Nurse anesthetist-anesthesiologist relationships: past, present, and implications for the future

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This article traces the historical roots of the nurse anesthetist-anesthesiologist relationship, puts into perspective the current status of the relationship, and cites the implications that the nurse anesthetist-anesthesiologist relationship has for the future delivery of anesthesia services in the United States.

It has been said that unless one has lived the black experience, one cannot fully understand or appreciate the inner rage or frustrations accompanying it. That feeling is analogous to the socio-cultural aspects of nurse anesthetists-anesthesiologists relationships; indeed, it is reflective to a large extent in the relationships between medicine and nursing. While much can be written about it, few can really relate to the history and accompanying socio-cultural developments of that relationship if they have not been a part of or are unable to transfer experiences of a similar nature to this situation. And, while integration can be forced through governmental decree or pressure, the full benefits from cooperation can result only when mutual respect and recognition of the full contributions and potentialities of each group replace the attitudes of forced toleration and the indomitable will of the physician to control.

This article traces the historical roots of the nurse anesthetist-anesthesiologist relationship, the current status of the relationship, and cites the implications it has for the future regarding the delivery of anesthesia services to this nation. I have made an honest attempt to present the facts in an unbiased manner, while recognizing that any such attempt by one intimately involved in this relationship is subject to influences, conscious or unconscious, which are subject to suspicion.

Early history

The historical roots of this relationship between nurse anesthetists and anesthesiologists are buried in the socio-cultural aspects of Western civilization characterized by male dominance, female subservience, and the resulting hierarchical layering of occupations and professions, both externally and internally. Even in ancient cultures and those so-called less-advanced cultures in today's underdeveloped nations, the medicine man holds a position of dominance in the tribe, and in matters of health, he is the controlling personality. This is most interesting, since in the early history of health care, it is evident that nursing, rather than medicine, had

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more to offer people in the way of keeping them well or nursing them back to health.

Even the physician role at the turn of the twentieth century was one of a little doctoring and a lot of nursing. In the early 1900's, there was one health care worker (most often the nurse) to support one physician. Since then, the revolution of science and technology and the resultant specialization brought about a situation where there were 13 supportive persons for each physician in 1969, with a projection that there would be 20 for each physician by 1975.¹

This situation caused a change in the operative models for the delivery of health care from one where the physician held pyramidal dominance and responsibility for all aspects of health care to a horizontal or side-by-side model where the responsibility for health care is shared between the professionals of the health care team. There is no question that there are overlapping functions and shared responsibilities between professionals. Relative to medicine and nursing, even the American Medical Association has stated, “there is a marked overlap in the technical areas common to medicine and nursing practice: the act when performed by a physician constitutes the practice of medicine; the same act when performed by the nurse, constitutes the practice of nursing.”²

For various and sundry reasons, legislation has not kept up with the trends and changing times, and the changing roles of health care professionals have taken their toll. There is increasing insecurity among many physicians as they see their role and influence in health care being challenged. There is also an increasing impatience on the part of those other health professionals, who for so long were maintained at the bottom of the ladder, to make contributions which exist within their potential to the health of the nation.

Thus, in economic theory, we have had a situation within health care in the United States which was virtually in the grip of a monopoly by medicine —since access to the health care system was available only through the physician. And, with the changing times, the increases in population, and increased social consciousness, medicine has become the bottleneck which strangled the health delivery system. Not even medicine was afforded the opportunity to live up to the fullness of its potential to all people, regardless of the escalating amounts of money poured into the system to try to make it workable.

Today, we know the system is unworkable for all people, despite our protestations that the United States affords the highest quality of health care in the world. No doubt this is true for some people within the United States, and even perhaps for the majority of the people; but, we cannot be satisfied until the right to that quantity and quality of health care necessary to afford all our people the opportunity for optimum health is assured and operative. A National Health Plan in the immediate or near future is evidence of the recognition of the unworkability of the current system. But, even that is doomed to failure if there is no realistic restructuring of the delivery system itself.

Now, what does all of this have to do with anesthesiologist-nurse anesthetist relationships? As specialists within medicine and nursing, they are a part and parcel of the socio-cultural environment from which they have been spawned. Their behavior as individual groups has been patterned to a large degree by these influences. But, they also have been imprinted with their own peculiar subculture which has made them possibly even more defensive and more aggressive than their average professional counterpart.

History of anesthesia

The history of anesthesia in the United States demonstrates that the first group from which members were con-
sistently trained as anesthetists was nurses. This is not remarkable in the light of the evolution of surgery and the requirements for anesthesia. For the most part, anesthesia could not be said to be diagnostic or therapeutic, although it facilitated diagnosis and therapy. Thus, in actuality, it did not fit into the cure model of medicine. It was viewed as an ancillary service.

Anesthesia did render a patient insensitive to pain, while at the same time, it increased the requirement for someone to care for him, since the patient was rendered incapable of caring for himself. And, the nurse was the care expert appropriate to the care model of nursing. Thus, surgeons learned the new technique only in order to teach it to others, predominantly nurses.

World War I found nurses being prepared by both the U. S. Army and the U. S. Navy to provide anesthesia services within their respective medical facilities. All three services, the Army, Navy, and Air Force are still largely dependent upon nurse anesthetists for the provision of anesthesia services in peace and war.

AANA formed

The 1930's was a crucial period in the history of the formalization of the fields of nurse anesthesia and medical anesthesiology.* In 1931, nurse anesthetists got together and formed the National Association of Nurse Anesthetists (the forerunner of the American Association of Nurse Anesthetists) for the primary purpose of upgrading the education and practice of nurse anesthetists. The organization of the group was originally intended to be a part of the American Nurses' Association (ANA); but when the group petitioned for recognition as a subgroup within that structure, the ANA denied the request based on differences pertaining to the avenues of membership existed at that time. The young group of nurse anesthetists, interpreting this as a rebuff from organized nursing, left the mainstream to make its own way in the health care field.

Dr. Knowles seems to feel that the conflicts between organized nursing and organized nurse anesthesia existed because the nurse anesthetist enjoyed generally higher salaries and better working conditions than her floor nurse counterpart. While this may have been a factor, it is more conceivable that nurse anesthesia represented a break with tradition within nursing (being the forerunner of today's nurses functioning in expanded roles), and nursing was not ready to accept this change at that time.

The nurse anesthetist became responsible and accountable to the patient, the physician, and the hospital administrator under the hospital organization, rather than to the director of nursing. In those authoritarian traditional days, this was heresy. Thus, the course of history based on the alignment of allegiances among nurse anesthetists, surgeons, and hospital administrators was set in motion. And, nurse anesthetists and the mainstream of nursing stopped communicating. The education of nurse anesthetists, while built on the nursing base and situated in the hospital where the nurse also was educated, became the responsibility of nurse anesthetists and surgeons under the sponsorship of the hospital.

ASA formed

In 1937, the American Society of Anesthesiologists was formed. At that time, there were ten anesthesiology residency programs in the United States, eight of which provided one year or less training. World War II brought about

*It should be noted that even the terminology used to designate the two fields in the United States is indicative of the schism within the field, since anesthesiology and anesthesiologist are terms established for use by physicians, and encroachment on either of those terms has been considered an invasion of the territorial prerogatives of the physician by many anesthesiologists.
the impetus for more physicians to enter the field, and the proliferation of residencies began. Many of these early residencies were opened in university settings about the time that baccalaureate education for nurses gained momentum. One nursing educator stated, “We were thoroughly indoctrinated that anesthesiology was a medical specialty and one into which nurses should not be admitted.” And, since nurse anesthesia and the mainstream of nursing were not communicating, nurse anesthesia got left out of the system of nursing education which moved into university settings where specialization became a function of graduate education.

The row the anesthesiologists were plowing in the field of medicine had its own difficulties, since many surgeons considered anesthesia an ancillary service and felt that the surgeon was responsible for the medical management of the surgical patient under all circumstances, including during anesthesia. John Adriani, a pioneer anesthesiologist, writing of the history of anesthesiology stated, “Hospital administrators employing nurse anesthetists, fearful of a loss of income to the hospital from a profit-making anesthesia department, opposed physician anesthesia. Disinterest and opposition were also encountered from surgeons who felt that nurses were as competent as or even more skillful than physicians in the art or who were fearful of displaying their lack of skill to other medical colleagues.”

Thus, the stage was set for anesthesiologists to blame nurse anesthetists for their lack of prestige and their failure to acquire immediate acceptance within the medical community. This attitude was a basis for the American Society of Anesthesiologists (ASA) to establish a policy which officially discouraged members of that society from participating in the education of nurse anesthetists or supervising their practice. This policy existed up until 1967 when “they [ASA] adopted a more liberal and realistic policy.”

Post-World War II developments

World War II brought about a delay of plans by the American Association of Nurse Anesthetists for a certification program for nurse anesthetists and an accreditation program for schools or programs of nurse anesthesia. In 1945, the first qualifying examination for certification was conducted; and in 1952, the accreditation mechanism for programs of nurse anesthesia was put into effect. Commissioner Brownell of the U. S. Department of Health, Education and Welfare officially designated the AANA as the accrediting agency for programs/schools of nurse anesthesia in 1955.

Despite the official policy of the American Society of Anesthesiologists, some outstanding anesthesiologists began to participate in the educational programs of nurse anesthesia, recognizing that the anesthesia needs of the country could not be met by an all physician cadre. Anesthesiologists and nurse anesthetists found that cooperation on a 1:1 level often led to rewarding relationships, both for each other and particularly for the patients. However, many of these same anesthesiologists found themselves being pressured by their colleagues for what was considered a betrayal of the aims of anesthesiology.

In 1962, Robert D. Dripps, a pioneer anesthesiologist at the University of Pennsylvania, wrote:

“There are not now enough physician-specialists to administer all the anesthetics in this country. It is unlikely that there ever will be. Who then will be available, how will they be trained, how supervised and controlled? The term 'nurse anesthetist' and 'nurse technician' arose strong emotional reaction in some quarters. Perhaps it is well to recognize this and to try to solve the problem of additional personnel in another way. I propose that the ASA urge other anesthesia organizations in this country to come under its supervision as auxiliaries. This is not a surrender of principle, it is recognition of an obli-
Cooperation requires maturity which we now have. As John Stuart Mill said 125 years ago, 'There is not a more accurate test of the progress of civilization than the progress of the power of cooperation.'

Dr. Dripps was a great man and made many contributions to the field of medicine and anesthesiology, but this statement is perhaps one of the most apt descriptions in literature of what physicians seem to believe is the meaning of cooperation. And, neither nursing nor nurse anesthesia has been able to accept that as a valid definition. Dripps continued his article by ignoring further references to the nurse anesthetist and proposed that technicians be trained in a two-year college program leading not to a baccalaureate but to an Associate of Arts degree.6

In 1972, Dr. John E. Steinhaus, Chairman, Department of Anesthesiology, Emory University School of Medicine, wrote: "Anesthesiology, as a medical specialty, became acutely aware of a manpower shortage, when A. M. Betcher, President-Elect of the ASA (1962) focused attention on the diminishing number of interns entering residency training in anesthesiology and initiated the Anesthesia Survey to assess the status and problems facing anesthesiology. Findings of this study included deficiencies and marked variation in the anesthesiology educational programs in medical schools, which ranged from non-existent to fairly adequate. Many residency programs were largely devoted to service, and anesthesia care ranged from excellent to superficial and perfunctory. There was confusion as to the role of the nurse anesthetists; obstetrical anesthesia and respiratory and emergency care were generally provided in an inadequate manner.

"The recognition of these problems led the National Institute of General Medical Science of the NIH to hold a conference on the 'Crisis in Anesthesia Manpower' in September, 1965. There was general agreement at this conference that physician manpower should be increased and that programs in anesthesia research should be expanded. Although it was recognized that nurse anesthetists contribute a large portion of anesthesia service, there was no agreement as to the role this group should play in the future. The definition of the relationship between the physician and the nurse in general medicine has been difficult, that between the anesthesiologist and the nurse anesthetist is even more so. A suggestion that the nurse should fill the new demands as a physician assistant led to prompt disclaimer by officials of the ANA and the assertion of the independent status of the nursing profession.7

This meeting of which Steinhaus speaks also typifies medicine's habits—calling and holding unilateral meetings to discuss problems and plan for the future without requesting or even feeling a need for representation by those whose practice is involved and on whom the future plans will impact. Neither nursing nor nurse anesthesia was represented at this meeting. Can one wonder why the ANA responded as it did?

In 1967, Clinical Anesthesia devoted a major portion of its second volume to the discussion of anesthesia manpower. This discussion used a "no holds barred" approach of brainstorming the situation. There were both advocates of nurse anesthetists and those who believed this advocacy was a betrayal of the soul of anesthesiology among the physicians writing for that volume. Dr.

*A 1965 survey by the AANA showed that nurse anesthetists administered 46% of the anesthetics in the nation as opposed to 39% by anesthesiologists, with the other 15% being provided by physicians, nurses, or other persons untrained in anesthesia.
H. H. Bendixen, in discussing the manpower shortage, wrote:

"In the early sixties, storm signals were hoisted and warnings issued of the manpower crisis in anesthesia. We must point out that the storm signals were hoisted, not by a deprived public, but by the teaching departments which were unable to fill a rapidly expanding number of residency programs. I believe the warnings were a far-sighted and valuable public service, but the real issue has only begun to emerge and quite a few of the early reactions to the 'crisis' had undesirable features. As the growth rate slowed down, a number of measures, individual and concerted, were taken to increase recruitment for anesthesia. Two facts stand out: one is that recruitment became indiscriminate to the point of padding residency programs with poorly trained physicians who were incapable of rising much beyond a technician's level of function. The other is that the cherished goal, of eventually covering all anesthetics with trained physician anesthetists, was not subjected to a critical enough reexamination.

"As a consequence, with an increasing clinical load, the great majority of physician anesthetists found themselves confined to the head of the operating table, often performing at a too technical level, and without the freedom to travel across medicine and its sciences in the company of other physicians. A vicious cycle was created—with self imposed technician status of a physician acting as a deterrent against recruitment."78

Dr. Bendixen continues, "The total national anesthetic case load cannot possibly at present or within the foreseeable future, be administered by trained physician anesthetists. We could not at present take the responsibility for the total anesthetic case load, working with nurse anesthetists, because trained nurses are not available in sufficient numbers (13,000 currently available).... "

"We need to increase the number of U.S. graduates in our residencies.... "

"We should reduce sharply the recruitment of foreign physicians into technician service. This trend has been a mistake and a waste of valuable training. At present 50.14% of anesthesia residents are foreign graduates.

"I do not have the facilities or the time to predict our manpower needs for the next decade or two, but I offer the general observation that the shortage of nurses and technicians is far more serious than the physician shortage. We need to train more nurses and to assume responsibility for their work. Above all—we need to obtain the statistics necessary for realistic planning."

Taking the opposite side of the debate, Dr. J. G. Converse stated:

"The so-called 'manpower shortage' in anesthesia is an ill-defined entity, not nearly as critical as portrayed, and, even if it were, the concept of 'physician's assistant' is a poor solution just as the 'marriage' of physician and nurse anesthetist is a poor match, and the assumption of responsibility by the physician anesthetist for all anesthetics in a given community is sheer folly. I would not be concerned with the reckless talk about medical manpower shortages in anesthesiology, except that instead of just philosophizing on the subject, as has been the custom in the past, the threat of the 'critical shortage' is being utilized as rationalization to legalize and render morally right the 'stable of technicians' approach that has been frowned upon and condemned by the ASA for almost two decades.... It may come as a great shock to those in teaching centers to find that neither all surgeons, qualified or otherwise, nor all patients, knowledgeable or not, desire the services of the physician anesthetist, or the physician supervised anesthetist. The reasons for this attitude are multiple, ranging from financial insolvency to personality dislike."9

Converse, speaking from the vantage point of private practice, continued his discussion taking pot shots at nurse anesthetists and blaming them for en-
croachment on the potential earnings of the anesthesiologist which made for an unstable economic situation in the specialty. He further stated: "Add to all this the fact that there are certain communities and certain hospitals which can never support an anesthesiologist financially or emotionally, and you have ample cause for a lesser number of anesthesiologists than one would expect at this stage of the development of the specialty. ... What we need now most of all is a reaffirmation of anesthesiology as a medical specialty. This is a poor time to talk of training physician assistants when we are having difficulty in proving to the U.S. Congress that we are physicians just like other medical school graduates."  

Converse's comments are interesting in the light of remarks by Dr. Henry K. Beecher, another anesthesiology pioneer. Dr. Beecher wrote in 1962, "Economically, the status is better in anesthesia than in any other field in this country for a comparable amount of training. ... Some thoughtful people believe as Bunker does—and I share that view—that in this country the force shaping the field of anesthesia the most is an economic one."  

And in an editorial in Anesthesiology in 1961, Dr. Forrest E. Leffingwell warned, "We often find ourselves in monopolistic positions and the temptation is great to indulge in sharp monopolistic practice. In such situations the heaviest loser is apt to be the patient."  

As late as in the September-October, 1974, issue of Anesthesia and Analgesia, Dr. David L. Bruce, Department of Anesthesia, Northwestern University Medical School, stated the following while discussing the post-graduate medical education of foreign physicians: "A fundamental question we have not faced is whether we want all anesthesia in the United States to be given by physician specialists. If we do, and intend ultimately to replace entirely the nurse anesthetists with anesthesiologists, foreign graduates will continue to find ample opportunity for private practice in this country and will continue to come here for training."  

This sampling of the anesthesiology literature demonstrates why nurse anesthetists are and remain wary of reapproachment with organized anesthesiology. Advocacy of reapproachment by anesthesiologists always appears to be on their terms, rather than any consideration being given to open discussions between the two groups to try to arrive at a consensus. This is not surprising in view of the "cultural pattern ing" addressed earlier. 

An attempt at reapproachment between the ASA and the AANA was the formation of an ASA-AANA Liaison Committee in 1964. Meetings are currently held twice a year. According to Dr. C. R. Stephen in a statement in 1969, "Progress has not been rapid, but the dialogue has enhanced understanding."  In 1972, a joint statement pertaining to qualifications of individuals administering anesthetics was issued by both organizations. This statement did recognize the certified registered nurse anesthetist as an appropriate anesthesia care provider and conceded, "that the ideal circumstances of qualified anesthesiologists and nurse anesthetists working together as an anesthesia care team may not be totally possible in the future."  

The present  

Where do we stand today? Anesthesiology has been coming under increasing criticism by government, the public, and health care planners. Two of the major criticisms relate to:  

1. The increased number of foreign medical school graduates in anesthesiology residencies (having risen from 50% to 58% between 1967 and 1972).  

2. The increasing health care costs associated with anesthesia services that have been demonstrated since the advent of Medicare, with the increase being largely attributable to increases in anesthesiologist fees.  

Nurse anesthetists, on the other
hand, have become more secure in their education and practice and more confident that their place on the health care team is assured. Nurse anesthetist education has become more formalized, with a greater balance between theory and clinical practice being achieved. More nurse anesthetists are assuming greater responsibilities in educational administration and curriculum planning. The expansion of nursing roles in other specialties has brought about a degree of legitimization of the nurse anesthetist's role so far as nursing is concerned, and there is evidence that reapproach- 
ment between nursing and nurse anesthesia is taking place.

Current trends in the field of nurse anesthesia are:

1. More independence in the preparation of nurse anesthetists, addressing to the necessity to prepare the nurse anesthetist to be capable of functioning independently of an anesthesiologist.

2. Tightening up of accreditation procedures for programs of nurse anesthesia to comply with new criteria for accrediting agencies defined by the U.S. Office of Education.

3. Increased security in a legitimate nursing role.

4. The reapproachment between nursing and nurse anesthesia.

These events are being interpreted by the ASA and individual anesthesiologists as evidence that the AANA is pulling away from the ASA and is setting out on an independent course of education and practice which the ASA cannot endorse. This is despite assurances to the contrary and evidence of organizational changes which will include anesthesiologist representation as members of the community of interest with decision-making responsibility on the AANA Councils of Accreditation, Certification, and Practice and on the Advisory Committee of Education and Accreditation.

Certain leaders of the ASA (working within the framework of the ASA Ad Hoc Committee on Anesthesia Health Care Team) have taken it upon themselves to make unwarranted charges and complaints against the AANA to legislators and legislative assistants, to the Accreditation and Institutional Eligibility Staff of the U.S. Office of Education, and to other anesthesiologists, particularly those participating in educational programs for nurse anesthetists. They have brought increasing pressure on nurse anesthetists and anesthesiologists who have worked well together trying to achieve mutual aims, even if it means disruption of long established relationships. Their apparent aim is to force the accreditation of programs of nurse anesthesia into the American Medical Association Council on Medical Education, thereby assuring control by medicine and the anesthesiologists. And, control of the education of nurse anesthetists will assure control of the nurse anesthesia practitioner.

While some of the anesthesiologists may be acting from a position of sincerity in what they envision would be best for patient care, the past experience of the AANA has shown that, in reality, this concern is most often expressed in what is best for the physician anesthesiologist—which is not necessarily synonymous with what is best for the patient. Some anesthesiologists are even predicting or advocating the preparation of another “paramedical” person to assist the anesthesiologist if the nurse anesthetist persists in his/her “independence.” (It also might be noted that while the AANA is opening up its structure for anesthesiologist participation in decision making, it has seen no reciprocating move on the part of the ASA.)

*At the time this article went to press, it appeared that the push to get nurse anesthesia education within the accreditation framework of the AMA-CME had been supplanted by a proposal from the newly formed Association of Physician Faculty of Training Programs of Nurse Anesthetists (known in its first month of existence as the Association of Physician Faculty Anesthesia Care Team Schools).
Basically, the philosophy of practice of the two groups is incompatible with merger as envisioned by anesthesiologists. Their view of the nurse anesthetist is that of a physician's assistant, while most nurse anesthetists perceive themselves as nurse specialists. The difference in these views is that the anesthesiologist sees the nurse anesthetist as being a physician extender, helping him to do more work, while being dependent upon him in all aspects of practice.

The nurse specialist view is one in which the nurse anesthetist provides anesthesiological services to a patient as an agent of a physician, any physician, while providing nursing services to that same patient and holding independent professional responsibility for those nursing services. In this role, the nurse anesthetist may consult with an anesthesiologist, (or with other physicians) as may be indicated, or refer the patient through the patient's primary physician to an anesthesiologist if patient requirements warrant such referral.

In fact, as a philosophical construct, the practice of anesthesia is neither exclusively medical nor exclusively nursing, though it more nearly fits into the nursing model of the care process than it does into the medical model of the cure process. Anesthesia is a procedure or a process through which patients are rendered insensitive to pain, and in many instances, paralyzed for purposes of facilitating diagnosis and/or treatment.

By rendering the patient incapable of providing care for himself, the anesthetist must become the care provider—and this care is basically nursing. However, in those instances where the patient's health status and the magnitude of the surgery predisposes him to requirements for a predominance of medical judgment, the care provided is medical in nature. Dr. Meyer Saklad, a prominent anesthesiologist, has stated that, "The number of medical judgments made by the anesthesiologist in any single (anesthetic) administration are few indeed." Therefore, anesthesia, as a specialty, can appropriately fit into both medicine and nursing.

**The future**

It is this author's belief that patients will continue to get better anesthesia care if the two types of anesthesia care providers continue to co-exist as separate entities, hopefully with more cooperation than there has been in the past. The advantages seen in this system are:

1. Patients will have access to anesthesia services from two sources, thus preventing monopolization of the market and the inherent associated problems.*

2. Patients may have access to nursing as well as medical services during the anesthetic experience.

With regard to health care professions, educators recognize that curriculum content is dependent upon the meshing of the philosophy of practice with a philosophy of education to derive educational objectives compatible with the preparation of a practitioner competent for entrance into the profession. This is why it is generally accepted that the group best qualified to determine educational standards for accreditation of professional programs is the profession itself.

Thus, we see the AANA and its associated accreditation program as being the appropriate structure for the accreditation of nurse anesthesia programs. The incompatible philosophy of the anesthesiologist relative to the nurse anesthetist and his/her practice makes the AMA Council on Medical Education totally inappropriate for the accreditation of nurse anesthesia programs, and as a result, unacceptable to the AANA.**

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*Inherent associated problems include: decreased accessibility to care, possible patient and nurse exploitation, and lack of healthy competitive practice of the type that promotes quality in care. (Both the nurse anesthetist and the anesthesiologist have to be better because the other exists.)

**This would be equally true in any other physician controlled accreditation mechanism.
In the final analysis, there appears to be little hope for improvement in the relationships between organized anesthesiology and organized nurse anesthesia without the physician’s willingness to give up his pursuit to control the total practice of nurse anesthesia, and thus, nurse anesthetists. The nurse anesthetist is too proud of his/her accomplishments and survival during those arduous years when it was the aim of anesthesiology to eliminate the nurse anesthetist, and the cost of that survival has been dear.

Even if cooperation becomes organized anesthesiology’s goal rather than control, the patterning of the past 40 years would make it very difficult for nurse anesthetists to develop a trusting relationship with them. Possibly, hope lies in the changing trends of health care which are springing up all over the nation; although, resistance to these changes also is evident. Witness, for example, the increasing maneuvers within all of medicine to regain what many feel they have lost in the way of control. The public may have to be the influence which ultimately forces this change.

Dr. Barbara Bates, Professor of Medicine, University of Rochester School of Medicine and Dentistry, and co-director of the Medical Nurse Practitioner Project at Rochester, presented the graduation address to the Family Nurse Practitioner class at Cornell University-New York Hospital School of Nursing. Her words are appropriate to nurse anesthetists:

“By the effort you have made to acquire greater knowledge and skill—you have, paradoxically, increased indefinitely, possibly forever, your need for more knowledge and skill, just to stay in place.... You will sometimes be called physician’s assistants rather than nurse practitioners. But, paradoxically, you will probably function less as physician assistants than do most hospital nurses today.... By expanding your knowledge and skills into medicine, and thereby acquiring some of that control, you can in fact expand into nursing. In so doing, you will be bringing the patient the guidance, care, help, understanding, and comfort that he has needed all along and perhaps not received from the physician.... By virtue of your having learned more medicine and enhanced your ability to move into a more medical role, the patient may get less medicine. Less medicine, when mixed with more nursing, is probably better medicine (or, to translate, better health care).... By expanding into medicine, you will need—more than ever before—to increase your consciousness of what nursing is all about. The values of nursing must not get lost in the dominant medical culture. If they do, you justly risk the epithet of junior doctor. Our patients do not need junior doctors. They need the knowledge and skills of both medicine and nursing.”

Dr. Bates has eloquently verbalized what nurse anesthetists have been trying to communicate about their practice throughout the years, distinguishing their practice from that of physician anesthesiologists, even though they utilize many of the same procedures. The fact that the nurse anesthetist’s practice is not identical with that of the anesthesiologist, or a mini-practice of the physician, should pose no threat to anesthesiologists. In fact, it should provide the freedom for both groups to fulfill the potential each brings to the specialty as a nurse and as a physician.

It is through maintaining their separate identities that cooperation and collaboration have the potential to amalgamate the anesthesiologist and nurse anesthetist into the most indispensable team in the field of acute care. But, this is a function of freedom rather than control, and only time will tell whether anesthesiology has attained sufficient maturity to be willing to take that risk.

REFERENCES

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