Editorial Views

The Status of the Consultant

THE purpose of a consultation is to seek the opinions and advice of those whom we recognize to be more expert in a particular field of medicine than we are. Unless the criteria of expertness and soundness of judgment are fulfilled, the opinions and advice we receive are worthless. On the whole, most surgeons regard the anesthesiologist as a consultant, and once they have gained confidence in a particular individual, they rely implicitly upon his judgment concerning problems of anesthesia. At times some surgeons go even further in their endeavor to give their patients the ultimate in expert care by seeking the assistance of other specialists concerning matters not related to surgical diseases. They call upon cardiologists, pulmonary physiologists, hematologists, neurologists, pediatricians, and others who are able to be of assistance. Among this group the most frequently sought opinions are those of specialists in internal medicine and pediatrics. A learned and modest consultant limits his opinion to matters pertaining to his speciality and grants to his colleagues that mutual respect which an expert in one field holds for an expert in another field. Both the anesthesiologist and the surgeon benefit from the assistance of consultants who manifest this attitude. To some consultants, however, a request for a consultation is construed as an admission of ineptness and a sign of weakness on the part of both the surgeon and the anesthesiologist. Consultants such as these often attempt to dictate the choice of drugs and to outline the details and techniques of anesthesia. Such phrases as "use no cyclopropane," "spinal is contraindicated," "use no atropine," "use an anesthetic with high oxygen" exemplify some of their dogmatic pronouncements. Obviously, consultations of this sort are worthless, since the individual is pontificating about a subject about which he lacks detailed knowledge and experience. Not only do such utterances disclose a lack of knowledge of basic principles of anesthesiology, but at times they even reveal a certain high esteem in which some self-centered individuals hold themselves and the varying degrees of contempt these individuals have for fellow human beings.

The selection of anesthesia is not based upon the patient's status or upon some single pharmacologic peculiarity of a particular drug. Other factors such as the nature of the contemplated surgical procedure, the skill of the surgeon, the skill of the anesthetist, the availability of and the necessity for using specialized types of equipment or instruments may temper our judgment in matters pertaining to anesthesia. Obviously the experienced internist recognizes that he is in no position to evaluate such factors and does not broaden his scope into a field in which he is not an expert.

What puzzles us most in the relationships between anesthetists and nonsurgical consultants is that some anesthetists cringe at the pronouncements of some of our brethren who are not experts in the field of anesthesiology and hasten to accede to their wishes. We hear such queries: "But 'medicine' has indicated that we do 'thus and thus' on the chart," "Where do we stand medical-legally if we do not follow the dictums of a medical consult?" The question concerning our position in such situations is easily answered. The internist is not an expert in matters pertaining to anesthesiology. We would be in the same position medical-legally in conforming to a dictum which is obviously incorrect as a surgeon would be who follows a consultant's advice to use hemp instead of cat gut or silk for suturing, or if he followed some similar, ridiculous suggestion. A consultation is merely a request for an opinion that is to be used to help formulate a final thought or to lead to a decision by those directly responsible to a patient. It is not an order from some superior being that is to be followed blindly and without question. The opinions expressed in some of the written consultations of some of our colleagues, particularly certain internists and pediatricians, would constitute malpractice were we to follow them literally.

The anesthesiologist is the recognized authority concerning matters pertaining to anesthesia in the operating room. Time after time

he has been held culpable for his acts in courts of law while the surgeon has been absolved. The law recognizes him to be the authority and we quote directly from Wasmuth's *Anesthesia and the Law:* [*]

"Although the surgeon is the prime contractor his rights are neither prior to or superior to those of the anesthesiologist once the operation has begun. The surgeon has a contract with the patient to perform a certain operation. The anesthesiologist, too, has a contract with the patient for the administration of anesthesia. The law imposes a collateral duty on each not to be negligent or, in other words, to exercise a certain degree of care in the performance of these contractural duties.

"Not infrequently the surgeon requests the anesthesiologist to give anesthesia of a type that in the judgment of the anesthesiologist is contraindicated. In such a situation the anesthesiologist must state his objection. Remembering his collateral duty of care to the patient which the law imposes with his contract he cannot compromise his own judgment nor may it be commanded by the surgeon.

"The anesthesiologist, therefore, cannot discard his own judgment to satisfy the dogmatic and incorrect direction of the surgeon. If the surgeon remains adamant in his request and if the anesthesiologist cannot convince the surgeon of the proper anesthesiologic procedure the anesthesiologist has but one action—to withdraw from the case. A cardinal rule in medical law is that a physician cannot be held liable for malpractice for not accepting a patient."

Obviously the consultant is neither the prime contractor nor are his rights prior to or superior to those of the anesthesiologist or the surgeon. He is not the recognized authority in matters pertaining to the operation and to anesthesiology any more than the anesthesiologist would be an authority in the consultant's specialty. The anesthesiologist, therefore, is obligated to disagree and voice his objection and is obligated to proceed as he deems best to assure safe and proper conduct of anesthesia. The question, then, is not what will happen if we fail to follow a consultant's suggestions, but what will happen if suggestions are followed which are contrary to sound principles of safe practice.

Consultants who usurp the prerogatives of the surgeon or the anesthesiologist are actually not as numerous as we imply. Yet, we find that certain of our colleagues are constantly plagued by disagreements with consultants concerning the selection and conduct of anesthesia. Perhaps the fault lies, not with the consultant, but with us, since the consultant may not know exactly what it is that we are consulting him for. Perhaps we have not succeeded in conveying to him the thought that the information we seek and find most invaluable is his expert opinion concerning the general status of the patient. We concede that the internist is more expert than we are in evaluating a patient and interpreting clinical, physical, and laboratory findings. We are eager to have such expert advice and to utilize this information to the patient's fullest advantage.

The question of mutual respect will not be resolved unless the consultant is made aware of the capabilities, prerogatives, and responsibilities of an anesthesiologist. This we can only do by being the experts we are supposed to be. As long as we act as technicians, think as technicians, and behave as technicians, we will be regarded as technicians. Pronouncements, resolutions, and manifestoes of organized groups of anesthesiologists accomplish little in making our colleagues aware of our capabilities. We can succeed in this endeavor by acting individually in our respective institutions and communities, by displaying our professional competence as physicians, and by asserting our unwillingness to compromise in matters of principle, particularly for economic gain. Those of us confronted with situations which appear to be insoluble may have no one but ourselves to blame for permitting an adverse state of affairs to develop and for failing to correct it, once it has developed. We must examine ourselves introspectively and ascertain that the failing is not within us before we are able to stand on firm ground and refuse to compromise our principles and command the same respect which is accorded to other physicians. Respect is something which must be commanded. We cannot demand it.

JOHN ADRIANI, M.D.

[*] Wasmuth, C.: Anesthesia and the Law. Charles C Thomas, Publisher, Springfield, Illinois, 1961.