

# The Anesthesiologist-Anesthetist Team\*

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How ironic it is that we should be presenting the team concept of anesthesia practice at a conference whose format is "What Is New in Anesthesiology." Ironic because the team concept is not new in medicine in 1972. It has evolved in many areas with outstanding success in all. For example: coronary care units could not function so efficiently and excellently without teamwork; patients requiring acute and chronic respiratory care would probably be doomed without a team of physicians, nurses, and technicians; and stroke victims requiring the expertise of the physician during the acute phase of their illness, could not realize their full potential once again without a team of nurses, speech therapists, physical therapists, and other Allied Health Professionals. So also in anesthesiology, the concept of a team of anesthetists and anesthesiologists must evolve to enable us to adequately meet the needs of our consumer—the patient.

Let us for a moment digress and think about the patient, after all he is the reason why we do what we do. Have you noticed how sophisticated he has become lately? Insurance companies certainly have. No longer are we afforded the luxury of mysticism in medical practice. Medical knowledge, little as it may be, is possessed by a significantly greater segment of the population than ever before. The patient now demands his money's worth from the high cost of medical care. Magazines and newspapers, such as the Wall Street Journal, with their tremendous circulations make sensational headlines about the occasionally disastrous, albeit rare, effects of drugs or therapy. When reading such information, the patient more often than not becomes actually

more misinformed than informed. Nevertheless, he takes this information (or misinformation) to the hospital with him practically demanding that we guarantee him safe passage through his illness.

Anesthesiology has by no means been able to escape the well-informed patient. In fact, it seems to me that as a specialty we have been practically singled out by the intellectual patient and his attorney. With the increasing onslaught of medical pseudo-education available to the consumer and our lack of ability or desire to set the record straight for him, our clinical judgment in many instances is in jeopardy of being compromised by our legal judgment. Because of the more sophisticated consumer and the trend towards team medicine in general, it is absolutely essential that where physicians and nurses work together to deliver this health care service they do so as a team.

Unfortunately, the team concept is not commonplace in anesthesia today. This situation prevails because relations between the anesthesiologist and the anesthetist have not been good over the years. Anesthesiologists have claimed that they should be the only professionals to deliver this type of health care; nurse anesthetists have made similar claims. Anesthesiologists have not enjoyed the prestige that their colleagues in surgery or other specialties have received. After all, what self-respecting doctor would want to devote his professional life to the same task that could be performed just as well by a nurse? On the other hand, nurses have not enjoyed the greatest acceptance into the specialty by their colleagues who, to this day, do not consider schools of anesthesia as offering post-graduate nursing education. Animosity and bad relations have through the years been the rule rather than the exception between CRNA's and M.D.'s. In many local areas today, nurse anesthetists feel threatened

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by the presence of anesthesiologists and vice versa. We cannot deny that in some areas there is good reason for these feelings to exist. Unethical practices on the part of both groups have not served any beneficial purposes except those of the practitioners.

In 1970, the American Society of Anesthesiologists invited several nurse anesthetist educators to participate in a symposium conducted at the annual meeting. I was honored to have been the first speaker on that program, and at that time I saw great hope for the future interrelations of our respective groups. My view has not changed in 1972. Recent steps taken by both the American Association of Nurse Anesthetists and the American Society of Anesthesiologists to assure better relations between the two have convinced me that a team of well-trained nurse anesthetists and anesthesiologists is the single best answer to the challenges the future will bring.

The trend toward development of programs to train nonprofessional anesthesia technicians to supply manpower in this health care area is in my opinion an unnecessary endeavor and a mistake. There is no shortage of applicants to our program for nurse anesthetists, and I am sure this situation exists in most other schools as well. There is, however, a limit to available space in all schools, and this will probably continue as long as the teacher shortage exists and until more facilities are constructed. The establishment of technical programs to educate assistants whose functions are limited, backgrounds diverse, motivation uncertain, and whose place is still ill-defined is beyond my comprehension.

Anesthesiology is the one speciality which has had for years physicians' ideal assistants but has failed to utilize them. Nurse anesthetist programs have evolved to high degrees of excellence through the efforts of many talented individuals, and the full potential of these programs is still to be realized. The awarding of an academic degree in conjunction with professional certification is now a reality. This trend must and will continue. University officials are now beginning to recognize their obligation to educate as well as train nurse anesthetists so that they may not only be prepared for clinical practice, but also be qualified by degree to teach others in the field. In short, the nurse anesthetist and anesthesiologist learning together and practicing together are the future of anesthesia health care delivery in this country.

How is such a team to be suddenly implemented after years of indifference? The answer is both complex and simple. It requires maturity and a realization of limitations, capabilities, and potential of all members of the group.

Just as a football team requires a quarterback to call signals and make plays, so the anesthesia team requires a leader. The quarterback of the anesthesia team is acknowledged to be the physician; however, without lineman for defense and pass receivers to carry the ball, the quarterback would not get very far before being inundated by the opposing line. In our anesthesia team, the nurse anesthetist backfield often carries the ball. Nevertheless, we must never forget that in all successful football teams the quarterback has been not only a playmaker, but also a scrambler who is capable and willing to take the ball downfield himself.

**The Anesthesiologist.** An important part of residency training, it would seem to me, should be spent in learning how to supervise. This is the most neglected phase of resident teaching, but its importance must not be underestimated. All too often the anesthesiologist finds himself in a situation where he is responsible for two or three operating rooms at one time. If he has experienced this during his residency, he will be much better prepared to act as the consultant and overseer of the anesthetists who are actually administering the anesthetics. I submit that it is much more difficult to supervise two or three anesthetic administrations than to be responsible for the actual administration of only one.

If the anesthesiologist is to be an effective supervisor, he must be an accomplished clinician. Currently, most residencies offer an abundance of clinical experience, thereby meeting this requirement. The anesthesiologist must know the problems of the individual patients whose anesthetics he is supervising. This knowledge can be gained during the preoperative visits. He must be able to identify which of these patients is most likely to require the closest attention. Finally, he must know the limitations and capabilities of the individual anesthetist assigned to administer the anesthetics. This all-important knowledge will enable him to provide all of the patients with the best possible care available.

Teaching the resident to supervise would be best accomplished in the latter part of the final year of a two- or three-year residency. At this time, the clinical experience should be adequate and the knowledge of individual capabilities should be known.

It would probably be best to assign the resident supervisor to cases which would be performed by experienced staff members rather than other students or residents in the department. Experienced staff members are generally more mature, and rapport with them can be established more easily than with students who may not readily accept supervision by someone other than the clinical instructors and attending physicians with whom they are accustomed to working. Also, the beginning supervisor should not have the added burden of working with inexperienced persons while he himself is learning. In my opinion, teaching proper clinical supervision to residents is a necessary part of anesthesia education and a must if the team concept of anesthesia care is to be successful.

**The Nurse Anesthetist.** With the organization of colleges of Allied Health Professions, nurse anesthetist programs have finally found a place where they can grow and develop independently, yet in conjunction with the university. A program based in Allied Health can offer students the benefits of university level basic science courses for which academic credit can be awarded. No longer must the nurse anesthetist program be chained to the hospital where the temptation is to utilize its students to provide service in return for education. The potential for obtaining federal funding for such programs is yet to be put to the full test; however, a program structured within the university will be in an extremely good position to obtain such funding when it is available.

I am, of course, vitally interested in sound education for nurse anesthetists. I am devoting my professional life to seeing its development progress. At the Medical College of Virginia, we are committed to elevating standards for nurse anesthetist education. With the cooperation of the University officials, we are seeking to develop a meaningful curriculum around which we will train and educate the nurse anesthetist of the future at the baccalaureate level. My colleagues in similar positions are no less dedicated. We foresee the day when all Schools for Nurse Anesthetists will have faculties trained at the university-based schools, with the credentials to provide sound educational experi-

ences for their students. We foresee the day when all nurse anesthetists will be assured of equivalent education. We encourage the cooperation and guidance of the American College of Anesthesiologists to play a greater role in the development of these programs.

It has been said that an anesthesiology residency cannot be successfully conducted within a hospital where nurse anesthetists are also being trained. I believe we have shown that it can be done. If anything, dual programs can serve to reinforce and complement each other, and it is the most practical way to develop the attitude of team practice at an early stage. Nurse anesthetists and residents trained together quickly see the advantages of each other. This serves to develop a healthy attitude among the trainees working together.

Currently, our nurse anesthetist program requires a two-semester intensive basic science course during which clinical experience is limited to developing basic techniques. Following this, the students' education is oriented to the clinical situation where they spend a period of one year administering approximately 750 anesthetics. The clinical instruction also includes affiliation with community and military hospitals so experience may be gained with all types of anesthesia techniques in various environmental situations. We would like to think that this program will serve as a model for emerging university-based programs. At the same time, however, we stand ready to learn from others if such learning will improve our standards.

In summary, I call upon anesthesia educators to abandon technician-training programs and instead help us develop nurse anesthetist programs to a higher level nationally. Let us remove our finger from the panic button and begin working together as a team, acknowledging our shortcomings and limitations. The time for us to establish the strongest possible ties both in our educational systems and our service-oriented institutions is right now. Mutual respect and cooperation are the keys to a smooth, efficient operation of an anesthesiologist-anesthetist team. And finally, let us be certain that the next meeting with the format of "What Is New in Anesthesiology" does not require a lecture on the anesthesia team.