

1/10/48

ANESTHESIA REPORT FOR THE
SURGICAL EXECUTIVE COMMITTEE

STAFF

The Anesthesia Service is administered jointly by a staff of graduate physicians and nurse anesthetists, under the direction of Dr. Apgar and Miss Penland. The total number of anesthetists employed for the past five years has been fourteen, which has been adequate for the average operating schedule. During vacations, and at times of maximum demands, this number has not been enough. Also, during the last six years, the total number of anesthetics administered has increased by two thousand. This does not include the newly acquired Neurological Service. Below is a table showing in more detail this increase in cases.

	<u>1933</u>	<u>1934</u>	<u>1935</u>	<u>1936</u>	<u>1937</u>	<u>1938</u>	<u>1939</u>
Presbyterian Hospital	4459	4377	4451	4654	4749	4415	4866
Sloane Hospital	1117	1136	1253	1215	1299	1344	1290
Babies Hospital	448	1434	1653	1543	1600	1687	1633
Eye Institute	436	559	553	670	739	860	765
Vanderbilt Clinic	1085	1066	1139	1093	1263	1053	1042
Wards	242	194	267	299	273	279	313
Cystoscopies	62	76	61	49	22	34	35
	<u>7849</u>	<u>8842</u>	<u>9380</u>	<u>9523</u>	<u>9945</u>	<u>9672</u>	<u>9944</u>

Other factors also contribute to the need for some increase in staff.

1. We believe that for the patient's welfare, and for the training of anesthetists, that it is not only desirable but necessary to make a preoperative and postoperative study of the patient. This takes a certain amount of time, and limits the actual number of anesthetics one person can administer.

2. The Obstetrical Service has frequently suggested that we assist in teaching its residents, or take over entirely its anesthesia problems. This would be desirable from both our points of view, but we have been unable to do anything because of insufficient staff.

3. With the teaching program for residents and medical students quite well under way, we are awaiting the opportunity to start the research program. It has been impossible because of a shortage of both staff and time.

4. Since July, 1938 we have supplied one full-time anesthetist for Welfare Hospital, assigned to the Columbia University Surgical Division. This position offers an opportunity for the resident to work on his own responsibility before going into practice, and to work with a group of poor risk patients which present so many anesthesia problems.

5. The presence of medical anesthetists on the staff has occasioned requests for service other than for surgical anesthesia. Among these procedures are treatment for intractable pain, diagnostic and therapeutic nerve blocks, difficult sedative problems and resuscitation, all important parts of an anesthetist's training. These again take time from surgical anesthesia.

The proportion of resident physicians to nurse anesthetists, we believe should be a labile one. At present we have vacancies, salaries and teaching material for two more graduate physicians, but we cannot fill the vacancies because of housing conditions. Thorough investigation reveals no hope for more than four rooms now occupied by anesthesia residents. In view of the great demand for specialists in anesthesia, and the excellent clinical material available at the Medical Center for teaching, it is unfortunate that training in anesthesia is limited by housing conditions.

BUDGET

We welcome the news that the Anesthesia Department is to be presented with a budget. Such a step will enable us to determine accurately the cost per patient for an anesthesia, and to suggest

measures for economy, as well as to simplify the maintenance of the department. However, it should be a truly unified budget. It should include all the types of anesthetic agents used by the staff, i.e., inhalation, intravenous, rectal, local and regional drugs, in any part of the Medical Center, i.e., Presbyterian Hospital, Sloane, Babies, Vanderbilt Clinic, I.O.P.H., and Neurological Institute. Psychiatric Institute and the Dental School are excepted. The same applies for anesthesia equipment, which includes machines and their maintenance, stationery and store room supplies. The analeptic drugs, such as coramine and ephedrine, belong more properly on the anesthesia budget than on the operative budget.

CHARGES

This problem will be considered in detail by the Charges Committee, but we wish to record here a few impressions.

1. We believe the prevailing ward, semi-private and private charges for use of operating room to be just. It is desirable to determine how much of the fee can be credited to the Anesthesia Department budget. We suggest that about 40% of the fee would cover anesthesia expenditures.

2. We feel that a charge should be made to two other groups of patients.

(a) Ward patients anesthetized in the treatment room. In Harkness, the charge for the use of the treatment room would cover this. The sum of one dollar would probably cover the cost of gases.

(b) Harkness patients anesthetized in their own rooms. This should be about the same as the treatment room fee.

3. The Vanderbilt Clinic rate seems correct.

4. The advent of physician anesthesiologists permanently employed by the hospital raises a new question, a charge for professional services. Anesthesia in most hospitals is considered a consulting service on a par with Radiology or Pathology. When anesthesia service is requested, whether actual administration or consultation, a professional fee is submitted. It is a detriment to the development of the

specialty here that such a fee cannot be charged. Many times these past two years, private patients have asked regarding their anesthesia fee (when anesthetized by physicians), and have been surprised to find that there would be no charge. Such an answer leaves one wondering whether we value the professional service.

It has always been a privilege of the surgeons to bring in an outside anesthetist if he so desires. In this case, the anesthetist always submits a fee.

It is suggested that any physician employed by the hospital, who is qualified by the American Board of Anesthesiology, be allowed to charge a professional fee. This is naturally on a sliding scale, and practically amounts to 10% of the surgeon's fee. Whether the money collected would be applied to the anesthetist's salary, an Anesthesia Research Fund, or to the budget can be decided later.

USE OF EXPLOSIVE AGENTS

The Anesthesia Service feels that the medical and physiological advantages of the explosive anesthetic agents (especially cyclopropane and ether) far outweigh the possible explosive hazard. We are acutely aware of the problem and are making every effort to acquaint the surgical and anesthesia staffs with the hazard and to teach ways to minimize it.

EQUIPMENT

Until 1935, the equipment for inhalation anesthesia was quite adequate. Since then, fundamental improvements have been made in gas machines. The improvements lead to a more accurate, safer and more economical administration of the agents. Since May, 1936 when cyclopropane was introduced, the demand for this gas/^{has} been far ahead of our apparatus to administer it. Of the sixteen gas machines in daily use, only seven can be used for cyclopropane. Five obsolete models need urgently to be replaced.

The equipment for regional, intravenous and rectal anesthesia is sufficient.

Submitted by: Virginia Apgar

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Anne Penland