FOUR DECADES *of* LEADERSHIP

WASHINGTON STATE SOCIETY
OF ANESTHESIOLOGISTS

FOUNDED 1948

Published by the Washington State
Society of Anesthesiologists
804 United Airlines Building, 2033 Sixth Avenue
Seattle, Washington 98121

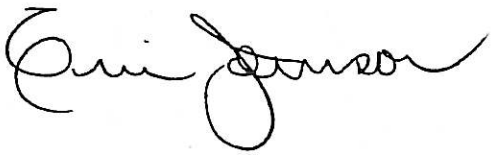
Fall 1989

This is the centennial year of the State of Washington. Celebrations, exhibits and stories remind us of our state heritage, the strength of character of our pioneers, and the tremendous changes that have occurred since this state's inception.

The Washington State Society of Anesthesiologists is middle-aged in comparison, but to anesthesiologists, its history is no less interesting and its pioneers no less formidable. The names and personalities of the founders of the WSSA; their impact on the science, politics and practice of anesthesiology; and the evolution of the WSSA over the past half century all make for an enlightening story. There is truly much to learn from the past. The Board of Directors felt that this year was an appropriate time to obtain a history of our state Society.

We were fortunate to find a person with the ability and perseverance of Sabrina Porter Lindquist, who was commissioned to collect the historical data and put it into a readable form. Her efforts and results are first-rate, and we are indebted to her. We also would like to thank Dr. Lucien E. Morris for his considerable help with and great enthusiasm for this project.

We, the Board of Directors, hope you enjoy reading the story of the WSSA.



Eric Johnson, M.D.
President, Washington State Society of Anesthesiologists

BEGINNINGS

Since the end of World War II, the explosive growth of anesthesiology has obscured the battle that pioneering Washington state practitioners fought to establish the specialty here. Changes brought by the specialty's growth and development — notably in advanced knowledge, greater financial reward and higher professional esteem — have all but erased from memory the challenges faced by anesthesiologists when the Washington State Society of Anesthesiologists (WSSA) was formed in 1948. That knowledge rests with the men and women who laid the foundation for the growth from which current anesthesiologists in Washington benefit. Here, from their collective recollections, is their story.

Before the United States' entry into the war in 1941, the history of anesthesia in Washington state is sparse but significant. From 1920 to 1924, Dr. John S. Lundy practiced at Seattle's Columbus Hospital. This influential pioneer in American anesthesia went on to found the anesthesia section at the Mayo Clinic and eventually returned to Seattle after his illustrious 35-year career there. King County Hospital (now Harborview Medical Center) in Seattle initiated the state's first permanent educational anesthesia program in 1928 with Dr. Louis H. Maxson as chief. During his 11-year tenure, he moved the program into a new facility, named Harborview Hospital, in 1931 and published an important text on spinal anesthesia in 1938. Dr. Maxson oversaw guided experiences in anesthesia for interns at a time when residencies for physician training in anesthesia were almost non-existent in the United States.

The Post-War Era

"Our founding philosophy was fellowship. We got together with our fellows and discussed the issues because we were so few. We needed the comfort and support of each other."
— Dr. John Bonica.

World War II launched anesthesiology as a field of medical practice. The war's obvious effect was to spur the demand for new anesthetic agents and techniques and for trained professionals to handle them. Many physicians returning home with wartime experience giving anesthetics wanted to specialize, and asked for formal residency training programs rather than the informal preceptorships available until that time. The war also brought a group of bright, young anesthesiologists to the state's several military hospitals to teach, learn and practice.

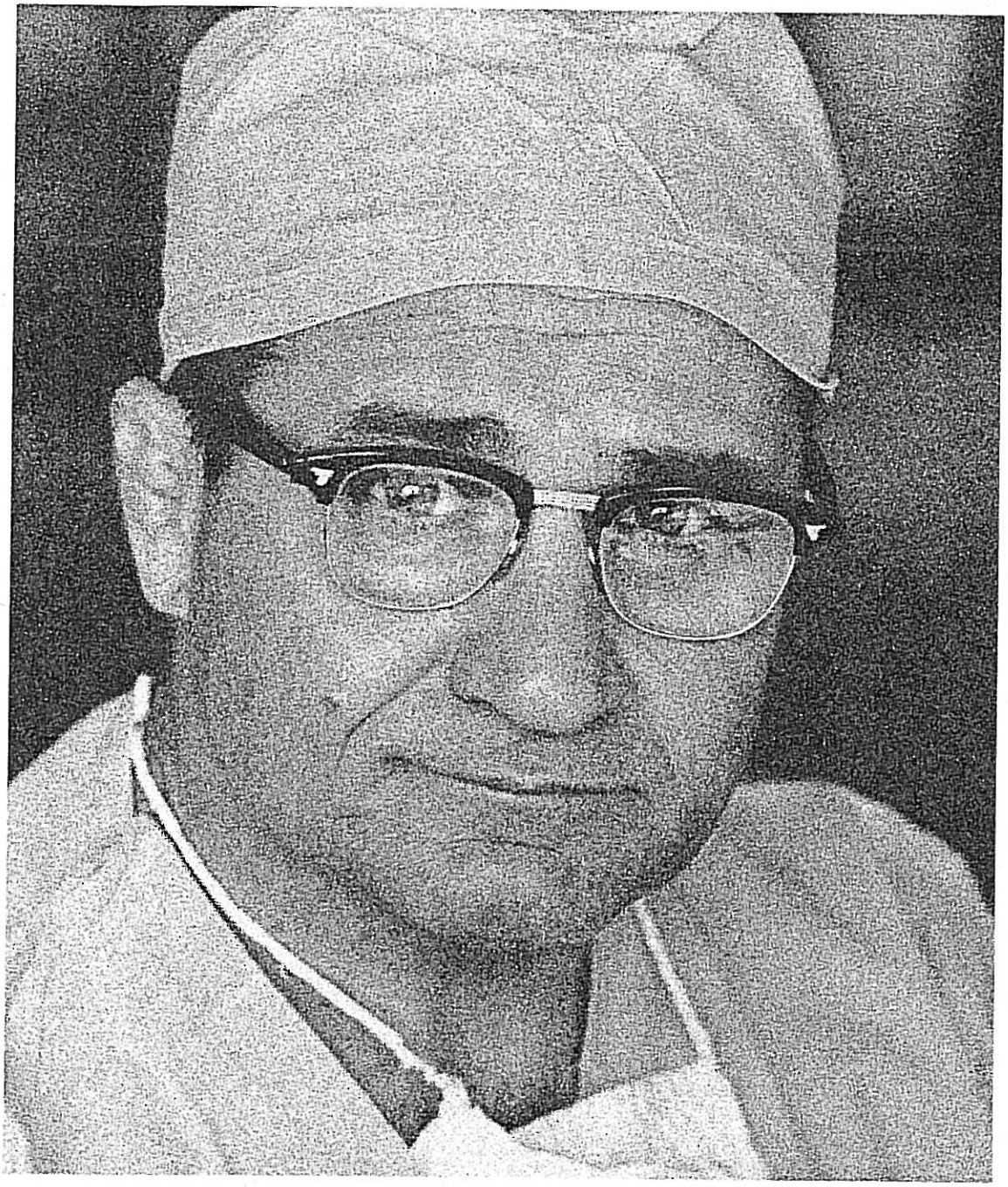
Dr. John J. Bonica, a native of Italy who studied anesthesiology at New York's St. Vincent's Hospital, served in the U.S. Army at Madigan Army Hospital, Fort Lewis, during which time he taught physicians and nurses how to administer anesthesia. When Dr. Bonica completed his military duty in 1946, Dr. J. Joseph Mattes had been in private practice at Swedish Hospital for five years. To aid in his own career decision-making, Dr. Bonica arranged to meet Dr. Mattes in June to talk about the prospects for anesthesiology in the area. At that Seattle Yacht Club dinner, the seeds for a statewide professional organization for anesthesiologists were planted. In February of the following year, the two met again in Seattle with Dr. Gordon A. Dodds to plan for such a group. Dr. Dodds had three months of anesthesia training during his internship at Harborview from 1935 to 1937 and eventually went to Seattle's Providence Hospital.

Many regional organizations of anesthesiologists began springing up around the country as the specialty developed after the war. The regional societies were uncoordinated, however, and the American Society of Anesthesiologists (ASA) undertook to organize state and regional societies under a national umbrella.

From that February 1947 meeting, the Puget Sound group began to coalesce. In August 1948, Drs. Bonica, Dodds and Daniel Moore, who trained in anesthesiology at Wesley Memorial Hospital in Chicago, met at Harborview Hall with nine others to informally organize the WSSA. The group adopted the constitution of the American Society of Anesthesiologists and applied for status as a member state society. Such status was officially granted on October 9, 1948.

The first slate of officers included Dr. Mattes as president, Dr. John MacKinnon of Providence Hospital as president-elect, Dr. Dodds as vice president, Dr. Bonica (then with Tacoma General Hospital) as secretary and Dr. Moore (then at The Mason Clinic) as treasurer. Also present at the first official meeting were Dr. James D. Mathwig, who followed Drs. Maxson and William Millington as chief of anesthesia at Harborview Hospital; Dr. Samuel Goldenberg of Olympia; Dr. S.T. "Thatch" Hubbard, who eventually went to Spokane; Drs. L. Donald Bridenbaugh and Lawrence Turnbull, who were residents at Harborview at the time; Dr. Clayton Wangeman, from Ellensburg, who had served at Barnes Army Hospital in Vancouver, Wash., during the war; and Dr. Paul Kundahl, who helped to organize Associated Anesthesiologists, a Seattle partnership. Others listed in the Society that first year were Dr. Delores D. Mills, the state's first woman anesthesiologist and wife of a prominent Seattle surgeon; Dr. Kenneth Downie, another Associated Anesthesiologists organizer; and Dr. Phillip Backup, a resident at Tacoma General under Dr. Bonica.

The group met in each other's homes, as well as at hospital locations such as Harborview Hall. The members gathered three or four times per year at meetings that resembled a journal club. In the course of discussing new research findings and patient care techniques, the early members became close friends. This camaraderie would stand them in good stead in the tumult of the coming decade.



Dr. John J. Bonica came to Washington during World War II and settled in Tacoma when his Madigan Army Hospital assignment ended.

Thrust Into The Legal Limelight

A series of events that began around 1950 set the stage for the WSSA's biggest challenge and, ultimately, its biggest achievement. This milestone hinged on two important policies established by the American Medical Association (AMA). In June 1950, the AMA adopted a code of ethics for physicians that made it unethical to sell their services to a hospital or corporation, thus declaring the practice of medicine to be a private practice. The AMA also voted that membership in the national organization be acquired only through membership in state and county medical societies, and AMA membership became an unofficial prerequisite for anyone administering a teaching program.

"We were a struggling group, not well-recognized, and among the poorest-paid specialties in medicine. Patients and doctors didn't appreciate our importance. We had to organize to have any power at all."

— Dr. Lawrence Turnbull, who completed the Harborview residency program in 1950.

The first ruling had important ramifications for anesthesiologists. Prior to the end of the war, anesthesiologists were categorized among such hospital-based specialties as radiology and pathology, while internists, surgeons and obstetricians, for example, were private practitioners. Hospital-based specialties were a great source of profit for the hospitals that controlled them, and hospital representatives thus had a large stake in maintaining the status quo.

The growing number of WSSA members began to discuss the implications of practice on a fee-for-service basis and agreed that private practice would ensure the specialty's future growth and development. They decided to push the American Society of Anesthesiologists to adopt the American Medical Association's same principles of practice.

In November 1950, the WSSA sent Drs. John Bonica and Daniel Moore to Houston as its representatives to the American Society of Anesthesiologists annual meeting. The group that year followed the American Medical Association's lead and adopted the same practice code. In the ensuing months, the ASA also voted to make an individual anesthesiologist's ASA membership dependent on county medical society membership.

These policies had immediate repercussions in Tacoma, where Dr. Bonica was campaigning to establish a private practice while remaining as director of Tacoma General's anesthesiology department and head of its anesthesia residency program. With the ASA policies on his side, Dr. Bonica had cards printed announcing that he would be a private practitioner as of January 1, 1951. He told Tacoma General administrators that without such a move, he would be practicing illegally, risking ouster from the Pierce County Medical Society, and thus threatening the viability of the hospital's anesthesiology residency program.

Tacoma General, with support from the American Hospital Association, offered Dr. Bonica a huge salary increase if he would agree, in essence, to close the hospital to other anesthesiologists. He refused, and the confrontation moved onto Pierce County Medical Society turf. Dr. Bonica and his supporters lobbied every member of the county group to take a stand in favor of the private practice of medicine. Their position carried the day.

But the battle was just beginning. A similar situation developed at Swedish Hospital, where Dr. Mattes, settled in a fee-for-service practice, was asked to accept full employment. He refused. The hospital began a national search for someone — at an allegedly fantastic salary — to direct the Swedish Department of Anesthesia and what amounted to a closed anesthesia shop. Many applicants for the job, consulting with various members of the WSSA while in Seattle, were counseled against taking the position. But the hospital and the American Hospital Association

eventually found their man in Dr. Lloyd H. Mousel, a nationally recognized anesthesiologist and a protege of Dr. Lundy's from the Mayo Clinic. Drs. Bonica, Moore and Wangeman met Dr. Mousel in New York at the American Society of Anesthesiologists meeting in October 1951. Despite their concerns, he took the job, and the door for anesthesiologists at Swedish Hospital clanged shut. All 18 anesthesiologists in the Puget Sound area tested the policy by applying to work at Swedish, and each application languished.

The battle lines were drawn. The 21 members of the WSSA hired the law firm of Bogle, Bogle & Gates and organized the same lobbying effort in King County that had proved successful in Pierce County. Each of the 21 was allocated names of King County Medical Society members to contact. The result was that Dr. Mousel's first application to join the King County Medical Society was rejected by a majority vote. The second application six months later was rejected by an even larger majority, and the third and final application six months later was rejected by a still higher "no" vote. That action meant Dr. Mousel's membership in the American Medical Association and the American Society of Anesthesiologists could be revoked, and a residency program at Swedish Hospital not approved.

The consequences were predictable. *Lloyd H. Mousel v. Washington State Society of Anesthesiologists, King County Medical Society, et al.* was filed in King County Superior Court. In response, the WSSA gathered statements from surgeons saying that Dr. Mousel's unavailability when his presence was specifically requested meant that anesthesia was administered instead by nurses, and that patient welfare was endangered in some cases. The threat that such information would be released to the media brought an out-of-court settlement in September 1955. The terms of the agreement included:

- A Swedish Hospital staff open to all qualified anesthesiologists who applied.
- Dr. Mousel accepted no further salary for supervising nurse-anesthetists or anesthesiology residents.
- Swedish Hospital did not charge for the services of any anesthesiologist or anesthesiology resident. Patients were billed directly for anesthesia services by individual physicians rather than by the hospital.
- Dr. Mousel was recommended for admission to the King County Medical Society and the WSSA.

"Mousel stood for the type of practice that those of us in the state didn't believe in."

— Dr. John Porter Reed, WSSA member since 1954.

from the

WSSA Articles of Incorporation adopted October 25, 1953

II. (a) To advance the science and art of anesthesiology and to stimulate interest and promote progress in the specialty of anesthesiology.
(b) To further the aims and program of the American Society of Anesthesiologists, Inc.
(c) To aid the establishment and maintenance of suitable standards for the practice of anesthesiology, to better protect and serve the patient and to encourage the development of a sound practice in the specialty.

"Mousel didn't anticipate the power of a small group of unified individuals."

— Dr. John Bonica.

The process was watched very closely by the ASA. When we were able to do it with a small number of people, it gave the Society great stature. It threw us a little bit into the limelight."

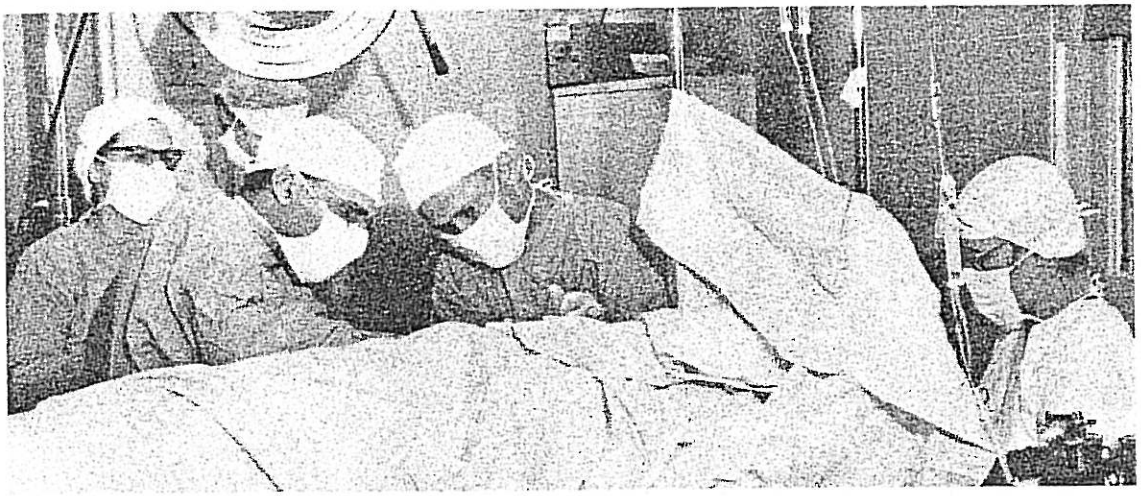
— Dr. Daniel Moore.

The WSSA membership authorized the settlement by resolution. It had been a long, bitter, expensive battle. In February 1955 the WSSA membership had approved a $150 assessment for the legal defense fund but, at the same time, voted down a $35 assessment for the organization's operating fund. The result was an operating balance in the WSSA treasury of $11.97.

In November, WSSA President Clayton Wangeman sent an "immediate action" letter to active members soliciting $500 each "for legal fees and expenses in connection with the defense of the recent litigation." At a time when the annual WSSA membership dues were $5, attorney fees to date were $22,500, of which $2,500 had been paid. The remaining $20,000 had to be paid by member assessment, a "legitimate business expense deductible on your income tax return," he noted.

Dr. Mousel was voted into the King County Medical Society on December 5, and the WSSA met on December 16 at the Virginia Mason Nurses Home to vote on his admission. "By legal agreement the corporate practice of medicine, so far as anesthesiology is concerned, has been stopped in the State of Washington, when Dr. Mousel is voted into the Society," President Wangeman commented in a letter to WSSA members announcing the upcoming vote. The 29 members present approved his admission. Ironically, Dr. Mousel's admission made him eligible for the $500 lawsuit-related assessment, which he paid.

The lawsuit had attracted the attention of hospitals and anesthesiologists nationwide, and the settlement's splash rippled to the corners of the country. The suit established that hospitals could not furnish anesthesia as a service by technicians and that hospitals were required to have open staffs to accommodate qualified physicians. Because of the demonstration in Washington state that the medical community likely would no longer support contrary practices, the American Hospital Association did not continue those policies, with the resulting creation of more opportunities for anesthesiologists to practice. By ASA estimate, 85 percent of the nation's anesthesiologists were in private practice by the mid-1960s.



Marian Sequin administered anesthesia during this May 1958 operation at St. Joseph Hospital in Vancouver, Wash., which was the first permanent hospital in the Washington Territory.

REGIONAL ISSUES: EAST AND WEST

As in many other facets of life in Washington, the Cascade Mountains serve as a dividing line for more than just the weather. Some issues facing the WSSA also resulted from geography-imposed differences.

Meeting attendance was one such concern. With the overwhelming majority of the state's practicing anesthesiologists located in the greater Puget Sound area, meetings were set in "Pugetropolis" locales. As the specialty grew and anesthesiologists began moving out into smaller cities and towns across the state, the long drives or expensive flights created an obvious hardship for far-flung members. Their attendance lagged, and by 1952, the idea of a component society in Spokane was proposed "to achieve more complete representation."

In May 1952, the WSSA membership unanimously approved a plan to organize a separate Eastern Washington division, and in June, the "Inland Empire Component" of the WSSA was formalized. In March 1953, the Inland Empire Component proposed that official WSSA meetings be held only once or twice per year rather than monthly, a proposition that garnered favorable comment at the WSSA meeting the following month. In September 1953, a proposed amendment to the WSSA bylaws to make the component society official was deferred. According to a retrospective report written in 1956: "Thereafter, the constant business associated with a lawsuit required frequent meetings and no more was said about the subject until the Tacoma meeting in April 1956."

With the frenzy of the Mousel lawsuit behind them, the WSSA in 1956 again faced the hurdle of better representation for Eastern Washington members and the question of the optimal number of meetings. Official organization business was consistently delayed for lack of a quorum, so a membership survey was undertaken to solicit member opinion and to address "the understandable desire of members east of the Cascades to be properly represented in business actions." In considering the representation issue, it was determined that the American Society of Anesthesiologists accepted only state societies and granted no authority to intrastate components. Members wrestling with the problem decided that little could be done to improve Eastern representation unless a more central site were chosen for some or all WSSA meetings, and that more WSSA business should be handled by mail. If the number of official meetings was reduced to four or fewer per year, they theorized, distant members could still meet informally for social and scientific purposes without conducting official ASA/WSSA business.

The WSSA membership followed those recommendations. The Society henceforth had four meetings per year, one each in Seattle, Tacoma, Spokane and Yakima. This early policy gradually evolved into the current quarterly meeting schedule.

The Western Washington contingent, however, naturally remained strongest in number and influence. In 1965, a motion was made to establish a representative board of directors, rather than an at-large executive committee elected by plurality vote, as the organization's governing body. This move was designed to encourage participation in the Society by members from all areas of the state and to correct the perceived imbalance of representation on the executive committee.

"It's a long way from here to meetings in Seattle. If we are successful anesthesiologists, we keep our schedules pretty busy. It took three days to go to a meeting. We accepted that as part of the price we paid when we decided to practice in a small community."

— Dr. LeGrande Anderson of Walla Walla, who in 1952 was first to complete the Virginia Mason residency training program.

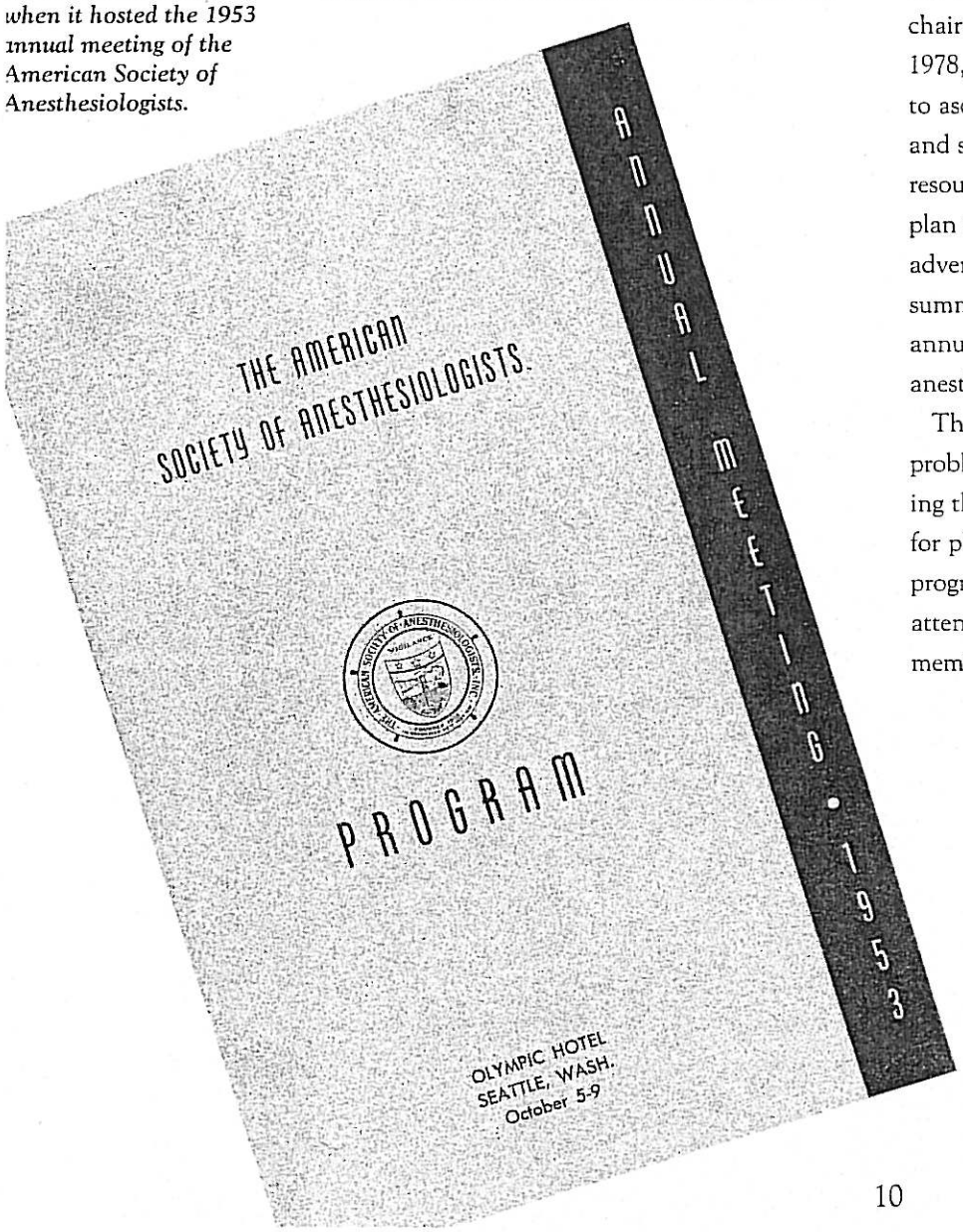
The districting proposal eventually gave rise to the current guidelines for board composition, adopted in 1985, which augment the executive committee with directors from three state districts consisting of Snohomish, King and Pierce counties; the other Western Washington counties, and Eastern Washington.

Addressing the attendance problem, however, proved more difficult. A report of the April 1958 meeting by WSSA President Kenneth Eather states: "Poor attendance at recent meetings has been a disgrace to the specialty. Come and heckle if you will but don't expect your opinions to be respected if you aren't there to voice them!"

A special meeting in June 1962 at St. Cabrini Hospital, Seattle, was attended by 21 of the 101 active members at the time to consider abolishing the quorum requirement. The previous two WSSA meetings had lacked a quorum, so no business had been conducted and the group was unable to admit to membership some applicants whose status had been pending for many months. Such circumstances were deemed unfair to the applicants and also played havoc with American Society of Anesthesiologists records. The group decided instead to take a mail vote of active members on certain matters in the absence of a quorum.

Attendance continued to be a thorny problem into the 1970s. One proposed solution was to reduce the number of meetings to two per year, but Dr. William Horton, who took over as chairman of the WSSA Program Committee in 1978, had a better idea. He spearheaded a survey to ascertain member preferences of meeting sites and set out to capitalize on Washington's resource of expertise in regional anesthesia. His plan to develop a program worthy of national advertisement culminated in 1978 with the first summer Seafair meeting. Ten years later, the annual three-day event drew approximately 350 anesthesiologists from around the country.

The WSSA sought to mitigate attendance problems and to meet member needs by providing the continuing medical education required for physician licensure. Having desirable CME programs available to members through meeting attendance proved beneficial both for individual members and for the Society as a whole.



The WSSA enjoyed the national spotlight when it hosted the 1953 annual meeting of the American Society of Anesthesiologists.

THE QUESTION OF FAIR PAYMENT

Another issue that split the WSSA along geographic lines was that of fee schedules for the payment of medical costs by various third parties. Battle lines were drawn around large metropolitan areas, where — unlike in the outlying areas of the state — county hospitals cared for the medically indigent. Reimbursement fees from the state for uninsured cases were so low that it was a financial hardship for anesthesiologists to treat them. King and Pierce counties had county hospitals, but elsewhere in the state, as much as half of an anesthesiologist's caseload might be government-assisted patients. For those physicians, often primarily those outside Seattle and Tacoma, fee schedules were a very high priority.

In January 1957, the WSSA appointed a Fee Schedule Committee which began negotiating schedules for patients covered by such insurers as the state Department of Labor and Industries, the state Welfare Department, the state Division of Vocational Rehabilitation, and Crippled Children's Services of the state Department of Health. A special effort was made to get statewide representation on the committee, with a resulting membership that included Dr. Kenneth Downie of Seattle, Dr. Phillip Backup of Tacoma, Dr. Robert Fisher of Yakima and Dr. Delbert Small of Spokane.

By 1961, fee schedules were a hodgepodge of formulas. The Medicare (originally for military veterans and their dependents) fee schedule was time-based; the state industrial and the welfare fee schedules were based on a percentage of surgeons' fees. It was a problem-plagued system. For example, in March 1960, the WSSA was notified that the state Welfare Department had reduced the anesthesia fee for vaginal deliveries, a fee that originally had been negotiated in 1957 by the WSSA Committee on Liaison with Insurance Organizations. When the WSSA protested, the group was invited to appear before the state Welfare Medical Care Committee, and had to organize a contingent to attend. Constant vigilance was required.

As a result, WSSA members felt the need to approve a standard fee schedule. However, no clear consensus existed among the membership in favor of any of three possible fee-schedule plans: procedural, time-based, or relative unit value, the latter using the 1960 California plan as a model.

Support gradually grew for a relative value scale of payment factors, including patient status, time, type of operation, and considerations of anesthetic difficulty. In March 1962, the WSSA notified the Washington Physicians Service — the insurance company sponsored by the Washington State Medical Association with component county medical bureaus — that it sought a unified relative value fee schedule. The group also sent the King County Medical Service Bureau, the forerunner of King County Medical Blue Shield, a letter requesting a relative value fee schedule, like the one in use in California, at a rate of $5 per unit statewide.

To establish a relative value fee schedule in the state, members at the June 1962 WSSA meeting were instructed to use it in their private practices so that a "backlog of experience" would be available when the issue came up at the Washington State Medical Association meeting set for the next September. In December 1962, the membership adopted the recently completed ASA Relative Value Guide as the basis for WSSA negotiations regarding fees.

"We wanted appropriate return for the expertise, time and effort we expended on any individual patient...Most anesthesia fees had been set at a percentage of a fixed surgical fee, usually 20 percent. An anesthesiologist had to take care of two or three surgeons to have a net income even close to a surgeon's, and the fees did not reflect the time and knowledge requirements of anesthesia."

— Dr. Lucien Morris, 1962 chairman of the WSSA Liaison with Insurance Organizations Committee.

'We had trouble getting the county medical service corporation to let us in. They considered anesthesiology a luxury and covered only the basics, yet the basics included all the other specialties."

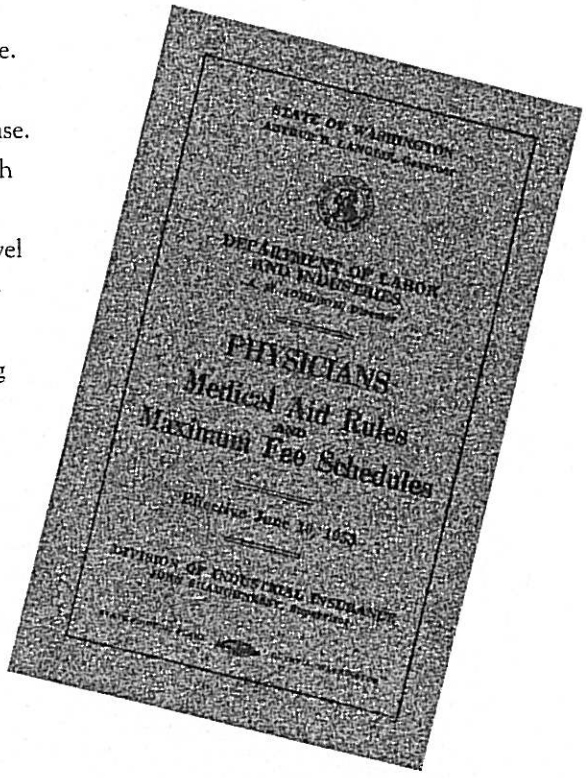
— Dr. Delbert Small, Spokane.

The Society's efforts began to produce results in 1963, not coincidentally the same year that Dr. Lucien Morris became Society president. He was interested in the problems, knowledgeable about the subject, and tenacious in pursuing solutions. One example of progress occurred in May, when anesthesia services were included for the first time in the Washington Physicians Service contract with the state Department of Public Assistance concerning welfare patients. More than two years of meetings had not produced a satisfactory method of including anesthesia services, but Dr. Morris renewed the Society's negotiation efforts in January 1963, and reached an agreement between the local bureaus, the WSSA and the state Department of Public Assistance that anesthesiologists would be treated as all other physicians in administration of the Washington Physicians Service contract with the department.

Another area of long-standing dispute had been with workmens' compensation claims, handled by the state Department of Labor and Industries. The department was charged with establishing a direct relationship between a worker's job and injury or occupational disease. To do so, it required clinical data from the physician to substantiate the details of each case. Many WSSA members found that dealing with the department involved cumbersome filing procedures and long-delayed payments at a level most anesthesiologists thought was unsatisfactory. By the same token, department officials frequently accused WSSA members of sending information that was incomplete, inaccurate or vague.

The WSSA initiated meetings with the Washington State Medical Association's Industrial Insurance Committee over the issue in 1964. WSSA members protested having to send anesthesiology records to the Department of Labor and Industries that they contended were virtually identical to the surgeon's records and that sometimes required divulging private information. Anesthesiologists routinely received 20 percent of the surgical fee, but wanted the department to accept the ASA Relative Value Guide with a $5 unit value. It finally did so in July 1966 after Dr. Morris negotiated directly with the department head.

For the WSSA, the issue of appropriate reimbursement for physician services was primarily a local one in the 1950s and 1960s, but the movement for physician payment reform involved the specialty more broadly since then. The ASA Relative Value Guide was in the news in 1989 as part of the effort to establish a national relative value guide to price physician services with some uniformity. In that year,



Without a relative value guide, figuring fee schedules was a complicated endeavor.

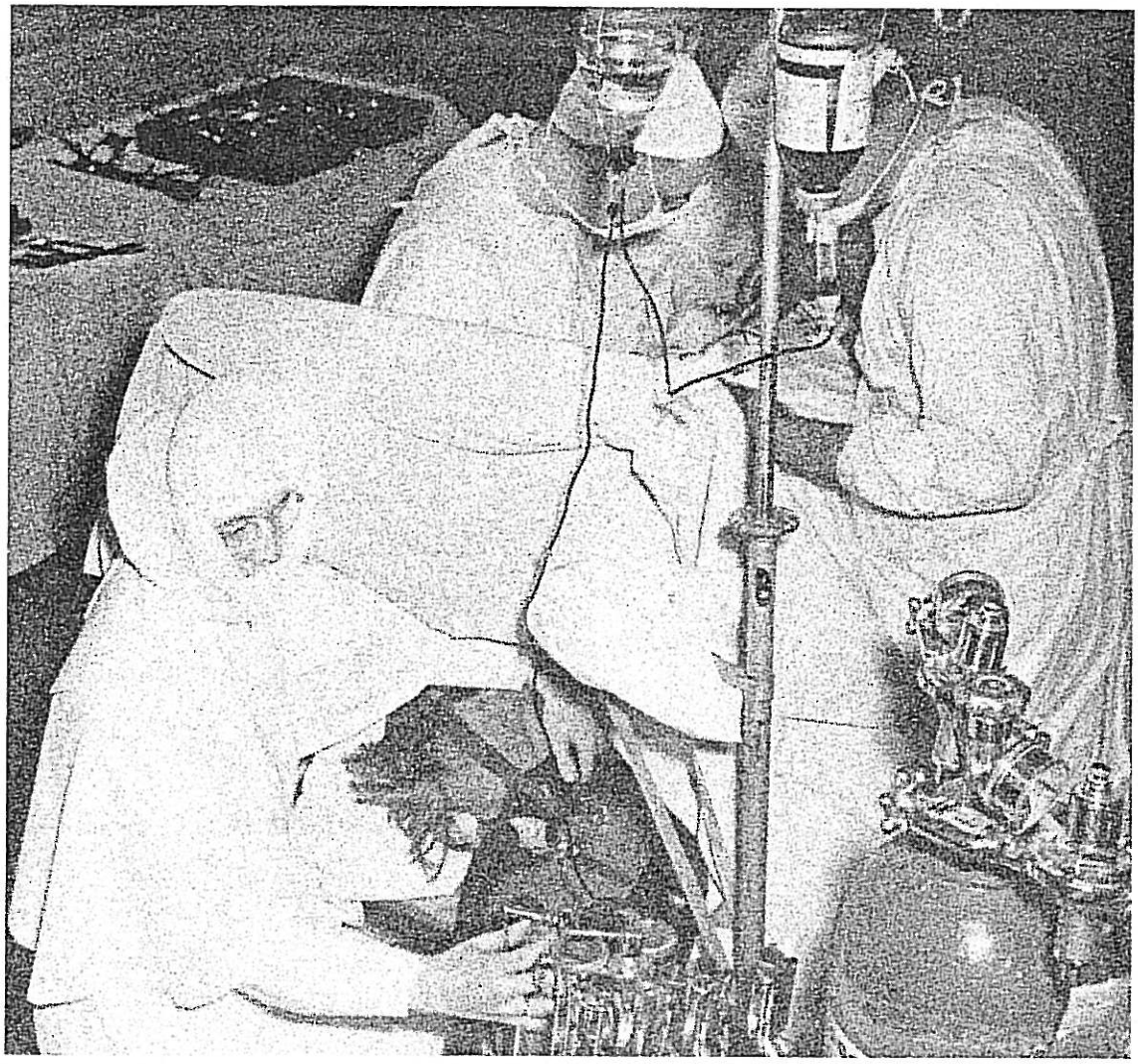
Congress' Physician Payment Review Commission recommended a resource-based Medicare fee schedule, with indications that the ASA scale would be adopted for all Medicare billing for anesthesiology services. This development was made possible by the ASA's successful defense of earlier legal challenges on anti-trust grounds by the Federal Trade Commission and the U.S. Department of Justice.

Just as the specialty invested its energy in the 1980s in negotiating the Medicare budget with Congress, the WSSA focus widened to a national scope. To effectively interact with policy-makers, the WSSA cultivated links with legislative offices, particularly that of U.S. Rep. Rod Chandler, a member of the Health Subcommittee of the House Ways and Means Committee.

By the same token, WSSA member efforts to become more visibly involved in ASA proceedings increased markedly in the 1980s. By the end of the decade, WSSA members held 19 of the 200 available ASA committee posts.

"There is a need for people in states with representatives on key committees concerned with health legislation to involve themselves."

— Dr. William Horton, Seattle.



Patient status, type of surgery, and duration and difficulty of anesthesia administration were factors, 30 years ago as now, in determining a relative value guide for fee payment.

STANDARDS OF PRACTICE

Regional differences in population density also affected WSSA attempts to set anesthesiology standards of practice. The problem of how to contend with the use of nurse-anesthetists in small hospitals that couldn't support their own physician anesthesiologists not only caused dissension within the WSSA, but also provoked a near-split with the American Society of Anesthesiologists.

Our orientation was to protect private practice. We wanted to prevent losing of staffs which would lock out the growth of the specialty. It was a question of survival."

- Dr. Lawrence Turnbull.

As a consequence of the move to establish anesthesia as the practice of medicine, it was no longer proper for nurse-anesthetists to administer anesthesia without a supervising physician. In 1963, the WSSA surveyed all the hospitals in the state to determine the extent to which anesthesiologists were responsible for surgical and obstetrical anesthesia care. Eighty of 107 hospitals replied; 30 of them (37 percent) reported having no anesthesiologist coverage, yet those 30 hospitals did 10 percent of all the surgeries performed in the state.

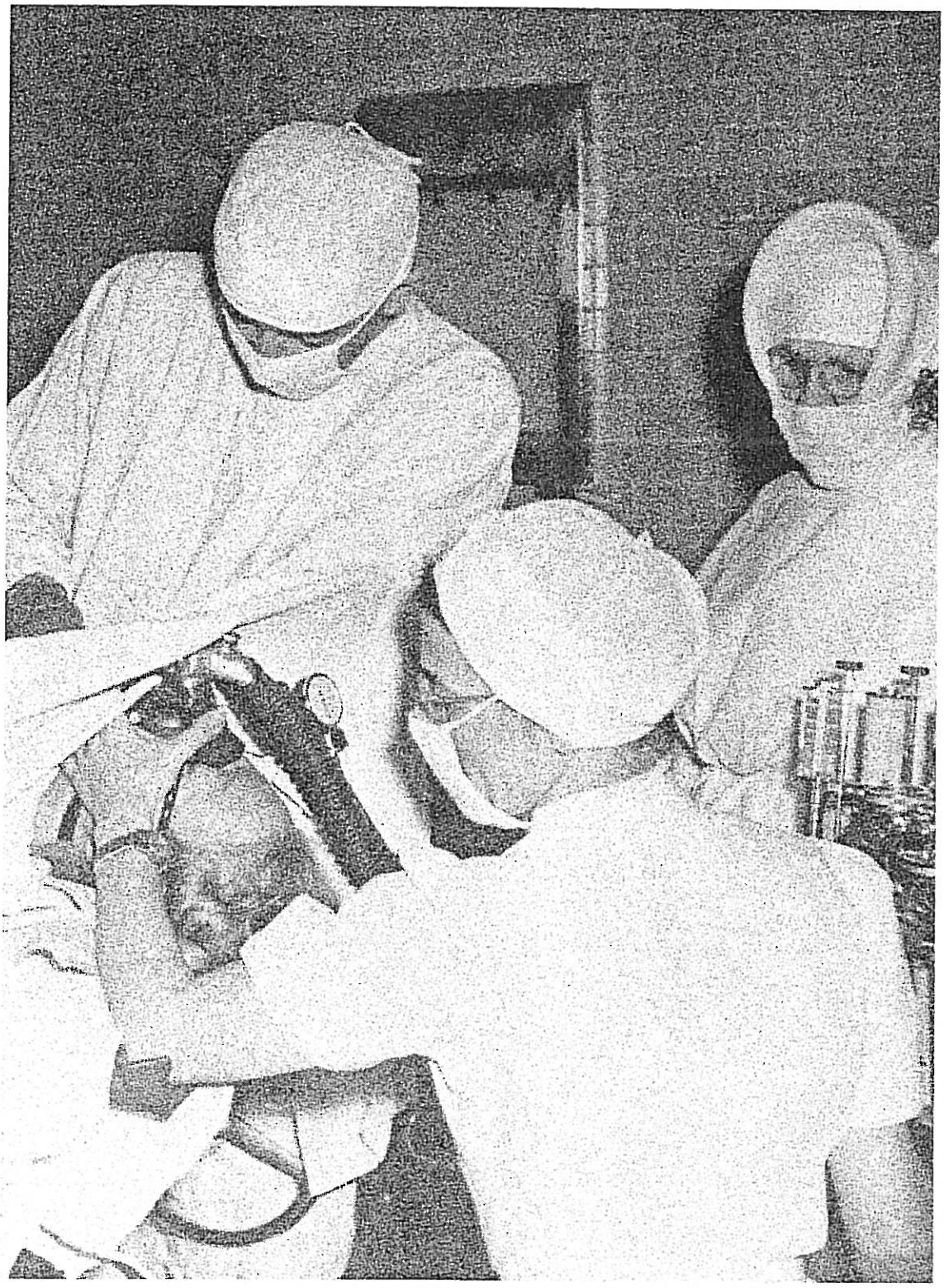
The survey results demonstrated that, in many cases, surgeons were the supervising physicians, and thus were responsible for anesthesia administered by nurse-anesthetists. It was not a fair system for surgeons, who often had no anesthesia training, nor for nurse-anesthetists, who were very competent but not always capable of giving the type of anesthesia a surgeon wanted. Patient care was less than optimal. Under the circumstances, it was not realistic to presume the surgeon was responsible; legal as well as ethical conflicts ensued.

An early solution to the problem seemed to be for small hospitals to have two or three nurse-anesthetists with an anesthesiologist responsible for their hiring and supervision. The anesthesiologist would make pre-operative evaluations, decide what type of anesthesia the patient should have and what type the nurse-anesthetists were capable of giving, and do post-operative anesthesia follow-up. Thus anesthesia care would be optimal, and employing nurse-anesthetists would make it economically feasible for anesthesiologists to practice in smaller hospitals.

The plan looked good on paper, but in practice could be compared to the earlier situation at Swedish Hospital that had fomented the lawsuit. It theoretically enabled an anesthesiologist to hire several nurse-anesthetists and bill for the work of each, which could result in financial exploitation of both patient and nurse-anesthetist without upgrading anesthesia care. Worse, it threatened to re-create the potential for a hospital staff closed to other anesthesiologists.

The American Society of Anesthesiologists had established guidelines for the ethical practice of anesthesiology that made it unethical for physicians to hire nurse-anesthetists. That policy frustrated small hospitals that couldn't support full-time anesthesiologists but that sincerely wanted help, and rankled a large contingent of WSSA members.

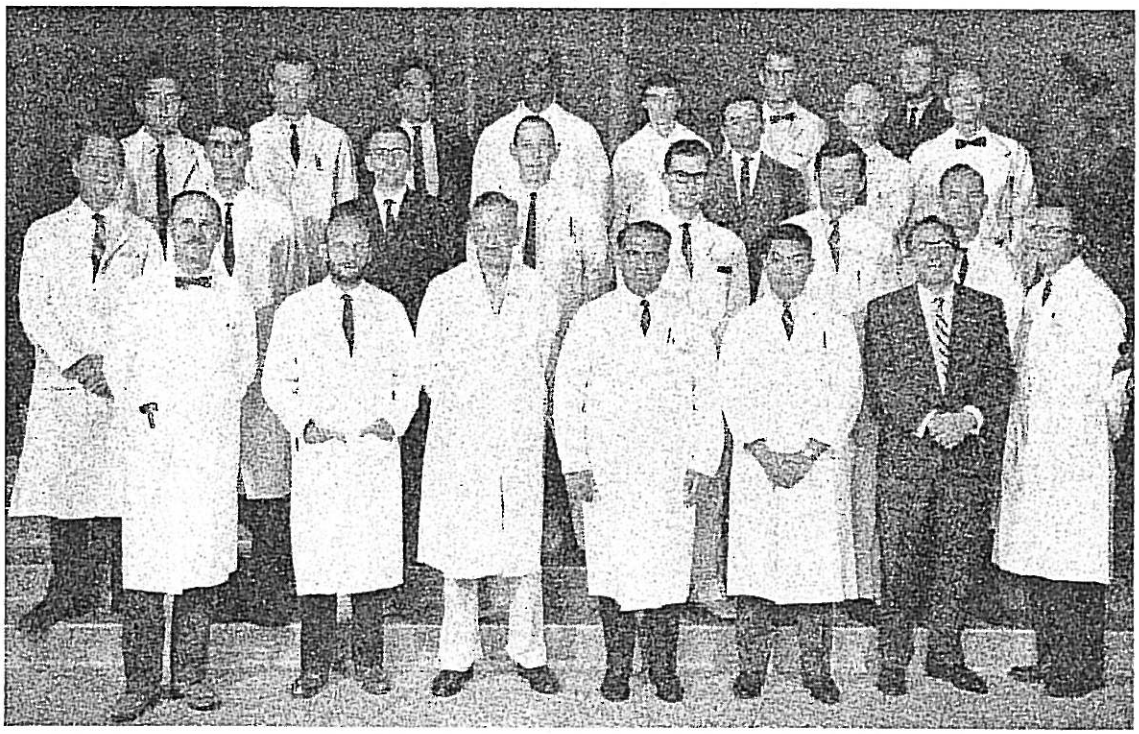
In an effort to be responsive to member and patient needs, the WSSA decided that if a supervising anesthesiologist met certain standards and was present before, during and after an operation and available for every case, then hiring and supervising nurse-anesthetists were questions of care and not of money. The WSSA modified the ASA guidelines to reflect this position, but also added a monitoring system. Any physician in Washington who hired technicians or nurse-anesthetists would have an annual inspection by the WSSA Committee on Standards of Ethical Practice, who would talk to the



The WSSA stance on the use of nurse-anesthetists in small hospitals influenced national policy.

anesthesiologist, the surgeon and the hospital administrator. Any evidence of questionable action would mean that the anesthesiologist's WSSA membership could be revoked and his or her malpractice insurer notified that the offender had been dropped for practicing unethically.

The WSSA believed this to be a reasonable policy with a considerable incentive. However, the ASA stood by its guidelines and discussed the possibility of rescinding the WSSA's component status. The controversy nearly led to legal action, but the WSSA was exonerated when, over about a five-year period, the ASA agreed with its stance. Concurrence came largely because many other ASA member states were in the same position as Washington state, with small hospitals facing the same dilemma in attempting to furnish the best anesthesia care. Once again, the WSSA had taken a controversial stand that evolved into a position of national leadership.



The mid-1960s University of Washington Department of Anesthesiology included current chairman Dr. Thomas Hornbein (front row, second from left), Dr. B. Raymond Fink (third), founding chairman Dr. John Bonica (fourth) and Dr. Richard Ward (far right).

COMMITMENT TO EDUCATION

Throughout the WSSA's history, continuing education for its members was a prime concern. That priority was manifested in the earliest meetings in members' homes and continued to be demonstrated. For example, the proceeds from the summer Seafair meeting support the WSSA Seafair Research and Education Grant for research on any anesthesiology topic. The first grant was awarded in 1987 for research into the role of central cholinergic depression in general anesthesia. The second grant, awarded in 1988, was for an investigation of the effects of spinal anesthesia on respiration in infants born prematurely.

The outstanding reputations of many WSSA founders enabled them to attract many world-class leaders in anesthesia to early WSSA meetings. In 1955 alone, the January meeting speaker was Dr. Arthur E. Guedel, one of the American founders of modern anesthesia and author of the classic text *Inhalation Anesthesia.* In June, Dr. Philip Bromage, a consultant "anaesthetist" from England, addressed the group at a Seattle Tennis Club dinner, and in August, 39 WSSA members and guests heard Dr. James McCulloch, president of the Australian Society of Anaesthetists. Other early presenters included Dr. Harold Griffith, who developed curare for anesthesia use, and Dr. Ralph Waters, who at the University of Wisconsin organized the country's seminal anesthesia teaching program and developed the use of a variety of anesthetic agents and equipment.

Many WSSA members and their wives particularly recall the 1963 annual meeting in September, where Dr. Thomas Hornbein recounted his recent experience as a member of the first American team to climb Mount Everest. Dr. Hornbein, who that same year was hired as an assistant professor of anesthesiology and of physiology and biophysics at the University of Washington School of Medicine, designed and tested the oxygen mask used by the climbers, and he and Willi Unsoeld completed the first ascent of Everest's West Ridge and the first traverse of a major Himalayan peak. Dr. Hornbein succeeded Dr. Bonica as chairman of the UW Department of Anesthesiology in 1977 and was selected to present the E.A. Rovenstine Memorial Lecture, the most prestigious presentation in anesthesiology, at the 1989 annual meeting of the ASA in New Orleans.

Some of the success of the WSSA's educational mission can be credited to the anesthesiology departments at The Mason Clinic and the University of Washington School of Medicine. Dr. Daniel Moore was hired in 1947 to direct the Department of Anesthesiology at The Mason Clinic and as chief of the companion department at Virginia Mason Hospital. As the only full-fledged anesthesiologist at Mason for the next

"We had the opportunity to meet the pioneers of anesthesiology that the Society got to come. They wouldn't have come just to visit me. They came because the Society was formed and they knew the founders."

— Dr. L. Donald Bridenbaugh, Seattle.

Dr. Arthur Guedel, left, chats with Dr. Lucien Morris in 1955.

By the late 1940s, it became quite evident that our way of getting chloroform vapor was crude... You either got none, a little, or too damn much. I must have said that any fool could make a better system than this, because in 1948, Dr. (Ralph) Waters went on vacation and sent a postcard back that said: 'Has Morris made a new vaporizer yet?'"

— Dr. Lucien Morris, on developing the Copper Kettle.

five years, he started Mason's residency training program in 1950 and initiated the first series of weekly anesthesia conferences that evolved into the all-city Seattle Anesthesia Conference. His interest in and experience with regional anesthesia — and later that of Dr. L. Donald Bridenbaugh, one of the first graduates of the Harborview residency program — are largely responsible for Virginia Mason's international reputation as a leader in regional anesthesia practice and research.

Without a hospital of its own at its founding in 1946, the University of Washington School of Medicine's clinical teaching focus was at Harborview Hospital, where an anesthesia residency program began in 1947 under the direction of Dr. James Mathwig, who had been a resident under Dr. Rovenstine in New York. In 1954, Dr. Lucien Morris, inventor of the Copper Kettle vaporizer and a protege of Dr. Ralph Waters, came to the UW School of Medicine as professor of anesthesia and head of the new division of anesthesiology in the UW Department of Surgery. To enhance anesthesiology resident and medical student learning opportunities, area leaders in the specialty were appointed to the division's peripheral clinical faculty, including Drs. Wangeman, Bonica, Moore, Eather and Turnbull, all of whom served as WSSA president.

In 1959, the division won one of the first four anesthesiology research training grants awarded by the National Institute for General Medical Sciences. The University of Washington Hospital opened that same year. Dr. John Bonica, who had begun the anesthesiology residency program at Tacoma General Hospital in 1946, replaced Dr. Morris and took over in 1960 when departmental status was conferred. The leadership and expertise of Drs. Morris and Bonica established the University of Washington's internationally recognized anesthesiology program.

The early excellence of the Virginia Mason and University of Washington training programs attracted some of the best minds in the field to Washington, and wide mutual benefits ensued. With the cream of the anesthesiology crop drawn to Seattle to study and practice, research and technology developments flourished. Residency programs expanded. Patient care quality earned a reputation for excellence. The state of Washington grew more desirable as a place to practice anesthesiology.

As WSSA membership rose, its financial base grew and its ability to lure top-notch speakers increased. In the early days, prestigious speakers came to WSSA meetings by virtue of the founders' personal connections and reputations. By 1966, the Society was able to offer guest speakers first-class air fare, lodging, and a $50 honorarium. Its programs grew in reputation and sophistication, with a growing perception among the state's anesthesiologists that WSSA membership was beneficial and worthwhile.

Another example of the WSSA commitment to education is also an example of its national leadership. In the early 1950s, Harborview's Dr. James Mathwig asked anesthesiology resident Dr. Richard Ward to study the records of patients who had died while under anesthesia. That early effort eventually led to a study, supported by a $500 education research grant from the WSSA, of 192 malpractice claims brought against Washington anesthesiologists from 1971 to 1982. Dr. Richard Solazzi, an anesthesiology resident at the University of Washington at the time, analyzed the files of Aetna Life and Casualty Company, the UW affiliated hospitals, the Group Health Cooperative, and the King County medical examiner's files involving anesthetic deaths from 1975 to 1982. Drs. Ward and Solazzi concluded that malpractice litigation protected patient rights but did not protect

Anesthesiology residents relax during a training seminar at Harborview in the mid-1950s. Dr. Milton Share, who served as WSSA president in 1965, is second from left.

physicians from incorrect allegations of malpractice. They also linked an "inordinately high" rate of suicide or suicide attempts — one per every 45 anesthesiologists — to malpractice accusations, and recommended that anesthesiologists in such circumstances seek counseling.

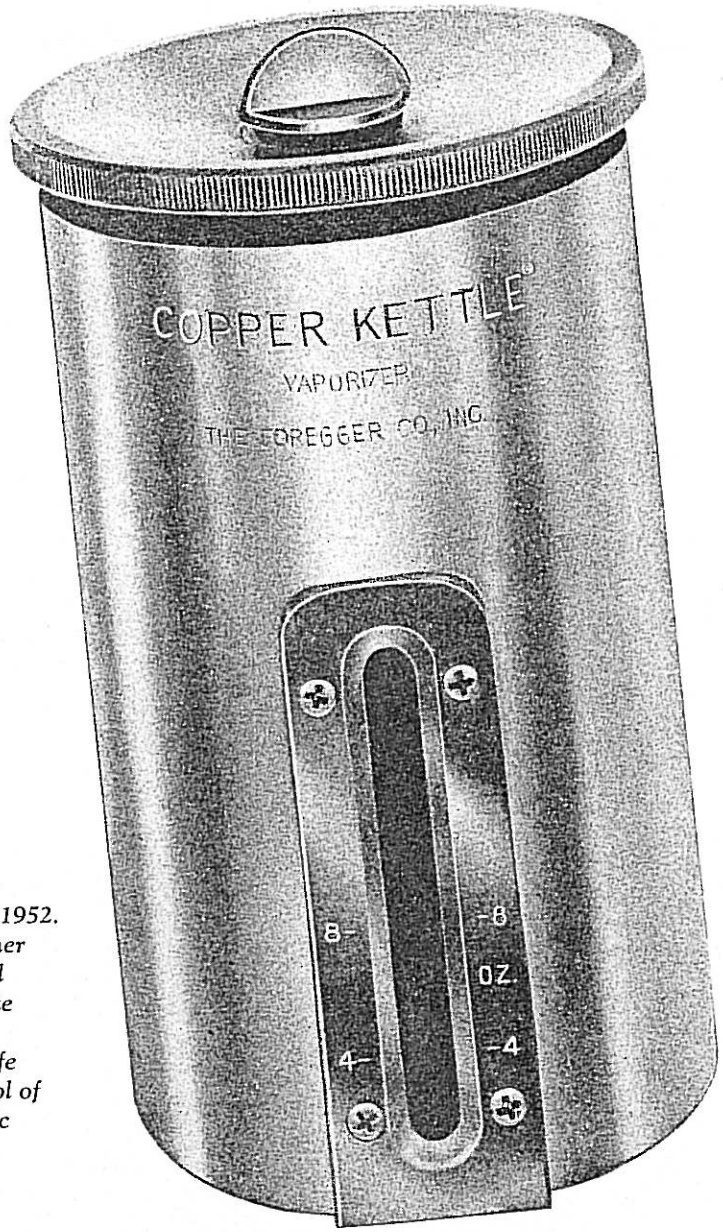
Their effort came to the attention in 1983 of ASA president-elect Ellison Pierce Jr., who asked Drs. Ward and Solazzi to write a chapter based on the Washington survey results for *Analysis of Anesthetic Mishaps*, the volume of *International Anesthesiology Clinics* he was editing for publication in summer 1984. That exposure led to the closed claims study, begun in 1985 by the ASA Committee on Professional Liability, for which the WSSA-sponsored survey served as a model.

The two WSSA members on the committee — Dr. Frederick Cheney, chairman, and Dr. Ward — participated in the review of approximately 1,650 cases from 22 insurance organizations as of 1989, with the help of WSSA member Dr. Robert Caplan of Seattle. The ASA closed claims study yielded many important conclusions, including that the use of such monitoring equipment as pulse oximetry and capnography would probably have prevented significant numbers of complications. On that basis, several states reduced the malpractice insurance premiums of anesthesiologists who use those monitors. Anesthesiologists are no longer considered as high an insurance risk as they once were, thanks in part to the efforts of WSSA members.

"The Society plays a role in bringing research developments to the people out in practice who otherwise might not be as well aware of their scope and usefulness. It's not easy to understand things when you read about them. It's much easier to have a chat with somebody about them."

— Dr. B. Raymond Fink, WSSA member and University of Washington anesthesiology faculty member since 1964.

In one of many published reports based on the ASA closed claims study, the committee determined whether anesthesia care was adequate in approximately 1,000 cases, then analyzed the financial losses in the instances where malpractice was deemed to have occurred. Among its conclusions was that a tort-based system of patient compensation for injury involves inequalities for both patient and physician. Efforts to improve the situation in Washington state focused on the impact of overly aggressive attorneys and led to tort-reform legislation in 1986-87. The legislation had direct effects — for example, it shortened the statute of limitations to three years — but more importantly, it created a sense of recognition that the costs of professional liability insurance are overly burdensome to society. The legislative action came about in part through efforts of the Washington State Medical Association Tort Reform Task Force and its WSSA representative, Dr. William Horton.



Dr. Lucien Morris created the Copper Kettle vaporizer in 1952. The copper container with a porous metal diffuser and separate oxygen flowmeter provided simple, safe and accurate control of vaporized anesthetic agents.

BEYOND THE CALL OF DUTY

Many members of the WSSA have been honored for their outstanding contributions to anesthesiology at local, state and national levels. Among the most prominent is Dr. Daniel Moore, who is internationally known for his expertise in regional anesthesia and published in 1953 the classic text on the subject, *Regional Block*. In addition to his status as a founder of the WSSA and its president in 1952, he also served as president of the ASA in 1958. He is credited during that time with returning the financially strapped association to a sound fiscal footing and moving the ASA office from downtown Chicago to its permanent headquarters building in Park Ridge, Ill.

Dr. John Bonica's credentials probably are familiar to WSSA members who attend the April WSSA meeting, held in conjunction with the University of Washington Department of Anesthesiology's annual Bonica lecture. While he was director of anesthesia at Tacoma General and Pierce County Hospitals beginning in 1946, he forged new ground in regional and obstetric anesthesia, and developed a multi-disciplinary approach to pain research, diagnosis and therapy. His books, *The Management of Pain* in 1953 and the two-volume *Principles and Practice of Obstetric Analgesia and Anesthesia* in 1967 and 1969, both are landmark texts. Bonica served as president of the ASA in 1966, during which time he overhauled many ASA committees and proposed new programs in the areas of teaching, patient care, obstetric anesthesia and professional activities. The budget he secured at that time to implement these programs was one of the largest ever approved by the ASA.

Dr. Clayton Wangeman in the mid-1940s.

Many other WSSA members, in addition to those whose contributions already have been outlined, deserve special mention. They include:

- Dr. Malcolm Bulmer of Wenatchee, who was WSSA president in 1962, a member of the ASA's first Committee on Peer Review, president of the Washington State Medical Association, and active in medical affairs in Chelan County;
- Dr. Richard Pokorny of Spokane, who was WSSA president in 1968, a trustee of the Washington State Medical Association, active in the Spokane County Medical Society, and contributed to many ASA subgroups;
- Dr. Clayton Wangeman of Seattle, who was a WSSA founder, president in 1955, and activist in many civic causes that contributed to community support of the WSSA, including the clean-up of Lake Washington;
- Dr. Delbert Small of Spokane, a recognized leader of the eastern contingent of WSSA members, and member of the WSSA Fee Schedule Committee and chairman of the WSSA Committee on Liaison with Insurance Organizations during difficult negotiations in the 1950s and early 1960s.

"We in Eastern Washington were once accused of having the tail wag the dog, but I thought we had something to offer."

— Dr. Delbert Small, who began practicing in Spokane in 1948.

"We Really Showed Them..."

"It was no coffee klatch. Everybody was independent and went his or her own way. We developed friendship and respect because we all weathered the problems together."
— Dr. L. Donald Bridenbaugh.

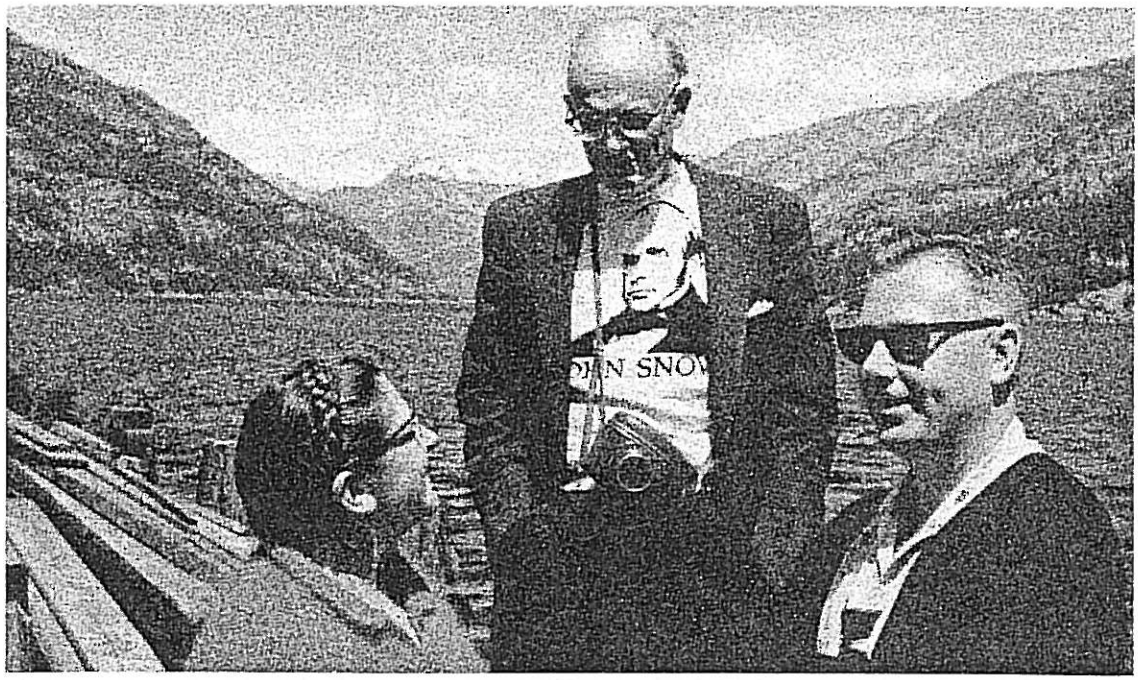
The history of the Washington State Society of Anesthesiologists is a remarkable saga that starts with fewer than two dozen physicians in 1948 on whose shoulders stand the 433 voting members of 1989. Many attribute the WSSA success to the unique character of that early group and the qualities nurtured in the early fights for what seemed to be the specialty's very survival.

The first WSSA members were comrades-in-arms. The intensity of their defense against the Mousel lawsuit packed WSSA meetings to the rafters month after month. Members didn't flinch in the face of the considerable financial demands the Society made on them. The lawsuit also forced the Society into the medical-legal arena, where it earned a national presence. The collaboration fostered close friendships among a group of individuals with diverse interests.

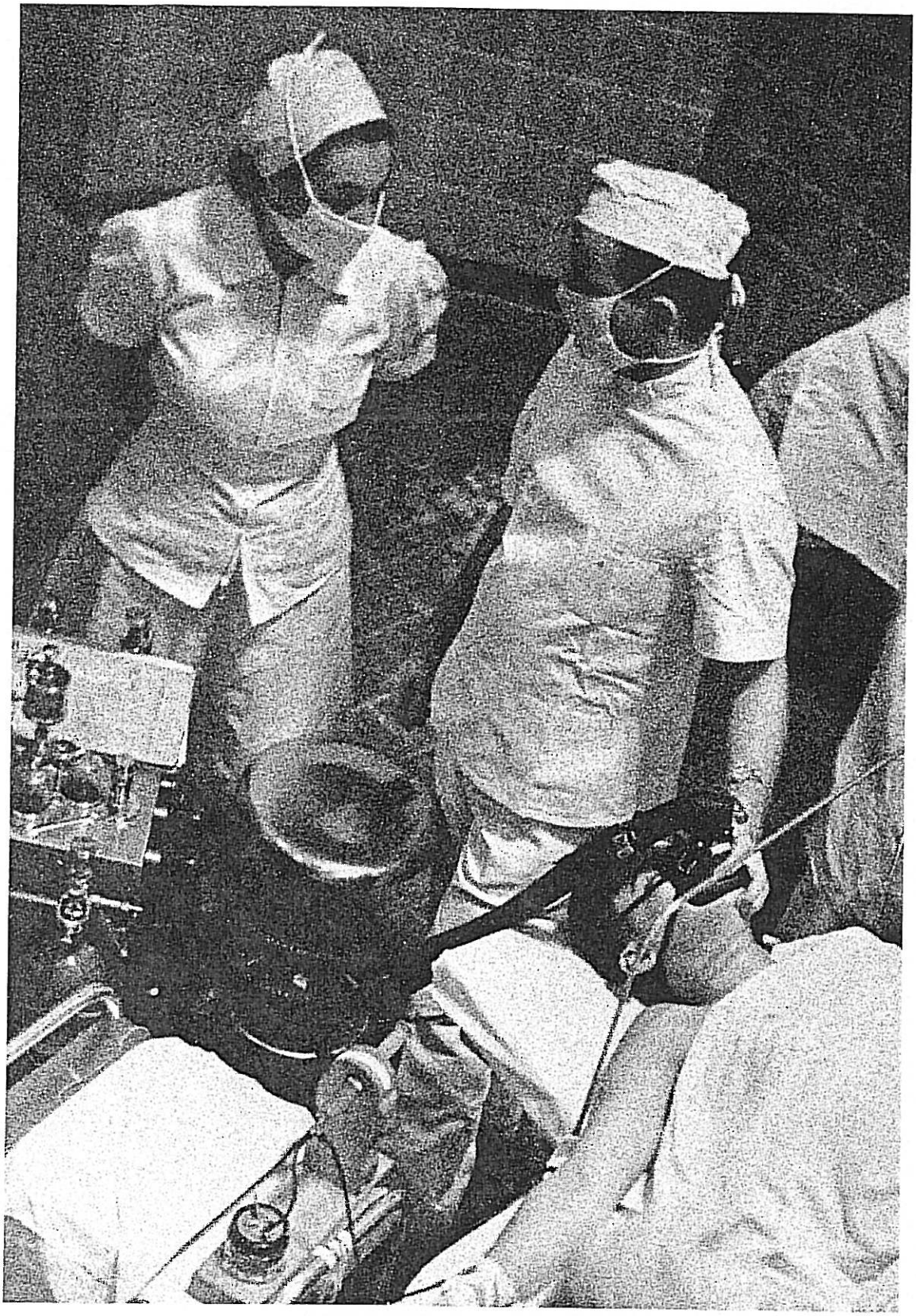
The organization gave the state's pioneering anesthesiologists an opportunity to counsel and advise each other. The specialty itself was a rarity in the 1940s, and each person who chose it faced his or her own set of unique challenges. Meetings gave them the opportunity to socialize, develop a network, and share opinions and experiences about their common calling.

Meetings also provided the chance to learn about new methods and techniques in clinical anesthesia, while the proximity of and ties to the University of Washington provided access to the latest research developments. With no budget for programs, the fledgling organization often planned meetings around the schedules of visiting scholars for guest presentations.

The WSSA founders and early members used hard work, determination, courage, resourcefulness and cooperation to lay the foundation for the growth and stature the WSSA now enjoys. These Washington pioneers helped to raise the levels of public respect, financial reward, professional responsibility and patient-care standards for today's anesthesiologists, whose challenge it is to protect and enhance that legacy for the future.



Dr. Greta McClelland of Australia and Dr. Robert Virtue of Denver enjoy the Lake Chelan scenery with Dr. Donald Schumacher, right, at the WSSA meeting in June 1966. Dr. Schumacher served as WSSA president in 1972.



"As a result of what my generation did, anesthesiologists gained a great deal of respect. When I went into the specialty, people thought you went into anesthesia because you couldn't do anything else. Now it has become one of the most prestigious specialties. During the early years, we really showed them how to do it."

— Dr. John Bonica.

Dr. Daniel Moore (center) consults with Dr. Mary Karp (left), chief of anesthesia at Wesley Memorial Hospital in Chicago. Moore, a medical student, gave anesthesia as an extern at Wesley from 1942 through 1945.

PRESIDENTS OF THE WASHINGTON STATE SOCIETY OF ANESTHESIOLOGISTS

1948	J. Joseph Mattes, M.D.	Seattle
1949	John MacKinnon, M.D.	Seattle
1950	Gordon A. Dodds, M.D.	Seattle
1951	John J. Bonica, M.D.	Tacoma
1952	Daniel C. Moore, M.D.	Seattle
1953	David W. Compton, M.D.	Mercer Island
1954	James D. Mathwig, M.D.	Seattle
1955	Clayton P. Wangeman, M.D.	Seattle
1956	L. Donald Bridenbaugh Jr., M.D.	Seattle
1957	Kenneth F. Eather, M.D.	Seattle
1958	W. Howard Pratt, M.D.	Tacoma
1959	B. Hood Baxley, M.D.	Spokane
1960	Robert S. Fisher, M.D.	Yakima
1961	Lawrence F. Turnbull, M.D.	Seattle
1962	Malcolm Bulmer, M.D.	Wenatchee
1963	Lucien E. Morris, M.D.	Seattle
1964	Edward S. Eylander, M.D.	Tacoma
1965	Milton Share, M.D.	Seattle
1966	Richard J. Ward, M.D.	Seattle
1967	Robert M. Kintner, M.D.	Wenatchee
1968	Richard L. Pokorny, M.D.	Spokane
1969	John Porter Reed, M.D.	Seattle
1970	Phillip O. Bridenbaugh, M.D.	Seattle
1971	Kiyoaky Hori, M.D.	Tacoma
1972	Donald P. Schumacher, M.D.	Mercer Island
1973	Haruto Sekijima, M.D.	Seattle
1974	William L. Collins, M.D.	Spokane
1975	Gene W. Mason, M.D.	Everett
1976	John E. Kemp, M.D.	Tacoma
1977	Peter M. Glass, M.D.	Spokane
1978	Roy C. Giles, M.D.	Bellingham
1979	Roberto Robles, M.D.	Seattle
1980	L. Charles Novak, M.D.	Wenatchee
1981	William G. Horton, M.D.	Seattle
1982	Wayne E. Martin, M.D.	Seattle
1983	N. Kirke White, M.D.	Clarkston
1984	Michael J. Bishop, M.D.	Seattle
1985-86	Vita S. Pliskow, M.D.	Tacoma
1987-88	Bruce F. Cullen, M.D.	Seattle
1989-90	Eric S. Johnson, M.D.	Spokane

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Daniel C. Moore, M.D. (pgs 10, 23)

Editor: Sabrina Porter Lindquist
Design: Currier Design

WSSA Executive Director: Shirley Bishop