

THE ART OF PREPARING THE PATIENT FOR ANESTHESIA

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A SIGNIFICANT problem in anesthesiology is the psychological unpreparedness of the patient for the contemplated anesthesia and operation with consequent anxiety, tension and restlessness. Some degree of fear and apprehension was found in 92 of 100 patients recently surveyed¹ in regard to emotional responses to anesthesia and operation. Much of this was unrelieved by opiates preoperatively. It was so disturbing that 65 per cent expressed a preference for general anesthesia, indicating a need for avoidance of operating room sights, sounds, and sensations. If drugs cannot relieve the anxiety, if general anesthesia presents a particular hazard, if a preoperative visit is impossible—what then? This same article pointed out the value of discussion with the patient, encouraging the ventilation of feelings, the sharing of worrisome thoughts, the asking of troubling questions. How can the busy anesthesiologist find the time? Perhaps the question is, how can he make the best use of whatever time is available?

Mrs. A. comes to the hospital for an emergency curettage. Perhaps to the anesthesiologist it is just another routine, an extra nuisance to be sandwiched in between two other operations. To her it means infinitely more. The potential for sudden pain and bleeding are frightening, implying the threat of death. The actual death of the fetus brings confused feelings. Perhaps she hadn't really planned this pregnancy—was only beginning acceptance of it. Could it have been something she did—or even thought—which brought the pregnancy to an end? Guilty feelings, driving toward punishment, bring about the intensification of pain as atonement. She regrets the enforced separation from the family. "How will they get along without me?" she wonders. "Will they be frightened? Will their care impose too much on neighbors?"

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Will I be well enough to look after them when I get home?"

Mrs. A. was hustled into bed. The nurse, the laboratory technician, the intern, the anesthesiologist all besieged her at once; seeing her respectively as a chart to be readied, blood and urine specimens to be examined, a history to be taken, an anesthetic to be administered—with seeming disregard for her as a person. She tried desperately to maintain her equilibrium by making witty remarks in a brittle voice.

"How do you feel about all this?" asked the anesthesiologist, taking a bit more time and bringing to the patient a rush of relief at the chance to put a little of it into words to someone who realized she *does* have feelings. The query elicited such information as:

She wanted to be asleep.
She can't stand a mask over her face.
She finished eating dinner recently.
She always vomits after Demerol.

With this exchange, her attention narrowed to where it encompassed only the anesthesiologist. Her eyes had the glassy stare of the hypnoidal state. Her voice became quiet, facial muscles relaxed, words began to lag, relaxation was obvious. This interesting change is characteristic of the hypnoidal state which follows closely on the heels of good rapport, forming a continuum with the hypnotic state.² In this instance, attention was altered partly in answer to the words chosen by the anesthesiologist, even more in response to intercommunication from "para-language."³ This included the long, quiet gaze exchanged by patient and physician, whereby each assessed the other; the concentration of the physician's attention on the patient, excluding others in the room, and other subtle clues given by the manner and appearance of the anesthesiologist and responded to with increasing confidence by the patient. She sensed that here was an answer to her need

for a person who knew how to manage this situation. She was now, in a few moments time, in a state of increased suggestibility, in a calm, uncritical state of mind. Easy suggestions would be accepted without question. There is no need to develop a trance state in order to give posthypnotic suggestion with great benefit to the patient. This hypnoidal state was now used to implant the following suggestions:

"You will feel very comfortable throughout this whole procedure. You will be deliciously drowsy and may even fall asleep soon. [The patient did relax more deeply in response to the soothing tone of voice that became slower and more rhythmic.] You need to pay attention only when someone speaks directly to you. Then you can be entirely cooperative. You will continue to hear me talking to you. I will alert you as to anything you need to do. You will awaken in the recovery room, pleasantly surprised to find it's all over and you feel fine. You can enjoy noticing how readily the normal functions of your body are restored, how well you sleep, how good food tastes."

She entered the operating room calm and quiet, with no need for medication. A saddle block was given for anesthesia. She slept through the operation, awakening in the recovery room with her requirements safely and happily met.

This is an illustration of the use of hypnosis technique as an adjuvant to chemical anesthesia. It has a versatility and a flexibility found in no drug nor chemical agent. There is a dimension to our lives which cannot be measured by scientific methods and assessed by the double-blind technique. Webster gives as one definition of the word *person*, "the real self of a human being; individual personality." We cannot see it, cannot touch it nor feel it physically, cannot hear nor taste nor smell it. Yet it is recognized by us and known as the essential part to which all else is secondary. It is this part with its will to live, its struggle with the meaning of life, of pain, sickness and suffering, which calls on the physician as a *person* to minister to its needs in understanding acceptance. The conviction that "When pain is to be borne, a little courage helps more than much knowl-

edge, a little human sympathy more than much courage, and the least tincture of the love of God more than all"⁴ holds true of the pain of fear and apprehension as well as of physical pain. The advance of scientific medicine has neglected this aspect woefully. It has not solved the problem of pain and suffering any more completely than did primitive magic. Yet, perhaps science and faith, working together, can still give the kind of help that is most needed.

The person in distress urgently needs comfort in the sense of the word signifying fortification and strengthening. Properly applied, hypnosis offers an ideal vehicle for its administration. It is an interpersonal relationship based on trust and confidence. It provides physical relaxation free of interference with circulation, respiration or reflex activity. No longer scattered in fruitless motion, wasted in maintaining excessive tension, the body forces can be mobilized to the site of injury or operation. Inner calm and peacefulness allow respiration and circulation to function better. A calm quiet confidence is good insurance under the worst of circumstances. Then helpful ideas can be presented.

Even better than human sympathy is human empathy. A person who is aware of the dependency need of the human being, who has a real love of people and a belief in their wanting to function in a better way can help them do so.⁵ Such a man functions as a source of strength where parents leave off or cannot help. He is potent and competent to help the patient control himself and cope with fear or pain, to give him reassurance of his own inherent human worth.

The anesthesiologist, at best, has little opportunity for getting acquainted with a patient in the manner of the family doctor, but it is to him that the patient must entrust the guardianship of his life during anesthesia. It behooves him to find ways of demonstrating his trustworthiness quickly and effectively to the patient. He can best do so by leading him step-by-step through the unfamiliar territory, communicating by touch, manner and words the sort of person he really is, clarifying misunderstandings, explaining what is to come and what responses will be most helpful. For most patients, such a straightforward

rational approach, a willingness to answer questions, and a kind considerateness are adequate. Most patients integrate their fears well.

A large percentage of patients, however, have neurotic fears which are irrational and so cannot be explained away logically. These patients need more than ordinary patience and reassurance. In fact, they have difficulty accepting it. It often seems as if there is a glass wall between doctor and patient, shutting off communication. It is here that hypnosis can be of particular value, helping to lower unnecessary defenses. A person who has learned to respond to new situations with tense muscles and taut nerves, to mistrust people, to expect the worst to happen can be taught to respond in a more comfortable way.

Such a person was Mrs. B. who was admitted to the hospital for a hysterectomy. Her past history included postpartum psychosis and the psychiatric recommendation of sterilization. A sudden increase of bleeding led to the decision for an immediate curettage as an emergency measure. She was writhing about in bed, clutching the side rails, frightened and crying, her pain unrelieved by two recent doses of meperidine. "Don't give me any more shots please! They make me feel so awful and they don't do any good. I'm so afraid. Can't you do anything?"

A hand was held out for her to hold and the explanation was made that "You'd really be more comfortable if you could relax even a little, wouldn't you? I can tell you *how* to do it, but I can't do it *for* you and I can't do it *to* you. I can teach *you* how to do it. Begin to pay attention to your breathing. Allow it to become deep and even, the way it is at night when you go to sleep. [The voice becomes softer, slower, more singsong.] Just listen to my voice. Let other sounds fade into the background while you relax deeper and deeper with each breath. It feels so good. You might like to use your imagination to help you relax even further. Picture a pleasant place where you'd really enjoy stretching out to relax. . . . [Her head began to shake slowly from side to side and tears to roll from her eyes.] Then perhaps you'd rather just have me count for you while you

go on relaxing deeper with each count. You can cry just as much as you need to. Tears are a good safety valve. You'll feel better afterward. One, two . . . deeper relaxed with each count . . . three (to ten). Soon the nurse will ask you to move onto the carrier. You can do so without having to pay particular attention to it. Stay comfortably relaxed as you are now until you are back in your room again." She allowed the hand to be withdrawn. It was necessary to leave her for a little while. She remained fairly quiet, rousing when anyone came into the room but being easily soothed again by the nurse. She was met in the corridor outside the operating room and given instructions concerning the next procedures. She was now very cooperative. Only a small amount of thiopental was needed as an anesthetic agent. She awakened soon in the recovery room and was returned to her room comfortable. The next day, she was greatly relieved and elated at having been able to participate in gaining control over her fear and pain.

It frequently happens that a patient cannot accept fully the help that is offered at the time but the idea carries over to the next occasion. Mrs. C., at her third delivery, was afraid of nearly everything in the situation—of needles, of the prospect of spinal anesthesia, "You get severe headaches from it and whenever it rains your back hurts"—of the violence of pitocin, of being alone, of being under anesthesia, "While you're under you don't know what's going on. It might be kept from you." Relaxation was explained to her and its advantage to the baby. She made some attempt to go along. It was used as an adjunct to a saddle block. The necessity for supplementary general anesthesia was avoided, but her response was recorded as being very poor. She had opportunity to discuss it next day. About a year later, in labor with her fourth pregnancy, she asked, "Please get Dr. R. to talk to me like she did last time. It helped even though I know I didn't do very well. I don't want to be like that again, screaming and yelling and being uncooperative. I'm just as scared now but I'll try this time." She responded very well, needing no further medication (meperidine

75 mg. had been given shortly before she was seen). She had a saddle block, dozed through the delivery and was delighted that she was able to achieve such victory over her panic. The time spent in talking to her involved less than ten minutes extra. The relief that comes to someone thus aided is often astonishing. The satisfaction she feels at having been able to cooperate in the conquering of fear and pain is gratifying to both the patient and the guide. It is a welcome relief to the family, who know from long experience how difficult this member can be. This investment of time is one that pays dividends immediately and forever after. It spreads, too. The expectation of comfort and tranquility acquired from a roommate often saves explanation and provides necessary confidence to the patient.

Mr. D. was concerned about his coming cystoscopy. He had heard from friends what it could be like. As a result, he wanted to be asleep for as long before and after it as possible. He knew this was but a prelude for an operation to come which would be even worse! The anesthesiologist took a few moments, after gaining his full attention, to explain, in simple waking suggestion, "You will begin to be sleepy almost at once after the injection is given. We'd like you to be just enough awake to move onto the carrier and later onto the cystoscopy table. You'll be so very drowsy that you probably will not remember anything that happens from the time of the injection until you are back in your room. You will awaken in the recovery room, glad to hear that the procedure is over. Then you will doze comfortably. You'll be hungry for supper and will enjoy being able to drink all the water you want. There may be a slight feeling of fullness from the catheter. It will not be disturbing and can safely be ignored. When the catheter is removed you will void easily." He accepted these suggestions readily and followed them literally.

The next day was a busy one, with no time to see Mr. E. until he was in the cystoscopy room. "I'm Dr. ———, I'm going to give you your anesthetic. . . ." "Oh yes! I heard all about you from Mr. D. He's my roommate. He said he had no idea it could be

so easy." "That's fine. You'll be just as comfortable." He was. Two hours later, he was adjusting the TV set and waiting on Mr. D. who had been operated on in the morning and was feeling quite fit already.

The most effective point to deal with post-operative complications is preoperatively. Suggestions made then can smooth the way remarkably. They can be given at the routine preoperative visit with the patient in the waking, the hypnoidal, or the hypnotic state according to his particular need; or in the operating room during the starting of an infusion, at the induction of general anesthesia, or even during deep anesthesia.⁶ Worded positively and briefly, the phraseology should give enough latitude so that no promises are made which cannot be kept. "You can look forward to being comfortable throughout" (or "to having a normal delivery") provides for pleasant anticipation with leeway for an unexpected outcome or for details to be worked out as they arise. Once attention has been successfully gained and the patient knows what to expect so that he can rely on the guidance offered, it is easy to re-establish contact and to reinforce suggestions made previously. This can be effective even after drug sedation has decreased the patient's responsiveness. However, if initial rapport has not been made prior to the onset of the sedative effect, it is exceedingly difficult to initiate hypnotic techniques. Medication interferes with cerebration, making concentration and learning difficult or impossible. It is wise to take the opportunity to pave the way for acceptance of help well in advance.

Approach to the patient ought always to be with the thought of *his* needs uppermost. Manipulation of him to make the physician's task easier is an objective of very limited scope. That this often occurs is strictly as an extra dividend. It is serendipitous.

Knowledge of potential psychic pathology in the individual who faces anesthesia and surgery is helpful in dealing with emotional difficulties as they arise. Among rational fears are the following threats⁷ which vary in predominance according to age but may be present at any level:

- (1) Desertion or abandonment by parents or loved ones. 1 to 2 years.
- (2) Dismemberment, mutilation, disturbance of body image. 3 to 5 years.
- (3) Death. 5 years.
- (4) Deprivation of cherished material objects. School age.
- (5) Defeat. Will this operation interfere with my ability to compete? (in school work? business? sports? social activities?) Early adolescence.
- (6) Disgrace. Will I be able to perform like the others? to do what is expected of me by my peers? by those in authority? by myself? Adolescence.

Anxiety is increased⁸ by fearfulness the patient observes in a parent, other relative, or friend; by sensitization to past personal experiences; and by superstitions. A special organ-system may have particular meaning. A cultural attitude such as that toward malignancy may affect it. There may be an indirect influence such as the catastrophic medical expense involved that could eat up savings set aside for education or for cherished vacation plans. Loss of income, followed by potential loss of earning power, is stressful.

The expectation of a great event is common to all in anticipating anesthesia and surgery. Irrationally, it may provide a welcome excuse for the abdication of responsibility rather than being the stress and strain it is usually considered to be. It may provide a chance to lean on the surgeon's strength and incisiveness. Operation may be equated subconsciously with the wish for a child or with a wish for punishment. For the pregnant patient, even more is involved.⁹

Fear produces physiological effects. This is too well known to the anesthesiologist to need further elaboration. It may necessitate more sedation and consequently interfere with respiration and circulation. It makes for longer and more difficult induction, uneven maintenance, and stormy recovery. Changes in physiology are sometimes masked by it while pathological changes are emphasized.

Pain is frequently accentuated by fear and also by involvement in human relationships.¹⁰ The infant feels discomfort. His helpless crying brings mother speedily to administer

comfort. Pain becomes associated with this welcome aid. The "sweet pleasure of pain" comes largely from the anticipation of reunion with a loved one. The attention which follows may be worth the price. The young child soon learns that "badness" is followed by punishment. Pain may be accepted and intensified as expiation for guilt, real or fancied. He learns also that infliction of pain on others brings a feeling of power. This can be so frightening that he may later find it expedient to try to control his own aggression by experiencing pain himself rather than risk inflicting it on another and bearing the consequences.

Can this sort of psychogenic pain really come about? Pain is a subjective experience. It is described in terms of what causes it

Sharp—like a knife.

Dull—like a blow from a blunt instrument.

Lancinating—like a toothache.

As development proceeds, the things that cause pain and the part that hurts are permanently registered in the nervous system, building up a library of pain. Once psychic organization has evolved, it is no longer necessary to have a peripheral physical stimulus in order to evoke pain. It can be remembered or hallucinated vividly.

This is not so difficult to grasp when other subjective experiences are considered. We find it easy to understand when someone describes a sight or sound which they have experienced in a dream, a hallucination, or a daydream. Pain, too, can be hallucinated. This concept helps to explain much that has previously been obscure. In hypnosis, visual, auditory, and other sensory hallucinations can be deliberately evoked. Sensation, too, can be changed in quality, in quantity, in duration, in location. With psychogenic pain, it may be possible to persuade the patient to allow the severity to be decreased gradually, imperceptibly if need be, until it is bearable; to permit the duration to be shortened, even to the point where it can be given up; the location to be altered; or a less devastating substitute found which has the same symbolic significance but less interference with his functioning as a whole. Time distortion can be taught¹¹ to permit the interval between

hours of pain to seem like a long time, while duration of the pain itself seems like a very brief period. Dealing with pain of this type is not for the amateur. It is advisable to seek psychiatric aid rather than to persist in giving narcotics which are so readily habit-forming, or to continue to try controlling psychogenic pain with useless nerve blocks.

When pain is of organic origin, there is still a high emotional component of "painful thinking" about it which can best be alleviated by the use of hypnotic methods. Injury or disease is a threat to the whole person. There is particular need at this time for someone capable of helping to get the picture again into focus. Most often it is the family physician or the surgeon who has the best opportunity to do this. It is notable, however, that many times a patient will hesitantly express a feeling or a question to a sympathetic anesthesiologist that he has not dared put to the surgeon. There are innumerable factors. It may be the added stress of the moment, the additional pressure of impending anesthesia, or the fact that the personalities of surgeon and anesthesiologist differ, occasionally that the patient is willing to inquire of a woman what he could not of a man. It is an added advantage in time of trouble to have more than one person to aid in gaining perspective. Each one has his own special contribution to make. No single person can answer all the needs of another. The most important single thing is the underlying attitude in which assistance is offered.

An attitude of maturity, come to full fruition of ripe, mellow sweetness, permits and accepts for the patient his spontaneous regression in illness toward childishness. It answers his call for help by turning him gently but firmly so that he need retreat no further and no longer than is absolutely necessary. It matters little whether one labels this a "psychological approach," "psychosomatic" or "use of hypnotic techniques." Hypnosis is rather an explanation of how this works¹² than a therapy in itself. It is a means of redirecting attention, of helping the person to discover his own capabilities and how they can be put to use in this situation to work with instead of against other body forces.

Much of the time needed for such manage-

ment falls within that ordinarily allotted for the administration of anesthesia, though it is worth expanding it to accomplish whatever is needful. The expenditure of time comes in the initial learning of how to develop and to utilize this art. Much of it is done spontaneously by the understanding person who really cares how his patient feels, who inspires faith and confidence because of his own experience of them. Such technicalities as trance induction and deepening can, to some extent, be picked up from reading but are best learned from personal teaching in conjunction with underlying principles. Just as the neophyte learns the stages of anesthesia from observation of open-drop ether before proceeding to faster-acting agents, he must absorb basic preliminaries before expecting to be competent with techniques of hypnosis. Its scientific use, its specific application to the field of anesthesiology, and comprehension of the meaning of the hypnotic relationship are worth studying. The basic sciences, among them physiology, anatomy, pathology and neurology are a necessary basis both for the anesthesiologist and for hypnosis. Yet knowledge of them is insufficient unless it is integrated with understanding of their interaction with emotional responses. Hypnosis is only a tool by means of which this can be brought about and utilized. It is based first of all upon a relationship between two people.¹³ It is this relationship which provides the therapeutic factor.¹⁴ It is inadequate to have only a knowledge of the basic sciences and to be a skilled technician. To these must be added other factors. The physician must be mature enough to accept the patient's fears, to allow him to be afraid and to know that the doctor remains unafraid. He needs a deep conviction of the worth of each individual and of his right to have his needs met in a way that is acceptable to him. He must have an abiding faith in people⁵ and in their desire and ability to function in a better way. He must have a willingness to lower his own defenses, to lose his own self-consciousness so as to be able to listen and to speak to the patient in a meaningful way. It is the quality of the time spent in this endeavor and not the quantity that count. The willingness to communicate

and the possession of something worthy of communication are essentials.

Some have an inherent aptitude for this person-to-person dialogue which can acquire a high degree of polish as its possibilities are pointed out. Many, many more have capabilities not yet recognized nor fully accepted by themselves which can be encouraged, cultivated and developed by training. Much of it is caught from association with those whose intuitive understanding and responsiveness have blossomed forth. Few patients would be restored to health left exclusively to the tender mercies of technical procedures and to a strictly scientific approach, important as this is. Paré was entirely right in saying "I treat the wounds. God heals them." Even the love of God is administered through persons. It is in this personal approach that there lies the greatest medicine of all¹⁴ and in the treatment of the person as a whole, with body, mind, and spirit inseparably intergrated.

SUMMARY

The anesthesiologist, as a person, has much to give that cannot be supplied by medication, that is desperately needed. He may become aware of his own inner resources intuitively or by their being revealed to him by other persons. He can develop them further by taking courses, by reading, by clinical observation of the needs and responses of his own patients, by using the powers he discovers within himself, by continually searching for better ways of dealing with the problems of pain and fear. Thus he provides true strength to comfort and fortify the patient.

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