

## Reports of Scientific Meetings

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### Society of Academic Anesthesia Chairmen

In November 1969 the Society of Academic Anesthesia Chairmen met in Chicago to discuss, among other things, health manpower relating to anesthesia. The subject was introduced by Dr. John Dillon, who spoke on the responsibility of anesthesiologists in the future; Dr. Perry Volpitto, who raised the question: Who will administer anesthesia in the future?; Dr. John Steinhaus, who summarized legal, ethical and socioeconomic problems that could be foreseen; and, finally, this correspondent, who introduced the question of who should teach nonphysicians Anesthesiology.

The membership then formed four study groups to discuss the issues outlined above and to prepare brief reports of their deliberations.

Dr. Dillon's group addressed itself to the following questions:

Should anesthesiologists assume responsibility for the administration of surgical anesthesia and obstetrical anesthesia throughout the United States? Should they become responsible for inhalation therapy, the intensive care unit, blood banks, expanded pre- and postoperative care, supervision of nurse anesthetists and others, including less expert physicians? What should they do about a community in which no anesthesiologist resides? What amount of research is appropriate in the light of the problems this specialty faces?

The members of the study group did not have time to settle any of these issues, but they recommended that anesthesiologists, as an organized specialty, should assume responsibility for the administration of all anesthetics in the United States. Of course, they would not administer every anesthetic, but they would be responsive to any requests for assistance or consultation, and provide whatever aid anesthesiologists and anesthesiology can toward the solution of the many health manpower problems that beset the specialty and medicine in general. The members also agreed that anesthesiologists should be re-

sponsible in the same sense for the professional supervision and direction of the Recovery Room, and they should do as much as possible in participation in patient care outside of the operating room.

After a lively discussion, Dr. Volpitto's group agreed that shortages in anesthesiology existed in certain areas of the country, especially smaller communities. Maldistribution of anesthesiologists and poor scheduling contribute to the shortage; better scheduling of cases and improved operating room use would alleviate some, but not all, problems.

While everyone agreed that recruitment should be pursued vigorously, most thought it unlikely that we could be successful in recruiting sufficient physicians to cover all our needs in anesthesiology. Some also thought large increases in the numbers of nurses now entering anesthesiology would be neither practical nor wise.

The question of personnel other than nurse anesthetists was discussed. The aides working in anesthesia departments were considered acceptable, but concern about other technical personnel was voiced. New personnel with bachelor's or master's degrees, and the option to move vertically or horizontally in education and career, were acceptable to many. Perhaps some legal problems could be circumvented if such personnel worked only under the direction of responsible anesthesiologists.

The group encouraged pilot programs to explore the value of new assistants to anesthesiologists. Nurse anesthetists should be invited to join teams at individual hospitals so that rapport could grow from local to national levels. This might improve education and clinical training of nurse anesthetists and encourage the nurse anesthetists to become members of teams in which the anesthesiologists have the final responsibility.

The group discussing legal problems reported that the anesthesiologist has moral and ethical responsibilities to all patients who come under his care. These responsibilities include

the diagnosis and evaluation of patients to be anesthetized, the prescription of treatment for such patients, and the direction or administration of the treatment. These primary responsibilities could not be delegated to others, the group concluded, unless nurse anesthetists, anesthesiology assistants, and others who receive training in anesthesiology would assist the physician with the diagnosis and evaluation of the patient and administer the treatment prescribed by the physician (but not prescribe the form of the treatment).

The question who should train the nonphysician practicing anesthesia was discussed by the fourth group, which pointed out that we, as anesthesiologists, should guide the training of nonphysicians in our specialty, since it affects the welfare of the patients throughout the United States. The on-the-job training

found in hospitals today varies from poor to superb. An extensive discussion attempted to delineate the varieties of available training programs, including colleges of allied health professions, junior colleges, and bachelor's degree programs. The question was raised and not settled whether the nurse anesthetist or equivalent personnel should work for a bachelor's degree.

After a general discussion many participants felt that further examination of the complex issue is needed and that more time should be devoted to this important subject, which affects everyone in our specialty.

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### Obstetrics and Pediatrics

**APNEA IN PREMATURES** The respiratory patterns of 22 premature infants were monitored continuously using an impedance plethysmograph which activated an alarm system for apnea. Apnea which lasted longer than 30 seconds occurred in about 25 per cent of the infants studied in the first ten days of life. Bradycardia of less than 100 beats/min occurred within 30 seconds or less of the onset of apnea. The decrease in the heart rate was more rapid during those apneic episodes most difficult to terminate. All apneic episodes began in expiration during periodic breathing. In most instances, cutaneous stimulation resulted in resumption of breathing. However, 8 per cent of the episodes required resuscitation with oxygen by bag and mask. Apneic episodes of 45 seconds or more resulted in mottling, cyanosis, hypotaxia and unresponsiveness to stimulation, suggesting that early intervention is required to prevent significant hypoxia and central depression from apnea. In each of six additional infants, apnea was associated with a high environmental temperature. (*Daily, W. J. R., Klaus, M., and Meyer, H. B. P.: Apnea in Premature Infants: Monitoring, Incidence, Heart Rate Changes, and an Effect of Environmental Temperature, Pediatrics 43: 510 (April) 1969.*) **ABSTRACTER'S COMMENT:** This paper demonstrates that continuous monitoring of respiration in small infants is now clinically feasible.

**DIAZEPAM IN LABOR** A controlled, double-blind study of the effects of diazepam on the course of labor was made in 188 patients. The treated group required less supplementary analgesia than the control group. Uncorrected labor-progression data showed generally longer labors among control patients. Data obtained from pairs of patients matched appropriately for analgesia as well as for other pertinent factors revealed no significant differences in progression of labor, although the first stage was consistently more rapid with diazepam. Labors conducted with diazepam are relatively unimpaired by inhibitory effects of sedation. (*Friedman, E. A., Niswander, K. R., and Sachleben, M. R.: Effect of Diazepam on Labor, Obstet. Gynec. 34: 82 (July) 1969.*)