What Preanesthetic Visit?

For a psychiatrist to present an editorial to anesthesiologists implies a meeting of two, perhaps, opposite disciplines—strange bedfellows indeed—but really not so strange. As a matter of fact, carrying the bedfellow analogy further, the relationship might be construed as incestuous as the two disciplines have grown up together practically as siblings. A quick glance at history supports this notion.

The anesthesiologist and the psychiatrist are both concerned with removing consciousness, albeit by different techniques and for different purposes. However, the end result is to alleviate suffering. Both disciplines have their roots in ancient times when wine and opium were used, not only for anesthetic purposes, but also to relieve mental and emotional suffering. By mid-nineteenth century anesthesia was being used for surgery, and psychiatry was moving from its descriptive phase to its current dynamic period. One could follow this further from a pharmacological vantage point, as drugs have nourished both fields of medicine. However, this is not the purpose of this presentation. An editorial is a mandate for a point of view, and since we are in a sense of the same "family," I believe I can be most useful if I develop that point of view with which I have struggled for some years.

I have been concerned and distressed with a common lay view of the anesthesiologist. Unfortunately, most people do not consider the anesthesiologist as a person but consider only the anesthetic. One hears statements such as "will I stay asleep throughout the procedure?"; or "will I be able to awaken when the time comes?"; "will the drug really work?" "the anesthetist—oh! he's the one that puts you to sleep." A patient who had a better than average capacity for verbal expression when asked about an imminent operative experience said: "I know the surgeon who is going to operate on me, so I don't *have* to know what the surgeon is going to do. I trust him. The anesthetist, I don't know, but I do trust my doctor enough to know that he would not pick someone whom he did not feel was competent. The last time I had a D and C, I didn't meet the anesthetist until I was in the operating room. I had already had the needles in my room, and I was feeling dopey. He introduced himself and until this day I don't remember his name, but I did have a feeling at the time—something like—I guess he wants me to recognize his name when I get his bill."

The patient's most common complaint after operation is that he was not forewarned that he would awaken in an oxygen tent or that he would have drains, and other such sequelae taken for granted by his attendants. In self-defense the anesthesiologist may be justified in saying that this is the surgeon's responsibility. I am not so sure. Regrettably, when people talk about "preparation of the patient" they usually have in mind the role of the surgeon. This fact is confirmed by the literature in its consideration of the emotional aspects of "preparation" of surgical patients. Studies of the subject usually control the anesthetics and the surgical procedures so that the anesthesiologist and his armamentarium are neutralized. The anesthesiologist is considered as impersonally as are the drugs, the procedure or even the wall coloring, rather than a force in a relationship between two people. One wonders if the anesthesiologist is satisfied with this state of affairs.

One might ask, and with good reason, why the need for a preanesthetic visit? Certainly the surgeon knows the patient better. He has more opportunities to see the patient. The anesthesiologist won't meet the patient until usually less than twenty-four hours preoperatively. Yet for the past six years or so, I have questioned patients and medical students, which is more frightening, being put to sleep or the thought of the operation? Although they expressed fear of the knife, this fear is secondary to their concern as to what the knife will do *while* they are asleep.

Undergoing anesthesia is a unique situation. It brings up both realistic fear and infantile (unreal) anxiety. With adults there is often the notion indicated above—the fear of awakening prematurely or not at all. With children the experience is terrifying. One need only to listen to adults in psychiatric treatment as

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they refer to the tonsillectomies they had in childhood and the traumas experienced. It is not so much the operation and what was taken from them (this is bad enough), but this was done while they were helpless and unprepared. (The state of "sleep" does not preclude fantasies about the experience. In actuality the opposite is true. Unconsciousness leaves a void in recall that must be filled, and this can be accomplished only with fantasy.) This terrifying experience, real and fancied, becomes a keystone in an individual's character development. They are fearful of any situation which suggests that they will be rendered helpless and impotent.

In children fear of anesthesia is primarily one of separation (parental) and unexpressed fears; *e.g.*, of darkness, the bogey-man and the tones of the voices in the operating room. (I will never forget the patient who, in recalling an early surgical experience, had overheard someone in the operating room who obviously was trying to reassure the patient saying, "What beautiful hair. I'm going to change it for mine while she's under ether.") The postanesthetic personalities manifested by children are well known and include: night terrors, fear of strangers, enuresis, phobias, obsessions, hysterical phenomena, regression—all similar to the picture of adult combat neurosis.

In adults there is fear of loss of control, that they are relinquishing psychological mastery of themselves, that they will perform humilitating acts or use words that might embarrass them. There is also the fear of death which equates with separation (going away). If one would dare risk a generalization, one might say that in women the anxiety has to do with separation; with men it is the loss of control and thereby submission to passive mutilation not commensurate with reality. Previous traumatic experiences with anesthesia and/or instrumentation will exacerbate these fears. It is important to consider a reality factor which is necessary and useful, in that anesthesia results in a physiological and emotional loss of body image. However, in the predisposed patient this may cause subsequent havoc. Also, we must not overlook that some people insist on unconsciousness—that they want to "take the plunge," "get it over with." Others see this as a defensive submission in the manner of some birds and wolves who instinctively offer their jugulars to their opponents when the battle is lost. This act spares them from total annihilation.

Some anxiety by the patient is useful in order that he may prepare himself for what is ahead. Be leery of the patient who has no anxiety. He is the one who is going to be most difficult postoperatively. A preanesthetic visit can be used to reassure the patient and temper unrealistic anxieties. It is tempting to delegate this to the surgeon, but the sad reality is that, usually the surgeon defers all questions about the anesthesia to the anesthesiologist. They simply tell patients, "I'm going to leave the anesthesia up to the man who is going to give it to you." Leaving the choice of anesthesia to its administrator is desirable and rightly a matter of the anesthesiologist's judgment. But if the anesthesiologist limits himself to this function, alone, and regards the patient as a "case," rather than a person, then he remains a technician.

It is most reassuring to patients to be awake and alert when they meet the anesthesiologist. It is not really too important what the anesthesiologist has to say, as much as to present himself as a human being who is personally interested in the patient and is not a part of the hospital facilities. Meeting the patient more than twelve hours in advance of the procedure is most desirable. When patients are scheduled for elective procedures, the surgeon should encourage the patient-anesthesiologist meeting to be held at a mutually convenient time, even a week in advance. (In obstetrics this should be the rule.)

In essence the relationship is more important than the procedure. This takes into consideration the personality of the anesthesiologist. The anesthesiologist should not try to act a role but utilize his personality as is. If he is usually authoritative, he should be so with the patient. If he likes to jolly people along, then he should be so with the patient. In this way his approach is experienced by the patient as a sincere one.

There are times when he has emotional problems which he may, without awareness, displace onto the patient; *e.g.*, to be angry with his wife, then deal curtly and abruptly

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with his female patient. Another more serious extraneous emotional involvement occurs when the anesthesiologist feels his omnipotence threatened by the patient. This manifests itself as a resentment toward the patient who is "going sour" on the operating table. The doctor experiences the patient's actions as an attack on his training, competence, person and on the very integrity of his fantasies of being god-like.

With children it is important that parents prepare the child for operation and the anesthesia experience either by words or play, but not too far in advance. The anesththesiologist should allow himself adequate time to win the child's trust and then offer the child short, repeated, confident explanations. Ideally, the child should be asleep before being transported through the hospital corridors. In adults, for local anesthesia, a brief comment with each step should suffice. At no time should the technical aspects be over-explained. (Over-explaining reflects the doctor's own anxiety.) It is important that the patient not be engaged in weighty conversation in the operating room. We all know from personal experience that when we are anxious about an impending matter, such as an examination, our wife in labor, or the like, we have difficulty listening to what is being told us and even more difficulty in retaining what has been said. This has to be kept in mind during the preanesthetic visit when the patient is anxious and is told all the minutia of the next day's events. The most practical approach is to introduce oneself and chat for a while about anything, then ask the patient for questions, and at times raising "questions that must be on your mind."

I titled this editorial "*What* Preanesthetic Visit?" because of my concern for the patient and for those anesthesiologists who do consider this problem. The preanesthetic visit varies qualitatively and quantitatively from anesthesiologist to anesthesiologist. Some hospitals ignore the problem entirely and in others the visit is part of the routine.

In recent years there has been greater emphasis on the study of the "total person," and unfortunately, an increase in specialization. The anesthesiologist today has to approach his patient with a psychological awareness of both himself and the patient. We in psychiatry, and you in anesthesiology, face a similar problem. In our case the general practitioner, internist or surgeon knows the patient much better than we, yet turns to us for help. At times we feel that the referring physician is "dumping the patient in our lap." This applies as well to the surgeon who is familiar with his patient, yet turns him over to the anesthesiologist. I believe that this is a professional function we both must accept. In understanding the patient it is incumbent upon both of us to be cognizant of the basic problem: *that the patient has an illness with its own emotional factors, and that he brings to this illness or operation* his own *personality and* his own *anxieties*. And what about the anesthesiologist? The anesthesiologist who feels apologetic will have the most difficulty with the preanesthetic visit. The anesthesiologist who has a realistic pride in his skill, and faith in the importance of his function will communicate this to the patient for mutual benefit and satisfaction.

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ONE of the shortcomings of many democratic organizations, whether they be on a national, state, or local level, is the apathy and failure of the majority to exercise its duly endowed rights of participation. Too often this apathy and disinterest leads to control of an organization by a willing, dedicated, but at times, a misunderstood and castigated minority. This lack of interest permeates all aspects of our democratic way of life, including our professional societies.

It has been disturbing during the past several years to note the appalling lack of interest which our specialty has displayed towards

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