satisfied; the task of the surgeon can be facilitated; and an effort can be made toward coordination of the operating room personnel so that the procedure is performed as well as possible.

Not wishing to serve, his alternative is to force others to serve him, which is not the basic tenet of any religious philosophy—nor is it possible. The greatest paradox is the fact that it is not the receiver of such service who profits most, but the giver; so that when one believes he is serving others, he is actually working daily toward his own tranquility. "The Art of Preparing the Patient for Anesthesia" and the beliefs of its author should be read and pondered and then applied in our daily approach to each patient.

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