Anesthesia Practice in London Prior to 1962

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Before 1958, each anesthesiologist was a solo practitioner and was, therefore, booked by a surgeon for each case. Thus, the individual had to be available at all times and a person, often the wife, had to cover telephones calls and coordinate the anesthetic bookings for the physician. Cases could be at either of the two hospitals, so conflicts could be a problem due to a late running case. An example of this could be a D&C at St. Joseph's (8-9), followed by a hernia at Victoria (9-11), then back to St. Joseph's for a gallbladder at 12. This driving schedule could often be interrupted by a freight train on the CPR track.

The physician traveled with a black bag containing a selection of red rubber endotracheal tubes, BP cuff, stethoscope, laryngoscope etc. because only the gas machine and anesthetic drugs were provided by the hospital. Electrical monitoring, of course, was not used because explosive agents such as ether and cyclopropane were in common usage.

To be on the active staff of a hospital implied the provision of anesthetic services for public ward patients which were treated free of charge as there was no OHIP at the time. Thus, it was important to carefully guard the private practice and be amendable to the surgeon's needs. There was a call list organized by the chief to cover public ward cases, but most surgeons did make use of this for their private emergencies. For example, at a night there could be three different cases attended by three different anesthesiologists.

Obstetrical anesthesia was always a concern as members of the teaching staff (specialists) attended only 35% of the cases, whereas general practitioners provided 22% of the anesthetics, interns gave 20%, and nurses 10%. It was obvious to Dr. Spoerel that anesthesiologists worked hard but were not very productive. The surgeons were grumbling and the obstetricians complained about inadequate coverage. The interns in 1958 refused to continue providing obstetrical anesthesia.

Therefore, on February 1, 1958 under the leadership of Dr. C.A. Stewart and seven of his colleagues, an Anesthesia Booking office was opened. It was an improvement that increased efficiency and reduced cross-town travel. Gradually, this group increased in size and by September 1959, the sixteen practitioners formed the Anesthesia Bookings. The group had to take all requests for anesthesia services in the two hospitals and required full cooperation by all physicians. There were still three practitioners outside this group who were booked by individual surgeons. Each surgeon could select his anesthesiologist, but there was some unhappiness when a request could not be honored. This resulted in some cancellation of cases. It then became the responsibility of the booking office to assign a competent physician for the case and this became less of a problem as training improved.

As time went on, discussions developed that resulted in a type of group practice for anesthesia in London. This included the organization of holiday schedules, billing arrangements prior to medical care insurance, coverage of emergencies, support for teaching, etc. On January 1st, 1962 the Anesthesia Associates of London was born with nineteen members. It was the first city-wide group in Canada covering all the hospitals. It improved the efficiency of anesthesia care in London, supported the academic aspects of the University department and provided a much better lifestyle for its members.

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