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Careers in Anesthesiology, Autobiographical and Posthumous Memoirs, Volume X. By Donald Caton, M.D., and Kathryn E. McGoldrick, M.D., F.A.B.A. Park Ridge, IL, The Wood Library-Museum of Anesthesiology, 2007. Pages: 315. Price: \$48.00.

Careers in Anesthesiology X, edited by Donald Caton, M.D. (Professor of Anesthesiology and Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville, FL), and Kathryn E. McGoldrick, M.D., F.A.B.A. (Professor and Chair, Department of Anesthesiology, New York Medical College, Valhalla, NY), catalogs the profound scientific and academic achievements of three giants in the field of anesthesiology. Part of a series on anesthesiology history, Volume X encompasses three chronologically arranged independent works, consisting of autobiographical sketches from Lucien E. Morris, M.D. (Founding Chair and Professor Emeritus, Department of Anesthesia, Medical College of Ohio, Toledo, OH), and Thomas B. Boulton, M.D., F.R.C.A. (Consultant Anesthetist, Nuffield Department of Anesthesia, University of Oxford, Oxford, United Kingdom), and a posthumous biography of Burnell R. Brown, Jr., M.D., Ph.D., F.F.A.R.C.S. (Founding Chair, Department of Anesthesiology, University of Arizona, Tucson, AZ, 1933–1995), written by Adolph H. Giesecke, M.D. (Professor of Anesthesiology and Pain Management, University of Texas Southwestern Medical School, Dallas, TX), and Jeffrey R. Zavaleta, M.D. (Acting Instructor, Anesthesia Department, University of Washington, Seattle, WA). While the combined enormity of the contributions of these physicians seems almost overwhelming, each story demonstrates that a lifetime of honest hard work can be both inspiring to and even attainable by a younger generation of anesthesiologists or students of medical history. By reading and digesting this enjoyable book—filled with humor, humility, insight, and clarity—the reader can indeed see that greatness is grown, not made.

The two autobiographies of Drs. Morris and Boulton read like mirror images, each with widely successful careers in early academic anesthesia practice, albeit from opposite sides of the Atlantic. Both laud the importance of service, teaching, and maintaining the collegiality and friendships that proved to be so critical to the early development of our specialty. Likewise, the education and fascinating accomplishments of Burnell Brown, recounted so ably by Drs. Giesecke and Zavaleta, display the career of a brilliant innovator and leader in our field, whose life was tragically cut short in 1995.

The similarities in the lives of all three gentlemen are remarkable. Their upbringing and education, as well as the sometimes unconventional paths that brought them from common beginnings to uncommonly high achievement, bear witness to each man's devotion to scientific endeavor and to the service of those around them. Interrupting their clinical training after an internship (or "House Officer" appointment in Dr. Boulton's case), all three served honorably as junior physicians in the armies of their respective nations. With varying degrees of experience and training in the emerging specialty of anesthesia, each had the weight of responsibility as an independent practitioner thrust upon him earlier than is the norm today, performing solo anesthetics long before returning to complete clinical training. Dr. Morris was assigned to Europe in World War II, and Dr. Brown served in Germany during the Cold War. Though "not really a proper soldier," Dr. Boulton's humbly self-described military service belies the true importance of his own contributions to the Royal Army Medical Corps during the insurrection of Chinese Communists in Malaya. These military experiences taught each physician not only the importance of clinical self-reliance, but also an appreciation of service and the necessity of sometimes having to subordinate personal goals, which is regrettably less common today.

Upon completing formal academic anesthesiology training, each made important contributions to the science and academic organization of our field. Dr. Morris, an "Aqualumnus" of Ralph M. Waters, M.D.

(Founding Chair, Department of Anesthesiology, University of Wisconsin, Madison, WI, 1883–1979), embodied Dr. Waters' didactic principles, contributing to the development of academic programs at the Universities of Washington, Iowa, and Toronto and the Medical College of Ohio at Toledo, as well as training a diaspora of anesthesiologists from Iran to Nigeria. While at Wisconsin, Dr. Morris also developed the copper kettle vaporizer. Dr. Boulton served at St. Bartholomew's Hospital in London, the Royal Berkshire and Battle Hospitals at Reading, and the Nuffield Department of Anesthetics of the University of Oxford, contributing important work in the development of cardiac anesthesia and cardiopulmonary resuscitation. After training at Parkland Hospital in his native Dallas, completing a Ph.D. in Pharmacology, and working for a year with Leroy D. Vandam, M.D. (Anesthesiologist-in-Chief, Peter Bent Brigham Hospital, Boston, MA, 1914–2004), Dr. Brown served as the founding chair at the University of Arizona for 23 yr. We owe him particular thanks for his work in introducing α -blockers to the anesthetic management of pheochromocytoma, in determining the mechanism of halothane hepatotoxicity, and in gaining Food and Drug Administration approval of sevoflurane in 1995.

Mindful of the value of collaboration to the growth and recognition of anesthesiology, each physician also pursued yearlong sabbatical assignments across the Atlantic Ocean: Dr. Morris at London Hospital and the Royal College of Surgeons, London, United Kingdom; Dr. Boulton at the University of Michigan at Ann Arbor, MI; and Dr. Brown at King's College, London, United Kingdom. Throughout each work, the recurring theme of the importance of close relationships and participation in organized anesthesiology societies is emphasized.

Each physician was notably engaged in worldwide teaching and humanitarian service, contributing to the improvement of anesthetic care in many developing nations. In recognition of their accomplishments, each received recognition by the most prestigious societies of the others' country: Both Drs. Morris and Brown were elected to the Fellowship of the Faculty of Anesthetists of the Royal College of Surgeons, and Dr. Boulton was honored as the Laureate of the History of Anesthesia by the Wood Library-Museum of Anesthesiology. Yet despite their accomplishments, each was quick to credit their own teachers, colleagues, residents, and most importantly, their families, as critical underpinnings of their success.

Personally, I found this work's breadth and openness both humbling and inspirational. As a prior U.S. Marine Corps flight surgeon and a military anesthesiology resident, now on the cusp of graduating and entering the field as a new practitioner, I was proud to read of the accomplishments of these three pioneers. The fulfillment Drs. Morris and Boulton each gleaned from treating the casualties of their respective wars is not dissimilar to the lessons current military physicians are learning from the care of soldiers and Marines wounded in Iraq or Afghanistan. I can only hope that our generation will be as productive, creative, and energetic as these three legends in advancing our specialty. I commend this work to any student of anesthesia, young or not so young, for it is only by knowing our forefathers' accomplishments in the midst of adversity that we build a solid future for our calling.

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Perioperative Medicine: Managing for Outcome. By Mark F. Newman, M.D., Lee A. Fleisher, M.D., and Mitchell P. Fink, M.D. Philadelphia, Saunders, 2008. Pages: 464. Price: \$179.00.

As a recent graduate of an anesthesiology residency and someone preparing to take the oral board examination, I asked one of my

colleagues, "What is fair game on the oral board examination?" The answer was, "Everything!"

While at first I considered this unfair, upon further reflection I had to agree. For I have often been asked by my family and friends who are not in the medical community exactly what is an anesthesiologist and what do you do? I think a simple but valid answer is that we are primarily perioperative physicians. So while the orthopedic surgeon is busy fixing a femur fracture, who is worried about the heart, the kidneys, the brain, and the liver? We are! Our responsibilities seem overwhelming, and in many regards they are, but as one of my former attending physicians once stated so well, "It is our job to worry." Fortunately, much of the worry dissipates as you read this very comprehensive text.

As I read this text, I found one of its best features was its sequential organization. The first four chapters discuss some of the biochemical basis of complications associated with the stress of surgery and anesthesia. From there, the book essentially will allow you to follow the patient from the preoperative screening unit to the postanesthesia care unit or intensive care unit. Chapters 5–11 discuss risk assessment for the major organ systems including cardiac, central nervous system, renal, pulmonary, and hematologic. Scientific evidence from the currently available literature is presented so that decisions can be made about which patients may benefit from further work-up and intervention and which ones will not. At this point in the timeline of patient care, you now have the information to optimize your patients before they come for surgery.

No matter how well your patients are prepared, some are still going to come to surgery with significant heart, lung, renal, or central nervous system dysfunction. Their medical conditions may be optimized, but they still have a high risk for intraoperative complications. So now the question logically arises, "What can I do intraoperatively to improve patient outcomes?" This is the heart of this text.

Chapters 12–30 deal with intraoperative management and decision-making, with the goal of improving outcomes for patients. Perioperative management to prevent dysfunction or prevent worsening of preexisting conditions is clearly detailed. But if a complication does

occur, and inevitably one will, what can the anesthesiologist do? Treatment regimens are reviewed and, importantly, the level of evidence supporting these treatments is provided. These chapters are organized system by system. This allows the reader the option of reading this text cover to cover or to focus their reading on individual organ systems. This flexibility is a great asset of this text.

Eventually, the surgery will finish and the patient is off to the postanesthesia care unit or intensive care unit. What complications may occur and how do we treat them effectively? Chapters 31–37 deal with many of these problems and some of the major postoperative problems associated with specific surgeries. For completeness, there are also chapters dealing with sepsis, adult respiratory distress syndrome, endocrine/electrolyte disorders, and pain, delirium, and anxiety.

This logical progression from preoperative screening to operating room management to postanesthesia care unit or intensive care unit is one of the major strengths of this text. The text pushes anesthesiologists to consider the level of scientific evidence behind our decision-making. Too often, anesthesiology has been guided by treatments that make intuitive sense but that have been lacking in scientific scrutiny. This text has tables pertaining to each organ system that assess which treatments are beneficial, which may be beneficial, and which may be doing more harm than good. Importantly, it provides the level of evidence to support these conclusions.

In summary, this text takes you from risk assessment to perioperative decision-making to the postanesthesia care unit or intensive care unit, and provides you with the scientific support necessary to make decisions based upon good clinical evidence. This is the essence of what we are obligated to do for our patients. This textbook will undoubtedly challenge some of your beliefs and practices, but will undeniably give you the information to be a better perioperative physician.

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