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Establishment of the Department of Anaesthesia at Harvard Medical School—1969☆,☆☆

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Abstract

Background: The first academic departments of anesthesia were established in the United States at the University of Wisconsin–Madison in 1927, with Ralph M. Waters named as chairman, and in the UK at Oxford University in 1937, with Robert Macintosh as chairman. Compared to these early departments, more than 3 decades would pass before Harvard Medical School decided it was time to establish a department of anaesthesia, in 1969. We examine the forces on both sides of the issue, for and against, and how they played out in the late 1960s.

Methods: Published articles, books, interviews, and biographical and autobiographical notes as well as primary source documents such as reports of department and medical school committee meetings were examined to obtain information relevant to our investigation.

Results: The late 1960s were an ideal time for the chiefs of anesthesia at the various Harvard teaching hospitals to make a strong argument in favor of establishment of an independent department of anaesthesia. Although strongly opposed by Francis Daniels Moore, Chief of Surgery at Peter Bent Brigham Hospital, an independent department at Harvard was established in 1969.

Conclusions: The recognition of anesthesia as a distinctive specialty at universities across the country as well as the specific concerns over administration, hiring, and the future of the clinical service in the 1960s provided overwhelming support for the establishment of a separate, free-standing department of anaesthesia at one of the most tradition-bound universities in the United States—Harvard.

1. Introduction

Although the most widely recognized event related to the birth of our specialty occurred at Massachusetts General Hospital (MGH) on October 16, 1846, it would be more than 120 years before its Department of Anesthesia became independent in 1967, permanently escaping control and oversight from the Department of Surgery [1]. This granted clinical, administrative, and financial independence at 1 institution, whereas the medical school continued to treat anesthesia as a discipline under surgery. Two years later, in 1969, Harvard Medical School recognized the Department of Anaesthesia as an independent academic entity capable of appointing faculty, educating medical students, and directing research across all of its teaching hospitals [2]. Because 48 of 84 medical schools in the United States had autonomous

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departments of anesthesia at this time [3], an obvious question arises: Why did it take so long at Harvard? After all, the first US department of anesthesiology was established at the University of Wisconsin–Madison in 1927, with Ralph M. Waters as chairman [4], and in the UK at Oxford University in 1937, with Robert Macintosh as chairman [5]. We examine actions taken by Henry Knowles Beecher and others that led to the department's creation as well as the arguments made against it by its most strenuous opponent, Francis Daniels Moore. Analysis demonstrates that Harvard was no different from universities across the country in deciding to recognize anesthesia as a distinct specialty from surgery. The terms *anesthesia* and *anaesthesia* have been used throughout this manuscript. Harvard University, in keeping with Dr Oliver Wendell Holmes' use of the Anglicized diphthong, maintains a department of anaesthesia (similar to orthopaedics), whereas most departments in the United States use the term *anesthesiology* or *anesthesia*. During most deliberations related to the establishment of the department at Harvard, Beecher and medical school officials used the non-Anglicized form "anesthesia."

2. Dependency since birth

Due to its supportive and enabling function, the discipline of anesthesia has been intimately related to surgery since its very inception. The discovery of anesthesia has been hailed as one of the greatest medical discoveries; in fact, advances in many surgical specialties could not have occurred without parallel progress in safe anesthetic techniques. Unconscious patients allowed surgeons to explore operative treatment for many medical conditions.

While the discipline of surgery grew rapidly, the task of administering anesthetics was not seen as sufficiently challenging by physicians to consider it as a career. For many years, the task of administering anesthesia was relegated to the most junior members of the surgical team—medical students, nurses, orderlies, among others [6,7]. Surprisingly, complications and deaths from anesthesia failed to persuade potential physician anesthetists of the 19th century to take up the challenge of administering safe anesthetics. Due to a shortage of individuals who could provide safe anesthesia, many surgeons began to train nurses in that role. Formal training programs for nurse anesthetists were established, and it was not until the early 20th century that physicians were trained specifically to administer anesthetics [1]. The First and Second World Wars were a major impetus for increasing the numbers of both physicians and nurses who worked full time providing anesthesia care [6-8].

For many decades, there was little systematic study or investigation in this newly created state of human consciousness. It is not surprising that surgeons, in an effort to improve their outcomes, would be the ones to study and advance anesthesia. For example, Harvey Williams Cushing (1869-1939), the father of neurosurgery and the first Chief of Surgery at Peter Bent Brigham Hospital (PBBH), as a medical student at Harvard in the 1890s developed the first anesthetic record [9,10]. Later, during a visit to Europe, Cushing became familiar with Scipione Riva-Rocci's (1863-1937) method of determining blood pressure and realized the importance of normal blood pressure to a patient's well-being. Upon returning to the United States, he insisted that blood pressure be routinely monitored on all patients during surgery at PBBH. Considering anesthesia a surgery-related matter was a sign of the times. There was much give and take between the 2 disciplines, with anesthesia enabling advances in surgery and surgeons pushing for better and safer anesthetic techniques. Moreover, many early anesthetists were originally trained as surgeons, so it came as no surprise that anesthetists were selected and hired as members of surgery departments.

3. Early anesthetists at Harvard

As anesthesia became universally accepted in the late 1800s, it was expected that every surgeon would develop some skill in anesthesia for his own practice [1]. At MGH, the task of administering anesthesia fell to the "etherizer," a junior surgical house-pupil. A given etherizer would be on service for a few months before leaving the task to one of his colleagues. In 1903, MGH hired Freeman Allen, originally trained as a surgeon, as its first anesthetist. He was appointed as consulting anesthetist for the anesthesia service by MGH's Department of Surgery to systematically instruct the surgical house staff and administer anesthesia in difficult cases [1]. Allen's successor, Howard Bradshaw, remained anesthetist-in-chief at MGH from 1933 until 1936 before resuming a career as a surgeon [2]. Bradshaw was replaced by Henry Knowles Beecher, who would remain as chief at MGH until an independent department of anesthesia was established in 1969.

At PBBH, established in 1913, Walter M. Boothby was appointed by Harvey Cushing as the first supervisor of anesthesia. He left after a few years, and the hospital was without a physician anesthesiologist, relying entirely on nurse anesthetists, until William S. Derrick joined in 1948 and established a residency program. Derrick graduated from George Washington University Medical School and trained in anesthesia during World War II. He was assigned to Walter Reed General Hospital as a member of the anesthesia staff and later as chief of the anesthesia and operating room section [11]. Leroy D. Vandam, appointed by Francis D. Moore as anesthetist-in-chief in 1954, took the division of anesthesia to new heights in patient care, teaching, academic contributions, and leadership. He was succeeded by Benjamin G. Covino (1980-1991), Simon Gelman (1992-2002), and the current chairman Charles A. Vacanti was appointed in 2002. Beth Israel Hospital was established in 1916 to serve the needs of Boston's Jewish community. Samuel Gilman served as chairman between 1937 and 1967. He was succeeded by John Hedley-Whyte (1967-1987), Edward Lowenstein (1988-1997), Carol Warfield (2000-2007), and current