GUEST EDITORIAL

What the Obstetrician Expects and Hopes for from the Anaesthetist . . .

Discussions on this topic between obstetricians and anaesthetists generate more heat, more acrimony, and more hysteria than a husband and wife playing bridge together Too often the situation involves two tired men, in the early hours of the morning, one at each end of the table. One resentful because he has made six telephone calls to get the man he may not want, who may have arrived just later than the psychological moment, so spoiling the obstetrician's extravagant promise to his patient of complete pain relief. The other resentful, knowing that he is probably the sixth call, that he may have been called too early, to help someone who may not be too competent, he may have to suffer capricious demands for a particular anaesthetic or commands that his unpremedicated patient, possibly with a full stomach, be alternately put down and let up for no apparent reason, he may have a difficult foetal resuscitation and all this for a patient who, as likely as not on receiving her account, will reply "I don't know you, I didn't ask for you, so I won't pay you!"

I say all this in a mood of sympathy—and it is in this mood that I will examine the problem.

It is a serious thought that maternal deaths from anaesthesia now comprise 3 to 5 per cent of all obstetric deaths, and appear to be increasing It may be thought that this statement applies only to those areas in which a large percentage of anaesthesia is in the hands of the nurse anaesthetist, but this is not so. Dalziel (1) in a recent paper on "An Evaluation of Maternal Death Studies" states that between 1950 and 1955 out of a hundred maternal deaths in the Toronto area, eight were due to anaesthesia

Difficult anaesthesia in the surgical field has made great strides in safety because it is only placed in the hands of highly trained anaesthetists. one has only to mention hypothermia, the extracorporeal circulation, the increasing use of relaxant Yet obstetrics, the Cinderella of anaesthesia, in many centres still gets the leftovers, the untrained anaesthetist, the intern, nurse, medical student, or (probably safer) no one.

Analysis of obstetrical anaesthetic deaths reveals that it is not the agent that kills but the incompetent use of the agent. Incompetence here is not meant in any unkind way—it merely implies lack of training. In any survey attempting to decide what is the best anaesthetic for the obstetrical patient, the conclusion emerges that it is not the anaesthetic that matters, but the anaesthetist.

From this it follows that obstetricians would like—and the two patients involved deserve—not so much first-class anaesthesia as first-class anaesthetists. To put it another way it is the man behind the mask that matters, not the mixture under the mask.

It is my belief that the safest, the most effective, and in the long run the most beneficial way to all concerned to provide obstetrical anaesthesia is with a 24-hour

coverage by the trained anaesthetist. This must always imply a reserve pool of other anaesthetists on call or supervised residents in training.

The anaesthetic service must have a large enough staff to ensure that no anaesthetist works more than every fourth or fifth night and that this tour of duty is rarely followed by an eight to two operating schedule next morning.

Do we, as obstetricians, have the right to demand this? When the situation is analysed, there is no doubt that both sides are happier under these conditions. Equally obvious, though, is the fact that it will only work satisfactorily under certain conditions.

First, either the hospital concerned must be virtually closed or the partnership concerned must operate virtually as a monopoly Both these situations might invite valid criticism

The next condition that must be overcome is the obstetrician's demand for a special anaesthetist rather than the man on duty. This may prove difficult.

Another disadvantage often cited is aptly illustrated in a paper by Hanley (2) entitled "Regional Anaesthesia in Obstetrics" The author—an obstetrician—contracted for obstetrical anaesthesia in a private closed hospital to be covered by a private anaesthesia clinic. This group anaesthetized 96 per cent of 20,000 deliveries, 99 per cent of which were carried out by the spinal or caudal technique.

As always, when this sort of paper is given at an obstetrical meeting, fierce discussion followed, ending in the conclusion that because in present-day obstetrics a high proportion of deliveries could be managed under minimal anaesthesia, this approach was like swatting a fly with a sledge hammer. It also bespoke considerable anaesthetic agility—or possibly over-anaesthetization.

I do not think an obstetrician has the right to demand or expect 24-hour coverage unless the group concerned is virtually closed This is not always applicable, and until it is we will train our residents, and junior interns, in what appears to be statistically the safest method of anaesthesia—that is, pudendal block and self-administered trichlorethylene We must rely on the trained anaesthetist for complicated procedures. This is safer than asking the untrained to undertake anaesthesia.

Do we have the right to expect the anaesthetist to be responsible for maternal and foetal resuscitation?

Unlike Vishnu, the obstetrician has only one pair of hands, and these should be enclosed in sterile gloves and fully occupied with the patient. The most dangerous time during delivery for both mother and baby is just before and just after the delivery of the placenta. At this stage it is dangerous for the obstetrician to leave his patient. It may also be dangerous for the anaesthetist. However, it is always a comfort—and I would say a necessity—to have an anaesthetist, competent to undertake foetal resuscitation, to take care of the first dangerous few minutes of a newborn baby's life.

In the matter of maternal resuscitation the interests of anaesthetist and obstetrician occasionally clash. The anaesthetist may not be keen to transfuse the patient under anaesthesia. On the other hand, an obstetrician feels that as long as he is in the driver's seat as far as blood replacement is concerned, he will not lose his patient from post partum haemorrhage.

It must be remembered that a healthy pregnant woman can compensate very well for blood loss She can withstand a loss of 1,000 cc. of blood without change in vital signs. A lowering of blood pressure, increase in pulse, coldness, and sweating all imply a blood loss of at least 1,500 cc Therefore, I make a plea not to wait for change of blood pressure and pulse before transfusing the patient but rather to rely on the conscientious estimate of the amount of blood lost into the obstetrician's lap. This will allow resuscitation to be carried out while veins are plentiful rather than waiting until the inevitable collapse occurs following removal of the oxygen mask

Lastly, it is my belief that a useful addition to the delivery suite would be a recovery room to take care of the post-partum patient during the so-called fourth stage of labour. So often collapse will sneak up on the patient because the nurse is unwilling to commit the social blunder of disturbing the husband holding hands with his wife.

Who will control the recovery room?—the 24-hour anaesthetist, of course

So I do feel that the obstetrician is entitled to expect the anaesthetist to carry out maternal and foetal resuscitation.

Has the obstetrician the right to dictate the type of anaesthesia? My main theme is that we need trained anaesthetists If properly trained the anaesthetist will know what is best for the patient and baby under the particular set of circumstances.

There are, of course, certain specialized situations in which the obstetrician should have a very definite say. But this usually devolves on the need of relaxation of the uterus for bringing down a leg in a breech presentation, or the desire for regional anaesthesia for prematurity, Caesarean section, or difficult mid-forceps delivery after a prolonged labour It should be realized that although ether and breech extraction are traditionally associated, this type of anaesthesia is not necessary unless the legs are extended, making difficult intra-uterine manipulation mandatory

There is now an increasing desire on the part of the patient for the awake delivery. This may be just a fashion of the time, but I think it should be fostered, if only to reduce foetal narcosis The acme of satisfaction to the patient who desires this is a successful epidural anaesthesia It does not need a brilliant prophet to say that skill in this type of anaesthesia will properly be the hallmark of the successful obstetrical anaesthetist When anaesthetics are discussed with patients, they inevitably say once an epidural, always an epidural Again, the disadvantage of over-anaesthetization must be guarded against

Complementary to this, should the anaesthetist prescribe analgesia during the first stage of labour? After all, with 24-hour coverage he is there. I do not consider that analgesia during the first stage is premedication for operative delivery. The woman in the first stage of labour often needs the presence and moral support of her obstetrician rather than analgesia

There is a trend towards lessened analgesia during labour. This is healthy and should be encouraged so long as it is not at the expense of desired pain relief There is no doubt that rational psycho-prophylaxis has contributed to this trend

and it may be that one of the most important roles of the obstetrician is support in the first stage of labour.

Lastly, every analgesic and anaesthetic drug passes the placental barrier. The umbilical cord presents opportunity for easy simultaneous sampling of foetal venous and arterial blood. Therefore, in an area where very intensive research is going on into the materno-placental-foetal relation we would welcome our colleagues in the department of anaesthesia to add their co-operation.

As you can see, we are no happier than you are about the *dash in–clap on the mask–dash out* type of anaesthesia. We would like to see the difficult art of obstetrical anaesthesia receiving the same consideration as surgical anaesthesia.

What the obstetrician expects and hopes for, then, is a completely trained anaesthetist who will relieve him of the anxiety of thinking of the top end of the patient or of her baby, once it is delivered, who will carry out prompt maternal and foetal resuscitation, and who may look after the patient in a recovery room. In short, we are asking for a friend in need. In the vast majority of cases we get him.

REFERENCES

1 DALZIEL, D An Evaluation of Maternal Death Studies Am J Obst 75 988 (1958).
2 HANLEY, B J Regional Anaesthesia in Obstetrics Am Ass Obstetricians & Gynecologists (Sept, 1958, in press).

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