EDITORIAL

THE ANESTHETIST'S SECOND POWER

THE emergence of anesthesia's second power, as Beecher refers to the use of anesthetic technics in psychiatry, should be accompanied by the emergence of the anesthesiologist's second power—the psychological approach to the handling of patients. This frontier has been forgotten in our overly scientific approach to anesthesia. Many of us have been dealing with machines and not patients. In particular we are to be criticized for our handling of children. The prevalent picture of a crying, struggling, wide-eyed, terrified child seems to be accepted by many as a necessary evil and the anesthesia is chiefly accomplished by brute force.

Such a situation is completely unnecessary and is actually intolerable. Those anesthetists who have children will undoubtedly agree and those without children should take heed. Therefore, it is pertinent to mention a few "old fundamentals" and to make a few cogent suggestions.

Firstly, the second stage of anesthesia is properly designated as a dream state and should be generally pleasant. It is not an excitement stage, and when an excitement does occur it should be considered as an anesthetic complication. During this stage patients have no volitional control but all their special senses are present and may be acutely active. Hearing in particular is active and is the last sense to be obtunded. Since sounds are likely to be distorted, it behooves one to eliminate all extraneous and harsh noises and sounds. This single factor above all others will do most toward achieving a calm second stage.

Secondly, young patients, like old, should receive a preoperative visit from the anesthesiologist. Let the child see you and know you; gain his confidence; tell him what you are going to do the following day and explain your anesthetic procedure in disguised terms using some analogy to things that are familiar to the child. We have been asking each child routinely if he would like to hear a song and usually promise to sing one. Our repertoire consists of two or three children's songs and since the favorite is a folk song (2) called "The Lollypop Shop" the words are herewith presented:

I wish I owned a lollypop shop,
I'd eat and eat and never never stop.
Think of all the kinds there would be,
Think of all the kinds there could be,
  Lemon, green and chocolate cream,
  Peppermint stick you can take your pick.
I wish I owned a lollypop shop,
I'd eat and eat and never never stop!

Thirdly, premedication should be decided upon. We use morphine in amounts similar to those outlined by Leigh (3). This is combined with scopolamine in doses of at least 0.2 mg. Scopolamine definitely seems to quiet the patient and is equally as effective as atropine if not more so in allaying secretions.

Fourthly, on the day of operation the keynote to handling the patient is DIVERSION. 1. Relatives and friends—including well-meaning family physicians—are excluded from the induction room and from the operating floor. 2. Extraneous noises are eliminated as far as possible and talk is taboo during induction. All personnel are instructed to cooperate in this regard. 3. No restraints are used and children are not forced to lie down—on several occasions induction has been carried out with the patient sitting. The only precaution taken is to have a nurse beside the operating table to support the child as relaxation occurs and to limit involuntary movements, should they occur. 4. The child is usually allowed to hold the Yankhauer mask and to smell it. This is always a pleasure because the gauze is impregnated with a few drops of oil of spearmint. 5. We then begin a conversation with each child talking in a low, modulated, comforting and reassuring voice. This "vocal anesthesia" is indeed the oldest sedative we have. This conversation leads up to the promised song. Meanwhile, open drop anesthesia is started using vinethene followed by ether for older children and ether throughout for those under two years in general. The mask is held well away from the patient's face and the further addition of oil of spearmint to the anesthetic helps no end to make the situation pleasant. Of course, the anesthetic is dropped and not poured and the administration is not hurried.

Following this routine most children are asleep in five minutes with a remarkable lack of excitement and absence of struggling which is very gratifying. However, one must not expect immediate success. Do not, for instance, blast the child out of the operating room by singing "Old MacDonald Had a Farm" in stentorian voice as one anesthetist friend recently did and then conclude that singing a child to sleep does not work. Practice and patience are needed and since the whole program is simply a "sales talk" there will be many initial failures. Time will increase the sales and a sense of achievement will be the reward.

REFERENCES

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2. O'Mara, Florence: Personal communication.
3. Leigh, M. Digby, and Belton, M. Kathleen: Premedication in Infants and Children, Anesthesiology 7: 611–616 (Nov.) 1946.

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