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Society of Anesthetists. Until his death in 1940, he played a key role in the organization of anesthesiology by forming and holding leadership roles in most of the anesthetic societies in the United States and Canada. One of his last achievements was to arrange the exhibition on anesthesia at the New York World's Fair in 1939.

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Henry Ruth and History: His Rightful Place?

To the Editor:—We read with great interest and excitement Rosenberg and Axelrod's article on Henry Ruth.¹ As a leading practitioner in the defining years of our specialty, Ruth can serve as an example of the finest anesthesiology has to offer. He is richly deserving of our admiration, yet unfortunately he has been forgotten by many. Due to our interest in this time period and the specialized nature of our research, we have some unique additional information that will further clarify some of the issues surrounding Ruth's career.

It is a controversial and complex historical question defining when "modern anesthesia practice can be considered to have originated." For example, James Gwathmey had published 57 articles in the leading journals of his day by 1920. His classic 945-page text, *Anesthesia*, was published in 1914.² Francis Hoeffler McMechan was out of practice by 1915 because of his severe rheumatoid arthritis. However, he already had published 28 papers and had practiced anesthesia

* Dearborn FM: Tom Buchanan. Quarterly of Phi Alpha Gamma 37-41, 1940. In the collected papers of Paul Wood, M.D. Park Ridge, The Wood Library-Museum of Anesthesiology Collection.

† "With you we agreed to make no publication until such time as *Anesthesia and Analgesia* should not be published or some other individual is editor." Letter from Paul Wood to Francis Hoeffler McMechan, February 8, 1937. The collected papers of Paul Wood, M.D. Park Ridge, The Wood Library-Museum of Anesthesiology Collection.

‡ Minutes of meeting for 1937-1939 World's Fair Exhibition Committee: The collected papers of Paul Wood, M.D. Park Ridge, The Wood Library-Museum of Anesthesiology Collection.

§ Letters between Ralph Waters and Henry Ruth, August 10, 1939-September 26, 1939. The collected papers of Ralph Waters, M.D. Madison, University of Wisconsin, Steinbock Library Collection.

|| Minutes of meeting of the Committee on Amalgamation, October 21, 1940. Cleveland, Archive of the International Anesthesia Research Society.

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exclusively for 15 yr.³ Elmer I. McKesson began manufacturing machines to administer inhalation anesthesia in 1910!⁴ Although small in number, physician anesthetists had begun to develop the specialty in the decades before 1920.

Thomas Drysdale Buchanan, the first president of the American Board of Anesthesiology, held many university appointments. Most notably, he was the first physician in America to hold the title of Professor of Anesthesia, granted in 1904 by the New York Homeopathic Medical College. Almost all other teaching positions were in the Columbia University system. Three of his academic appointments were made before 1920,⁵ another indication of the growth of the specialty of anesthesia. At the time of his death, Buchanan was Professor of Clinical Surgery (Anesthesia) at the New York Postgraduate Medical School and Clinical Professor of Anesthesia at the New York Medical College.⁵

In describing the decision to begin publication of a second anesthesia journal, the authors are to be complimented on their forthright discussion of the events leading up to the decision to publish *ANESTHESIOLOGY*. Our research has revealed an additional reason: the decision to begin publishing *ANESTHESIOLOGY* was made after McMechan's death, to accommodate a prior, secret agreement between the American Society of Anesthetists (ASA) and McMechan.†

Ruth was a medical consultant to an exhibit on anesthesia at the 1939 New York World's Fair. He was a member of an ASA-sponsored committee, chaired by Paul Wood, that designed the Anesthesia exhibit at that World's Fair.‡ The display, sponsored by Winthrop Chemical Company, was housed in the Hall of Man. It was one of the first opportunities that organized physician anesthesia had to explain the specialty to the general public.⁶

One of Ruth's most challenging political assignments remains virtually unknown today. After McMechan died, a movement to unite the McMechan-sponsored Associated Anesthetists of the United States and Canada and the ASA into one great anesthesia society was born. Ruth chaired a committee, for the ASA, charged with exploring the possibility of merging. Negotiations began in the fall of 1939,§ and both sides met October 21, 1940.|| Ultimately, the committee failed

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to accomplish the union of the two groups, but Ruth's efforts were not at fault.

Rosenberg and Axelrod are to be complimented on reminding us of the boldness of our pioneer colleagues and that, through their hard work and sheer force of will, they created the infrastructure that anesthesiology now enjoys. We owe an unrepayable debt to Ruth and his colleagues for their efforts on our behalf.

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Anesthesia Studies Should Include Costs

To the Editor:—In their editorial, White and Watcha advised that new drugs “not only require evidence that they are safe and effective, but that they improve outcome and are cost-effective. . . .”¹ This is the third editorial in 2 yr emphasizing the importance of cost-effectiveness and the economic consequences of anesthetic drugs and techniques.^{2,3} Obviously, these directives require collecting and publishing cost and other economic data. Despite this, neither the three articles discussed by White and Watcha nor those in the remainder of the January issue include specific cost information. This omission of costs is especially regrettable for the lead articles because drug company employees were coauthors and favorable results were presented for very expensive drugs.

Wong *et al.*⁴ concluded that ketorolac, when used in an intravenous and then oral sequence, “is a safe and effective analgesic in the ambulatory surgical setting.” They failed to mention that the wholesale cost of ketorolac for the 73 patients in their K30 group is \$1,552, whereas the cost of fentanyl and codeine for the 76 patients in their F50 group is \$74.* When these drug costs are increased by hospitals to cover inventory, personnel, and record-keeping expenses (usually a multiple of 3), the differences can become very large. These additional costs may be more than anesthesiologists and patients want to bear and are certainly worth considering before reaching a conclusion. Similarly, in the study by Scuderi *et al.*⁵ the wholesale cost

* United Hospital Consortium prices. Assumes new fentanyl ampule opened for each dose.

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of ondansetron for the 119 patients receiving 4-mg doses is \$2,058, whereas the cost of alternative antiemetic therapy, such as droperidol or promethazine, is approximately \$40. This cost of \$2,058 for ondansetron assumes use of the 20-ml multidose vial and no waste; if a new vial is opened for each patient, the cost would be \$20,577! McKenzie *et al.*⁶ found “the 4-mg ondansetron dose was 30% more effective than placebo in preventing emesis.” They concluded that, “because of a marginal improvement in the efficacy of ondansetron compared with droperidol, a trial that directly compares these two compounds is needed.” Anesthesiologists making this comparison should know that ondansetron costs nearly 5,000% more than droperidol.

We have no argument with the recommendation or administration of expensive drugs if these costs are recognized and considered. However, the drug costs are missing from these articles, and they are not widely known to either anesthesiologists or patients. Recently, an anesthesiologist in a nearby hospital unknowingly cost his pharmacy more than \$100,000 when he gave every recovery-room patient an injection of ondansetron during a trial period.

Our cost comments also apply to non-drug studies. Also in the January issue, Hickey *et al.* found that intraoperative somatosensory evoked potential monitoring “may be of benefit in all types of surgery. . . .”⁷ The cost of 5 h of this monitoring at our hospital is \$1,974, which is far more than the cost of the anesthetic and certainly worth considering. Similarly, Mamourian *et al.*⁸ recommended magnetic resonance imaging (MRI) as a primary imaging technique to diagnose epidural abscess in patients with back pain after epidural injections.