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The Last Should be First*

M. C. NEWLAND†
Adelaide

A presidential address is a final burden inflicted on a retiring president, and as such he bemoans his lot in having to prepare it. However, it is at the same time a heaven-sent opportunity, given to few mortals, to have a captive audience to whom he may air his views on some subject of his choosing. The subject is one on which he ordinarily lacks both the courage and the opportunity to expound; it may have a philosophical flavour, and it is necessarily one on which he feels a deep personal conviction. Whether or not the matter put forward is of earth-shaking import is quite irrelevant; it is important to the speaker, and personal conviction is the essential criterion.

It is with these considerations in mind that I present this address. If I must put a title to it, this might be "The Last Should be First", because essentially I want to consider our priorities in our every-day work of caring for the sick, and discuss some small but fundamentally important ways in which I believe these priorities are awry.

Clearly, we live in an era of enormous and exciting progress in a technological sense, and our progress in this sense is faster, ever faster. It is probably no exaggeration to say that knowledge and skill in most fields of human scientific endeavour have advanced more rapidly in the lifetime of those sitting in this room than in the whole previous history of mankind, resulting in such inestimable (cynics might say questionable) benefits as, say, the harnessing of atomic energy, supersonic transport, walking on the moon, to name but a few. Hand in hand with these marvels, in the medical sphere we might mention antibiotics, transplant surgery, or the incredibly complex and sophisticated electronic devices which have become commonplace in our day-to-day clinical and experimental work.

But, and here is the rub, there is a price to be paid for our cleverness—and this is ever so. You will recall how some hundred years ago Alfred Nobel invented dynamite, fondly dreaming of the many benefits this source of power would confer on puny mankind, and recall too the uses to which his discovery was put in man's efforts to wreak bigger and better destruction. Nobel, of course, is the same Nobel who used his riches to found the Nobel Prizes, reputedly in an attempt to atone for the damage his discovery had caused. So too, use has been overborne by misuse in the application of atomic energy. So too, Concorde enables us to cross the world in half the time taken by Jumbo, but leaves behind a trail of broken windows, stampeding cattle and pollution of the atmosphere.

In medicine, too, our new-found expertise exacts its price, the loser here being human dignity. The doctor of today is tending too often to regard his patient as so much clinical material on which to exercise his skills, and the patient in need of treatment is becoming more and more depersonalized. Of course, a quarter of a century ago medicine had so much less to offer, and supporting the morale of the patient was a correspondingly more important part of his treatment. But our new-found skills have certainly not removed the necessity for this, whatever we may think; and while the tempo of our lives is now such that little time is left for the simple business of talking and explanation, none the less this time must still be found.

Let us start by considering the public hospital, whose very nature renders it about as warm and personal as Flinders Street Railway Station. I recall as a student my elders and betters drumming it into me that in a teaching hospital there is the ever-present danger that the patient will cease to be recognized as a human being and will instead be looked on as a case—a

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† M.B., B.S. (Adel.), D.A. (Melb.), F.F.A.R.A.C.S., President, Australian Society of Anaesthetists 1971-1972.

Address for reprints: 11 East Terrace, Hawthorndene, S.A., 5051.

case of pneumonia or a case of intestinal obstruction, rather than Mrs. Brown with pneumonia or Mr. Jones with an obstructed bowel. I think that if I thought about it at all, I comprehended only dimly what they were driving at, but now I know. It is so terribly easy for the patient seeking help to become engulfed in the vast maw of the system, his cherished rights and dignity swept aside as he is ground helplessly through the sausage machine, until he is finally spewed out at the far end, bemused and bewildered, his illness maybe cured, but his individuality in tatters.

But it is easy to be critical. The very size and complexity of the organization make it itself impersonal. Moreover, teaching requirements must inevitably encourage the attitude that patients are so much clinical material and also often mean a multiplication of indignities according to the number of students to be taught. And sheer weight of numbers makes it more difficult to treat each patient as a human being, meaning inevitably less time for explanation of what we are doing and why, and for consideration of, to us, insignificant personal problems and worries. But this is the training ground for our doctors and nurses, and attitudes and habits engendered in this seed-bed are likely to endure throughout a professional lifetime. Surely, then, it is all the more important to make every attempt to preserve and safeguard whatever dignity is left to the patient, rather than giving up the unequal struggle and processing the patient like a piece of machinery on a production line. How often do we hear a trainee nurse, or a young resident medical officer saying to the elderly patient, "Never mind, pop, it'll soon be finished", or "You'll be right, grandma". The intention is good, but what a cheek! And worse, what an attitude of mind it reveals towards the patient as being of no importance as a person in the general scheme of things. "Pop" in any other surroundings is Mr. Jones and "grandma" is Mrs. Brown, and let it never be forgotten.

Plato tells us that in ancient Athens there were two classes of doctors—"the freeman, who attends and practises on freemen. He carries his enquiries far back and goes into the nature of the disorder: he enters into discourse with the patient and his friends, and is at once getting information from the sick man, and also instructing him as far as he is able."

On the other hand, "the slave doctors run about and cure the slaves, or wait for them in the dispensaries—practitioners of this sort never talk to their patients individually, or let them talk about their own individual complaints. The slave doctor prescribes what mere experience suggests, as if he had exact knowledge: and when he has given his orders, like a tyrant, he rushes off with equal assurance to some other servant who is ill."

That is all very well, you say. That was over 2,000 years ago. True enough, but in all honesty, you must admit that the slave doctor is far from extinct, as one or two instances will show.

Not so long ago a very senior and semi-retired member of the profession ran into difficulty while attempting to jack up his car and in the process had the misfortune to run over himself. He was taken to the casualty department of a public hospital bleeding freely and in some considerable discomfort, where he awaited the attention of the R.M.O. on duty. He tried to make himself known and explain the nature of his injuries, but the generation gap was too great, and the response of the people attending to him was "Don't fret, Granddad, you'll be alright". Some 45 sutures later he was bundled into a taxi and sent home. Incidentally, next day he managed to organize what he had been seeking all the time, an X-ray examination, and he thereafter spent some time (in a different hospital) on account of his fractured pelvis and shoulder. A funny story no doubt, but how much better would it have been if someone had been prepared to "enter into discourse with the patient".

Another elderly medical practitioner was admitted to a public hospital with a mortal illness. He commented bitterly only a day before he died that while putting a drip into him the doctor and nurse concerned had ignored him completely and over the top of him as they worked had carried out an animated conversation about a party they had both recently attended. He might just as well have been a frog pinned out for dissection for all the notice that was taken of him as a person.

That these are by no means isolated instances is shown by the following quote from a recent journal:

> "It was in a hospital, which had better remain anonymous, where large numbers of patients were given appointments for tonsillectomy on Saturday mornings. It was a mass production process, with no racial discrimination. The Chinese gentleman seemed anxious and uncertain at the desk, and the

receptionist cut short his fumbling for words by producing his card, reassuring him that all was well and putting him into the queue for the anaesthetist who, in turn, said, 'There, there, Charley: You'll be all right. Don't be so worried, just lie down here', and put him to sleep. Some hours later, when Charley had a sore throat and was still drowsy, but it was time for him to go home, he beckoned a young nurse who came and gave him her client-centred attention long enough to decipher his croakings. He was saying he had come to hospital to apologize for his brother Charley, who was unable to keep his appointment that day. This is a true story."

Stories such as these, all true, must surely suggest that the patient is being lost sight of as the very central figure of the medical scene, and is being regarded rather as purely incidental to the exercise of our skills; all too closely reminiscent, in fact, of the slave patients of Plato's time. However, I am by no means suggesting that the mischief is confined to the public hospital: the essential dignity of the individual is ignored and degraded in the private hospital as well. It is true, though, that the affronts to the private patient are less, and this not only because money is involved. In the private hospital technological help is less readily available, and there is much less delegation to juniors of the management of the patient, so that the doctor responsible for the patient's care must necessarily do so on a more personal basis.

But in all hospitals, private or public, nurses too are in danger of becoming technicians, far more knowledgeable than their forebears, able to talk learnedly about serum electrolytes and study sophisticated monitors. But the current product is also less likely to consider the patient as a patient, to arrange his pillows properly, to pull up the bedclothes round his shoulders when he is cold and helpless, and so on—or in a nutshell less likely to treat her patient as a human being who is sick. Two small instances will suffice to illustrate my point. There used to be a technique whereby when changing the sheet or blanket for a fresh one, the new sheet was placed on top of the one already covering the patient, then the old one pulled out from underneath the new one, so that the patient remained covered all the time. But now, almost without exception, when the covers are changed in anteroom or theatre before putting the patient to sleep, the old one is removed first, leaving the patient in a gown about the length of a mini-skirt while the nurse gets a fresh covering. Incidentally, in a top class private hospital I recently remonstrated with the glamorous girl carrying out this procedure, and asked, "How would you like to be left lying there with nothing on below your waist?" She replied, "Oh, I wouldn't mind at all", which left me with nothing to say.

I am quite frequently involved in gynaecological surgery, and many of these procedures involve putting the patient into the lithotomy position as a first step. A more undignified position it is hard to imagine. Yet how often does the nurse hasten to put the stirrup posts up in position as soon as the patient is on the table, before the anaesthetist starts; or, even worse, one is in position before the patient is wheeled in, ready to greet her with its stark reality. Either way the patient is left with no illusions as to what is going to happen to her as soon as she is asleep. Surely it is more pleasant for the patient if the stirrup equipment is kept out of sight until she is asleep. Small points these, you may say. Just so, but not to a sensitive patient. And these are the straws in the wind which determine our whole attitude to our patients as human beings, and it is my contention that such points can never be neglected if we are to claim to treat our patients as people.

This impersonal approach was carried even further in a hospital I visited in the U.S.A. Here the nurses' station was equipped with two television screens. One of these spent its life ceaselessly, endlessly, producing a picture of each patient in turn—twelve seconds devoted to each, then on to the next. I watched one writing a letter, one lying looking miserable, one using a urine bottle. The other receiver was available for unremitting concentration on any particularly sick patient. I suppose those nurses sometimes went near the patients in their charge but such human exchanges as "How do you feel?", "Are you quite comfortable?", "Is there anything you want?" could all too easily become superfluous.

Let us look for a moment at our surgical colleagues. In the hierarchy in which we work, the surgeon stands at the top. His power and influence are considerable, and he is more directly concerned with the patient and his management than any other member of the team. But all too often the surgeon too forgets that the patient is a person and omits to show him the consideration that is his due. Many

surgeons make a point of speaking to the patient before anaesthesia is induced, but some do not bother. And how often are we embarrassed by the audible conversation from the scrub-up area, the patient being forgotten, and how often do we feel constrained to hurry our induction for fear of further embarrassment? Two examples will suffice:

"I always reckon this is one of the most gruesome operations in surgery"—this while a scared old lady about to have a radical mastectomy was having the Gordh needle inserted.

Or take this one:

"Well, I made 32,000 before tax last year and I paid out 1,400 in tax, but I'll improve on that with deductions this year. My accountant tells me that if I . . . ."

Ten mls of very rapid thiopentone put an end to my discomfort.

Throughout the operation, too, the well-being of the surgeon remains paramount. I seem to recall that before the golden days of air-conditioning, operating theatres were kept warm, and this, together with steam from sterilizers and autoclaves, gave an atmosphere which would have done admirably for the orchid house at the Botanical Gardens. This was suffered gladly, as everybody knew that this was necessary to keep the patient warm, to ward off the development of shock. Nowadays we have learnt to cool our environment as well as to warm it, and guess who benefits from this advance? The warmly clothed surgeon, sweating over a difficult gastrectomy, has simply to say "Sister, can't they turn up the cooling?", and the atmosphere rapidly becomes that of the morgue. Thereafter the anaesthetist shivers and the patient, in whose interest the whole procedure has supposedly been arranged, is transferred to the recovery room as grey and cold as a corpse. Theories of shock may change, but I find it hard to accept that it is beneficial to the shocked patient to use up the scanty supply of oxygen to his tissues in violent paroxysms of shivering in the recovery room.

However, this is not intended to be in any sense vituperative. We anaesthetists are every bit as guilty where consideration for the patient is concerned. One instance is enough. In almost every hospital in which I work, it is drilled into the nursing staff that it is an unforgivable sin to leave dentures in situ when sending a patient to the theatre. This despite the so commonly expressed horror of patients, particularly women, with remarks we have all heard so many times—"The one thing I dread about an operation is having to take my teeth out", or "Even my husband has never seen me without my teeth". The woman then arrives at the theatre holding her hand over her mouth, or with the sheet pulled up over her mouth, endeavouring to hide the embarrassment caused by her edentulous state. Surely, at this time if we thought at all we should be exerting ourselves to bolster the patient's morale rather than inflicting what to many is a crowning indignity? Yet where is the necessity for this? The practice of removing dentures stems from the open ether days, when inductions were often stormy, and were not infrequently associated with vomiting and the urgent need to force patients' jaws apart with a mouth gag to clear out the pharynx and ensure an airway. Under such conditions the presence of dentures could add to the difficulty of the anaesthetist and sometimes be actually dangerous. But this was a quarter of a century ago and more. Now, I suggest, the reverse is true. Intravenous agents and relaxants suddenly made the induction of anaesthesia remarkably smooth. Sometimes, however, we give ourselves an iatrogenic fright, when we have difficulty in inflating the paralysed, edentulous patient, whose teeth are on his locker upstairs and whose nose and chin meet like the jaws of a nutcracker, making impossible a gas-tight fit with a face mask. Surely, then, it is to everyone's advantage to leave the dentures in place until immediately prior to the insertion of the laryngoscope blade. And in the non-paralysed patient breathing spontaneously from the face mask they are better left in the mouth for the duration of the anaesthetic. The interests of patient and anaesthetist thus coincide in this regard, and I personally have absolutely no fear of a patient ever swallowing or inhaling a complete upper or lower denture. A partial denture, I freely admit, is a different kettle of fish—a small plate with two or three teeth and several wire hooks protruding is a most dangerous object to be free in the patient's mouth. However, most patients can part with these without embarrassment, though if they are in the front and the patient feels strongly about it, I personally am quite prepared to leave such dentures in place until immediately before anaesthesia is commenced.

But as a working rule, my own practice in the interests of the dignity of the patient has been,

"Full upper or lower dentures to remain in, partial dentures to be removed". I have succeeded in introducing this rule into one hospital where I have some influence and have yet to see any trouble arise from it, and nobody's dentures have been lost as a consequence.

So far I have touched on various aspects of our daily work where I consider we, the healers of the sick, fall short, and ever shorter, in the preservation of the essential dignity of our patients.

I come now to the final aspect of my theme, but perhaps the most serious of all. Let us consider the greatest affront of all in the assaults on the dignity of our patients, the denial of the right of dying with dignity. All too often it happens that because we are so technically skilled at keeping death at bay, we lose our sense of proportion in these matters and are unable to refrain from exercising our skills, whatever the circumstances. Since ageing and dying go hand in hand, and death is the natural sequel to growing old, it is most often the aged who suffer at our hands in this regard.

A very respected and intelligent medical scientist, some 70 years of age, had already suffered coronary occlusion twice. When the third one came along in due course, he was admitted to hospital, and while of very sound mind, expressed himself in this fashion: "I understand my situation quite clearly, and if I should collapse or suffer cardiac arrest, I definitely do not want to be resuscitated", and at his insistence this was recorded in his case notes. In due course he suffered his arrest, and what happened? Technological prowess could not be denied. Its success was only matched by the patient's chagrin when he re-entered the land of the living to find that his clearly expressed wishes had been ignored. He lived a further week or so, then mercifully was permitted to expire.

Some time ago I had occasion to consider a small series of so-called anaesthetic deaths, and in this particular series I was appalled to find that exactly half of these deaths were people in the age group 85–95 who had undergone surgical repair of a leaking aortic aneurysm and who had lived for up to five days after their operation. No doubt some of these procedures were justified. But the 95-year-old was a man subjected to operation because he was in severe pain and his attendants judged that operation was necessary to relieve this (morphia one must presume was unavailable). Accordingly, he was taken to the theatre and over the next four hours his aorta was repaired. Unfortunately, an hour or so later the suture line gave way, so believe it or not the patient was returned to theatre for a second operation. Fortunately, after some three hours of this operation he succeeded in eluding his tormentors and managed to die. Another one in the series was even less fortunate. She was subjected to the initial four-hour operation and survived a further 14 hours, in discomfort that can be imagined, before suffering a cardiac arrest. She was finally allowed to escape after being defibrillated three times.

A year or so ago I was at a dinner party and one of the guests was a brilliant young academic physician. This subject came up, and I remarked how difficult it was becoming to die with dignity without first being treated to a full exhibition of technological virtuosity. This physician could not see my point at all. He felt that medicine being a university education, the student should be taught all that the academics could teach him from a purely academic viewpoint, and that after graduation he could then learn to treat patients if that was to be his calling in life. Just where are we going? I had thought in my naivety that the fundamental object of a medical education was to rear doctors, whose essential attainment was that they would then be qualified to treat sick people, rather than to produce graduates versed only in the application of a purely scientific doctrine. The difference seems to me to be the difference between mere technical training and true education. Let me hasten to assure you that I am in no sense decrying academic medicine, but let us retain a sense of proportion. Medical education comes increasingly into the hands of the academically inclined, and in exact measure that this happens so do patients tend to be regarded as scientific material, rather than as human beings with rights and dignity.

Cicero maintained when writing on the subject of old age:

> "Old age is honored only so long as it maintains its rights, is subservient to no one, and to the last breath rules over its own domain."

Yet when the frail, bewildered and often lonely and unwanted octogenarian cries "Please, doctor, I've had enough, please let me die"—and everyone of you here must have heard this pitiful request—we say airily, "Don't you fret, granddad", and proceed to the sacrifice on the

altar of technical prowess. Is this maintaining his rights or letting him rule over his own domain?

Surely every one of us has the right to beseech, as Job besought God in his extremity,

> "Cease then and let me alone, that I may take comfort a little before I go where I shall not return, even to the land of darkness and the shadow of death."

It is true that God paid scant heed to Job's entreaties, but this is no justification at all for us too to ignore the appeals of our patient and make the arrogant assumption that we always know what is in his best interest. Let us never forget that we are the servants of our patients, however humble they may be, not their masters.

Anaesthesia is more and more a scientific discipline with less in the way of personal contact with the patient than many specialties and we run a correspondingly greater risk of losing sight of the fact that we are dealing with living, breathing, struggling, suffering people. And we as anaesthetists play a major role as prominent members of the resuscitation team. Surely we of all people must have our priorities right.

Let me make myself clear: I am not advocating euthanasia in the sense of actively putting to death one who has outlived his usefulness to society, though over-population and diminishing resources may force this on us in a brave new world. I speak rather of the danger to which our increasing skill has exposed us, the danger of prolonging suffering, of prolonging the act of dying, when the urge to live has gone, and death is round the corner. An eminent British psychiatrist summed it up this way:

> "Death of course, is nothing: it is the prolongation of dying that is to be shunned, not death but the illnesses and injuries that destroy the value of life. We must distinguish between terminal illnesses and death; death is the end of terminal illness. For the dying man death is a boon. If illness is distressing and incurable that boon should not be withheld. But all too often we do withhold it."

But of course it is not ever easy. Each new specialist consulted about a case naturally assumes that since he has been called in he must make his expected contribution, but someone has to be prepared to say at some point, "I think it would be kinder to let him die". Our fathers and grandfathers knew when to say this, but of course, with their limited resources it was easier for them.

Let us at least be sure he whom we are saving will live to thank us, not revile us, for our efforts.

I have touched on various aspects of our daily work where I consider we, the healers of the sick, fall short, and ever shorter, in the preservation of the essential dignity of our patients. Modern technology has given us much, but it has also taken much away. Electronic snooping devices can restrict our privacy: the computer and the dossier ensure that whatever is found out about us is indelibly recorded for future reference. Such things as these reduce the human to the inhuman level of a cipher. Let us at all cost beware of permitting technical advances in our own field to do the same, or in any degree to erode the dignity and individuality of our patients.

Perhaps some of the matters I have mentioned may seem trivial; perhaps we should not let them cloud our minds or distract us even for a moment from the important business of PCo_2's and M.A.C.'s and so on. But if such is your view, you have failed to take my point. These matters may seem of little moment, but they are straws in an inclement wind; to the patient they loom large and surely, surely each and every patient merits this consideration.

Perhaps one way to avoid such pitfalls is ever to keep before us the simple dictum of Joseph Lister:

> "Always put yourself in the patient's place."

Finally, in time-honoured phrase but in the deepest possible sincerity Thank you for doing me the honour of electing me your president.