

EDITORIAL

THE ANESTHETIST'S PART IN THE DOCTOR-PATIENT RELATIONSHIP

I do not suppose that ANESTHESIOLOGY normally invites and carries contributions from theologians. I am, therefore, entitled to a few preliminary words as to why and how I, the Dean of a Divinity School, am appearing on these pages.

Some three or four years ago a friend, Dr. J. Howard Means, at that time Chief of the Medical Services at the Massachusetts General Hospital, invited me to come over and talk to his staff. He said that in the course of his hospital rounds he and his house officers kept coming upon problems which were moral rather than medical. He cited two or three such cases. The most striking was that of a woman who had been diagnosed for an inoperable cancer of the stomach. She was bleeding internally and was being kept alive by transfusions. The difficulty was that she had to have Rh negative blood and the blood bank in the Hospital had only a limited supply of this type. The keepers of the bank began to protest against what seemed to them the useless waste of their limited stock, and said that they thought their Rh blood should be kept for some patient whom it could really help and permanently save. They regretfully announced that they thought the patient in question should be denied further transfusions, even though the result of that action would almost certainly be fatal. Should the Hospital go on giving her the blood, or should it withhold it? As Dr. Means said, this was a moral rather than a medical problem.

The invitation itself and my acceptance of it were an instance of the ways in which the fields of medicine and morals and the interest of doctors and ministers are finding more in common than was once the case. Our professions do not coincide, but today they do overlap. I had an interesting hour with the staff at a late afternoon hour in the historic ether dome of the Bulfinch Building of the Hospital. The *New England Journal of Medicine* asked for the text of the talk and eventually printed it as a leading article in its issue of December 23, 1948. The publication of this paper brought me a flood of invitations to speak at medical schools on the whole subject of medical ethics in general. In response to these invitations I have lectured twice to the Medical School of the University of Michigan, once each to the Medical School of the University of Wisconsin, the Cornell Medical School and the Harvard Medical School. Being quite unable to turn aside from my own job and go circuit riding in this new field I finally elaborated what I had tried to say in a small book.*

* *The Ethical Basis of Medical Practice*, by Willard L. Sperry, with a Foreword by J. Howard Means, M.D. New York, Paul B. Hoeber, Inc., Medical Book Department of Harper

This volume fell into the hands of one of the Associate Editors of ANESTHESIOLOGY, and on a recent trip to Boston he did me the honor of coming out to Cambridge and spending a mutually interesting hour going over some of the matters I had discussed. The book as a whole is tentative; it does not attempt to dogmatize, but it does try to discover what some of the stubborn moral problems are in the practice of both our professions. In due time the Editor of this journal solicited a contribution to these pages. The book roams over a series of familiar problems and advances only tentative solutions: Specialization vs. General Practice, Socialized Medicine, Telling the Truth to the Patient, Codes of Medical Ethics, the Prolongation of Life, Euthanasia, and so forth.

This is not the occasion for making a mere abstract of the book as a whole. Any or all of these matters have a theoretical interest for doctors, as indeed they have a collateral interest for ministers; since a parishioner, as a patient, often talks these matters over with his minister. At times he does so when he is reluctant to ask his doctor what the prognosis is. Is he going to get well or is he going to die? The minister will be well advised to say that he is not competent to answer that question and refer the questioner back to his physician. Nevertheless we are often asked for what may be a confidential prognosis which prudence and common charity prompt the doctor and the family to withhold from the patient. (Incidentally, two years after my talk at the M.G.H. Dr. Means wrote me that the woman who had, as he put it, "started this chain reaction" on my part, was getting well and required no more blood transfusions!)

I have been a little hard put to it to decide what, in particular, I might say to your specialized branch of medicine. But I have plucked up courage to respond to the Editor's invitation on the basis of my own experience as a patient. I have had eight major operations in the course of the last thirty years. To be specific: an appendix, a vein ligation in the groin, three successive operations on a gall bladder, a shattered and splintered shoulder marvellously put together by Dr. Smith Petersen, and two prostate operations. The Phillips House at the M.G.H. has no terrors or novelties for me, and is indeed, in the words of Mr. P. G. Wodehouse, a kind of "home from home," particularly the "fifth floor." You will agree, then, that I have a fair amount of evidence on anesthetization from the patient's end of the line.

The book as a whole tried to defend the primacy of the "doctor-patient" relationship. This primacy is affirmed in all the standard codes of medical ethics. But its theoretical affirmation in the book of the rules is by no means a guarantee of its observance in practice.

The modern world is confronted, as never before in our tradition, by

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movements in politics and economics, which deny the value of the individual and affirm the supremacy of society as a whole, or at least some class or racial or social group. The traditional Jewish-Christian ethic which theoretically dominated our western culture for centuries held that the single individual is of independent and all important worth. This principle is announced in the classic words, "The Sabbath was made for man and not man for the Sabbath." All our modern democracies presuppose that premise; the state is made for man, not man for the state.

In the middle of the last century that principle was challenged by the German philosopher Hegel, who inclined to the view that the individual citizen is of value only as a cog in the social machine, a necessary cog but nevertheless a cog and not a being of inherent and individual worth. His views were adopted by the German statesmen and militarists before the First World War and have been elaborated, matured and implemented by all the totalitarian states of the past twenty or thirty years. Cruelty is nothing new in this world; what is new is the rationalization of much of the cruelty of these last years in the interests of Fascism, Nazism and Communism. That rationalization provided Hitler with what he thought was his moral warrant, not merely for his brutal racial purges, but for his earlier systematic "liquidation" of some 250,000 incurable and useless patients in his hospitals (useless from the economic and military point of view), before ever he launched World War II. He held that the state has not merely no moral need, but no moral right to handicap itself by continuing to care for such persons and keep them longer alive. Down the road of this logic lay all the bestialities which followed at Belsen, Dachau and the like. There is no reasonable doubt that the Kremlin looks the same way at the individual Russian peasant. Were not some 5,000,000 Kulaks allowed to starve to death on this grim premise?

Sophisticated cruelties of this sort are no part of our democratic pattern of life. But practically the individual American citizen is today a much more regimented person than he was even fifty years ago. "Rugged individualism" is a tradition rather than an achieved fact. No one, at the beginning of the century, would ever have supposed that the United States would accept fifty years later, and without protest, the principle of universal military service. We have much less control of our time, our money, our vocation and its conditions, than our fathers had a half century ago. The area of our actual liberties and opportunity for private initiative has been steadily shrinking. It is probably true the rugged individualist had over-bid his hand and in the order of history was due to be set. Beyond the town of Concord, Mass., as represented by Emerson, Thoreau, Alcott and the like, no integrated society is possible. Its rugged individualism was inviting an inevitable reaction.

But it is a fair question whether that reaction has not, in practice, gone as far as it can decently go without a theoretical revision of our hereditary profession of faith in the value of the single human individual. Have the Germans and Italians and Russians and Spaniards been not merely realistic in their attitude toward the single man, but right? Are you and I and our patients and parishioners little more than cogs in the social machine, of no account in and for our individual selves?

It is well to realize that the affirmations of our religious classics and our political constitutions that individually we do matter, that indeed we are what matters most, are by no means a guarantee that this is a fact. We Americans are temperamentally rhetorical. We like to put these statements on a kind of prayer wheel and watch them blow around in the wind, in the bland assurance that by so doing we validate and fulfill them. But, as citizens of the kind of country we now live in and more particularly the kind of age in which we are living, we ought to ask ourselves how far we believe in the classic hereditary dogmas that of all values in the world that of the individual human life is the first and most sacred.

Let me come to closer range with our two professions. As I see our present set-up religion and medicine, the ministers and the doctors, are the two groups on whom the responsibility mainly rests for vindicating our hereditary faith in the value of the individual. Can we still make him feel that in and for himself he matters? On the whole ministers try to do this, not so much in sermons as in parish work. The best of them agree with a famous Anglican clergyman who spent his life in the East End of London, that the "only permanent good done in such a society is done by those who are willing to take time and trouble with individuals." Taking time like that is a costly process, but I believe it to be true.

You, in medicine, are tempted to fall between two stools. The general practitioner is always willing to take time and trouble with individuals. The successful specialist has less and less time for that luxury, or thinks he has. I can think of more than one specialist's waiting room where I have sat in line, waiting for my turn as the next "case." No one, from receptionist, nurse and doctor, seemed to indicate that I was a distressed human being with my own personal perplexities and perhaps my own distinctive values. I was merely put through the mill as the latest medical item to go into the hopper.

Now this is where the anesthesiologist comes in. I can think of no branch of medicine in which it is more difficult, even to the point of professional impossibility, for the medical man to vindicate the prime importance of the doctor-patient relationship. Let me state the case from the patient's standpoint.

He is due for a major operation. He goes into hospital at 5 p.m. His watch and his wallet are left at the desk. His clothes are stored

away. He is put into a "johnny" and put to bed. A johnny is undoubtedly an ideal garment for its purposes, but is an awkward and rather humiliating substitute for pajamas. At about 5:30 he has an austere meal of clear weak tea, and unbuttered toast. Somewhere after six a competent looking woman, a technician, comes in and draws some blood from the ear and then a larger amount from a vein inside the elbow joint. She packs up her apparatus and leaves without saying a word. An hour later a nurse comes in and announces that she is going to bathe you. This unfamiliar and semi-humiliating procedure is accepted. She is followed by an orderly who "finishes" the bath by dealing with the more intimate parts of the body. Eventually another orderly arrives and proceeds to shave the prospectively involved surfaces of the body. All this is familiar routine with you. But you should realize that to the patient it is, for the first time at least, a rather cold-blooded proceeding.

It is probable that at this stage of the game, shall we say 8 p.m., the family doctor looks in to give a friendly and reassuring word, and then the surgeon-of-the-morrow comes in to say much the same thing. Up to date the proceedings have been definitely impersonal. These two final visits are more intimate. The final act in this drama remains to be enacted about 6 o'clock the next morning—an enema. It is undoubtedly necessary, but if the patient has been lucky enough to get a little sleep and has to be roused from troubled sleep for this proceeding it is a peculiarly unappetizing initiation into his big day. Now all this has been competently and efficiently done and the patient ought probably to try to see these various transactions from the standpoint of nurses, orderlies and the like.

There has been in his mind, however, one question which he may not have plucked up courage to ask, "What kind of anesthesia am I to have?" Or, if he asked the question, he has been fobbed off by the doctor or surgeon, being told, "We will decide that when we see the anesthesiologist tomorrow morning." It may not occur to you, in your specialized field, that this matter has any advance interest to a patient. But I can assure you that it does. He often lies awake for hours during the first half of the night thinking about it.

The patient may be the type of person who is very reluctant to take ether and hand over his consciousness to the anesthesiologist. Or, again, he may be the sort who asks nothing better than to be entirely out of the picture while on the operating table and therefore averse to anything like a spinal or local anesthetic. These are vague psychological matters and not entitled to serious consideration on the part of the doctor or surgeon. The surgeon has a right to see that the anesthetic most suitable for his purposes is used and it is the patient's plain duty to accept that fact. Nevertheless he would be got aboard the trolley, into the operating room and onto the table in a more relaxed frame of mind if he knew what was going to happen next. The medication given

him while he is still in bed may dull his perceptions somewhat, but he still has wits enough to know what is going on and to have at least a certain curiosity, if not apprehension, about it.

In one of my operations Dr. Henry Beecher gave me a spinal anesthetic. It goes without saying that it was 100 per cent effective. I occasionally glanced down between my outspread legs to see the surgeon getting on with his reaming. But he and his affairs might as well have been miles away. Meanwhile Dr. Beecher and I carried on a long discussion about the charms of the Italian hill towns in Umbria, Perugia, Assisi and the like. He had been there with the Army during the War, I had been there years earlier as a tourist. We really had a congenial visit. On a later occasion another anesthesiologist spent half an hour in a vain attempt to get a needle into my spine. This was the fault of my spine, not of his hand or his needle; but it was a nerve racking experience for me, sitting bowed forward on the edge of the table. Finally I was told to lie back and rest for a bit. The next thing I knew I was waking up in my own bed.

Now, I have no bones to pick with the skill of the anesthesiologists who have shared with the surgeon, the operating room nurses and usually my on-looking family doctor in these proceedings. But I do have one comment. On only one occasion, as far as I remember did the anesthesiologist look in on me the night before the operation. For the most part I have met the anesthesiologist for the first time either in some ante chamber to the operating room or in the operating room itself. By that time the anesthesiologist is probably wearing his mask and I have not been able even to look him in the face. By the time I am "coming round" he is gone and I never see him again. The patient's relation to his anesthesiologist is, in some ways, the most impersonal part of the whole experience of hospitalization. Only occasionally can it be said to meet the ideal requirements of the primacy of the "doctor-patient relationship."

As far as I can make out this situation arises, at least in part, from the financial pattern of modern hospital life in which the anesthesiologist is considered as part of the impersonal and official set-up of the hospital organization, and not as an independent practitioner. His proper fee, and it ought to be considerable, is charged and collected by the hospital. Whether this is a simpler and more satisfactory arrangement than that which expected him to send his own bill direct to the patient I do not know. On one or two occasions I have not known even the name of my anesthesiologist. It may be that, as a minister, I have been granted the sort of courtesy which often prevails between our two professions. But most of us, at least those of us in the ministry who are on adequate salaries, would much prefer not to enjoy this "benefit of clergy." That, however, is beside my main mark.

I have never ceased to wish, during the long and often sleepless night before an operation, that the anesthesiologist might have looked in to

tell me what he was proposing to do in the morning. A major operation is, in the very nature of the case, for the patient a venture into the unknown. The patient has made his peace with that fact. But he would like to know by what door he is to be inducted into the unknown. If he has, as many of us have, some apprehension as to a local anesthetic he could be reassured. And he could be told why, from the surgeon's standpoint, that method is preferable to the all out ether or its equivalent. Then, it would have been nice if the anesthesiologist had just come in the door later in the day or the next morning to conclude what has had to be a very brief and impersonal instance of the ideal "doctor-patient relationship."

I simply do not know whether the anesthesiologist's schedule and duties allow him time for these pre-views and post-views. He probably is not around a hospital in the mid-evening as the doctors and surgeons are. If his time is wholly at the disposal of a hospital he simply may not have leisure for these human amenities.

But if I am right in saying that medicine and religion are the two concerns upon which the responsibility for vindicating the value of the individual primarily rests today, then no doctor can afford to treat a patient as being primarily and solely a "case." The patient lying on the trolley, waiting to be anesthetized, is undoubtedly a case and not a subject for sentimental sympathy. We all understand the absolute necessity for a rather impersonal and wholly business-like handling of an operation. My respect for the skill of the modern anesthesiologist is very great and my indebtedness to him even greater. But somehow I wish that the conditions of his highly specialized life allowed him a little more chance to get inside the circle of those intimate human relationships in which each reassures the other as to his inherent human worth.

I hope I have not been too candid in telling this story from what is perhaps too personal a point of view. I do not think that I am inordinately self-centered in the matter. But, given our total social pattern today, I am aware of what has been rightly called the progressive "depersonalization" of modern life, and of the duty which I have, as a minister of religion, and you have as good physicians, to resist that subtle drift of affairs and to continue to defend the doctrine of the value of the individual, in the practice of our kindred professions.

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