EDITORIAL

THE ANAESTHETIST AS A CLINICIAN

When in these days a contrast is made between anaesthesia as it was twenty-five years ago and anaesthesia as it is to-day, it is more often the technical side of the work which is being considered. In spite of this it is not to improvements in technique that anaesthesia owes its emergence as a specialty. Manual dexterity and operative skill alone, important though they are, no more make a good anaesthetist than they do a good surgeon. It therefore follows that if we wish to obtain full and final recognition for our specialty we must draw more attention to those parts of our work in which mere technical skill plays a minor part and where medical judgement similar to that required in other specialties is needed. In other words it would seem desirable that we should devote a greater proportion of our time and energy to those parts of our work in which we appear in a direct doctor-patient relationship, and lay less emphasis on those occasions when our activities are ancillary to those of the surgeon.

On superficial consideration it might seem that the opportunity for the exercise of clinical judgement in anaesthesia begins and ends with the choice of the best form of anaesthetic for any particular patient. In fact however there are many other sections of our work which call for the approach of the physician rather than that of the technician. Premedication for example is an art calling for much care both in case selection and in the prescription of the drug most suitable to the individual patient. If the best possible results are to be obtained routine premedication is quite useless. Instead suitable variation must be made both in the agents used and in their dosage to allow for age, infirmity, apprehension, probable resistance to drugs and the disorders of function produced by complicating medical conditions. It is obvious that premedication of this standard cannot be done through an intermediary and the anaesthetist who himself undertakes this part of his work will find that his patients are better premedicated and therefore more grateful to him. He will also find that his colleagues recognise him as more than a competent technician who gives good anaesthetics.

A duty which the anaesthetist may with advantage undertake is the care of a patient with a complicating medical condition in addition to the disease for which the operation is being performed. In the past it has been customary to call in physicians to treat such patients but the results have been unsatisfactory because those who were called in had necessarily so little idea of what were the stresses and strains im-
posed on the vital functions by anaesthesia and operation. In fact it is the anaesthetist who by virtue of his observations of the patient before, during and after the operation is able to take the proper measures to minimize the disturbances which arise largely as a result of his own activities. The outstanding example of this type of work is of course the care of the diabetic during the operative period and there can be no doubt that the anaesthetist is the best member of the surgical team to estimate the probable severity of the upset of carbohydrate metabolism which will be produced by the morphine, the trauma and the anaesthetic agent, and to make suitable provision for the period during which the patient is unable to take his ordinary diet. Many other instances could be given of medical conditions in surgical patients in whose treatment the anaesthetist can give valuable help, for example, the control of digitalis dosage in cardiac disease, the prescription of prostigmine in myasthenics and above all in the administration of the fluids and minerals required to correct the metabolic errors produced by gastro-intestinal disease and other disorders of the electrolyte metabolism. The treatment of wound shock before, during and after the operation is yet another outstanding example of work of this kind and many other instances could be given. So often these matters are left in the hands of house surgeons or junior registrars but there is no doubt that they can be so much more competently dealt with by the anaesthetist.

Probably the greatest contribution which the anaesthetist's ward work can make to the success of the surgical team is his pre-operative assessment of the fitness of patient for the operation. At present there are no really reliable criteria of operability in the vast majority of conditions and most decisions on the subject are ex cathedra statements based on the rather vague experience of surgeons who do not have the time or skill fully to examine the patients for complicating medical conditions, or of physicians who have little real knowledge on which to base their conclusions. The anaesthetist, on the other hand, in the course of his training has become a competent physician and, as a result of his practice of examining all his patients regularly before the operation and following their progress after the operation, has an extensive and useful knowledge upon which to base a decision as to the wisdom of surgical interference in the presence of complicating medical diseases. Anaesthetists are however only beginning to work on this problem and their conclusions must still be regarded as provisional. There is a tremendously wide field for development in this section of our work and the extent to which we make use of this opportunity may well be one of the major factors in the degree of recognition which our specialty obtains.

There is a contribution calling for the very highest type of medical judgement which every anaesthetist can make in the operating room itself. The surgeon deeply engrossed in the technical details of the
apparatus does not wish to interrupt his work periodically to assess
the condition of the patient. He will depend on his anaesthetist to do
this for him. Further he will expect to receive information of adverse
changes in the patient’s condition at a time at which he can still take
steps to retrieve the position. Thus if the anaesthetist is aware that
a patient undergoing a pneumonectomy is becoming progressively more
ill and is unlikely to withstand the operation it is obvious that notice
of this fact must be given to the surgeon before any of the major hilar
structures have been divided; for after the bronchus or the main vessels
have been cut across premature termination of the operation means
only the avoidance of a possible death on the table at the expense of a
certain death later. Similar “points of no return” exist in other op-
erations, for example, division of the duodenum in gastrectomy, and
the anaesthetist must be careful to assess his patient as accurately as
possible just before this stage is reached. If he allows the surgeon to
go further he must be prepared to let him complete the operation; only
requests for greater speed or for periods of rest are permissible after
the point of no return has been passed.

The anaesthetist who advises the abandonment of an operation or
the substitution of a less radical procedure for that originally proposed
must however consider more than the patient’s condition at the time.
He must also reflect on the purpose of the operation. If the aim of
the surgeon is merely to improve the function of some part of the body
whose preservation is not essential to useful life the anaesthetist will
have little hesitation in suggesting that the operation should be aban-
donned if the patient’s condition deteriorates. If however the opera-
tion offers the patient his sole chance of recovery from an otherwise
incurable disease the anaesthetist will allow the surgeon to continue
until it has become apparent that successful resuscitation is going to
be a matter of extreme difficulty, indeed until the patient has almost
no chance of recovery. The anaesthetist who weighs these matters
carefully and offers to his surgical colleagues useful and timely advice
of the type outlined will always find that notice is taken of what he
says and very often will discover that the full and onerous duty of
deciding whether a patient shall or shall not have a curative operation
has to be borne by him. It is his duty to shoulder the responsibility
and if he makes his decisions intelligently he will find that he is the
more respected for it.

These examples by no means exhaust the possibilities for clinical
work in anaesthesia. Thus there is the anaesthesia out-patient depart-
ment where patients can be reviewed before admission to hospital with
a view to eliminating those conditions which militate against safe an-
aesthesia. Therapeutic nerve blocking may well be performed on out-
patients in the same clinic. Yet other types of clinical work are open
to anaesthetists working in special departments. For example, the
anaesthetist in a thoracic unit may well undertake the bulk of the aspi-
ration bronchoscopies; in a neuro-surgical department he may be made responsible for the care of those unconscious for long periods; in the obstetric clinic the anaesthetist may undertake the provision of analgesia in labour. Many other similar types of work no doubt exist in other spheres of medicine where by reason of his special knowledge or technical skill the anaesthetist is the person best qualified to take charge. It is of great importance that we should take every opportunity to extend these sections of our specialty as it may well be that before long our standing in the medical world will be judged rather by the quality of our clinical work than by our technical skill.

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