EDITORIAL

ANAESTHESIA AND GOLF: AN ANALOGY

SINCE a large number of medical men are addicted to the playing of golf, and since certain errors in playing that game are analogous to certain mistakes made in the administration of anaesthetics, it may be diverting to pursue the comparison.

I. "UNDER-CLUBBING"

The professional golfer is always pained to see an amateur select a number two iron at a hole measuring two hundred and ten yards and reach the green with a glorious full swing and a shot slightly topped. Similar shots are often played with mashies and mashie-niblicks at ranges of a hundred and sixty to a hundred and thirty yards. The professional will urge the amateur to use a spoon for the first and a number three or four iron for the second type of stroke, and to shorten his swing and concentrate on accuracy rather than distance. The argument is that by doing so there is no need to "force" or "press," and the stroke gains in "control" even if it is not so refreshing to play. The amateur is tempted to "force" by the fact that the more lofted clubs are easier to use and he feels a greater confidence in them.

An analogous mistake is often made in the choice of anaesthetic agents. Agents are potent or impotent as their "toxicity" is great or small. This toxicity has been appraised by pharmacological methods in experimental animals, often with little regard to the depth of anaesthesia produced, and by workers not in the habit of administering anaesthesia. In every case there is, as in golf, a certain "distance to be covered" to the point at which anaesthesia is sufficiently deep to furnish ideal conditions for operation. There is a tendency among anaesthetists to prefer to "force" with agents such as nitrous oxide, ethylene, procaine, or evipal, rather than to "spare" with cyclopropane, chloroform, ether, nupercaine, or pentothal. There results a lack of "control" of the anaesthesia because patients vary as much as the amateur golfer's swing, and therefore the desired result often proves unattainable. A relative overdose of anaesthetic is no more to be desired than the approach shot which runs across the green to bury itself in a deep tangle of vegetation. The expert performer gains in assurance and control by using a tool which he knows to be fully adequate to its task. He can then afford to use it sparingly and subtly.

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II. RASHNESS

A distinguished golfer—I believe Mr. R. T. Jones—once gave as his formula for success that "golf should be played from between the ears." By which he meant that thought is required to ensure that one shall be safe rather than sorry. Certainly the secret of his magic touch was rather that he rarely encountered difficulties than that he had occasion to display his superb power of recovery from them. The golfer who strays not from the straight and narrow way and whose first putt is always "dead" is in better case than the spectacular performer who can dig his ball from deep rough with a heavy niblick and make it alight upon a green two hundred yards distant. What sane professional, with a critical hole at stake, will attempt an approach shot which involves a "carry" of two hundred and forty yards over bunkers instead of playing short and being safe? Yet such shots sometimes succeed, and their thrill haunts the memory for years afterward. Golf, however, is supposedly a pastime, intended for the diversion of the player. Anaesthesia is not a pastime: its purpose is the treatment of a patient: and the penalties of stupidity are more serious than the loss of a hole or a match. It is therefore of even greater importance to the anaesthetist to "be safe rather than sorry." I have commented elsewhere on the fact that intubation of the trachea, deliberately performed as prophylaxis, can preclude many of the difficulties of the maintenance of anaesthesia.

Diathermies, cauteries and electric switches which may give off a spark, and electric lights which may develop a short-circuit or become very hot are all frequently used in a modern operating room. Any of these may cause an inflammable vapor to ignite. The marvel is not that three hundred or so explosions have occurred in the course of several million administrations, but that there have not been many more. There is, of course, only one logical preventative: when it is known that a source of heat will be present during the operation anaesthesia should be conducted by methods not susceptible to fire or explosion. It has always seemed incredible to me that, seeing that deaths during the proper use of chloroform are fortunately infrequent whereas an inflammable agent mixed with oxygen will invariably explode or burn if ignited, anyone should feel that chloroform is "too dangerous to be used" in cases of this type. It is true that we are still searching for a non-inflammable agent of full potency but lesser toxicity than chloroform, and trichlorethylene may prove to be such a substitute. Until this is shown to be the case, however, I shall continue in the belief that it is wiser to "spare" a patient with chloroform and ample oxygen, than to "force" with nitrous oxide and hypoxia.

Patients are of certain types which can be recognized at sight after some experience. The large and "tough" men who will probably fight on induction; those with short wide necks who are wont to develop

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respiratory obstruction; those who are red-headed, liable to sudden accidents of circulation or respiration, and showing cyanosis easily; the anaemic who can die of hypoxia when of a vaguely slate-grey color; the terrified and tense who are prone to sudden circulatory collapse and who require full saturation to obtain relaxation; and the desperately ill in whom a ludicrously small amount of the agent will produce deep anaesthesia. "Praemonitus praemunitus" said the antient wisdom. The good golfer considers the difficulties of a particular hole and decides how he should play it safely. In the same way the good anaesthetist decides how he should anaesthetise a given patient for a particular operation.

It is said that the good golfer plays for the flag and not for the green. Accuracy of objective is equally essential to the anaesthetist, but is more difficult to attain. The flag on the green is visible, whereas the desiderata of good anaesthesia are far from obvious. They vary with every operation and must sometimes be modified in deference to the condition of the patient. To appraise them the anaesthetist must have had experience of operative surgery and must constantly watch and listen.

Good anaesthetists are born rather than made, though some attain skill by practice. To the golfer born, the old Scottish two-ball foursome is still the finest form of the game. It teaches charity, forbearance, unselfishness, and self-discipline. We must learn to regard our surgical colleague as our partner in a two-ball foursome rather than as our opponent in a match. Often our drive lands him in the rough, and when it does we should be duly penitent. If the drive is good and his second shot finishes in a bunker from which we must recover, we should do our best without complaining, and rejoice if we succeed and apologise if we fail. It is wise and courteous to consult one's partner as to how a hole or a shot should be played. Sometimes he knows the course better than we do, and only a fool rejects sound advice. The end, however, must always be "to play for the side": the good of the patient. No partner will upbraid you if you win the match, and no true surgeon will bear you a grudge if the patients consistently recover well after operation.

If, when the last putt has been holed, we can share a drink in the clubhouse and talk it all over as old friends we shall play the better next time for our deeper insight into each other's idiosyncrasies. Thus, in due process of time, we may become the redoubtable combination usually described by their fellows as "they are a good pair." For this depends as much on understanding as on skill.

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